STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING ______ B. WING ______	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/05/24 through 02/12/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZMDY11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 02/05/24 to conduct a recertification and complaint investigation survey and exited on 02/08/24. Additional information was obtained on 02/09/24 and 02/12/24. Therefore, the exit date was changed to 02/12/24. The following intakes were investigated NC00209481, NC00209993, NC00210652, NC00210707, NC00211268, NC00211392, and NC00211797. Five of the fourteen complaint allegations were substantiated resulting in deficiencies. Event ID# ZMDY11.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		3/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/02/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 565	Continued From page 1 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews the facility failed to provide updates or resolutions to group grievances (evening snacks, better meal choices, transportation to outings, and cold food) that were brought to Resident Council meetings for 4 of 4 months reviewed (October, November, December of 2023 and January 2024). The findings included: A review of Resident Council meeting minutes from October 2023 through January 2024 was completed. Each month's meeting minutes had an "Old Business" and a "New Business" section. Residents brought the following concerns to Resident Council: Review of the October 2023 minutes revealed	F 565	1. On 2/26/2024 grievances were filed and addressed for Residents #7, #25, #27, #21, #70,#78, #6, #69,#84, #60, #81, #34 concerns related to evening snacks, better meal choices,transportation to outings, and cold food. 2. The Executive Director and/or Social Service Director reviewed the Resident Councilminutes for the last 30 days. Grievances expressed were addressed. 3. On 2/26 /24, the Activity Director received education by the Regional Director of Clinical Services on the grievance process as it relates to the resident council. If a resident expresses a concern during the resident council meeting, the Activities Director will	

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F 565 Continued From page 2

under "Old Business"1. Residents would like a bigger bus for outings 2. Residents would like better meal choices such as soup, salads, and fresh fruit.

The November 2023 Resident Council minutes noted, "New Business" 1. Residents would like a bigger bus for outings 2. Residents would like better meal choices such as soup, salads, desserts, and fresh fruit. Under "Old Business" 1. Residents would like a bigger bus for outings so that more residents can attend 2. Residents would like better meal choices such as soup, salads, desserts, and fresh fruit.

Review of the December 2023 Resident Council Minutes revealed under "New Business" 1.Residents were "still" not receiving snacks at night 2.Breakfast was served cold 3.Better meal choices were requested. Under "Old Business" 1.Residents would like to have snacks at night. 2.Better meal choices were requested 3.Residents would like a bus to go on outings.

The January 2024 Resident Council meeting minutes noted, "New Business" 1.Residents were "still" not receiving snacks at night 2.Breakfast was served cold 3.Better meal choices. "Old Business"- 1.Residents would like to have snacks at night 2.Food was cold 3.Better meal choices (soup, salads, fresh fruits) not honored.

Interviews conducted on 2/7/24 (2:00 PM to 3:18 PM) during the Resident Council meeting with Resident #78, #6, #69, #84, #60, #81, #34, #7, #25, #27, #21, #70 revealed they were still not getting evening snacks and discussed the issue with the food committee. However, if snacks were brought to the nurse's station, there was never

F 565 (Provider's Plan of Correction)

complete a grievance form and provide a copy to the appropriate department for follow up and the original to the Social Service Director. The Executive Director will review the Resident Council minutes after the meeting with the Activity Director to ensure follow up. The Executive Director will review the summary of grievance resolution with the Resident Council President. Summary of grievance resolution will also be reviewed in next month Resident Council meeting by the Executive Director and/or Director of Clinical Services and documented in the minutes.

4. Executive Director and/or Social Services Director will conduct random audits ofresident council minutes to ensure grievances expressed were followed up/reported with resolution three (3) times a week for twelve (12) weeks. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but, not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Director of Clinical Services will report the results of the quality monitoring (audits) to the

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F 565	Continued From page 3 enough to distribute to all residents. Attendees further revealed they had been complaining about "no snacks" for several resident council meetings. Resident council attendees indicated they had not been on an outing since August 2023 because the facility van could not accommodate more than 6 residents and the van was being used for resident appointments or facility business. Resident attendees further indicated their cold food complaints and alternative food choices have not been addressed despite having brought their concerns to resident council meetings for at least 3 or more months. One resident council meeting attendee stated she received soup only one time after the food committee was held and would have liked to have soup offered during the winter months. During an interview on 2/6/24 at 2:21 PM the Activities Director indicated she forwarded resident council grievances to the social worker and grievances were discussed during morning staff meetings. If she did not receive an update from a department head and if resident council attendees indicated the concern/ issue continued, she would add the concern to the resident council minutes for the next month and re-submit a grievance. She further indicated she was instructed by the Activities Coordinator Consultant to copy "old business" from the previous month's minutes to the next month's "new business" until the concern was resolved or addressed. She stated resident council attendees voiced concerns from October 2023 through January 2024, related to receiving no evening snacks, receiving cold food, and not going on outings due to lack of appropriate transportation to accommodate residents.	F 565	Quality Assurance Performance Improvement Committee monthly for three months. Date of Compliance is 3.11.2024	

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Continued From page 4

During an interview on 2/7/24 at 11:26 AM the Social Worker (SW) revealed it was her understanding that the resident council minutes listed old business as new business the following month, if it had not been addressed, improved, or resolved. She further revealed she submitted grievances to appropriate departments, such as the Dietary Manager, the Director of Nursing (DON) and the Administrator during the morning meetings as needed.

During an interview on 2/8/24 at 3:33 PM the Dietary Manager indicated she met with residents during the food committee meeting in November 2023 and believed the issue was resolved when she sent more snacks to each unit. However, she was unaware residents were still not receiving their snacks and could only report on snacks that were delivered nightly to both nurse's stations. She further indicated she believed alternate meal choices were adequate and believed residents were receiving a variety of meals (soup, salads, and fresh fruit) as discussed in food committee meetings. However, she was unaware it was still a concern. The Dietary Manager stated resident meals left the kitchen soon after they were plated from the hot steam tables and was not aware of the time the food sat on the hall before nursing staff served trays to residents.

