STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345543	A. BUILDING _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 01/08/24 through 01/11/24. The facility was found in compliance with the requirement CFR 483.73 Emergency Prepardness Event ID DUOJ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 01/08/24 through 01/11/24. Event ID: DUOJ11. The following intakes were investigated: NC00210758, NC00197348, NC00211354, NC00208452, NC00207629, NC00198694, NC00205071, and NC00201536. 7 of 15 complaint allegations resulted in deficiency.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		1/19/24

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

Electronically Signed | 01/31/2024

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews the facility failed to provide a clean homelike environment for 1 of 6 units (Unit 600). The facility failed to repair a missing lower closet door and failed to repair a upper closet door, failed to repair missing and cracked dry wall at the base of the air conditioning unit that daylight could be seen through and had the potential to allow small rodents into the facility (Room #607), failed to clean a privacy curtain that was noted to have a white outline of hand print and a brown stain that was approximately 3 centimeters by 5 centimeters, failed to repair chipped and missing dry wall near the bathroom, failed to clean the brown ring of dirt and grim around the base of the toilet (Room 601), and failed to clean and repair	F 584	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. F584 Safe/Clean/Comfortable/Homelike Environment Corrective action for affected residents. For residents on 600 halls. Corrective	

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F 584	Continued From page 2 the floor at the bathroom room threshold (Room 603), and failed to secure baseboard to the wall (Room 605). The findings included: 1a. An observation of Room #607 was conducted on 01/08/24 at 5:20 PM revealed that there was a lower closet door missing from the wardrobe and one of the upper closet doors was hanging unevenly and would not close unless the door was lifted into place. The wall next to the air conditioning unit was broken and missing and daylight could be seen through the cracks. An observation of Room #607 was conducted on 01/09/24 at 5:05 PM revealed that there was a lower closet door missing from the wardrobe and one of the upper closet doors was hanging unevenly and would not close unless the door was lifted into place. The wall next to the air conditioning unit was broken and missing and daylight could be seen through the cracks. An observation of Room #607 was conducted on 01/10/24 at 11:39 AM revealed that there was a lower closet door missing from the wardrobe and one of the upper closet doors was hanging unevenly and would not close unless the door was lifted into place. The wall next to the air conditioning unit was broken and missing and daylight could be seen through the cracks. The Maintenance Director was observed sitting in the upper cabinet and was working on repairing the upper closet door. An observation of Room #607 was conducted on 01/11/24 at 10:40 AM revealed that there was a lower closet door missing from the wardrobe. The	F 584	action for resident(s) on 600 hall affected by the alleged deficient practice: For Room 601, On 1/ 11/2024, housekeeper replaced privacy curtain and cleaned baseboard around toilet, on 1/15/24, maintenance director repaired drywall near bathroom For Room 603, On 1/15/2024, Housekeeper cleaned floor in bathroom and on 1/15/2024, Administrator reached out Ready Carpet to obtained estimate to repair bathroom floor. Ready Carpet scheduled to come to facility on 1/29/2024 to complete estimate for repairs/ new flooring. For Room 605, On 1/15/2024, maintenance director secured baseboard to wall. For Room 607, On 1/12/2024, maintenance director repaired upper and lower closet doors and on 1/16/2024, maintenance director repaired cracked drywall at base of air conditioner. Corrective Action for Potentially Affected Residents. On 1/17/2024, the Environmental Service Director completed 100% audit of all rooms/hallways in the facility was completed to ensure that all rooms and halls were cleaned according to policy. Any rooms/halls identified as needing cleaning were added to deep cleaning schedule. On 1/17/2024, the Maintenance Director completed 100% audit of all rooms in the facility to ensure that all floorings were in good repair. Results: any rooms/bathroom floors needed cleaning were placed on deep cleaning schedule. Any rooms that	

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F 584	Continued From page 3 wall next to the air conditioning unit was broken and missing and daylight could be seen through the cracks. An interview with Resident #69 who resided in Room #607 stated that the closet door had been missing since he came to that room which had been over a year ago. 1b. An observation of Room #601 was conducted on 01/08/24 at 5:15 pm revealed the privacy curtain between the two beds had a white outline of a handprint along with a brown stain that measured approximately 3 centimeters (cm) by 5 cm, there was chipped and missing dry wall to the right of the sink, and the toilet was noted to have a brown ring around the base of it. An observation of Room #601 was conducted on 01/09/24 at 5:00 PM revealed the privacy curtain between the two beds had a white outline of a handprint along with a brown stain that measured approximately 3 cm by 5 cm, there was chipped and missing dry wall to the right of the sink, and the toilet was noted to have a brown ring around the base of it. An observation of Room #601 was conducted on 01/10/24 at 11:37 AM revealed the privacy curtain between the two beds had a white outline of a handprint along with a brown stain that measured approximately 3 cm by 5 cm, there was chipped and missing dry wall to the right of the sink, and the toilet was noted to have a brown ring around the base of it. An observation of Room #601 was conducted on 01/11/24 at 10:32 AM revealed the privacy curtain between the two beds had a white outline of a	F 584	identified flooring in need of repair and /or replacements were placed on repair/replacement list. Administrator obtained estimates for repairs. Systemic Changes Education was started on 1/12/2024 of all full-time, part-time, as needed staff and agency on the process for reporting items that need repaired in the facility by going to www.TELS.com and initiating a work order. Staff was also educated that it is the responsibility of all staff members to report identified issues that require repair in the facility. The Maintenance Director and the Environmental Service Supervisor were educated when staff approach them in person to make them aware of needed repairs they are to refer them to initiate a work order at www.TELS.com. All housekeepers and maintenance staff will be re-educated by the Environmental Service Director and Maintenance Supervisor beginning on 1/15/2024 on cleaning rooms according to policy on regular intervals to include dust mop and damp mop resident room floors, empty trash receptacles, replenish toilet tissue, paper towels, soap, hand sanitizer, and odor control. Clean furnishings used by residents and visitors. Clean spot on walls. Complete cleaning of bathrooms. Complete cleaning of overbed lights, high areas, window blinds and window sills on regular intervals. Removing and cleaning privacy curtains on regular intervals or as needed. Sanitize beds on deep cleaning schedules. Facility maintenance staff re-educated regarding completing facility maintenance repairs timely and rounding	

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F 584	Continued From page 4 handprint along with a brown stain that measured approximately 3 cm by 5 cm, there was chipped and missing dry wall to the right of the sink, and the toilet was noted to have a brown ring around the base of it. Housekeeper #1 was interviewed on 01/11/24 at 2:38 PM. Housekeeper #1 confirmed that she was responsible for cleaning the 600 unit including Room #601. She stated that she started by spraying the bathroom with disinfectant and while that sits on the surfaces, she would sweep the floors in the room and bathroom. Then she would wipe down all the surfaces in the room including frequently touched surfaces like light switches and door handles and then she would mop the floor before moving to the next room. She stated that she checked the privacy curtains in the rooms and if they were dirty or needed to be replaced, she would let the Maintenance Director know and he would change them. Housekeeper #1 stated that she had not noticed the dirty privacy curtain in Room #601 when she cleaned yesterday but stated she would have it changed today when she cleaned that room. 1c. An observation of Room #603 was conducted on 01/08/24 at 5:30 PM revealed the floor outside the threshold of the bathroom was bubbled and cracked and was dirty with brown dirt and grim. An observation of Room #603 was conducted on 01/09/24 at 5:02 PM revealed the floor outside the threshold of the bathroom was bubbled and cracked and was dirty with brown dirt and grim. An observation of Room #603 was conducted on 01/10/24 at 11:41 AM revealed the floor out side the threshold of the bathroom was bubbled	F 584	to identify areas in need of repair. 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 process to verify that the change has been sustained. The facility specific in-service will be provided to all maintenance, laundry and housekeeping staff. Any of the above identified staff who does not receive scheduled in-service training by 1/18/2024 will not be allowed to work until training has been completed. Quality Assurance Beginning the week of 1/22/2024, the Administrator or designee will monitor compliance utilizing the Quality Assurance Tool Clean/ Safe Homelike Environment weekly x 4 weeks then monthly x 2 months. The tool will monitor a sample of rooms and bathrooms for cleanliness and stains on walls and baseboards, assuring all baseboards are secured to the wall, assuring there are no chips or cracks in drywall or cracks around PTAC units, bathroom thresholds have no cracked or bubbled floor tiles, and closet doors are hung correctly and in good repair. Administrator will review the TELS report weekly times 4 weeks, then one-time month times 2 months. Reports will be presented to the weekly Quality Assurance (QA) 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,	

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F 584	Continued From page 5 and cracked and was dirty with brown dirt and grim. An observation of Room #603 was conducted on 01/11/24 at 10:33 AM revealed the floor outside the threshold of the bathroom was bubbled and cracked and was dirty with brown dirt and grim. 1d. An observation of Room #605 was conducted on 01/08/24 at 5:25 PM revealed the baseboard behind the bed closest to the door was held in place with white paper tape and was loose in places. An observation of Room #605 was conducted on 01/09/24 at 5:04 PM revealed the baseboard behind the bed closest to the door was held in place with white paper tape and was loose in places. An observation of Room #605 was conducted on 01/10/24 at 11:43 AM revealed the baseboard behind the bed closest to the door was held in place with white paper tape and was loose in places. An observation of Room #605 was conducted on 01/11/24 at 10:34 AM revealed the baseboard behind the bed closest to the door was held in place with white paper tape and was loose in places. The Maintenance Director was interviewed on 01/11/24 at 1:28 PM. The Maintenance Director observed Room's #601, 603, 605, and 607 and stated that he had been working at the facility for a year and had been working diligently to get all the repairs done that needed to be done. He stated that when he came to work at the facility,	F 584	indefinitely or until no longer deemed necessary for compliance with the housekeeping and personal laundry issues. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Rehab Manager, Health Information Manager, Environmental Services Manager, and the Dietary Manager Date of Compliance: 1/19/2024	

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F 584	Continued From page 6	F 584		

he discovered a lot of projects that had been started but not finished like they would patch the dry wall but not sand or paint it. He further explained that another staff member had told him about the upper closet in Room #607 on 01/10/24 but he could not recall which staff alerted him to the issue. He stated that he was able to repair the upper closet door, but the lower closet door was not attached and would either need to be repaired or replaced and he would work on that. He stated he was not aware until he went into fix the upper closet that the lower closet needed repaired as well. The Maintenance Director added that when staff see something that needed to be repaired, they need to fill out the repair slip in the electronic system and then he would repair the needed item. He added that the long-term plan in the facility was to upgrade some of the things identified but he was not sure the time frame of that plan.

