STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CHARLOTTE	5939 REDDMAN ROAD CHARLOTTE, NC 28212

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E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency	E 006		1/17/24

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

Electronically Signed | 02/09/2024

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E 006	Continued From page 1 Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and record review, the facility failed to notify law enforcement per their emergency operations plan when Resident #86 left the facility for a planned leave of absence (LOA) but failed to communicate or return to the facility as planned. This failure occurred for 1 of 1 sampled resident reviewed for a LOA. The findings included: The facility policy, Rapid Response guidelines of the All-Hazards Emergency Operations Plan, Missing Resident, reviewed/revised 7/20/23, documented in part, "If the missing resident is not	E 006	E006: Plan of correction; Plan Based on all Hazards risk Assessment. Deficiency practice: the facility failed to notify law enforcement per emergency operations plan under missing person requirements. Address how corrective action will be accomplished for resident (s) found to have been affected. All residents have the potential to be affected by this deficiency. Administration and Director of Nursing immediately started education to IDT	

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E 006	Continued From page 2 found following an expedient search, call 911." Resident #86 was admitted to the facility on 11/9/22 with diagnoses that included alcoholic cirrhosis of the liver with ascites, anxiety disorder, and depression, among others. The medical record for Resident #86 documented the Resident was her own responsible party (RP) with family as the emergency contact. A quarterly Minimum Data Set assessment dated 8/16/23, assessed Resident #86 with adequate hearing/vision, clear speech, understood and able to understand, no corrective lenses or use of hearing aids, intact cognition, no change in mood and no wandering behavior. She required supervision of one person for activities of daily living, ambulated independently without mobility devices, no impairment with range of motion, occasional bladder incontinence, frequent bowel incontinence, no falls, and no active discharge plans at the time of the assessment. An Out of Facility Release of Responsibility for LOA document for Resident #86, recorded the Resident's name but did not document that Resident #86 signed out on 10/14/23. The document recorded "Authorization must be signed by the resident or by the nearest relative in the case of a minor or when the resident is physically or mentally incompetent." A nurse progress note, dated 10/14/23, written by Nurse #1 recorded Resident #86 left the facility in a wheelchair, alert, awake and oriented with (named family member) in her private vehicle to be out on a pass until Tuesday, October 17. The Administrator and Director of Nursing (DON)	E 006	team on facility policy Missing person protocol. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same deficiency practice. Education provided to IDT and nursing staff on the facility policy Rapid Response guidelines of All-Hazard Emergency operating plan, Missing resident procedures by 1/17/2024. Emergency Preparedness Plan policies, including Missing Resident policy, will be reviewed with all new hires during orientation. IDT will list and monitor residents out on LOA at the daily morning meeting starting 1/17/23. Address what measures will be put in place or systemic changes made to ensure that the identified deficiency does not occur in the future. The administrator, Director of Nursing and Social worker Director will Audit resident leaving LOA 5 days a week x 4 weeks, weekly x 8 weeks, then monthly for 3 months to ensure all requirements are met by evidence of audit follow ups and weekly event risk assessments monitoring. Administrator will monitor orientation to ensure emergency preparedness plan policies are taught 5 days a week x 4 weeks, weekly x 8 weeks, then monthly for 3 months. Administrator will monitor LOA list from	

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E 006	Continued From page 3 were made aware. Nurse progress notes dated 10/18/23 to 10/24/23 written by Nurse #2 recorded that Resident #86 was still on LOA. A social services progress note dated 10/24/23 written by the Social Services Director (SSD) recorded Resident #86 had been on LOA since 10/14/23 but had not returned to the facility and had not communicated her plans to return. The progress note documented that the SSD called Resident #86 and received an automated message and then called the Resident's emergency contact who was unaware of the Resident's whereabouts. The progress note recorded that the emergency contact was notified of the facility's LOA policy and that Resident #86 would be discharged against medical advice (AMA) on 10/29/23 if the Resident did not return to the facility. A nurse practitioner progress note dated 10/29/23 recorded that Resident #86 had not returned to the facility from a LOA on 10/14/23; efforts to reach Resident #86 were unsuccessful which resulted in a discharge AMA. A progress note written by the Administrator dated 10/30/23 documented the Administrator spoke to Resident #86 who advised she was safe but was not returning to the facility. Phone calls by the surveyor to Resident #86 and her emergency contact were attempted, but unsuccessful. A phone interview with Nurse #1 occurred on 1/10/24 at 5:49 PM. Nurse #1 stated that she	E 006	morning meeting 5 days a week x 4 weeks, weekly x 8 weeks, then monthly for 3 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The IDT team will review Audits in the Quality Assurance Performance Improvement meeting monthly for 6 months including strategies for addressing events identified by weekly risk assessments to ensure all requirements are met for the safety of all the residents. Compliance within this deficiency will be completed by 1/17/24	