During an interview on 2/8/24 at 3:55 PM the DON revealed she was aware of resident concerns related to not receiving snacks and she believed the concern was resolved since nursing staff signed off on dietary staff delivering snacks to the nurse's station. She was not aware that residents were still not receiving evening snacks. Her expectation was for all residents to receive evening snacks, hot/ warm meals and to attend

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F 565	Continued From page 5 outings. During an interview on 2/8/24 at 1:18 PM the Administrator revealed he expected all residents to be offered nightly snacks, receive warm/ hot meals, and attend outings with transportation soon, since the van had been repaired.	F 565		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for Gradual Dose Reduction for 2 of 5 residents (Resident #15 and Resident #20) reviewed for unnecessary medications. The findings include: 1. Resident #15 was admitted to the facility on 06/22/21 with diagnoses that included anxiety, depression, dementia and psychotic disorder. A review of Resident #15's physician orders dated 09/23/21 for Seroquel 100 milligrams (mg) (an antipsychotic medication used to treat symptoms of psychosis) by mouth twice a day and 06/12/22 for Seroquel XR Extended Release 50 mg by mouth once a day in the afternoon. A review of Resident #15's Psychiatry progress note dated 09/13/23 indicated to continue the current medications as prescribed at the current	F 641	1. Resident #15 and Resident #20 Minimum Data Set (MDS) assessments were modified on 2/8/24 to correct assessment for Gradual Dose Reduction (Section coding N0450). 2. Minimum Data Set (MDS) Nurse completed a quality review audit on all current residents triggering for an antipsychotic to ensure correct coding of N0450 as of 2/28/2024 for Assessment Reference Dates 9/1/2023 and after to ensure assessment for Gradual Dose Reduction was coded accurately. Any issues noted were addressed as identified. 3. Regional Minimum Data Set (MDS) Nurse completed education with facility Minimum Data Set (MDS) Nurse on 2/26/2024 on correct coding of section N0450.	3/11/24

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F 641	Continued From page 6 doses as any reduction attempted may cause decompensation of the resident. A review of Resident #15's quarterly Minimum Data Set (MDS) assessment dated 12/19/23 indicated the resident received an antipsychotic medication on a routine basis and no Gradual Dose Reduction (GDR) had been noted as attempted and no physician documentation of GDR as clinically contraindicated was noted. A review of Resident #15's Medication Administration Record for 12/2023 indicated that the resident received Seroquel XR Extended Release 50 mg by mouth one time a day in the afternoon and Seroquel 100 mg by mouth twice a day. During an interview with MDS Nurse #1 on 02/08/24 at 12:59 PM the Nurse acknowledged the MDS was not coded correctly and explained that she was "really" sick on and off for about a month around the time the resident's MDS was due and still tried to do her job. An interview was conducted with the Administrator on 02/08/24 at 4:15 PM who stated he expected the MDSs to be coded correctly. 2. Resident #20 was admitted to the facility on 08/03/23 with diagnoses that included progressive neurological conditions such as Parkinson's disease, dementia and schizophrenia. A review of Resident #20's physician orders dated revealed 08/04/23 for Risperdal (an antipsychotic medication used to treat symptoms of schizophrenia) 0.5 mg by mouth one time a day	F 641	4. Audits will be conducted weekly x four (4) weeks then monthly x two (2) months by Regional Minimum Data Set Nurse to ensure correct coding of N0450. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Director of Clinical Services will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Correction will be 3.11.2024	

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F 641	Continued From page 7 and 09/25/23 for Risperdal 3 mg by mouth at bedtime. A review of Resident #20's Psychiatry progress note dated 10/11/23 indicated to continue the current medications as prescribed at the current doses as any reduction attempted may cause decompensation of the Resident. A review of Resident #20's Medication Administration Record dated 12/2023 revealed the Resident received Risperdal 0.5 mg by mouth one time a day and Risperdal 3 mg by mouth at bedtime. A review of Resident #20's quarterly Minimum Data Set (MDS) assessment dated 01/01/24 indicated the Resident received an antipsychotic medication on a routine basis and no Gradual Dose Reduction (GDR) had been noted as attempted and no physician documentation of GDR as clinically contraindicated was noted. During an interview with MDS Nurse #1 on 02/08/24 at 12:59 PM the Nurse acknowledged the MDS was not coded correctly and explained that she was "really" sick on and off for about a month around the time the Resident's MDS was due and still tried to do her job. An interview was conducted with the Administrator on 02/08/24 at 4:15 PM who stated he expected the MDSs to be coded correctly.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		3/11/24

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F 656	Continued From page 8 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 9 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to implement nutrition care plan interventions to monitor and document food/fluid intake at each meal for 2 of 2 sampled residents reviewed for nutrition care plans (Resident #142 and Resident #80). The findings included: 1a. Resident #80 was admitted to the facility 8/22/23. Diagnoses included type 2 diabetes mellitus, protein calorie malnutrition, hyperkalemia, end stage renal disease with hemodialysis, and anemia, among others. A nutrition care plan initiated 9/1/23 identified Resident #80 had potential for nutritional problems due to a therapeutic diet and 32-ounce fluid restriction. Interventions included for nursing staff to monitor food/fluid intake and record intake at each meal. A quarterly Minimum Data Set dated 1/5/24 assessed Resident #80 with intact cognition, required set up/clean up assistance with meals and no weight loss or weight gain. A review of the electronic medical record revealed food intake was not recorded for Resident #80 the following meals: -Breakfast - 13 days; 10/2/23, 10/17/23, 10/24/23, 12/15/23, 12/18/23, 12/19/23, 12/31/23, 1/14/24, 1/27/24, 1/31/24, 2/1/24, 2/2/24 and 2/6/24.	F 656	1. Resident #142 and Resident #80 were assessed by Medical Director, and it was determined that no adverse complication was noted.Current residents with a nutrition care plan intervention to monitor and document food/ fluid intake had the potential to be affected. 2. Quality review of residents with a nutrition care plan intervention to monitor and document food/fluid intake was conducted by Director of Clinical Services on 3/1/2024. Findings were reviewed with Medical Director and Registered Dietician. 3. Education on Food/Fluid Intake to include monitoring and documentation will be presented to all Licensed Nurses and Certified Nursing Assistants by Director of Clinical Services and Unit Managers by 3/11/2024. Any staff not educated by 3/11/2024 will not be allowed to work until education is completed. Newly hired nursing staff will receive education as part of the orientation process. Point of Care documentation will be reviewed daily in Clinical Morning Meeting.Incomplete documentation will be addressed by Unit Manager. 4. Director of Clinical Service and/or designee will review Food/Fluid Intake for	