The Housekeeping Director was interviewed on 01/11/24 at 1:41 PM and again at 2:33 PM. He explained that the housekeepers on the hall should be checking the privacy curtains daily and if they were soiled or needed to be changed, they would let him, or the Maintenance Director know, and they would take care of it. The Housekeeping Director added that the housekeepers cleaned all resident rooms daily and had a scraper that they could use to get the dirt and grim off the floor if needed. He added t that they had done a lot of work on the resident rooms on some of the other units but not much on the rooms on the 600 unit and he had heard that the facility was going to undergo a remodel this year but could not say for sure when it would start.

The Administrator was interviewed on 01/11/24 at

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F 584	Continued From page 7 4:43 PM who stated that the company had planned to replace the floors on the back half of the facility including unit 600 this year sometime but it was going to be quite expensive. She added that there was things that they could do on the 600 unit in the meantime to make the rooms better in appearance.	F 584		
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 Minimum Data Set assessments when they failed to document a gradual dose reduction for an antipsychotic medication and documented the use of an ostomy for a resident without an ostomy, for 4 of 23 residents reviewed. (Resident's #35 and Resident #50) The findings included: Resident #35 admitted to the facility on 01/18/23 with diagnoses that included unspecified mood disorder. A review of Resident #35's annual Minimum Data Set assessment dated 12/07/23 revealed she was cognitively intact with no psychosis, behaviors, or rejection of care. Resident #35 was coded as receiving antipsychotics on a routine basis, a gradual dose reduction (GDR) had not been attempted and a GDR was not clinically contraindicated.	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 date or dates indicated. F641 Accuracy of Assessments For resident #50 a corrective action was obtained on 01/10/2024 by modifying and correcting MDS assessment for assessment reference date of 12/28/2023. Coding of question H0100C (Ostomy) was corrected to accurately reflect that resident did not have an ostomy present during the specified lookback timeframe. Correction was	1/19/24

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F 641	Continued From page 8 Review of Resident #35's electronic physician orders revealed the following order: Abilify Oral Tablet 2 milligrams - Give 1 tablet by mouth, once daily for psychotic mood disorder. During an interview with the Pharmacist on 01/10/24, she revealed she was familiar with Resident #35 and was aware she was taking an antipsychotic. The Pharmacist reported Resident #35 had a gradual dose reduction in March of 2023 when the dose of her Abilify went from 4milligrams, down to 2 milligrams. A review of Resident #35's quarterly Minimum Data Set assessment dated 05/06/23 which would have been the first Minimum Data Set assessment completed after the GDR revealed Resident #35 was coded as receiving an antipsychotic on a routine basis, a GDR had not been attempted, nor was a GDR clinically contraindicated. During an interview with MDS Nurse #1, she verified she was the MDS nurse that completed the 05/06/23 quarterly assessment for Resident #35 and reported she just missed the GDR attempt that happened in March, 2023. She reported she would immediately modify the assessment to accurately reflect the GDR. During an interview with the Director of Nursing on 01/11/24 at 3:55 PM, she reported she expected Minimum Data Set assessments to be completed accurately and thoroughly and that MDS nurses should monitor new orders to catch and antipsychotic medication changes. 4. Resident #50 was admitted to the facility on	F 641	completed by MDS Coordinator 01/10/2024, re-submitted and accepted into state database on 01/11/2024 with submission identification 31327346. For resident #35 a corrective action was obtained on 01/11/2024 by the MDS Coordinator by modifying and correcting the MDS assessment with assessment reference date of 05/06/20. The assessment was modified and coding for question N0450B was corrected in order to accurately reflect that resident did have a gradual dose reduction completed 03/29/2023. Correction was completed by MDS Coordinator on 01/11/2024, re-submitted and accepted into state database on 01/12/2024 with submission identification 31334063. 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 three months (10/17/2023 thru 01/17/2024) was completed in order to identify all residents who were coded as having an ostomy in question H0100C. This audit was conducted by the Regional MDS Consultant. The residents identified as having been coded with an ostomy were further reviewed to determine if coding is accurate. Audit Results: 2 of 2 residents identified using the Resident Response Analyzer Report as being coded yes for presence of ostomy	

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F 641	Continued From page 9 10/07/19 and most recently readmitted to the facility on 03/31/23. Resident #50's diagnoses included chronic respiratory failure, diabetes, congestive heart failure and others. Review of the quarterly Minimum Data Set (MDS) dated 12/28/23 revealed that Resident #50 was cognitively intact and had an ostomy. The MDS further revealed that Resident #50 was coded as always incontinent of bowel. The MDS was completed by MDS Nurse #1. An observation and interview were conducted with Resident #50 on 01/08/24 at 10:57 AM. Resident #50 was resting in bed with his eyes open. Resident #50 stated that he wore briefs for his incontinent episodes of bowel. Resident #50 stated he did not have an ostomy of any kind. Review of a health status note dated 01/09/24 at 2:18 PM revealed that Resident #50 was incontinent of bowel. MDS Nurse #1 was interviewed on 01/10/24 who stated that Resident #50 did not have an ostomy and that was coding mistake on her part. MDS Nurse #1 stated that she would correct the mistake immediately. The Administrator was interviewed on 01/11/24 at 4:39 PM. The Administrator stated that she expected all MDSs to be coded as accurately as possible.	F 641	for question H0100C (ostomy) between 10/17/2023 thru 01/17/2024, were accurately coded. An audit was completed for all current residents who had an active order for antipsychotic medication with MDS assessments using Order Listing Report, physician and/or psychiatric visits that were completed during the past three months (10/17/2023 thru 01/17/2024) for GDR (Gradual Dose Reduction) coded in section N0450B. Audit Results: 16 of 16 residents identified as receiving Antipsychotic medications between 10/17/2023 thru 01/17/2024 were noted with accurate coding of question N0450B for GDR (Gradual Dose Reduction). Systemic Changes On 01/16/2024, the Administrator provided an in-service training for the facility Minimum Data Set Coordinators that included the importance of thoroughly reviewing the medical record during the assessment process and before coding the MDS assessment. Special emphasis was highlighted on: " Section H0100C: Coding of the presence of an ostomy (including: colostomy, urostomy, and ileostomy). The education emphasized the importance of examining the resident in order to determine the presence of an ostomy. It also detailed the importance of thorough review of the medical record including progress notes, nurse aide documentation, nursing notes, orders, etc. in order to determine the presence of an	

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F 641	Continued From page 10	F 641		

ostomy. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

" Question N0450: In order to accurately code whether or not a GDR (Gradual Dose Reduction) has been completed of antipsychotic medication or is contraindicated, the MDS nurse must conduct a thorough review of the medical record. Review of the physician progress notes, pharmacist review notes, order listing report and nursing notes for information that would indicate if the physician had documented gradual dose reduction. Physician documentation indicating dose reduction attempts are clinically contraindicated must include the clinical rationale for why an attempted dose reduction is inadvisable. This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident□s function, well-being, safety, and quality of life. The Director of Nursing will ensure that any of the above identified staff who has not received this training by 1/18/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the

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F 641	Continued From page 11	F 641	regulatory requirements. Beginning the week of 1/22/2024, the Director of Nursing or designee will begin auditing the coding of MDS items: H0100C (ostomies) and N450 (Physician Documented Clinical Contraindication for Gradual Dose Reduction) using the quality assurance audit tool entitled Accurate Minimum Data Set Coding Audit Tool-H0100C and N0450B. This audit 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, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: ¿¿¿1/19/2024	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		

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F 689	Continued From page 12 accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Medical Director interviews the facility failed to provide care in a safe manner to prevent a resident from rolling out of bed during incontinent care for 1 of 6 residents reviewed for accidents (Resident #344) . During incontinence care Resident #344 was rolled onto her side by staff and then rolled out of the bed onto the floor. She was admitted to the hospital for five days due to worsening atrial fibrillation with rapid ventricular response (very fast heartbeat) caused by significant sympathetic response (the body's response to stress) from pain from the fall. The findings included: Resident #344 was admitted to the facility on 05/10/17 and expired in the facility on 08/24/23. Resident #344's diagnoses included: atrial fibrillation, age related osteoporosis, and dementia. Review of the quarterly Minimum Data Set (MDS) dated 01/04/23 revealed that Resident #344 was moderately cognitively impaired and required extensive assistance of one staff member for bed mobility and total assistance of two staff members for toileting. Review of a care plan that was updated on 01/12/23 read in part, Resident #344 has an activities of daily living self-care performance deficit related to dementia. The goals read; "I will maintain current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene" and "I will receive staff	F 689	Past noncompliance: no plan of correction required.	

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assistance with all aspects of my daily care to ensure that all of my needs are met." The interventions included staff assistance to reposition and turn in bed, staff assistance to use the toilet, and staff assistance with grooming and personal hygiene.

NA #1 was interviewed via phone on 01/10/24 at 5:22 PM. NA #1 stated that she worked at the facility through an agency and recalled the fall that occurred in January 2023 with Resident #344. NA #1 stated that she had cared for Resident #344 prior to the fall on 01/15/23 and provided care to her by herself with no issues. She stated it was later in the evening and dark outside, but she could not recall the exact time, but she was providing incontinent care to Resident #344. She stated that she turned Resident #344 onto her right side toward the window in the room and away from her (NA #1) "and I don't know what happened, but she fell and "I tried to catch her" but couldn't. NA #1 stated that there was no rail on the bed, and Resident #344 was positioned in the middle of the bed then rolled onto her right side then rolled out of the bed to the floor and there was no fall mat, so she hit the tile floor. NA #1 stated that the bed height was above her waist, and she was approximately 5 foot 3 inches tall. She confirmed that Resident #344 was total assistance with activities of daily living and that she was providing incontinent care to her alone without assistance from other staff. NA #1 stated that she immediately alerted the nurse working the hall that night, but she could not recall who that was but believed it was Nurse #1. She added that Resident #344 had a dark purple bruise on her face and was complaining of pain, but she could not recall where her pain was at. NA #1 stated that Nurse #1 came to the room

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and assessed her, but they did not move Resident #344 from the floor. She stated that she stayed with Resident #344 until EMS arrived and when they loaded Resident #344 to the stretcher she vomited. NA #1 recalled that Resident #344 did not return to the facility on her shift but stated she did return several days later.

Review of a facility incident report dated 01/15/23 at 8:15 PM read; nurse was informed that the resident fell out of bed during a brief change. Upon the nurse entering the room, the nurse noted that resident was on the ground between the bed and the air conditioning unit. The resident's head was under the bed at the head of bed with her body lying on her right side with her legs spread out (in a V) towards the foot of the bed. The report was completed by Nurse #1.