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E 006	Continued From page 4	E 006		

worked at the facility on the 7a-7p shift for almost 2 years. Nurse #1 stated she was a regular Nurse for Resident #86 and was her Nurse on 10/14/23 when Resident #86 left the facility on a LOA to attend a funeral. Nurse #1 stated the LOA was planned and approved by the SSD and DON and the SSD communicated the plan for the LOA to Nurse #1. Nurse #1 stated when the family came to pick up Resident #86 on 10/14/23, the Out of Facility Release of Responsibility was given to Resident #86 to sign herself out, Nurse #1 gave her a list of medications, her medications, and instructions on how/when to take her medications. Resident #86 said her LOA would be 2 - 3 days, but when Nurse #1 returned to work the following Friday (10/20/23), she was notified that Resident #86 was not back from her LOA on 10/14/23. Nurse #1 stated she was not given instructions to do anything regarding Resident #86's return to the facility, so she did not consider calling 911.

A phone interview with Nurse #2 occurred on 1/11/24 at 9:18 AM. Nurse #2 stated that she worked at the facility on the 7p - 7a shift and that she was the assigned nurse for Resident #86 on that shift. Nurse #2 stated she wrote the progress notes which documented that Resident #86 was still on LOA, but that she did not question how long the Resident would be on LOA or when she was expected to return. Nurse #2 stated that most residents do not return to the facility from a LOA on the 7p-7a shift, so she did not call 911 because LOA is usually handled by day shift staff.

An interview with the Assistant Director of Nursing (ADON) occurred on 1/10/24 at 1:06 PM. The ADON stated that Resident #86 left the facility for a planned LOA to visit family and attend a funeral,

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E 006	Continued From page 5	E 006		

but that the Resident did not return as planned and did not communicate with the facility a change in her plans, so she was discharged AMA. The ADON stated he was the supervisor when Resident #86 went on a LOA for a couple days, she did not come back, so the facility tried to call the family, but the family did not know where the Resident was and had not spoken to her. The ADON stated he did not think calling 911 would help because the family did not indicate that she was not safe.

The SSD was interviewed on 1/10/24 at 1:31 PM. The SSD stated she was made aware by Resident #86's family in October 2023 that there had been a death in Resident #86's family and that Resident #86 wanted to attend the funeral. The SSD stated that she was out of the facility for a few days in October 2023 and when she returned on 10/24/23, she learned during a department manager's meeting that Resident #86 had not returned from a LOA on 10/14/23. The SSD stated she called Resident #86 on 10/24/23, but got an automated message, so she called her family the same day, but they did not know where she was, but the family stated they would contact some of her friends to try and locate her. The SSD said she explained the LOA policy to the family and asked the family to contact the facility if they learned anything about Resident #86's whereabouts. The SSD stated that she later heard in a department manager's meeting that Resident #86 called the facility and spoke to the Administrator and advised that she was not coming back. The SSD stated that she did not call 911 while Resident #86 was away from the facility because when she spoke to the family, they did not express concerns that Resident #86 was unsafe and because the SSD was made

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E 006	Continued From page 6 aware during a department manager's meeting that Resident #86 had not returned, so she expected nursing would follow up on the Resident's plans to return to the facility. The SSD stated that in her experience, if the family felt a resident was safe, she did not think calling 911 had to be done. An interview with the Administrator and DON occurred on 1/10/24 at 03:03 PM. During the interview, the DON stated that Resident #86 went on a planned LOA to attend a funeral for a family member. Resident #86 expressed she would be gone for about a week, but when she was set to return, she did not return when expected. The DON stated she noticed that the Medication Administration Record continued to document LOA after Resident #86 was supposed to have returned, so it was discussed in the department manager meeting on 10/19/23, two days after Resident #86 was set to return. The facility reached out to her on 10/19/23, 10/20/23 and 10/22/23, but did not get an answer. The DON stated that the SSD spoke to the family on 10/24/23, but they did not know where she was. When Resident #86 called back on 10/30/23, Resident #86 said she was not going to return. The Administrator stated that the facility did not call 911 or consider her missing because the family said they thought she might be with some of her friends.	E 006		
F 000	INITIAL COMMENTS An on-site recertification and complaint investigation survey were conducted from 1/8/2024 through 1/11/2024. An extended survey was completed on 1/17/24. Therefore the exit date was changed to 1/17/24 Event ID# PH5U11.	F 000		