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F 656	Continued From page 10 -Lunch - 15 days; 9/3/23, 9/5/23, 10/1/23, 10/17/23, 12/7/23, 12/15/23, 12/18/23, 12/19/23, 12/31/23, 1/14/24, 1/27/24, 1/31/24, 2/1/24, 2/2/24, and 2/6/24. -Dinner - 14 days; 9/2/23, 9/5/23, 9/8/23, 9/10/23, 9/13/23, 9/22/23, 10/1/23, 10/9/23, 10/24/23, 10/28/23, 12/7/23, 12/10/23, 12/12/23 and 12/15/23. A review of the electronic medical record revealed fluid intake with meals was not recorded for the following: -All meals - 68 days; 9/1/23 - 9/8/23, 9/10/23 - 9/12/23, 9/14/23, 9/15/23, 9/20/23, 9/23/23 - 9/25/23, 9/27/23 - 9/29/23, 10/2/23, 10/4/23, 10/6/23 - 10/8/23, 10/10/23 - 10/15/23, 10/18/23, 10/20/23 - 10/24/23, 10/26/23, 10/28/23 - 10/31/23, 1/3/24 - 1/5/24, 1/7/24, 1/10/24 - 1/12/24, 1/15/24 - 1/31/24, 2/1/24, 2/2/24, and 2/4/24. Resident #80 Medication Administration Record, September 2023 - February 2024, recorded fluid intake with medications per the physician order for a 32-ounce fluid restriction. Resident #80 was observed in his room eating lunch on 2/5/24 at 12:53 PM and 2/7/24 at 12:30 PM. During each observation he received a renal diet with fluid restrictions as per his diet order. During the observations, he drank his fluids and ate small portions of each lunch meal. Nurse Aide (NA) #1 was interviewed on 2/7/24 at 12:42 PM. NA #1 stated that she was familiar with Resident #80 and often took him meals for breakfast and lunch. NA #1 stated she was aware to record food intake for all residents, but she was not aware that fluid intake should also be	F 656	five (5)residents weekly for twelve (12) weeks. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services,Unit Manager, Director of Social Services, Medical Director, Maintenance Director,Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Director of Clinical Services will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Correction will be 3.11.2024	

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recorded, so she did not record fluid intake for residents.

An interview with NA #3 occurred on 2/8/24 at 3:25 PM. NA #3 stated she worked all shifts at the facility since September 2023. NA #3 stated that at times she ran out of time or may have forgotten to document food/fluid intake for her assigned residents, but that she received constant reminders with in-services regarding documentation in the medical record.

A phone interview with Nurse #1 occurred on 2/9/24 at 12:52 PM. Nurse #1 stated she was a Nurse at the facility on the 7A - 3P shift for about 2 years until January 2024. Nurse #1 stated that she could not speak to the how much food/fluids residents consumed with meals as it was the responsibility of the NA to record the food/fluids consumed by the resident with each meal and nurses were responsible to monitor/document fluids consumed with medication administration for residents with fluid restrictions.

Nurse #3 was interviewed by phone on 2/12/24 at 8:46 AM and stated that she worked at the facility PRN from June 2023 until February 2024 on the 7A - 3P shift and sometimes worked until 7P. Nurse #3 stated fluid restrictions with medication administration was monitored and documented by the nurse, but that she could not recall food/fluid intake during meals as the NA charted food/fluid intake for meals for the residents.

During a phone interview with Nurse #2 on 2/9/24 at 4:04 PM, Nurse #2 stated she worked on the 11P - 7A shift. Nurse #2 stated that meals were consumed on the 7A - 3P and 3P - 11P shifts, so she was not aware of how well residents

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ate/drank with meals, but the NA was supposed to record the intake from meals.

An interview with Unit Manager (UM) #1 on 2/08/24 at 2:45 PM revealed that NA were responsible to monitor how much food/fluid residents ate and record the amount in the resident's medical record. UM #1 stated that if a resident did not eat at all, the NA would report to UM #1 and she would go and talk to the resident to see if the resident wanted an alternate. UM #1 stated that during clinical meetings a report regarding medical record documentation was discussed and if documentation was missing, she contacted the staff to ask them why the documentation was missing and educate them on the importance of documentation. UM #1 stated the lack of documentation in the medical record was an ongoing discussion during clinical meetings.

A phone interview with the Registered Dietitian (RD) occurred on 2/8/24 at 1:07 PM. The RD stated that she expected nursing staff to monitor the food/fluid intake per the care plan for residents because she used this data to complete her clinical assessments. The RD stated that she reviewed documentation of food/fluid intake in the medical record for the seven days prior to her assessment and that nursing should monitor for documentation for all other days.

The Director of Nursing (DON) was interviewed on 2/8/24 at 2:33 PM and stated that nursing staff should follow the care plan and should document the amount of food/fluid consumed at each meal in the medical record. The DON stated that the facility reviewed a report during clinical meetings regarding documentation in the medical record

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and if the report showed less than 80% documentation rate, managers would look more closely to identify trends to determine what corrections were needed and discuss the issue further during clinical meetings. The DON stated that managers did not look at specific residents without documentation in the medical record until the documentation error rate was less than 80% documentation.

The Administrator stated in an interview on 2/9/24 at 4:31 PM that he expected nursing staff to document in the medical record per the care plan and as needed.

1b. Resident #142 was admitted to the facility 11/15/23. Diagnoses included type 2 diabetes mellitus, elevated BMI (basal metabolic index), hyperlipidemia, hypokalemia, chronic kidney disease stage 3, and anemia, among others.

An admission Minimum Data Set dated 11/22/23 assessed Resident #142 with intact cognition, required set up/clean up assistance with meals and no weight loss or weight gain.

A care plan initiated 11/29/23 identified Resident #142 had potential for nutritional problems due to a mechanically altered, therapeutic diet with diet restrictions. Interventions included nursing staff to encourage good nutrition/hydration, monitor food/fluid intake and record intake in the medical record at each meal.