Review of a nurses note dated 01/15/23 at 10:30 PM read in part, nurse was informed that resident fell out of bed during a brief change. Upon the nurse entering the resident room, the nurse noted that the resident was on the ground between the bed and the air conditioning unit. The resident's head was under the bed at the head of the bed with her body lying on her right side with legs spread out (in a V) towards the foot of the bed. Resident stated that she was in pain. Stated that her head, right arm, and bilateral knees were hurting her. Nurse did a head-to-toe assessment and obtained a set of vital signs. Blood Pressure 132/70, Pulse 66, Temperature 98 oxygen saturation level 95% and blood sugar 185. Called on call provider and got an order to send to the Emergency Room (ER). Family notified of the fall and that she was being sent out via Emergency Medical Services (EMS) to be evaluated at the hospital. Once EMS arrived nurse noted that

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resident started to vomit. The note was electronically signed by Nurse #1.

Nurse #1 was interviewed via phone on 01/11/24 at 12:23 PM. Nurse #1 stated that she no longer worked at the facility but had worked there for approximately seven months and recalled Resident #344's fall that occurred in January 2023. Nurse #1 stated that she had just finished her medication pass that evening and was at the nursing station charting and Nurse Aide (NA) #1 called her to come to Resident #344's room. When Nurse #1 entered Resident #344's room she asked NA #1 what had happened and was told that she had rolled out of bed. Nurse #1 stated that Resident #344 was on the floor between the bed and the air conditioning unit. She explained that at baseline Resident #344 was bed bound and "could not hold onto or move anything" and added that she could move her hands but had no lower body control and "she had no way to protect herself from the fall." When Nurse #1 entered Resident #344's room the bed was a "couple of feet" off the floor, it was not in the highest position but was not in the lowest position and could not recall if the bed had grab rails on it or not but stated "95% of the beds in the facility had them." Nurse #1 stated that she did a head-to-toe assessment of Resident #344 while she was on the floor and was able to do range of motion to her arms, legs, and hand grasp. Nurse #1 stated "knowing how she fell I was concerned about the back of her head that was under the bed resting on the bottom of the bed wheel locks." Nurse #1 explained that she did not want to move Resident #344, so she felt the back of her head and noted a bump or indentation, and she was "concerned about that." Nurse #1 stated that after she completed the head-to-toe

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assessment, she called the on-call provider and got an order to send Resident #344 out to the ER. She called EMS and they came quickly and transferred Resident #344 from the floor to the stretcher and when they started moving Resident #344 around, she began to vomit. She added that she did not see any obvious injuries, no bleeding or bruising just the bump or indentation to the back of her head and stated that Resident #344 did not return on her shift and stayed a few nights in the hospital.

The Discharge Summary from the local hospital dated 01/20/23 read in part; "patient had significant fall resulting in age indeterminate T11 (vertebrae in back) fracture with 25% height loss likely causing worsening of her Atrial Fibrillation with rapid ventricular response due to significant sympathetic response from pain." "She was better rate controlled with intravenous (IV) Metoprolol (beta blocker used to lower blood pressure) 5 milligrams (mg) times 2 and was given p.o (by mouth) 12.5 mg with heart rates remaining slightly above 110. She was transitioned to Metoprolol 25 mg every 6h hours and unfortunately, she then had heart rates in the 50's. Her Metoprolol was then transitioned to 37.5 mg which still caused her to have rates in the 40's so her beta blockers was discontinued. Her Diltiazem (calcium channel blocker used to lower blood pressure) was increased to 300 mg and her heart rate remained in the 70-100's after cessation of the beta blockage."

Medication Aide (MA) #1 was interviewed on 01/10/24 at 3:25 PM. She stated that she had worked at the facility for 2 years and was familiar with Resident #344. She stated that Resident #344 was bed bound, total care but could feed

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herself with setup. MA #1 stated that Resident #344 was incontinent of bowel and bladder and required two-person assistance with bed mobility and incontinent care. She explained that she was working the medication cart that night passing medications and NA #1 came out of Resident #344's room and stated that she had fallen during a brief change. MA #1 stated that they alerted Nurse #1 of the fall, and she immediately went to Resident #344's room and assessed her. MA #1 stated that when they entered the room Nurse #1 had asked NA #1 what had happened, and NA #1 explained that when she rolled Resident #344 towards the window and away from her (NA #1) and she rolled out of the bed to the floor. She stated that when she entered Resident #344's room she was lying on the floor between the bed and the air conditioning unit and had no visible injuries that she could see. MA #1 stated that EMS arrived very quickly after Nurse #1 called and they transported Resident #344 to the hospital, and she did not return on her shift.

An attempt to speak to the former Director of Nursing (DON) on 01/11/24 at 9:19 AM was unsuccessful.

The Administrator was interviewed on 01/11/24 at 11:48 AM who stated that Resident #344 was a bed bound patient who required one person assistance with her activities of daily living. She recalled that on 01/15/23 during incontinent care NA #1 had turned Resident #344 toward the window in her room and had grabbed the draw sheet to pull Resident #344 back to the middle of the bed and before she could do that Resident #344 rolled out of bed to the floor. The Administrator stated that they asked Resident #344 what happed, and she replied, "it happened

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so quickly." She stated that they (she and the former DON) had thoroughly investigated the fall and because of the fall they made Resident #344 a two person assist for activities of daily living. She added that Resident #344 did go to the hospital because she was complaining of pain and returned, and the Administrator stated she thought she had a fracture of T11.

The Medical Director (MD) was interviewed on 01/11/24 at 2:17 PM. The MD explained that she was not the MD at the time of Resident #344's fall but that she did care for her prior to her passing. After reading the hospital records for Resident #344 she stated that Resident #344 had an age indeterminate fracture of T11 which probably did not come from the fall and compression fractures of T2, T3, and T4 which certainly did not come from the fall. The MD explained that Resident #344 had osteopenia which is weak bones but once she had a fracture the osteopenia becomes osteoporosis which caused her compression fractures of T2-T4. The report was not clear if the fracture of T11 came from the fall or consequences of her osteoporosis. The MD explained that the majority of Resident #344's hospital stay was regulating her heart rate. She further explained that when you are in pain your heart rate goes up and will put people into Atrial Fibrillation (heart arrythmia) or switch the patient to rapid ventricular response which is when your heart beats so fast that you wear it out. The treatment for both of those conditions is to control the heart rate. The hospital doctors started with IV metoprolol and then made adjustment from there to get her heart rate controlled and at that point she was stable enough to return to the facility.

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F 689	Continued From page 19 The facility provided the following corrective action with a compliance date of 1/25/23. " Corrective action taken for resident involved: On 01/15/23 at approximately 8:20 PM NA was attempting to assist Resident #344 with perineal care and resident attempted to turn over on side and rolled to the floor. Resident #344 was assessed by the nurse. MD notified and order was given to send Resident #344 to the hospital for evaluation and treatment. " Corrective action for potentially impacted residents: On 01/17/23 the Director of Nursing and Assistant Director of Nursing identified residents that were potentially impacted by this practice by completing fall review audits for all current residents to determine if any falls occurred with patient care during bed mobility or while performing incontinent care. This was completed on 01/18/23. The results included: No other residents identified with falls during patient care. " Systemic changes: On 01/16/23, the Administrator in-serviced all full time, part time, and as needed clinical staff (including agency) on falls, bed mobility/positioning, Kardex process, and ADL care for dependent residents. This training will include all current staff including agency and has been added to the new hire orientation. As of 01/20/23 10% of staff members have not attended the in-service. The Director of Nursing will ensure that any of the above-mentioned staff who does not complete the in-service training by 01/23/23 will not be allowed to work until the training is completed. " Quality Assurance: Beginning the week of 01/23/23 the Director of Nursing will monitor fall/injury using the quality assurance tool for falls with injury to ensure staff are complying related to	F 689		

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F 689	Continued From page 20 falls while providing incontinent care. This will be completed weekly for 2 weeks and monthly for 3 months or until resolved. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and ongoing auditing program reviewed by the weekly QA meeting. The weekly QA meeting is attended by the Administrator, DON, MDS coordinator, Therapy Director, Heath Information management director, and Dietary Manager " Date of compliance 01/25/23. The plan of correction was validated on 01/11/24 which included reviewing the initial audits of falls that identified residents that may have potentially been affected. The education used for training was reviewed and included incident/fall education and reporting, ADL care provided for dependent residents, bed mobility/positioning, and Kardex process. Staff signatures sheets reviewed indicating that all staff had been educated in the above-mentioned subjects. Audits of 5 residents were observed during care to ensure two-person assistance were completed on 01/27/23, 02/03/23, 02/10/23, 03/03/23, and 04/05/23 and were taken to QA on 02/07/23, 02/14/23, 03/08/23, and 04/05/23. Interviews with current staff members revealed that they recalled having education on falls, bed mobility/positioning, Kardex, and providing ADL care to dependent residents. They verbalized that the facility adapted the policy that all dependent residents would require 2-person assistance with ADLs. Observation of ADL care throughout the survey revealed the correct number of staff were present for care according to the resident's plan of care and facility policy. The facility's compliance date	F 689		

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F 689	Continued From page 21 of 01/25/23 was validated.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		1/19/24

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F 690	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to secure a urinary catheter tubing to prevent tension or trauma and failed to prevent the catheter bag and tubing from touching the floor to reduce the risk of infection for 1 of 2 residents reviewed for urinary catheters (Resident #66). The finding included: Resident #66 was admitted to the facility on 05/10/23 with diagnoses that included stage IV sacral pressure ulcer. A review of Resident #66's physician order dated 07/07/23 for a #14 French urinary catheter with 5 cc (cubic centimeters) of water due to stage IV pressure ulcer. Ensure leg band in place. A review of Resident #66's care plan dated 12/22/23 revealed the Resident had a urinary catheter related to stage IV pressure ulcer to sacrum. The goal that the Resident would remain free from catheter related trauma would be attained by utilizing interventions such as checking for kinks in the catheter tubing, applying a leg stabilization device to prevent pulling or trauma and positioning the catheter bag below the level of the bladder. The quarterly Minimum Data Set (MDS) assessment dated 12/24/23 revealed Resident #66's cognition was severely impaired and was dependent on staff for activities of daily living. The MDS indicated the Resident had an indwelling urinary catheter and four (4) stage IV pressure ulcers.	F 690	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. F690 Bowel/Bladder Incontinence, Catheter, UTI Corrective action for resident(s) affected by the alleged deficient practice: On 1/9/2024, Resident #66, catheter was secured with leg band and catheter adjusted to ensure not touching the floor the Director of Nursing. Corrective Action for Potentially Affected Residents. All residents in the facility who have an indwelling Foley catheter have the potential to be affected. Beginning 1/15/2024, the Unit Support Nurses completed visual audits for all current residents with Foley Catheters to ensure leg band in place and secured and catheter bag and tubing not touching floor. No other issues with Foley catheters being secured and touching the floor were identified. This was completed on 1/15/2024. Measures/Systemic changes to prevent	