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F 000	Continued From page 7 The following intakes were investigated NC00206669, NC00207062, and NC00211618. Six (6) of the 6 complaint allegations did not result in deficiency. Substandard Quality of Care was identified at: CFR 483.24 at tag F680 at a scope and severity F.	F 000		
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have an Activity Director who was certified by an approved accrediting body. This practice had the potential to affect all residents in the facility.	F 680	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " By 02/08/24 The Director of Clinical	2/9/24

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F 680	Continued From page 8 The findings included: During an interview with the Activities Director on 1/11/2024 at 9:38 PM, a request was made to view her certification. The Activities Director reported she did not have certification from an accredited agency. The Activities Director explained she was hired in early 2021, almost 2 years ago, and had several years of experience at an adult care facility but did not have a diploma or a degree and had not taken the activities director course. The Activities Director explained that she thought her experience was enough for the position and she was not aware she was required to take the accreditation course. The Activities Director further explained she did not have an activities consultant and her assistant had not taken the course, either. The Administrator was interviewed on 1/11/2024 at 9:42 AM. The Administrator reported he was not aware the Activities Director was required to have certification from an accrediting body. The Administrator explained when the Activities Director was hired 2 years ago, the former facility managing company did not have a Human Resources department that would check accreditation. The Administrator reported he hired the Activities Director based on her prior experience.	F 680	Services revised the job description for Activities Director to include proof of previous completion of the NCCAP certification enrollment prior to being hired or completion or currently enrolled the federal educational requirements of an Activities Director in a skilled nursing facility. " The Administrator will educate the Hiring Managers on the revised job description For Activities Director by 02/09/24. " The Administrator secured a Certified Activities Director from a local facility to provide weekly support and oversight to the current Activities Professional 2/6/24. " The Administrator enrolled the current Activities Professional into an Activities Accreditation program through NCCAP on January 16, 2024. 2. Address how corrective action will be accomplished for those residents having a potential to be affected by the same deficient practice; " NCCAP Classes begin on February 12, 2024 and will be finished on 5/8/24. " By 02/09/24 an Accredited Activities Director from a local facility (Mentor) will be assigned to support and oversee the Activities department. " On 1/16/24 a meeting was held by the Administrator with the Resident Council and residents who have attended activities during the last 30 days, to explain the Activities DIrector responsibilities and to discuss satisfaction with current Activities Program. 3. Address what measures will be put into place or systemic changes made to	

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F 680	Continued From page 9	F 680	ensure that the deficient practice will not occur; " The Administrator will validate the activity calendar/schedule is created with guidance from the Mentor each week for 12 weeks " The Administrator will observe activities are completed according to the calendar/schedule each week for 12 weeks. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility. " The revised Activities Director job description will be reviewed in the February QAPI meeting. The Administrator will report the results of these audits during the monthly QAPI meeting and the committee will make recommendations as needed. The Administrator will confirm that the Activities Director completed the accreditation class by 5/8/24, and will validate monthly thereafter that the Activities Director has acceptable accreditation.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily	F 732		1/17/24

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F 732	Continued From page 10 basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to post a Daily Staffing Record with the current facility name for 4 days of the survey (1/8/24 - 1/11/24) and failed	F 732	F732 Plan of Correction. Posting Staffing Information. Deficiency Practice: The facility failed to document the current facility name and	