A review of the electronic medical record revealed food intake was not recorded for Resident #142 the following meals:
- Breakfast - 6 days; 12/2/23, 12/5/23, 12/10/23, 12/13/23, 12/14/23, and 12/15/23

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F 656	Continued From page 14 - Lunch - 2 days; 12/14/23, and 12/15/23 - Dinner - 2 days; 12/14/23, and 12/15/23 A review of the electronic medical record revealed fluid intake was not recorded for the following meals: - Breakfast - 18 days; 11/29/23, 11/30/23, 12/1/23, 12/2/23, 12/3/23, 12/4/23, 12/5/23, 12/6/23, 12/7/23, 12/8/23, 12/9/23, 12/10/23, 12/11/23, 12/12/23, 12/13/23, 12/14/23, and 12/15/23. - Lunch - 17 days; 11/29/23, 11/30/23, 12/1/23, 12/3/23, 12/4/23, 12/5/23, 12/6/23, 12/7/23, 12/8/23, 12/9/23, 12/10/23, 12/11/23, 12/12/23, 12/13/23, 12/14/23, and 12/15/23. - Dinner - 16 days; 11/29/23, 11/30/23, 12/1/23, 12/3/23, 12/4/23, 12/5/23, 12/6/23, 12/7/23, 12/8/23, 12/9/23, 12/10/23, 12/11/23, 12/12/23, 12/23/23, 12/14/23, and 12/15/23. Resident #142 was observed in her room eating breakfast on 2/6/24 at 10:15 AM. She received a carbohydrate controlled, no added salt, mechanical soft diet as per her diet order. She drank eight ounces of milk, four ounces of juice, ate a small portion of her food and she was complimentary of the meal. Nurse Aide (NA) #1 was interviewed on 2/7/24 at 12:42 PM. NA #1 stated that she was the assigned NA for Resident #142 often and that the Resident fed herself after her meals were set up. NA #1 stated she was aware to record food intake for all residents, but she was not aware that fluid intake should be recorded at meals for Resident #142, so she had not recorded that in her medical record. A phone interview with NA #2 occurred on 2/8/24	F 656		

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at 11:49 AM. NA #2 stated that she worked in the facility on 12/17/23 but that she did not recall caring for Resident #142, and she could not explain why she did not record food/fluid intake with meals.

An interview with Nurse Aide (NA) #3 occurred on 2/8/24 at 3:25 PM. NA #3 stated she worked all shifts at the facility since September 2023. NA #3 stated that at times she ran out of time or may have forgotten to document food/fluid intake for her assigned residents, but that she received constant reminders with in-services regarding documentation in the medical record.

A phone interview with Nurse #1 occurred on 2/9/24 at 12:52 PM. Nurse #1 stated she was a Nurse at the facility on the 7A - 3P shift for about 2 years until January 2024. Nurse #1 stated that she was the assigned nurse for the first time for Resident #142 on the 7A - 3 P shift on 12/16/23. Nurse #1 stated she monitored her and offered her fluids throughout the shift, but that she did not know how much she ate/drank with meals during the shift. Nurse #1 stated it was the responsibility of the NA to record the food/fluids consumed by the resident with each meal.

Nurse #3 was interviewed by phone on 2/12/24 at 8:46 AM and stated that she worked at the facility PRN from June 2023 until February 2024 on the 7A - 3P shift and sometimes worked until 7P. Nurse #3 stated that she was the assigned Nurse for Resident #142 on occasion. Nurse #3 stated that she knew Resident #142 fed herself, but that the Nurse was not familiar with how well Resident #142 ate or drank at meals, she did not recall how she took her medications or how much she drank. Nurse #3 stated the NA charted food/fluid

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F 656	Continued From page 16 intake at meals for the residents. During a phone interview with Nurse #2 on 2/9/24 at 4:04 PM, Nurse #2 stated she was the assigned Nurse for Resident #142 on the 11P - 7A shift. Nurse #2 stated that meals were consumed on the 7A - 3P and 3P - 11P shifts, so she was not aware of how well Resident #142 ate/drank, but the NA were supposed to record the intake at meals. An interview with Unit Manager (UM) #1 on 2/08/24 at 2:45 PM revealed that NA were responsible to monitor how much food/fluid residents eat at meals and record the amount in the resident's medical record. UM #1 stated that if a resident did not eat at all, the NA would report to UM #1 and she would go and talk to the resident to see if the resident wanted an alternate. UM #1 stated that during clinical meetings a report regarding medical record documentation was discussed and if documentation was missing, she contacted the staff to ask them why the documentation was missing and educate them on the importance of documentation. UM #1 stated the lack of documentation in the medical record was an ongoing discussion during clinical meetings. A phone interview with the Registered Dietitian (RD) occurred on 2/8/24 at 1:07 PM. The RD stated that she expected nursing staff to monitor the food/fluid intake at meals per the care plan for residents because she used this data to complete her clinical assessments. The RD stated that she reviewed documentation of food/fluid intake in the medical record for the seven days prior to her assessment and that nursing should monitor for documentation for all other days.	F 656		

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F 656	Continued From page 17 The Director of Nursing (DON) was interviewed on 2/8/24 at 2:33 PM and stated that nursing staff should follow the care plan and should document the amount of food/fluid consumed at meals in the medical record. The DON stated that the facility reviewed a report during clinical meetings regarding documentation in the medical record and if the report showed less than 80% documentation rate, managers would look more closely to identify trends to determine what corrections were needed and discuss the issue further during clinical meetings. The DON stated that managers did not look at specific residents without documentation in the medical record until the documentation error rate was less than 80% documentation rate. The Administrator stated in an interview on 2/9/24 at 4:31 PM that he expected nursing staff to document in the medical record per the care plan and as needed.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, a family interview, interviews with the Physician, Nurse	F 684	1. On 12/15/2023, per Nurse Practitioner Progress Note, Plan for Resident #142	3/11/24

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Practitioners and staff, the facility failed to obtain a STAT (immediately) chest X-Ray, transcribe an as needed order for Tylenol in response to a fever, follow a recommendation to monitor vital signs, and provide STAT lab results to the Nurse Practitioner for 1 of 3 sampled residents reviewed for hospitalization (Resident #142).

The findings included:

Resident #142 was admitted to the facility 11/15/23 and transferred to the hospital on 12/16/23 at the request of the family. Diagnoses included osteoarthritis knee pain, anxiety disorder, chronic obstructive pulmonary disease, essential hypertension, and atrial tachycardia (increased heart rate), among others.

A care plan initiated 11/17/23 identified Resident #142 used medications that required monitoring. Interventions included nursing to report important lab results to the MD.