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F 690	Continued From page 23 On 01/08/24 at 2:41 PM an observation was made of Resident #66 lying in bed on her back sleeping. There was a stabilizing device attached to the upper catheter tubing, but the device was not anchored to the Resident's thigh to prevent pulling or trauma. The catheter drainage bag and tubing were touching the floor. An observation made on 01/08/24 at 4:08 PM revealed the catheter bag and tubing touching the floor. An observation on 01/09/24 at 9:05 AM was made of Resident #66 lying in bed sleeping. The stabilizing device was not attached to the Resident's thigh and was folded in half with the taped sides stuck to each other. The Resident's urinary catheter bag was touching the floor. During an observation made on 01/09/24 at 12:55 PM the urinary catheter bag remained on the floor. An interview was held on 01/09/24 at 2:45 PM with Nurse Aide (NA) #2 who was responsible for Resident #66 on 01/09/24 explained that Resident #66 was total care and had an indwelling urinary catheter. The NA continued to explain that the Resident had multiple pressure ulcers and she had to turn and reposition her about every two hours and provide incontinent care if needed. The NA indicated she made sure Resident #66's stabilizing tape was in place taped to her thigh to prevent pulling and the catheter bag was not on the floor. On 01/09/24 at 3:25 PM Nurse Aide #2 accompanied to room observe Resident #66 who	F 690	reoccurrence of alleged deficient practice: Beginning 1/12/2024, the Director of Nursing began an in-service education to all full time, part time, and PRN (as needed) registered nurses, licensed practical nurses, medication aides and certified nursing assistants. Topics included: Catheter Care: Indwelling Catheters The Director of Nursing will ensure that any of the above identified staff who has not received this training by 1/18/2024 will not be allowed to work until the training is completed. 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 process to verify that the change has been sustained. Quality Assurance- Beginning the week of 1/22/2024, The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Monitoring Foley Catheters to ensure catheters are secure and not touching the floor. The monitoring will include reviewing a sample of residents with new orders for antibiotic to ensure timely administration. This will be completed weekly for 4 weeks then monthly x 2 months or until resolved to ensure medications are administered without delay. Reports will be given to the Monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing,	

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F 690	Continued From page 24 was lying in bed sleeping. At the time, the Resident's catheter bag and tubing were touching the floor. The NA remarked the bag and tubing should not be touching the floor because it could cause infection. The NA also looked at the stabilizing device and noted the device was not attached to the Resident's thigh. The NA remarked that she knew it was not attached earlier that morning and reported it to Nurse Manager #1 because she could not get the supplies to replace it. During an interview with Nurse Manager #1 on 01/10/24 at 9:07 AM the Nurse confirmed that she was responsible for Resident #66 on 01/09/24 and did not notice the Resident's catheter bag touching the floor. The Nurse explained that the bag should never touch the floor due to possible infection and there should be a stabilizing device in place to prevent pulling or trauma. The Nurse continued to explain that Resident #66 was known to pull the taped stabilizing device from her thigh and added that they should be more vigilant to that in the future. The Nurse Manager denied being told by NA #2 that the stabilizing device on Resident #66 needed to be replaced. Nurse Aide #3 who was assigned to Resident #66 was not able to be interviewed during the survey. On 01/09/24 at 3:40 PM an interview was held with the Director of Nursing (DON) and an observation was made of Resident #66. The DON observed the Resident's stabilizing device was not attached to her thigh and the catheter bag and tubing was touching the floor. Informed the DON of the multiple observations made of the Resident's urinary catheter during the survey and	F 690	Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker, and Maintenance Director. Date of compliance: 1/19/2024	

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F 690	Continued From page 25 the DON explained that the stabilizing device should have been replaced when it was noted to be detached and the catheter bag and tubing should never touch the floor. The DON corrected the concerns. An interview conducted with the Administrator on 01/11/24 at 4:42 PM revealed her expectation was for the residents with urinary catheters to have stabilizing devices in place and the catheter bag and tubing should not be touching the floor.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and resident interviews the facility failed to administer supplemental oxygen as prescribed by the physician for 2 of 3 residents reviewed for respiratory care (Resident #4 and #10) and failed to ensure oxygen concentrator filters were clean for 2 of 3 residents (Resident #10 and Resident #69) reviewed for respiratory care. The findings included: 1. Resident #4 was admitted to the facility on 10/17/19 with diagnoses that included chronic	F 695	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. F695 Respiratory/Tracheostomy Care and	1/19/24

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F 695	Continued From page 26 obstructive pulmonary disease. A review of Resident #4's quarterly Minimum Data Set assessment dated 10/02/23 revealed the Resident was cognitively intact and received supplemental oxygen. A review of Resident #4's physician orders revealed an order dated 01/04/24 for supplemental oxygen continuously at 2 liters per minute per nasal cannula. A review of Resident #4's care plan dated 01/04/24 revealed the Resident wore supplemental oxygen and the goal to have no signs or symptoms of poor oxygenation would be attained by interventions such as ensuring oxygen setting as prescribed by the physician. On 01/08/24 at 11:57 AM an interview and observation were made of Resident #4 who was sitting in her recliner positioned adjacent to the head of the bed and the oxygen concentrator was positioned at the foot of her bed near the wall. The Resident was receiving oxygen via nasal cannula at a flow rate of 3 liters on the oxygen concentrator. Resident #4 advised that she recently returned from the hospital for respiratory problems and had to wear the oxygen all the time. She indicated she did not know what the flow rate of the oxygen should be set on. On 01/09/24 at 8:48 AM Resident #4 was in bed with her breakfast tray in front of her on the over bed table. The Resident wore the oxygen cannula, but the oxygen concentrator was not on. The oxygen setting was on 0. The Resident displayed no visual signs or symptoms of respiratory distress.	F 695	Suctioning Corrective action for resident(s) affected by the alleged deficient practice: On 1/10/2024, For resident #4, Nurse 2 confirmed oxygen administration order and adjusted O2 setting to 2L/min as ordered. On 1/10/2024, For resident #10, Nurse 2 confirmed oxygen administration order and adjusted O2 setting to 4L/min as ordered and removed filter from concentrator and cleaned and replaced. On 1/10/2024 For resident #69 the Environmental Service Supervisor removed oxygen concentrator from resident□s room. The oxygen concentrator□s filter and the entire concentrator was cleaned and all white dust was removed. When cleaning was completed the concentrator was taken back into resident #69□s room. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning 1/15/2024, the Director of Nursing and Unit Manager began audited all current residents receiving oxygen. Oxygen flow rate was observed for compliance and orders for oxygen confirmed with the physician to assure there were no conflicting oxygen orders in place. Additionally, Director of Nursing and Unit Manager audited all oxygen concentrator□s filters in facility for cleanliness. Any concentrator filter needed cleaning was removed and cleaned. This was completed on	

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F 695	Continued From page 27 During an observation of Resident #4 on 01/09/24 at 12:56 PM the Resident was in bed with the oxygen infusing at 3 liters per minute via nasal cannula. An observation was made of Resident #4 on 01/10/24 at 9:50 AM. The Resident was sitting in her wheelchair at her bedside with the oxygen concentrator behind the wheelchair near the wall. The Resident wore the oxygen cannula, and the oxygen setting was on 3 liters per minute. On 01/10/24 at 11:53 AM during an interview with Nurse #2 the Nurse confirmed she was responsible for Resident #4 on 01/08/24. The Nurse acknowledged by reviewing the Resident's Treatment Administration Record (a record used to record the administration of oxygen prescribed to the Resident) that Resident #4's oxygen setting should be set at 2 liters per minute. Accompanied Nurse #2 to Resident #4's room where the Nurse observed the oxygen setting which was at 3 liters per minute and the Nurse adjusted the oxygen rate to the prescribed setting. Nurse #2 offered no comment on the discrepancy in the flow rate. An interview was made with Nurse Manager #1 on 01/10/24 at 12:00 PM who confirmed she was responsible for Resident #4 on 01/09/24 and 01/10/24. The Nurse explained that Resident #4 had recently returned from the hospital (01/04/24) and her oxygen setting was prescribed at 3 liters per minute. The Nurse observed the oxygen order at 2 liters per minute and the Nurse was informed that the Resident's oxygen setting had been on 3 liters since 01/08/24. The Nurse stated she thought it was supposed to be at 3 liters since her return from the hospital.	F 695	1/16/2024. 100% compliance in place. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/12/2024 all nursing and housekeeping staff full-time, part-time, as needed and agency staff were educated on the brand of concentrator, location of filters placement for each brand as well as the need to clean the concentrator□s exterior daily by housekeeping. Filter cleaning weekly by nursing and internal filters audited quarterly by respiratory company for any needed filter changes. Beginning 1/12/2024, the Director of Nurse/Assistant Director of Nurses began education to all full time, part time, and PRN licensed nurses, medication aides, and certified nursing assistants including agency staff on the following: " Resident□s liter flow of oxygen must be set at the amount ordered by the MD and the order confirmed by the nurse. " The liter amount should be verified at eye level. " If the resident is adjusting the oxygen liters, then their respiratory status should be assessed or if refusing to utilize the oxygen notify the MD/RP of your findings. " Oxygen orders should be clarified to assure there are no conflicting orders in place. " Documentation of notification and education should be completed in the progress notes for the resident along with the resident□s condition. " Following orders related cleaning O2 concentrator filters	

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F 695	Continued From page 28 On 01/11/24 at 4:42 PM during an interview with the Administrator and Director of Nursing the Administrator stated she expected the oxygen concentrators to be set at the rate prescribed by the physician. 2. Resident #10 was admitted to the facility on 08/03/23 with diagnoses that included heart failure. A review of Resident #10's physician orders revealed an order dated 08/03/23 for continuous supplemental oxygen at 3 liters per minute via nasal cannula and to clean oxygen filter every weeknight on Thursday for oxygen use. A review of Resident #10's care plan revised 10/24/23 revealed that the Resident received continuous oxygen with the goal that there would be no signs and symptoms of poor oxygen absorption. The interventions included ensuring the oxygen was set at the prescribed rate. A review of Resident #10's Minimum Data Set assessment dated 10/25/23 revealed the Resident was cognitively intact and received supplemental oxygen. During an observation of Resident #10's room on 01/08/24 at 2:13 PM, the Resident was out of the facility to dialysis. The Resident's oxygen concentrator was positioned adjacent to her bed near the wall. The oxygen filter connected to the back of the concentrator was light gray with thick dust that rippled down when touched. An interview and observation were made of Resident 10 on 01/08/24 at 4:18 PM. The	F 695	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 process to verify that the change has been sustained. The facility specific in-service will be provided to the above identified staff who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training by 1/18/2024 will not be allowed to work until training has been completed. Education will be added to nursing and housekeeping new hire paperwork as well as educating all new agency staff. 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. Beginning the week of 1/22/2024, The Director of Nurses or designee will monitor compliance utilizing the F695 Quality Assurance Tool. Monitoring will occur weekly x 4 weeks then monthly x 2 months or until resolved. The Director of Nursing will monitor compliance with oxygen liter flow according to MD orders and ensure O2 concentrators and filters are cleaned. 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. The weekly QA Meeting is	