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F 732	Continued From page 11 to document the current facility name and accurate staffing data for 14 of 14 days of nurse staffing data reviewed. The findings included: 1a. An observation at 10:15 AM on 1/8/24 and at 8:45 AM on 1/9/24 through 1/11/24 of the posted Daily Staffing Record, revealed the name of the facility prior to the change in ownership was recorded. 1b. A review of 14 Daily Staffing Records (10/6/23, 10/14/23, 10/17/23, 10/23/23, 11/8/23, 11/14/23, 11/24/23, 11/27/23, 12/1/23, 12/7/23, 12/13/23, 12/22/23, 1/2/24 and 1/5/24) revealed the name of the facility prior to the change in ownership was recorded. 1c. A review of the Daily Staffing Records revealed licensed and unlicensed nursing staff was not recorded accurately for 14 days: - 10/6/23, the Daily Staffing Record documented 5 registered nurses (RN) provided 36 hours of nursing care, 7 licensed practical nurses (LPN) provided 60 hours of nursing care, and 23 nurse aides (NA) provided 172 hours of nursing care. The staff assignment sheet recorded 4 RN, 5 LPN and 21 NA. - 10/14/23, the Daily Staffing Record documented 5 RN provided 36 hours of nursing care, 7 LPN provided 48 hours of nursing care, and 31 NA provided 172.5 hours of nursing care. The staff assignment sheet recorded 3 RN, 4 LPN and 24 NA. - 10/17/23, the Daily Staffing Record documented 6 RN provided 48 hours of nursing care, 11 LPN provided 68 hours of nursing care, and 22 NA provided 165 hours of nursing care. The staff	F 732	accurate staffing data. Address how corrective action will be accomplished for resident (s) found to have been affected. All residents have the potential to be affected by this deficiency. On 1/10/2024 DON created a new staff posting template reflecting the new facility name. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same deficiency practice. On 1/10/2024 the administrator in-serviced the Director of Nursing on the requirements on Nursing information posting. On 1/10/2024 The Director of Nursing then in- serviced the scheduler, the Unit Managers on the same requirements. Adress what measures will be put in place or systemic changes made to ensure that the identified deficiency does not occur in the future. The administrator, Director of Nursing will audit the daily staffing board starting 1/11/24. Auditing will be done 5 days a week for 30 days, weekly for 1 month, and monthly thereafter for a total of 6 months of monitoring to ensure current completion as well as accuracy. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CHARLOTTE	5939 REDDMAN ROAD CHARLOTTE, NC 28212

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F 732	Continued From page 12 assignment sheet recorded 5 RN, 6 LPN and 24 NA. - 10/23/23, the Daily Staffing Record documented 4 RN provided 36 hours of nursing care, 9 LPN provided 64 hours of nursing care, and 23 NA provided 172.5 hours of nursing care. The staff assignment sheet recorded 3 RN, 5 LPN and 24 NA. - 11/8/23, the Daily Staffing Record documented 3 RN provided 24 hours of nursing care, 10 LPN provided 76 hours of nursing care, and 23 NA provided 172.5 hours of nursing care. The staff assignment sheet recorded 4 RN, 5 LPN and 24 NA. - 11/14/23, the Daily Staffing Record documented 6 RN provided 48 hours of nursing care, 11 LPN provided 76 hours of nursing care, and 21 NA provided 157.5 hours of nursing care. The staff assignment sheet recorded 4 RN, 6 LPN and 22 NA. - 11/24/23, the Daily Staffing Record documented 10 RN provided 72 hours of nursing care, 4 LPN provided 48 hours of nursing care, and 21 NA provided 157.5 hours of nursing care. The staff assignment sheet recorded 6 RN, 3 LPN and 22 NA. - 11/27/23, the Daily Staffing Record documented 10 LPN provided 72 hours of nursing care, and 22 NA provided 165 hours of nursing care. The staff assignment sheet recorded 6 LPN and 23 NA. - 12/1/23, the Daily Staffing Record documented 10 LPN provided 72 hours of nursing care, and 21 NA provided 157.5 hours of nursing care. The staff assignment sheet recorded 5 LPN, and 24 NA. - 12/13/23, the Daily Staffing Record documented 3 RN provided 24 hours of nursing care, 10 LPN provided 72 hours of nursing care, and 19 NA	F 732	develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. All results of the audit will be reviewed and discussed at the weekly IDT Risk meeting for 4 weeks, then monthly at the monthly facility Quality Assurance Committee (QAPI) meeting for 3 months and then quarterly thereafter once compliance is at 100%. Compliance within this dificiency will be completed by 1/17/24	