An admission Minimum Data Set (MDS) dated 11/22/23 assessed Resident #142 with adequate hearing, adequate vision with corrective lenses, clear speech, able to understand, be understood and intact cognition. The MDS indicated Resident #142 received scheduled and as needed (PRN) pain medication for moderate, occasional pain that did not interfere with daily activities.

The December 2023 Medication Administration Record (MAR) for Resident #142 recorded the following:
- Acetaminophen (Tylenol) 325 mg, give 2 tablets for osteoarthritis pain, time recorded was 9:00 AM, pain rate recorded was 8/10 (12/14/23), 0/10 (12/15/23) and 6/10 (12/16/23).

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was to obtain STAT labs, STAT Chest XRAY, Urinalysis with Culture and Sensitivity, monitor vital signs, and administer Tylenol 650mg by mouth every 6 hours as needed. STAT labs were obtained on 12/15/2023, however, results were not available to Nurse practitioner on 12/16/2023. Trident Radiology was notified on 12/15/2023 to obtain STAT chest XRAY. When Radiology Technician arrived at the facility, resident had been transferred to the hospital. Urinalysis was not obtained prior to resident transfer to hospital. Vital signs were not monitored. Tylenol order was not carried out as prescribed.

2. Current residents who experienced a change in condition are at risk for being affected. All residents with a change in condition in the last 30 days were reviewed by Director of Clinical Services and Unit Managers to ensure all orders were properly processed and carried out. Any concerns noted were addressed as identified.

3. Director of Clinical Services and/or designee will educate Licensed Nurses by 3/11/2024 on Resident Change in Condition to include following physician orders and processing STAT orders. Any staff not educated by 3/11/2024 will not be allowed to work until education is completed. Newly hired nursing staff will receive education as part of the orientation process. All providers will be educated to put all new orders in Electronic Medical Record (EMR) by

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- Acetaminophen 325 mg, give 2 tablets for osteoarthritis pain, time recorded was 5:00 PM, pain rate recorded was 6/10 (12/14/23), 0/10 (12/15/23), not administered on 12/16/23 (hospital).
- Acetaminophen 325 mg, give 2 tablets every 6 hours as needed for osteoarthritis pain, not to exceed 3.0 grams in 24 hours, no record of administration.
- STAT 2 view chest X-Ray, one time on 12/15/23; discontinued 12/16/23 (hospital).

The electronic medical record recorded the vital signs (VS) for Resident #142, obtained on 12/15/23 on the 7A - 3P shift as the following:
- 9:27 AM, Blood Pressure (BP) 133/83, Temperature (T) 98.2, Pulse (P) 87 (elevated)
- 1:55 PM, BP 179/80 (elevated), P 108 (elevated); T 102.6 (elevated)

Nurse Practitioner (NP) #1's progress note electronically signed on 12/18/23 at 11:20 PM, recorded NP #1 assessed Resident #142 on 12/15/23 (no time indicated) due to reports from nursing of a fever (102.6), tachycardia, and elevated BP (179/80). The progress note recorded that on exam, Resident #142 was assessed with cognitive impairment, tachycardia, elevated BP, and she denied any acute symptoms. The progress note documented Resident #142 was in no acute distress, respiratory efforts normal, no wheeze, crackles, rales, bronchi heard upon auscultation. NP #1 ordered STAT labs for CBC (complete blood count), CMP (comprehensive metabolic panel) and chest X-Ray 2 view. NP #1 also ordered a urinalysis with culture and sensitivity, Tylenol 650 mg every 4 hours PRN as a plan for the fever, continue hypertensive medications and

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Director of Clinical Services by 3/11/2024. Providers will conduct an exit report with Unit Manager and/or Director of Clinical services after each facility visit. During Clinical Morning Meeting, the previous day Order Listing will be reviewed and all residents who have new orders and/or Change in Condition will be reviewed by Clinical Team to ensure that all orders have been processed. Clinical Team will include Director of Clinical Services, Assistant Director of Clinical Services, Unit Manager, and Minimum Data Set Nurse.

4. Director of Clinical Service and/or designee will review five (5) residents with Change in Condition weekly x twelve (12) weeks. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Director of Clinical Services will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly for three months.

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recommended nursing check VS each shift as a plan for the elevated BP.

A phone interview with NP #1 on 2/8/24 at 7:08 PM revealed she assessed Resident #142 during the 7A - 3P shift and wrote a telephone order that she gave to a nurse to process for STAT labs, a STAT chest X-Ray, a urinalysis, Tylenol PRN and to monitor VS each shift. NP #1 stated that she did not recall which nurse she gave the written orders to. NP #1 stated she expected the nurse to process all the orders the same day. NP #1 was aware Resident #142 had current orders for Tylenol scheduled but wanted the PRN order for Tylenol changed to every 4 hours in response to the fever. NP #1 stated that she did not recall the exact time of her assessment, but that it was sometime after lunch, and at the time of her assessment, there were no acute clinical changes for Resident #142 that required a hospital transfer.

The December 2023 MAR for Resident #142 did not record the 12/15/23 order for Tylenol 650 mg every 4 hours PRN or to check VS each shift. There were no VS for Resident #142 documented in the medical record for the 3P - 11P shift or the 11P - 7A shift.

A review of the electronic medical record for Resident #142 revealed the lab results ordered by NP #1 on 12/15/23 for CBC, CMP, chest X-Ray and urinalysis were not recorded as of 2/7/23.

During a phone interview with Nurse #2 on 2/9/24 at 4:04 PM, Nurse #2 stated she was the assigned Nurse for Resident #142 on Friday, 12/15/23 for the 11P - 7A shift. Nurse #2 stated that when she arrived on shift, the order for

Provider's plan of correction: Date of correction is 3/11/2024

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Tylenol 650 mg every 4 hours prn and the recommendation to check VS was not on the MAR, so she did not check the VS for Resident #142 on the 11P - 7A shift. Nurse #2 stated there were no acute changes with Resident #142 that she could recall, Resident #142 slept most of the shift and she monitored her throughout the shift. Resident #142 was in no acute distress, and denied pain, but that she would not have known to administer Tylenol 650 mg every 4 hours PRN since it was not recorded on the MAR.