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F 695	Continued From page 29 Resident had recently returned from dialysis and was sitting up in her bed wearing the oxygen nasal cannula. The oxygen flow rate was set at 4 liters per minute on the oxygen concentrator. The filter remained unchanged. Resident #10 explained that her oxygen setting should be set at 4 liters. She indicated that she did not ever change the setting on the concentrator (nor could she reach it) because it was always supposed to be set at 4 liters. An observation made on 01/09/24 at 1:11 PM revealed Resident #10 in her room sitting in the wheelchair beside her bed. The Resident wore an oxygen nasal cannula that was connected to the portable oxygen tank attached to the back of her wheelchair. The oxygen flow rate was set at 3 liters per minute. The oxygen filter remained unchanged. An observation made on 01/10/24 at 9:40 AM revealed Resident #10 was out of the room to dialysis. The oxygen filter remained dusty gray. An interview was conducted with Nurse #2 on 01/10/24 at 11:35 AM who confirmed she worked with Resident #10 on 01/08/24. The Nurse explained that the oxygen filters were cleaned by the third shift nurses on assigned days. She offered that she did not routinely check the oxygen filters for cleanliness when she worked. Accompanied Nurse #2 to the Residents room who was out to dialysis. The Nurse noted the filter on the oxygen contractor being dusty gray and commented "it was dirty" and needed cleaning which she removed the filter and cleaned it at that time. An interview was conducted with Nurse #3 on	F 695	attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 01/19/2024	

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01/10/24 at 5:05 PM. The Nurse confirmed she worked on Thursday night 01/04/24 and initialed the Treatment Administration Record (TAR, a record of ordered treatments) for Resident #10. The Nurse explained she did not change the oxygen filter because she did not have access to the supply room to get a new filter. When it was explained that the order was not to change the filter but to clean the filter the Nurse stated she did not clean the filter either.

On 01/11/24 at 1:02 PM an interview and observation were made of Resident #10 who was sitting up in bed with her dinner tray on her over bed table in front of her. The Resident was wearing the oxygen cannula with the oxygen concentrator delivering oxygen at 4 liters. The Resident stated, "it was set at 4 liters".

A review of Resident #10's Treatment Administration Record on 01/11/24 at 1:24 PM revealed Nurse Manager #2 initialed that Resident #10 was wearing continuous oxygen set at 3 liters per minute via nasal cannula.

During an interview with Nurse Manager #2 on 01/11/24 at 1:25 PM the Nurse explained that she had a lot of work to do and was not able to verify that every resident's oxygen setting was set at the prescribed rate and Resident #10 was one of the residents she did not get to. She continued to explain that she initialed that the flow rate was correct because the Resident had been on that setting for a long time and assumed it was set on 3 liters per minute. The Nurse Manager adjusted the flow rate to 3 liters per minute as the order was prescribed.

An interview was held with the Director of Nursing

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(DON) and Administrator on 01/11/24 at 4:42 PM. The DON explained that she did not think the nurses knew about the oxygen filters needing to be cleaned but regardless the Administrator stated that she expected the oxygen concentrators to be set at the prescribed rate and the filters to be cleaned as ordered.

3. Resident #69 was admitted to the facility on 03/22/22 with diagnoses that included obstructive sleep apnea and congested heart failure.

Review of the annual Minimum Data Set (MDS) assessment dated 01/03/24 revealed that Resident #69 was cognitively intact and required limited to extensive assistance with activities of daily living. The MDS further revealed that Resident #69 had shortness of breath when lying flat and required oxygen therapy during the assessment reference period.

Review of a physician order dated 11/23/22 read, clean oxygen filter weekly.

Review of Resident #69's Medication Administration Record (MAR) dated January 2024 revealed that Nurse #5 had signed off on cleaning the oxygen concentrator filter weekly on 01/03/24.

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An observation of Resident #69 was made on 01/08/24 at 5:15 PM. Resident #69 was resting in bed with oxygen via nasal cannula set to deliver 3 liters of oxygen in place. The black oxygen concentrator was covered in a white dust powder on the top, sides, front, and back of the concentrator. The seams of the concentrator where the machine came together was noted to have white/grey dust particles coming from within the machine. No filter was observed at this time.

An observation of Resident #69 was made on 01/09/24 at 5:05 PM. Resident #69 was resting in bed with oxygen via nasal cannula set to deliver 3 liters of oxygen in place. The black oxygen concentrator was covered in a white dust powder on the top, sides, front, and back of the concentrator. The seams of the concentrator where the machine came together was noted to have white/grey dust particles coming from within the machine. No filter was observed at this time.

Nurse #5 was interviewed on 01/10/24 at 5:07 PM. Nurse #5 stated she had worked at the facility for 9 years. She stated that third shift staff were responsible for cleaning the oxygen filters weekly. She added that it appeared on the MAR and would alert the appropriate staff when it was due to be done. Nurse #5 stated if the filter or tubing or oxygen concentrator were dirty, they could always be cleaned more frequently than every week. Nurse #5 added that she believed all oxygen concentrators had a filter. Nurse #5 accompanied the surveyor to Resident #69's room to observe the black oxygen concentrator. Resident #69 was resting in bed with oxygen cannula set to deliver 3 liters of oxygen. The black concentrator was covered in white dust

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BERMUDA COMMONS NURSING AND REHABILITATION CENTER	316 NC HIGHWAY 801 SOUTH ADVANCE, NC 27006

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F 695	Continued From page 33 powder on the top, sides, front, and back of the concentrator. While observing the concentrator there was a release button noted that when pushed opened the back of the concentrator to reveal a black filter that was white with approximately quarter inch of dust. Nurse #5 stated that she would clean the filter and concentrator immediately and did not recall ever cleaning Resident #69's filter or concentrator before. The Director of Nursing (DON) was interviewed on 01/11/24 at 11:57 AM. The DON stated third shift staff were responsible for changing the respiratory supplies and cleaning the oxygen concentrators and filters. She added that they had a company that came to the facility every 3 months to clean the internal filter of the oxygen concentrators, but the nursing staff were responsible for cleaning the external filter and concentrator weekly. The Administrator was interviewed on 01/11/24 at 4:41 PM. The Administrator stated that oxygen filters should be cleaned as ordered.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		

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F 755	Continued From page 34 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have a system for disposition and an accurate reconciliation of controlled medications for 1 of 1 resident (Resident #24) reviewed for pharmacy services. The finding included: Resident #24 was admitted to the facility on 11/30/22 with diagnoses that included peripheral vascular disease and fibromyalgia. A review of Resident #24's physician orders dated: -11/30/22 revealed Hydrocodone/Acetaminophen	F 755	Past noncompliance: no plan of correction required.	

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F 755	Continued From page 35	F 755		

5-325 milligrams (mg) take one tablet by mouth every 6 hours as needed for pain.
-12/07/22 revealed Hydrocodone/Acetaminophen 5-325 mg take one tablet by mouth every 6 hours for pain.

A review of a pharmacy delivery sheet (a list of controlled medications delivered to the facility) dated 12/21/22 revealed 60 tablets of Hydrocodone/Acetaminophen 5-325 mgs was sent for Resident #24. The delivery sheet was signed by Nurse #6.

Review of Resident #24's Medication Administration Record (MAR) dated 12/2022 revealed that staff had initialed the MAR every 6 hours beginning on 12/07/22 indicating the Hydrocodone had been administered. However, the facility was unable to locate the reconciliation sheet for Resident #24's Hydrocodone.

An attempt to interview the former Director of Nursing was made on 01/11/24 at 9:19 AM without success.

During an interview with the Administrator and Director of Nursing (DON) on 01/11/24 at 11:02 AM the Administrator explained that on 01/06/23 she and the former DON were notified by the pharmacy of a potential drug diversion in the facility. The Administrator stated that they immediately began an investigation of the residents in the facility at that time. They had the pharmacy send them delivery sheets of all controlled substances that were delivered to the facility for the 3 previous months. The Administrator stated that the former DON and the Assistant Director of Nursing began comparing the reconciliation record to the delivery sheets.

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During these audits they discovered that they could not account for Resident #24's Hydrocodone as they could not locate the reconciliation record associated with the Hydrocodone sent for Resident #24 on 12/21/22 that Nurse #6 signed for. The DON stated that the MAR indicated that Resident #24 received the medication, but they could not verify that because they could not locate the reconciliation record then nor has the reconciliation ever been found. She continued to explain that once they learned that Resident #24's Hydrocodone was unaccounted for they reported the missing medication to the appropriate agencies and Nurse #6 was terminated because once she signed for the narcotics, she was responsible for the putting the card of medication into the medication cart and the reconciliation record in the binder on the medication cart. The DON added that after this event the facility amended their policy that all controlled substances required 2 nurse signatures upon delivery and when a controlled substance medication supply was depleted or discontinued only a supervisor could remove the empty card or discontinued medications and reconciliation records from the binder located on each medication cart.

An attempt to interview Nurse #6 was made on 01/11/24 at 12:25 PM but was unsuccessful.

The facility provided the following corrective action plan:

Corrective Action for Resident Involved: On 01/06/2023 the Pharmacy notified the former Director of Nursing that a card of Hydrocodone/Acetaminophen (20) 5mg-325mg tablets were delivered to Bermuda Commons

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Nursing and Rehabilitation Center on 12/23/2022 by mistake. The resident was not a resident of the facility. The Director of Nursing began to search for the 20 tablets of 5mg-325mg Hydrocodone/Acetaminophen with the resident's name on the card. The Director of Nursing was unable to locate the narcotic card for the resident. The Director of Nursing notified the Pharmacy that the facility was not able to locate the narcotic card for the resident and the Director of Nursing asked for the pharmacy to fax the pharmacy narcotic delivery sheet to verify the nurse who signed for the narcotics for the resident. On the pharmacy delivery sheet there were two residents that were listed to have had narcotics delivered on 12/23/2022. The narcotic card was found for the resident who resided in the facility and reconciled as received and administered. The nurse that signed for each narcotic card was RN #6. RN #6's signature was on the pharmacy delivery sheet signified as accepting both the resident's narcotics. On 01/06/2023 at 3:45 pm the Administrator notified Davie County Sheriff's department of alleged narcotic diversion. On 01/06/2023 the facility self-reported 24-hour/5-day to NCDHHS of alleged diversion pertaining to the resident that did not reside in the facility. The Director of Nursing called RN #6 who was scheduled to work second shift on 01/06/2023 to ask if RN #6 was coming in to work. The nurse was late for her shift, but stated she was coming to work. The Director of Nursing and the Administrator were sitting in the Administrator's office awaiting the arrival of RN #6. When RN #6 walked in the front door the Director of Nursing asked to come into the Administrator's office and to have a seat. The Director of Nursing began to question RN #6 as to the delivery of the 2 narcotics delivered for the 2 residents on

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12/23/2022. RN #6 stated she remembered the narcotic for the resident who resided in the facility but did not recall her receiving the narcotic for the resident who did not reside in the facility. The Administrator presented the pharmacy narcotic delivery sheet to the RN and asked if the signature on the delivery sheet was her signature? RN #6 verified the signature on the delivery sheet was hers. The Administrator asked RN #6 if she recalled where she put the narcotics for the resident that did not reside in the facility and the RN stated she did not remember receiving the resident's narcotics but took the resident's narcotics who resided in the facility and placed them in the perspective cart. The Administrator asked RN #6 to go with the Assistant Director of Nursing to obtain a serum drug test, but the RN refused to submit to the serum drug test. The Administrator explained to RN #6 that if she refused to submit to a serum drug test she would be terminated. RN #6 stated she understood. RN #6 stood up and walked out of the Administrator's office and out of the front door. RN #6 did not work on or after 01/06/2023 and was terminated.