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F 732	Continued From page 13	F 732		

provided 157.5 hours of nursing care. The staff assignment sheet recorded 2 RN, 6 LPN and 20 NA.
- 12/22/23, the Daily Staffing Record documented 7 RN provided 48 hours of nursing care, 7 LPN provided 60 hours of nursing care, and 20 NA provided 153 hours of nursing care. The staff assignment sheet recorded 4 RN, 5 LPN and 21 NA.
- 1/2/24, the Daily Staffing Record documented 3 RN provided 24 hours of nursing care, 15 LPN provided 88 hours of nursing care, and 19 NA provided 142.5 hours of nursing care. The staff assignment sheet recorded 2 RN, 7 LPN and 21 NA.
- 1/5/24, the Daily Staffing Record documented 2 RN provided 12 hours of nursing care, 12 LPN provided 96 hours of nursing care, and 21 NA provided 157.5 hours of nursing care. The staff assignment sheet recorded 1 RN, 8 LPN, 20 NA, and 3 Med Techs.

The Staffing Coordinator was interviewed on 1/11/24 at 1:09 PM. She stated that she was responsible for completing the staff assignment sheets and completing updates to these records when the staffing pattern changed. The Staffing Coordinator stated that there were some staff that she did not include on the staff assignment sheets like the Assistant Director of Nursing (ADON), a RN, unless he was assigned a medication cart or herself because she was also the facility's Wound Nurse. She stated that the Director of Nursing (DON) was responsible for completing and posting the Daily Staffing Record.

The DON stated in an interview on 1/11/24 at 1:34 PM that the facility changed ownership in March of 2023. She stated that since the change

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F 732	Continued From page 14 the facility has transitioned to a new staffing data system and that she was in the process of changing the report system used for the Daily Staffing Record. The DON stated that the Daily Staffing Record did not always include the ADON or the Wound Nurse since their responsibilities also included tasks which were not direct patient care. The DON stated that most of the time there were more staff in the facility than the posted Daily Staffing Record documented. She stated that she recorded on the Daily Staffing Record the staff she was expecting at the beginning of each shift, but at times staff showed up for work who were not scheduled and when she was aware this occurred, she updated the Daily Staffing Record to reflect the additional staff.	F 732		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		1/17/24

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F 842	Continued From page 15 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 16 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that the medical records contained dental visit notes for 1 of 4 residents reviewed for dental care (Resident #1). The findings included: 1. Resident #1 was admitted to the facility on 8/18/2020. The quarterly Minimum Data Set assessment dated 11/8/2023 assessed Resident #1 to be cognitively intact. Electronic medical records were reviewed. No dental visit notes were scanned into the system. The facility did not have hard copy records. The Social Worker (SW) was interviewed on 1/10/2024 at 12:23 PM. The SW reported she made appointments for routine and emergency dental services for the residents. When asked to provide dental visit notes for Resident #1, the SW reported she had to call the dentist office and they would email the visit notes to her. The SW provided a dental visit note dated 10/3/2022 for Resident #1 on 1/10/2024 and explained that she was not aware dental visit notes should be part of the electronic medical record. The Administrator was interviewed 1/11/2024 at	F 842	F842 Plan of Correction: Resident Records- Identifiable information Deficiency practice: The facility failed to ensure that dental visit notes were scanned into PCC and facility did not have hard copies available. Address how corrective action will be accomplished for resident (s) found to have been affected. All residents have the potential to be affected by this deficiency. The Social Work Director audited all residents found to have been affected by this deficiency. All visits□ notes for the previous year were requested via email to Aria Care partners and will be scanned into each resident□s medical record by February 15th, 2024, and hard copies will be kept in a binder and be available upon request at the social□s worker□s office. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same deficiency practice. The Director of Nursing educated social workers and medical record personnel on January 10th, 2024, on resident identifiable-Information/ Medical records standards of practice.	

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F 842	Continued From page 17 3:45 PM. The Administrator reported the dental records should have been sent to the facility after the visit to be manually uploaded into the system. The Administrator explained he was not certain why the dental records were not in the electronic medical record.	F 842	Adress what measures will be put in place or systemic changes made to ensure that the identified deficiency does not occur in the future. The administrator, Director of Nursing and Social worker Director will Audit all visit notes 1 time a week x 4 weeks then monthly x 1 month for 3 months to ensure All visits notes are scanned into resident□s medical record on Point click care and hard copies are also available in a binder at the SW□s office. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The IDT team will review Audits in the Quality Assurance Performance Improvement meeting monthly for 3 months to ensure all concerns are addressed and appropriate practices are followed.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform	F 851		1/31/24

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F 851	Continued From page 18	F 851		

format according to specifications established by CMS.