NP #2 progress note electronically signed on 12/17/23 at 8:05 PM recorded Resident #142 was assessed on 12/16/23 (no time indicated) for a follow up to a fever and elevated BP. The progress note recorded that at the time of the assessment, Resident #142's BP was 179/80, T was 98, and Respirations were 18; the note recorded that she was afebrile. NP #2 indicated to continue the current antihypertensive medication for the elevated BP.

A change in condition nurse progress note by Nurse #1 dated 12/16/23 recorded the change in condition was a request by the family for a hospital transfer. The progress note indicated Nurse #1 assessed Resident #142 with no acute changes (neurological, gastrointestinal, urine, cardiovascular, respiratory, behavior, functional), no pain voiced, no signs/symptoms of pain observed and at baseline. The symptoms, condition and signs requiring the transfer were documented as unknown. MD on-call was notified at 1:00 PM of a family request to transfer Resident #142 to the emergency department (ED). The change in condition progress note recorded the Resident was transferred to the ED with non-emergency transport at the family

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request. The VS recorded were dated 12/15/23 at 1:55 PM.

A review of hospital records dated 12/16/23 revealed Resident #142 presented with a fever and altered mental status. Her temperature was 102.7 (elevated), pulse was 103 (elevated) and her BP was 121/74. She was treated with antibiotics for a urinary tract infection and pneumonia. Resident #142 was discharged back to the facility.

A family member for Resident #142 was interviewed by phone on 2/5/24 at 4:53 PM. During the interview, the family member stated that the family visited Resident #142 in the facility on the afternoon of 12/16/23 and she did not appear herself, but the Resident said she was fine. The family member stated that the family had to encourage Resident #142 to go to the hospital. She was transferred to the hospital the afternoon of 12/16/23 and was treated for pneumonia and a urinary tract infection. The family stated Resident #142 returned to the facility and when the family spoke to her by phone, after her return, she reported things were going well.

A phone interview with Nurse #1 occurred on 2/9/24 at 12:52 PM. Nurse #1 stated she was a Nurse at the facility on the 7A - 3P shift for about 2 years until January 2024. Nurse #1 stated she was not the assigned Nurse for Resident #142 on Friday, 12/15/23, but that she may have assisted a nurse, whom she could not recall, process orders for Resident #142, but she was not certain. Nurse #1 stated she could not recall anything further regarding MD orders for Resident #142. Nurse #1 stated that she was the assigned

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nurse for the first time for Resident #142 on the 7A - 3 P shift on 12/16/23. Nurse #1 stated she monitored her and offered her fluids throughout the shift because she was aware of her elevated VS from 12/15/23. Nurse #1 stated she checked her VS during the shift, and they were normal, but she forgot to document them and could not recall the results. Nurse #1 stated the Resident was afebrile, and without complaints during the shift. Nurse #1 stated that her family visited sometime that afternoon, said the Resident did not look herself and requested a hospital transfer, but Resident #142 declined to go. Nurse #1 stated she checked her VS, but they were normal, there was no clinical change noted by Nurse #1 during the shift, but the family continued to talk to the Resident about going to the hospital, and so she agreed to go. Nurse #1 stated she contacted the MD on-call and received an order to transfer Resident #142 to the ED at the request of the family. Nurse #1 stated that when she completed the change in condition progress note, she recorded the VS from 12/15/23 at 1:55 PM because she forgot the results of the VS she obtained.

Nurse #3 was interviewed by phone on 2/12/24 at 8:46 AM and stated that she worked at the facility PRN from June 2023 until February 2024 on the 7A - 3P shift and sometimes worked until 7P. Nurse #3 stated that she was the assigned Nurse for Resident #142 on occasion. Nurse #3 stated that she worked at the facility on Friday, 12/15/23 from 7A - 7P, but that Nurse #1 was the Nurse for Resident #142 that shift. Nurse #3 stated that Nurse #1 was on break when the NP wrote orders for Resident #142, so Nurse #3 processed an order for a chest Xray, but that she did not process the remaining orders. Nurse #3 stated

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when Nurse #1 returned from her break, she informed Nurse #1 of the remaining orders that still needed to be processed and Nurse #1 stated that she would complete the task. Nurse #3 stated she saw Resident #142 on Friday (12/15/23) and Saturday (12/16/23). Resident #142 was not in distress and appeared at baseline. Nurse #3 stated she was aware that Resident #142's VS were elevated during her shift on 12/15/23, and so she checked on the Resident to see how she was feeling and encouraged fluids. Resident #142 stated to Nurse #3 that she was fine and had received Tylenol for the fever. Nurse #3 stated she did not recall an order for Tylenol 650 mg every 4 hours PRN or a recommendation to check VS each shift. Nurse #3 stated that she took the VS for Resident #142 on the 7A - 3P shift on either Friday (12/15/23) or Saturday (12/16/23), but she could not recall which day, the results were normal, but she forgot to document them and did not recall the results.

Attempts to interview additional nursing staff were unsuccessful.

A phone interview with NP #2 on 2/09/24 at 12:17 PM revealed NP #2 typically rounded between 7A - 5P on Saturdays. She stated that on Saturday, 12/16/23, she did not recall the exact time, but she completed a follow up for a fever and elevated BP for Resident #142, "early that morning." NP #2 stated she asked the Nurse for the STAT lab results, but the results were unavailable. NP #2 stated that in a nursing home setting, she expected STAT lab results within 24 hours, so she completed her assessment without the lab results. NP #2 stated Resident #142 did not have a fever at the time of the assessment, her temperature was 98 and her BP was 179/80.

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NP #2 stated that for her elevated BP she wanted to continue the current treatment. NP #2 stated she completed her assessment based on Resident #142's clinical presentation and at the time there were no acute changes. NP #2 stated Resident #142's family visited later in the day, expressed to the Nurse that the Resident did not look herself and requested a hospital transfer. Initially Resident #142 declined, but later changed her mind so the Nurse called the MD on-call, and the Resident was transferred out to the hospital. NP #2 stated she was later informed that the STAT lab results were available at the time of her assessment, but under a different account. NP #2 stated that after reviewing the lab results since her assessment, the results would not have changed her clinical opinion, as she does not make decisions on "numbers", but rather on clinical presentation. NP #2 stated that would have possibly ordered more tests to identify the source of the infection, since her white blood cell count was "only slightly elevated," but a hospital transfer was not clinically indicated at the time of her assessment.