Corrective Action for Potentially Impacted Residents: On 01/06/2023, Education started immediately with all nurses that two nurses must sign for all narcotics that arrive in the building either sent by pharmacy or brought in from an outside pharmacy. On 01/08/2023 audits and reconciliation began for narcotics delivered to the facility for December 2022. December narcotics were reconciled. Findings: 18 tabs Norco 5mg-325mg missing for resident #3, 42 tabs Oxycontin 5mg tabs missing for resident #4, 15 tabs Norco 5mg-325mg missing for resident #5. On 01/08/2023, November narcotics were

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reconciled. Findings: 57 tabs Norco 5mg/325mg tabs missing. October narcotic reconciliation had 4 tabs of 5/325 missing, 39 tabs of Oxycontin, and 16 tabs of Oxycontin 5mg missing. September had no missing narcotics. RN #6 worked 12/23/2022, 12/31/2022, 1/1/2023 and 1/04/2023. Therefore, audits for those residents residing in the facility on those dates were reviewed for any change of conditions including increased complaints of pain, with no negative findings. No residents were found to be affected by deficient practice.

Systemic Changes: On 01/06/2023, the Staff Development Coordinator began in servicing all full-time, part-time, PRN and agency nurses and Medication Aides on the Drug Keeping Policy, which included narcotic delivery sheets from pharmacy must have a nurse manager and one other nurse sign the narcotics packing slip. The two nurses must be at least one nurse manager and one additional nurse signing the narcotic countdown sheet agreeing the card was added to the cart plus shift change card and count sheet verification. As of 01/17/2023 any staff members that have not received the education will have to be educated before they can work the floor. Director of Nursing, Assistant Director of Nursing, and Support Nurses will do daily cart audits Monday through Friday, removing completed narcotics. The audits will also include removing narcotics that have expired, been discontinued, non-utilized narcotics from all carts and returned to pharmacy for destruction. The pharmacy representative is to email all narcotic delivery sheets to the Director of Nursing every 15 days to ensure reconciliation of narcotics delivered to the facility is occurring every 15 days.

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F 755	Continued From page 40	F 755		

Quality Assurance: Beginning 01/12/2023 the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Support nurses will monitor narcotic receivable process weekly indefinitely for correct drug record keeping. Audits will verify narcotic count sheets to ensure accurate narcotic record keeping and signatures are legible and to verify that all ordered narcotics have been entered appropriately onto the narcotic count sheets. Reports will be presented to the weekly QA meeting by the Administrator or Director of Nursing to ensure corrective action is maintained as appropriate. Compliance will be monitored, and ongoing auditing program reviewed at the weekly QA meeting including but not limited to the Administrator, Director of Nursing, MDS Coordinator, Therapy, Dietary Manager. Compliance date of 01/18/23.

The plan of correction was validated on 01/11/24 which included reviewing the facility's initial audits that discovered Resident #24's unaccounted for hydrocodone and the reconciliation of other residents' medications. The current residents-controlled substances were verified with no discrepancies noted during a controlled medication count and interviews with staff revealed that they were able to verbalize the new policy for receiving narcotic that now required a signature from 2 staff members (the supervisor and nurse) and when a card of controlled substance was empty or discontinued only a supervisor could remove the card along with the reconciliation sheet. Ongoing audits every 15 days continue of all controlled substances sent. The facility's compliance date of 01/18/23 was validated.

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F 759	Continued From page 41	F 759		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Medical Director interviews the facility failed to ensure they had a medication error rate less than 5 % by having 2 errors out of 32 opportunities resulting in a 6.25% medication error rate for 1 of 3 residents observed during medication pass (Resident #97). The findings included: Resident #97 was initially admitted to the facility on 10/04/13 with diagnoses that included acute/chronic respiratory failure, chronic obstructive pulmonary disease, diabetes, unspecified convulsions, and others. Review of the quarterly Minimum Data Set (MDS) dated 12/23/23 revealed that Resident #97 was cognitively intact and required extensive to total assistance with activities of daily living. Review of a physician order dated 01/02/24 read; Neurontin 400 milligrams (mg) by mouth at bedtime for pain. Do not Crush. Review of a physician order dated 01/02/24 read; Gabapentin (Neurontin) 100 mg by mouth twice a day for pain. Do not Crush.	F 759	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. F759- Free of Medication Rate 5 % or More Corrective action for resident(s) affected by the alleged deficient practice: On 1/9/2024 the DON assessed resident # 97, those findings were no harm noted to resident #97. On 1/9/2021, the MD was notified of medication error with no new order. On 1/9/2024, the Director of Nursing verbally reeducated the medication aide and completed medication aide competencies with med pass observation. Corrective action for residents with the potential to be affected by the deficient practice: All resident receiving	1/19/24

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F 759	Continued From page 42 Review of a physician order dated 01/02/24 read; Fluticasone Propionate 50 micrograms (mcq) one spray each nostril one time a day for allergies. Shake before use. An observation of Medication Aide (MA) #2 preparing Resident #97's medication was made on 01/09/24 at 8:55 AM. The medications were prepared for administration included: Neurontin 300 mg and Fluticasone 50 mcq. After preparing Resident #97's medication, MA #2 entered Resident #97's room to administer the medications. Resident #97 was observed to take the cup of pills that included Neurontin 300 mg and put them in her mouth and swallow them. MA #2 was then observed to open the Fluticasone bottle, shake it, and sprayed one spray up in the air. MA #2 then proceeded to place two sprays in each of Resident #97's nostrils and then exited the room. MA #2 was interviewed on 01/09/24 at 10:02 AM which revealed that Resident #97 had both Neurontin 300 mg and 100 mg in the medication cart, and she just accidentally pulled the 300 mg instead of the 100 mg that was ordered to be given at 9:00 AM. MA #2 also stated that she always gave Resident #97 2 sprays of Fluticasone because one spay did not always come out and she wanted to ensure she had the full dose of medication. Nurse Manager #1 was interviewed on 01/09/24 at 10:06 AM who stated that Resident #97 had recently returned from the hospital and she thought that she had new orders upon readmission to the facility. She added she would get a clarification order on the Fluticasone spray so the staff could give 2 sprays instead of 1 to	F 759	medications have potential to be affected. On 1/15/2024 the Director of Nursing and Assistant Director of Nursing began auditing 100% of resident medication administration records administered by medication aides for medication errors. The results of the audit were no additional discrepancies noted. This was completed on 1/17/2024. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/12/2024 the Director of Nursing began educating all full time, part time, and prn (as needed) nurses and medication aides, including agency staff on the following topics: Medication administration process to assure that medications are provided to residents per medical order and steps to take if a medication error occurs. The Director of Nursing will ensure that any of the above identified staff who has not completed education by 1/18/2024 will not be allowed to work until education is completed. Medication Administration Process Education has been integrated into the standard orientation training and in the required in¿ service refresher courses for all staff identified above 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: Beginning the week of 1/22/2024, The Director of Nurses or designee will monitor Compliance with the regulatory requirements utilizing F 759 Med Pass QA monitoring tool. Monitoring	

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F 759	Continued From page 43 ensure she received the full dose. The Director of Nursing was interviewed on 01/10/24 at 2:25 PM who stated that MA #2 had informed her of the medication errors that occurred with Resident #97. She explained she educated MA #2 that those were both considered medication errors and they had to be written up and the Medical Director (MD) notified. The DON stated that MA #2 explained she had given 2 sprays of the Fluticasone because she wanted to be sure Resident #97 received the full dose of medication and stated she had grabbed the incorrect dose of Neurontin. The DON explained that Resident #97 had recently had a hospital stay and the facility usually kept the medication for 7 days before pulling it and returning it to the pharmacy. The DON stated the facility staff were probably aware Resident #97 was returning to the facility and that was why we kept the medication which included Neurontin 300 mg. The Neurontin had been increased to 400 mg while she was in the hospital. The DON added that she was going to call the pharmacy and see if they could send the Neurontin 400 mg and they would pull the 300 mg off the medication cart and return it to the pharmacy. The Consultant Pharmacist was interviewed via phone on 01/10/24 at 3:09 PM. She stated she was not familiar with the procedures for returning medication to the pharmacy when a resident discharged to the hospital. She stated that it would probably depend on if the resident was going to return to the facility or not. If the resident was going to return to the facility, then they would hang on to the medication for a while before returning them.	F 759	will include observing medication pass following the 6 rights of medication administration for 1 medication aide and 1 nurse weekly for 4 weeks, then monthly x 2 months. Additionally, medication aides re-competencies to be completed by the Director of Nursing and Unit Managers along with med pass observations. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 1/19/2024	

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F 759	Continued From page 44 The MD was interviewed on 01/10/24 at 4:47 PM. She stated the Fluticasone was not a significant error and giving an increased dose of Neurontin could potentially make Resident #97 more sleepy, but that would also not be a significant medication error.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and resident interviews, the facility failed to	F 761	The statements made on this plan of correction are not an admission to and do	1/19/24