§483.70(q)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through

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F 851	Continued From page 19 an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to electronically submit direct care staffing information based on payroll data to the Centers for Medicare and Medicaid (CMS) as required for quarter 1 of fiscal year (FY) 2023 (October - December 2023). The failure occurred for 1 of 5 quarters reviewed. The findings included: A review of the Payroll Based Journal (PBJ) Staffing Data report from the Certification and Survey Provider Enhanced Reports (CASPER) database revealed the facility failed to submit the required PBJ Staffing Data for the first quarter of FY 2023. The Director of Nursing stated in an interview on 1/11/24 at 1:34 PM, that she was aware of the PBJ staffing reporting error due to lack of reporting to CMS but deferred to the Administrator as to why this error occurred. The Administrator stated in an interview on 1/11/24 at 1:51 PM that he was aware that the facility failed to electronically submit PBJ staffing	F 851	F851: Payroll Based Journal. Deficiency practice: The facility failed to electronically submit PBJ staffing data to CMS in the first quarter of 2023. Address how corrective action will be accomplished for resident (s) found to have been affected. All residents have the potential to be affected by this deficiency. Email correspondence regarding PBJ submission between corporate Human Resources and Administrator will prevent future errors in CMS PBJ reporting starting 1/18/24. Address how corrective action will be accomplished for resident(s) having potential to be affected by the same deficiency practice. 1/31/24 The administrator was educated on the requirements of electronically submitting to CMS complete and accurate staff data.	

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F 851	Continued From page 20 data to CMS in the first quarter of FY 2023. The Administrator stated that the corporate office was responsible for submitting the PBJ staffing data for all the facilities in the corporation. He stated that during the first quarter of FY 2023, the corporation did not have a human resources department, so payroll tasks were outsourced to a 3rd party vendor at the time. The Administrator stated that the 3rd party vendor did not identify the facility as a focus for staffing data concerns, because the facility did not utilize agency staff and had more than sufficient staffing, and so he stated, "somehow we fell off the map" which he said caused the PBJ reporting error.	F 851	Adress what measures will be put in place or systemic changes made to ensure that the identified deficiency does not occur in the future. A designee Human resources personnel from the corporate office will be responsible for quarterly PBJ reporting Data to CMS. The administrator will be responsible for auditing payroll tasks including staffing data weekly x 8 weeks then monthly x for 6 months to ensure PBJ requirements are met according to CMS regulations. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented, and the corrective action evaluated for its effectiveness. The IDT team will review Audits in the Quality Assurance Performance Improvement meeting monthly for 6 months to ensure mandatory submission of staffing information-based payroll in a uniform format is accurately maintained and submitted timely. Complicance for this deficiency will be completed by 1/31/24	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345243	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/17/2024

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 609	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to submit a 5 Day Investigation within the required timeline to the State Agency for resident-to-resident abuse for 2 of 2 residents reviewed for abuse (Resident #50 and Resident #69). Findings included: In an interview on 01/09/24 at 9:46 AM with the facility Administrator, he confirmed he had received a phone call about an interaction between Resident #50 and Resident #69 on 07/26/23 at 6:45 PM. He stated the Activities Director observed the residents in their wheelchairs hitting each other outside in the smoking area. He stated the Activities Director separated the residents, both cognitively intact, and took each resident to their respective rooms. He stated Resident # 50 had a bleeding lip which was attended to by her nurse and Resident #69 sustained no injuries. He stated he completed the 24-hour documentation, and per the fax submission, it was faxed to the State Office on 07/26/23 at 7:23 PM. In an interview with the Director of Nursing (DON) on 01/10/23 at 2:29 PM she confirmed she was aware of the incident between Resident # 50 and Resident # 69. The DON stated she was aware of the requirement to report abuse an abuse investigation within 5 days of being notified of the allegation. A follow-up interview on 01/10/24 at 5:10 PM with the Administrator and DON revealed the Administrator was aware of the requirement to report an abuse allegation within 2 hours and the final investigation within 5 days. The Administrator stated he was dealing with several issues at the time that the 5-day investigation was due to be submitted to the State. He further stated he had somehow must have gotten confused on the actual

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 609	Continued From Page 1 date the report was due. The Administrator stated he had investigated the allegation and closed it as unsubstantiated on 07/28/23, but he didn't fax it to the State until 08/10/23 at 9:35 AM.