The Director of Nursing (DON) was interviewed on 02/08/24 at 7:10 PM and stated that typically, the practitioners processed their own orders and at times gave a verbal or written order to a nurse to process. The DON stated she reviewed the electronic medical record for Resident #142, and she did not see an order for Tylenol 650 mg every 4 hours PRN or the recommendation to check VS each shift. The DON stated that the order for Tylenol 650 mg every 4 hours PRN was not recorded on the MAR, but that it should have been and that she expected nursing would check VS each shift as recommended by NP #1.

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During a follow up phone interview with the DON on 2/9/24 at 2:49 PM, the DON stated that the facility had 2 accounts with the laboratory service provider and that the lab results ordered for Resident #142 on 12/15/23 were in the second account, the account not frequently used by the facility, so the nurses did not check that account for the lab results. The DON provided a copy of the lab results for review. The DON stated that since the lab results were not in the medical record for Resident #142, and practitioners did not have access to the electronic laboratory system, NP #2 did not have the lab results for Resident #142 to reference when she rounded on 12/16/23. The DON stated the urinalysis was completed, but the results could not be located. She stated that when the technician arrived in the facility on 12/16/23 for the chest X-Ray, Resident #142 was in the hospital and that she could not explain why the chest X-Ray was not obtained on 12/15/23 in response to a STAT order, so the order was discontinued.

The lab results recorded a blood specimen was collected on 12/15/23 at 5:39 PM and results available on 12/15/23 at 8:22 PM. The results for the white blood cell count, was 12.1 (high).

The Physician (MD)was interviewed on 2/08/24 at 1:59 PM and stated that in review of NP #1's progress note dated 12/15/23, the MD agreed with the course of treatment. The MD stated the STAT orders should be followed and processed by the nurse the same day and results available within 24 hours. The MD stated that she did not expect STAT orders in a nursing home setting to be processed and picked by the lab immediately as would occur in an acute setting. The MD stated the results would provide a source of data

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F 684	Continued From page 27 for clinical management to identify the source of a problem, but in this case, the lack of documentation did not contribute negatively to Resident #142 since she was being followed clinically. The Administrator stated in an interview on 2/9/24 at 4:31 PM that he expected nursing staff to process orders and update the medical record with any new orders or changes as needed.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews, the facility failed to reschedule and transport a resident to a consultation with an eye doctor for 1 of 1 resident reviewed for vision services (Resident #28). The findings included: Resident #28 was readmitted to the facility on 11/16/22 with diagnoses inclusive of acute	F 685	1. Resident #28 appointment has been rescheduled (3/4/2024). An audit of all current residents with scheduled appointments was completed to ensure no appointments had been missed. Any missed appointments have been rescheduled.All residents with scheduled appointments have the potential to be affected.	3/11/24

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respiratory failure and peripheral vascular disease.

A quarterly Minimum Data Set assessment (MDS) dated 1/2/24 indicated Resident #28 was cognitively intact, had impaired vision, was dependent on staff for toileting hygiene, dressing, chair to bed transfers and toilet; and required maximum assistance with personal hygiene, transfers to shower, and bed mobility.

A physician's order dated 1/2/23 indicated Resident #28 had an active order for cataract surgery consult per patient request.

A progress note dated 10/27/23 and written by Unit Manager #2 indicated the facility was unable to transfer Resident to eye appointment and that the appointment would be rescheduled once a method of transportation was arranged.

During an interview on 2/6/24 at 5:24 PM Resident #28 indicated his glaucoma was getting worse, and no one was doing anything about it. He further indicated he felt the facility was stalling due to his physical ability to be transported. He stated the last time the facility attempted to transport him was last October 2023, but the wheelchair was too small for him. He stated he had not heard anything about being transported to the eye appointment since then.

During an interview on 2/6/24 at 2:47 PM the Social Worker (SW) revealed she scheduled in-house appointments for residents and the scheduler resident makes appointments to offsite providers. She further revealed Resident #28 had an eye appointment in October 2023 but could not fit in the wheelchair provided. The SW stated

F 685

2. The facility transportation coordinator has been reeducated by the Executive Director to ensure all resident appointments requiring facility transportation are scheduled and transportation has been arranged; cancellations, rescheduling, and resident refusals are to be documented in the resident□s record. Rescheduling should be completed upon notification of any changes to originally scheduled appointments.

3.To ensure the deficient practice does not reoccur, the facility Assistant Director of Nursing or Unit Manager will notify the transportation coordinator of all scheduled appointments requiring facility arranged transportation. Newly scheduled appointments, as well as the day□s scheduled appointments will be reviewed during morning stand up meetings. Previous days appointments will also be reviewed and discussed. Any missed appointments will be reviewed and rescheduled as needed. The transportation coordinator will notify the Executive Director if any special assistance is needed.

4.The Executive Director will conduct a weekly audit of all appointments requiring facility transportation. The audit will be conducted to ensure new appointments have transportation secured and any missed appointments have been documented and rescheduled. Monitoring will be conducted twice weekly for four weeks, then weekly for two months. The

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the Resident needed to be transported in a bariatric chair.

During an interview on 2/8/24 at 11:30 AM, Unit Manager #2 revealed when the facility could not accommodate Resident #28 being transported until they ordered and received a bariatric chair in November 2023. However, another appointment was not rescheduled and should have once the appropriate chair was received. She further revealed there was most likely a breakdown in communication from the time the physician's order was placed on 1/2/2023. She also stated nursing should have followed-up and communicated to the Scheduler to reschedule the eye consultation, but this was not done.

During an interview on 2/8/24 at 3:15 PM the Scheduler revealed she began working at the facility in July 2023 and only scheduled the October eye appointment for Resident #28. She further revealed the Resident did not go to the appointment because the wheelchair was too small, and it would have been a risky transport. The Scheduler further revealed she usually received a physician's order from the nursing department and faxed it over to the offsite provider before scheduling the appointment. She received no further information or directive after the Resident missed the October 2023 eye appointment and after the bariatric chair was received. She stated she was instructed on 2/6/24 to reschedule the missed appointment.

During an interview on 2/8/24 at 3:30 PM the Director of Nursing (DON) indicated there were concerns about a safe transport and a need for an appropriate wheelchair to transport the Resident. Her expectation was for Resident #28

F 685

Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Executive Director will report the result of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly for three months.