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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 761	Continued From page 45 secure medicated creams that were stored at bedside for 2 of 2 residents (Resident #8 and Resident #66) reviewed for medication storage. The findings included: 1. Resident #8 was admitted to the facility on 06/05/15 with diagnoses that included Alzheimer's disease. A review of Resident #8's physician order dated 07/26/23 revealed an order for Minerin cream apply to arms and legs topically every evening shift for dry skin. The quarterly Minimum Data Set assessment dated 12/12/23 revealed that Resident #8 had moderately impaired cognition. A review of Resident #8 care plan revised 12/13/23 indicated no care plan to self-administer medication. On 01/08/24 at 10:50 AM during an interview and observation of Resident #8 a medicine cup that contained a creamy white substance approximately ¾ full was noted to be sitting on top of the Resident's bedside table. Written on the medicine cup was "minerin to upper legs". Upon inquiry, Resident #8 explained that "they put that on my legs, but it's all cleared up now". Resident #8 advised she could not apply the cream on herself. An observation on 01/08/24 at 3:26 PM revealed that the medicine cup with the creamy white substance remained on the Resident's bedside table.	F 761	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. F-761 Label/Store Drugs & Biologicals Corrective action for affected residents. For resident #8, the identified medications at bedside were discarded on 1/9/2024 by the Director of Nursing and nurse#2 was verbally re-educated by the Director of Nursing. For resident #66, the identified medications at bedside were discarded on 1/9/2024 by the Director of Nursing and nurse#2 was verbally re-educated by the Director of Nursing. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who receive treatment to apply ointments or creams have the potential to be affected. On 1/15/2024, the Unit Support Nurses audited all resident rooms to identify any medications at bedside. The audit revealed no other residents noted with medications at bedside. This was completed on 1/15/2024. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 761	Continued From page 46 During an observation made on 01/09/24 at 8:42 AM, the medicine cup with the creamy white substance remained on the Resident's bedside table. Observations on 01/09/24 at 12:56 PM and 01/09/24 at 3:52 PM remained unchanged. On 01/09/24 at 3:52 PM an interview conducted with the Director of Nursing (DON) revealed that for the residents to be allowed to keep medications at their bedside they had to have an order to do so, and they should be mentally and physically able to take their medications and apply their treatments. The DON was shown the medication cup with the white creamy substance that remained on Resident #8's bedside table and the DON explained that she did not know what the white substance was but that it should not have been left on the bedside table. The DON expressed that she had educated the staff to monitor medications left at bedside. An interview was conducted with Nurse Manager #1 on 01/10/24 at 9:16 AM. The Nurse Manager confirmed that she was responsible for Resident #8 on 01/09/24 on first shift. The Nurse explained that the residents had to have an order to be able to keep medications or treatments at their bedside and they had to be care planned to do so. The Nurse stated Resident #8 would not be able to self-administer medication or apply treatments. She indicated she did not notice the cream on the Resident's bedside table when she made rounds the day before. On 01/10/24 at 11:33 AM during an interview with Nurse #2, the Nurse confirmed she was responsible for Resident #8 on 01/08/24 on first	F 761	On 1/12/2021 the Director of Nursing began in-servicing all current full time, part time and PRN Nurses and CNA's. This in-service included the following topics: " Resident Health and Safety Program " Self-Administration of Meds Policy for Residents The Director of Nursing will ensure that any licensed Nurse or medication aide who has not received this training by 1/18/2024 will not be allowed to work until the training is completed. 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 process to verify that the change has been sustained. 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. Beginning the week of 1/22/2024, The Director of Nursing or designee will monitor compliance utilizing the F-761 Quality Assurance Tool. The audit will be completed weekly x 4 weeks then monthly x 2 months. The DON or designee will monitor for compliance by checking for medications at bedside. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program	

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F 761	Continued From page 47 shift and stated she did not notice the medicine cup with the substance in it on her bedside table. The Nurse indicated that the residents could not keep their medications at their bedside without an order to self-administer medication. She indicated Resident #8 would not be able to self-administer or physically apply creams efficiently. During an interview with the Administrator on 01/11/24 at 4:42 PM the Administrator stated her expectation was medications or treatments are not stored at bedside unless the resident had an order to do so. 2. Resident #66 was admitted to the facility on 05/10/23 with diagnoses that included unspecified dementia. A review of Resident #66's care plan revised 12/22/23 revealed that there was no care plan to self-administer medications. The quarterly Minimum Data Set assessment dated 12/24/23 revealed that Resident #66 had short and long term memory problems. A review of Resident #66's physician orders revealed no order to self-administer medications. On 01/08/24 at 2:41 PM an observation was made of Resident #66 lying in bed sleeping. At that time, a medicine cup that contained a creamy clear substance approximately ¾ full was noted to be sitting on top of the Resident's bedside table. Subsequent observations were made on 01/08/24 at 4:08 PM, 01/09/24 at 9:05 AM, 01/09/24 at 12:55 PM and 01/09/24 at 3:50 PM of the clear	F 761	reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 1/19/2024	

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F 761	Continued From page 48	F 761		

creamy substance in the medicine cup on the Resident's bedside table.

During an interview with the Director of Nursing on 01/09/24 at 3:40 PM who was at Resident #66's bedside, the DON was informed that the medicine cup with the clear creamy substance had been on the bedside table since the morning of 01/08/24. The DON acknowledged the substance sitting on the bedside table and explained that the Resident had multiple pressure ulcers and it could be that the wound nurse left the medication/ointment on the bedside table by mistake. The DON continued to explain that Residents had to be mentally and physically capable to apply treatments and medications and Resident #66 could not do that for herself.

An interview was conducted with Nurse Manager #1 on 01/10/24 at 9:07 AM. The Nurse Manager explained that the residents had to be assessed to be mentally and physically able to self-administer medications and apply treatments and Resident #66 would not be able to do so. The Nurse confirmed that she was responsible for Resident #66 on 01/09/24 on first shift and stated she did not notice the creamy substance on her bedside table, or she would have removed it.

On 01/10/24 at 11:33 AM during an interview with Nurse #2, the Nurse confirmed she was responsible for Resident #66 on 01/08/24 on first shift and stated she did not notice the medicine cup with the substance in it on her bedside table. The Nurse indicated that the residents could not keep their medications at their bedside without an order to self-administer medication. She indicated Resident #66 would not be able to self-administer medication or physically apply creams efficiently.

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F 761	Continued From page 49 During an interview with the Administrator on 01/11/24 at 4:42 PM the Administrator stated unless a resdient had an order for self administration of medication, medications should not be stored at bedside.	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and resident interviews, and test tray, the facility failed to provide palatable food to a resident that was appetizing in temperature for 1 of 3 residents reviewed for food palatability. (Resident #29) The findings included: Resident #29 was admitted to the facility on 11/17/21. A review of Resident #29's significant change Minimum Data Set assessment dated 12/30/23 revealed him to be cognitively intact with no psychosis or behaviors. During an initial interview with Resident #29 on 01/08/24 at 11:20 AM, he reported he did not like	F 804	The statements made in 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 compliance such as that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-804 For the dietary services, a corrective action was obtained 1/11/2024. During an interview of resident #29 on 1/8/2024 he stated that the food is often	1/19/24

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F 804	Continued From page 50 the food, and it was often served cold. Resident #29 reported the "the food ain't fit to feed a dog". A test tray was completed for the lunch meal on 01/09/24. The test tray was plated in the kitchen at 12:35 PM. At 12:37 PM, the test tray left the kitchen and headed to a hall adjacent to the hall where Resident #29 resided. The test tray consisted of baked ham, pinto beans with onions, braised cabbage, cornbread, and a frosted, chocolate cake. Upon removal of the lid, there was no visible steam coming from the food on the tray and there did not appear to be a metal hotplate underneath the food plate. At 12:41 PM the Dietary Manager tasted the pintos and cabbage. The Dietary Manager reported the pinto beans were cool and "could have cooked a little longer". An observation of the pinto beans revealed them to be clumped together and were crunchy when tasted. She also reported the cabbage was "ok" but needed more seasoning and "should be hotter". The Dietary Manager reported she would relay the information to her cooks and try to figure out where they were losing heat causing the meals to be cooler than they should be. During a follow-up interview with Resident #29 on 01/09/24 at 12:56 PM, he reported the lunch meal was "fair" but "could not have been much warmer than room temperature" when he got it. He reported he did not end up eating much of the meal and sent it back to the kitchen. Resident #29 reported he did not request an alternative meal. An additional observation of Resident #29 was completed on 1/11/24 at 12:45 PM during his mealtime. Resident was observed in his room, in	F 804	cold. A test tray was obtained on 1/9/2024 consisting of baked ham, pinto beans with onions, braised cabbage, cornbread, and frosted chocolate cake. Upon removal of the dome, there was no steam coming off the food, nor a metal plate under the plate. At 1241 PM the Dietary Manager tasted the pintos and cabbage and stated the pinto beans could have been cooked longer because the beans were clumped together and crunchy. The dietary manager stated that the cabbage was ok but needed more seasoning and should be hotter. On 1/9/2024 the facility added support staff in dietary to educate correct the concerns of food temperatures and palatability. On 1/11/2024 a follow-up interview with the dietary manager revealed that she did not know why the trays were not holding the heat. The dietary manager said the kitchen used plate warmers and dome lids and insisted all food items were temped above recommended holding temps. On 1/11/2024 another test tray was prepared for the surveyors, dietary manager, and administrator. The tray was brought from the kitchen Turkey and stuffing casserole, with green beans and a chocolate cherry cake as the dessert. The food items on the tray had a good temperature and looked appetizing. Surveyors said they would eat food on the plate and liked the taste of the dessert. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents could be affected by the	

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F 804	Continued From page 51 bed with his lunch meal tray on his overbed table. Resident #29 had not tried any of his food. An interview with Resident #29 on 1/11/24 at 12:46 PM revealed he had no intention on eating the meal served as it did not appear appetizing to him and he did not know if it was cold or not and did not plan on eating any of the meal. Resident #29 denied wanting an alternative meal at that time. A follow-up interview with the Dietary Manager completed on 1/11/24 at 1:02 PM revealed she did not know why the meals were not holding heat. She reported the facility utilized plate warmers and dome lids, but stated there were two halls that meals went out on open-air carts. She insisted that all food items temped above recommended holding temps. She also reported not hearing a lot of complaints from residents regarding the quality of the food coming out of the kitchen. She reported most of the complaints she heard were regarding the types of food served. She reported she had not heard complaints regarding the temperature of the food when it reached the residents. During an interview with the Administrator on 01/11/24 at 4:03 PM revealed she expected food to be served to residents that was hot, fresh, and palatable. The Administrator also reported she was aware there had been issues with the kitchen and the quality of food coming out of the kitchen. She reported she was trying to fix the issues but did not have an answer on how to resolve it. The Administrator reported the kitchen should be using a metal hot plate under the serving plate to try and retain as much heat to the food as possible.	F 804	alleged deficient practice. A new Dietary Service Director was hired 1/12/2024. On 1/16/2024 the Dietary Service Director initiated an in-service for all dietary staff to discuss dining experience to include palatability, meal objectives, and test tray completion. Test trays will be completed per protocol to reduce resident and family concerns. The Dietary Service Manager or designee will interview 7 residents/family members per week asking about the palatability and presentation of daily meals and following up with any food complaints/concerns as identified. The facility will start a Food Committee consisting of residents who chose to participate, Dietary Service manager, administrator, and dietary and floor staff as available. A food Committee consisting of residents will be initiated to meet weekly times 1 month, then biweekly times 1 month, then monthly. 3. Systemic Changes In-service education was provided by Dietary Service Manager on 1/16/2024 to all full-time, part-time and as needed staff. Topics included: Meal objectives and procedures Test Tray completion Focus dining experience Food nutritive value and palatability Utilization of daily/weekly menus, recipes, and spreadsheets, On 1/17/2024 the administrator educated the new Dietary Service Manager on ordering the food truck by utilizing weekly menus, recipes, and spreadsheets.	

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F 804	Continued From page 52	F 804	Meal objectives and procedures Test Tray completion Focus dining experience Food nutritive value and palatability Test trays will be completed per protocol to ensure a satisfactory dining experience. The Administrator will request a tray from dietary three times a week from various mealtimes to assure the nutritive and palatability of resident meals. This information has been integrated into the standard orientation training and in the required in-service refresher courses for dietary staff and will be reviewed by the Quality Assurance process to verify change has been sustained. Any dietary staff not in-serviced by 1/18/2024 will not be allowed to work until training has been completed. 4. Quality Assurance monitoring procedure Beginning on 1/22/2024 the administrator or designee will monitor the appearance and taste of a test tray from the various mealtimes for palatability and temperature. Dietary staff will prepare a test tray 3 times a week times 1 month, then 3 times biweekly times 1 month, and then monthly times 3 months. Monitoring will include reviewing food items for appearance and taste and visiting residents when complaints are received. 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	

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F 804	Continued From page 53	F 804	Assurance Meeting. The weekly QA meeting is attended by the administrator, Director of Nursing. MDS Coordinator, Therapy, Health Information Manager Date of Compliance: 1/19/2024	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		1/19/24

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F 867	Continued From page 54 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §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,	F 867		

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resident choice, and quality of care.

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

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its 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

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F 867	Continued From page 56 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 05/05/22 and for the complaint investigation conducted on 09/14/23. This failure was for three deficiencies that were originally cited in the areas of Resident Rights (F584), Quality of Care (F689), and Dietary Services (F804) that were subsequently recited on the current recertification and complaint investigation survey of 01/11/24. The repeat deficiencies during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F584: Based on observations, resident, and staff interviews the facility failed to provide a clean homelike environment for 1 of 6 units (Unit 600). The facility failed to repair a missing lower closet door and failed to repair a upper closet door, failed to repair missing and cracked dry wall at the base of the air conditioning unit that daylight could be seen and had the potential to allow small rodents into the facility (Room #607), failed to clean a privacy curtain that was noted to have a white outline of hand print and a brown stain that was approximately 3 centimeters by 5 centimeters, failed to repair chipped and missing dry wall near the bathroom, failed to clean the	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. 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: Based on observations, record reviews, resident, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 05/05/22 and for the complaint investigation conducted on 09/14/23. This failure was for three deficiencies that were originally cited in the areas of Resident Rights (F584), Quality of Care (F689), and Dietary Services (F804) that were subsequently recited on the current recertification and complaint investigation survey of 01/11/24. The repeat deficiencies during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program.	

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	345543	A. BUILDING _____ B. WING _____	C 01/11/2024

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F 867	Continued From page 57 brown ring of dirt and grim around the base of the toilet (Room 601), and failed to clean and repair the floor at the bathroom room threshold (Room 603), and failed to secure baseboard to the wall (Room 605). During the recertification and complaint survey of 05/05/22 the facility failed to maintain resident rooms and bathrooms for 4 of 6 halls. F689: Based on record review, staff, and Medical Director interviews the facility failed to provide care in a safe manner to prevent a resident from rolling out of bed during incontinent care (Resident #344) for 1 of 6 residents reviewed for accidents. During incontinent care Resident #344 was rolled onto her side by staff and then rolled out of the bed onto the floor. She was admitted to the hospital for five days due to worsening atrial fibrillation with rapid ventricular response (very fast heartbeat) caused by significant sympathetic response (your body's response to stress) from pain from the fall. During the complaint survey of 09/14/23 the facility failed to ensure the lift gate (a mechanical platform designed to raise and lower to allow an individual with a wheelchair to enter and exit a vehicle) was in the elevated position before unloading a resident from the back of the facility van. On 08/11/23 Resident was rolled out of the back of the transportation van in her wheelchair and fell approximately 2.5 feet to the ground landing on her right side and hitting the back of her head. F804: Based on observations, staff and resident interviews, and test trays, the facility failed to provide palatable food to residents that was	F 867	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: Resident Rights (F584) "Corrective action has been taken for the identified concerns in the areas of: Quality of Care (F689) Corrective action has been taken for the identified concerns in the areas of: Dietary Services (F804) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 1/1/17/2024/2024 to review the deficiencies from the 1/8/24-1/11/2024 annual recertification survey, CI survey, and reviewed the citations. On 1/ 17 /2024, the Regional Clinical Nurse Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 1/ 17/ 2024 the Regional Clinical Nurse Consultant completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Unit Managers, Health Information Manager, Maintenance Director, Environmental Services Manager, and the Dietary Manager, on	

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F 867	Continued From page 58 appetizing in temperature for 1 of 3 residents reviewed with food concerns. (Resident #29) During the recertification and compliant survey of 05/05/22 the facility failed to serve palatable food that was appetizing in taste and temperature. The Administrator was interviewed on 01/11/24 at 5:47 PM. The Administrator stated that the Quality Assurance (QA) committee met monthly and included all department heads and if had safety concerns to discuss they invited direct care to staff to join. The Administrator stated that they had revamped the QA process because they were reporting numbers but not really discussing what those numbers meant. She further explained that now they were really diving into what the numbers meant and how we could affect the numbers going forward. Additionally, they have performance improvement plans in place for antipsychotic medications, dietary issues, and falls with injury and they continue to work on those plans to improve the system in place. The Administrator stated that she generally kept performance improvement plans in place longer than she should, but she wanted to ensure long-term compliance.	F 867	the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. 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 of the above identified staff who does not receive scheduled in-service training by 1/18/2024 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. Beginning the week of 1/22/2024, The Regional Director of Operations or Regional Nurse Consultant will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The tool will 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 missing	

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F 867	Continued From page 59	F 867	laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 1/19/2024	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		1/19/24

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F 880	Continued From page 60 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and	F 880	The statements made on this plan of	

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F 880	Continued From page 61 interviews, the facility failed to implement their policy for Personal Protective Equipment (PPE) when Nurse #4 failed to don protective eyewear (goggles or face shield) before entering 1 of 4 resident's room with signage for transmission-based precautions (Resident #85). The finding included: Review of the facility's Infection Control policy for COVID-19 infection revised 05/2023 indicated Healthcare Personnel who enters the room of a patient with confirmed COVID-19 should adhere to Standard Precautions and use a NIOSH-approved respirator with N95 filters or higher, gown, gloves and eye protection (goggles or a face shield that covers the front and sides of the face). This type of Transmission Based Precautions is "Special Droplet Contact Precautions". An observation on 01/11/24 at 8:43 AM revealed signage posted on Resident #85's door for "Special Droplet Contact Precautions" which directed "all healthcare personnel must": wear a gown when entering room and remove before leaving, wear N95 or higher-level respirator before entering the room and remove after exiting, protective eyewear (face shield or goggles) and wear gloves when entering room and remove before leaving. A PPE tower was hanging on the door with all the listed items available for use. During an observation made on 01/11/24 at 9:04 AM Nurse #4 stood outside of Resident #85's room looking at the Special Droplet Contact Precaution signage which was posted on the residents' door. The Nurse sanitized her hands	F 880	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. F880 INFECTION CONTROL Corrective action for affected residents. For resident #85- On 1/11/2024, Assistant Director of Nursing ensured isolation cart with appropriate PPE was in place and outside room. On 1/12/2024, For Nurse #4 Education provided related Donning/ Doffing Personal Protective Equipment Corrective Action for Potentially Affected Residents. All current residents and staff have potential to be affected by deficient infection control practices. On 1/12/2024 the Infection Control licensed nurse completed Infection Control Rounds to determine if deficient practices noted related to donning/doffing of appropriate PPE for residents identified as at risk. This was completed on 1/12/2024 with no other deficiencies identified. Systemic Changes On 1/12/2024 the Director of Nursing/Infection Control Nurse began education with all staff on Infection Control	

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F 880	Continued From page 62 then donned a gown, gloves and N95 face mask then proceeded to enter Resident 85's room. At 9:13 AM on 01/11/24 Nurse #4 was observed to exit Resident #85's room. During an interview at that time, Nurse #4 explained that the reason the room was posted for Special Droplet Contact Precautions was that Resident #85 tested positive for COVID-19 the day before on 01/10/24. The Nurse was asked what she did while she was in the room and the Nurse explained she changed the oxygen tubing for Resident #85. When the Nurse was asked what PPE she donned for the COVID-19 positive room, Nurse #4 stated she put on all the PPE that was checked on the sign for Special Droplet Contact Precaution except for the face shield which was not stocked in the tower on the door. At that time the Nurse was directed to the second pocket on the PPE tower where there was a face shield available for use. The Nurse stated she did not see the face shield while she was preparing to go into the room. Nurse #4 was asked what she should have done if there were no PPE available to don before entering the COVID-19 positive rooms and the Nurse stated, 'go to the supply room and get some." When asked why she did not do that the Nurse stated "ignorance." An interview was held with the Infection Preventionist (IP) on 01/11/24 at 9:22 AM. The IP explained that all staff were educated on PPE procedures and the differences in the types of Transmission Based Precautions and what PPE to apply related to the specific signage. The IP stated Nurse #4 should have donned the PPE as specified on the signage before she entered the room per the policy.	F 880	and utilizing proper PPE. This education will be incorporated into new hire training for all staff. Education for all facility Registered nurses, Licensed practical nurse, medication aides, nursing aides, nonclinical staff, department heads, therapy department, environmental services, maintenance and dietary staff. Any of the above identified staff who does not complete the education by 1/18/2024 will not be allowed to work until education has been completed. Assurance Beginning the week of 1/22/2024, the Director of Nursing or designee will observe and monitor staff donning /doffing of PPE for 1-day shift and 1- evening shift to ensure that proper donning/doffing of PPE is occurring. This audit will be completed weekly x4 and then monthly x2 months. Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Minimum Data Set Registered Nurse, Environmental Services Director, Social Services Director, Dietary Manager, Health Information Manager, and Activities Director, Maintenance Director and Rehab Director. Date of Compliance 1/19/2024	

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F 880	Continued From page 63 During an interview with the Administrator and Director of Nursing made on 01/11/24 at 4:42 PM the Administrator explained that her expectation was for the staff to follow the instructions on the specific Precautions and retrieve the PPE necessary if the supply had been depleted from the tower on the door.	F 880		