Date of Correction will be 3.11.2024

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F 685	Continued From page 30 to be scheduled for a cataract consult per the physician's order and be transported once the larger chair was ordered and received. She further indicated nursing was responsible for providing the Scheduler with physician orders and updates on rescheduling appointments.	F 685		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Medical Director interviews, the facility failed to identify and develop a treatment plan for a resident with a right-hand contracture. This was evident for 1 of 3 residents (Resident #63) reviewed for range of motion. The finding included:	F 688	1. Resident #63 was evaluated and placed on therapy caseload on 2/8/24 to initiate a splinting program for R hand contracture. 2. By 3/11/24, the therapy department will identify residents who are at risk for contractures. Once residents are identified, resident will be evaluated and	3/11/24

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Resident #63 was admitted to the facility on 07/05/21 with diagnoses that included cerebral vascular accident (CVA), spastic hemiplegia affecting the right dominate side and aphasia.

Review of Resident #63's care plan dated 07/23/23 revealed the Resident had a self-care deficit in his activities of daily living (ADL) related to a history of a CVA with right sided hemiplegia, limited mobility and range of motion. The goal that Resident #63 would receive the assistance he needed for his ADL, and he would maintain his current level of functioning would be attained by anticipating his needs and providing assistance for ADL. The Resident was not care planned for a specific intervention for his right hand.

The quarterly Minimum Data Set (MDS) assessment dated 11/02/23 revealed Resident #63's cognition was severely impaired and had functional limitations in the range of motion of one side of his upper extremity.

On 02/05/24 at 11:21 AM an observation was made of Resident #63 lying in his bed on his back and appeared to be sleeping. The Resident's hands were resting on his abdomen with his right hand balled in a fist.

A second observation was made of Resident #63 on 02/06/24 at 2:48 PM. The Resident was lying in his bed awake and when asked if he could open his right hand (with demonstration) the Resident extended his index finger and thumb while the last 3 fingers remained tightly closed.

On 02/07/24 at 3:36 PM and 02/07/24 at 3:56 PM an interview and observation of Resident #63 were conducted with Nurse #7 who informed that

F 688

placed on therapy’s caseload. After a resident can tolerate the brace/splint for desired amount of time (specific to patient), therapy will train/educate nursing staff on proper DONNING/DOFFING, skin checks and wearing tolerance specific to the patient. Upon discharge from therapy’s caseload, the therapist will notify the Director of Nursing and Unit Manager of the resident being placed on Contracture Management Program and obtain physician’s order for that resident in Point Click Care (PCC). Minimum Data Set (MDS) nurse will update the care plan and Kardex with contracture management. The therapy department will also screen residents at risk for contractures upon nursing referral, quarterly screens and/or quality of life rounds. If the resident is deemed appropriate for the Contracture Management Program, the same procedures from above will be implemented.

3. By 3/11/24, Therapists to include Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST) and assistants and nursing staff including DON, ADON, RNs, LPNs, and CNAs will be reeducated by the Director of Rehabilitation or designee regarding the Contracture Management program. The education will include contracture identification and management. Any staff not educated by 3/11/2024 will not be allowed to work until education is completed. Newly hired staff will receive education as part of the orientation

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she recently transferred from third shift to second shift, and she often cared for Resident #63. The Nurse explained that she did not know anything about Resident #63's right hand except that he kept it in a fist and did not know if he had a splinting device for his right hand. The Nurse expressed that it was possible that he was on the restorative nursing case load. Nurse #7 was accompanied to Resident #63's room where he was lying in bed with his right hand balled in a fist. The Nurse asked the Resident to extend his fingers on his right hand and with assistance from the Nurse the Resident extended his index finger and thumb. The Nurse attempted to extend the Resident's last three fingers especially the middle finger but met resistance before the Resident flinched. The Resident's fingernails were approximately ¼ inch long, clean and trimmed. The surface of the palm of his skin was red and there were small particles of peeling skin.

During an interview with Medication Aide (MA) #1 on 02/06/24 at 2:35 PM the MA explained that she had been employed by the facility for almost 3 years and usually worked four days a week. She stated she routinely medicated Resident #63 and provided his care when necessary. The MA continued to explain that Resident #63 did not speak but he could follow simple directions when given if he was able. She stated Resident #63 fed himself with his left hand and he kept his right hand balled in a fist.

An interview was conducted with Nurse Aide (NA) #4 on 02/07/24 at 8:22 AM who stated he had only been working at the facility for a few weeks but had worked with Resident #63 a few times. The NA explained that he bathed the Resident during the last week of January 2023 and noticed

F 688

process. The process will also include obtaining and creating splint/brace physician orders in PCC upon discharge from caseload. Each resident's name will be placed on a google document which will be shared with therapy, nursing, Minimum Data Set (MDS) Nurse and Administrator so that each department will be aware of residents who are on the Contracture Management Program along with proper DONNING/DOFFING instructions. Shared google document will be updated by the therapy department as residents are added to the program. MDS will care plan and update Kardex regarding splint and/or brace reflecting proper wearing instructions from this shared google document.

4. Nurse management will utilize shared google document to audit residents on the Contracture Management Program. Nurse management will randomly audit five (5) residents three times per week for one month; weekly for two months; and monthly for three (3) months. Therapy department will screen residents on Contracture Management Program monthly to ensure that the current program regimen is appropriate. If any changes are needed, patient will be re-evaluated and placed on therapy's caseload to initiate an appropriate program. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality

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	345388	A. BUILDING ______ B. WING ______	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

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the skin in the palm of his right hand was peeling and it was difficult to clean his hand because the Resident kept his right hand balled in a fist.

An interview was conducted with Nurse Aide (NA) #3 and NA #7 on 02/08/24 at 8:58 AM. The NAs indicated they were assigned to the shower team and showered Resident #63 on Mondays and Wednesdays. The NAs explained that Resident #63 allowed them to clean his right hand, but it was difficult because the Resident kept his right hand in a fist. They stated the Resident did not have any skin breakdown in his right hand. When asked if they had reported the condition of his right hand to someone, they stated they thought the Administration was already aware of his right-hand contracture.

During an interview with Nurse Aide (NA) #7 on 02/08/24 at 9:59 AM the NA stated she started at the facility in January of 2024 and was still getting to know the residents. She explained that she had worked with Resident #63 a few times and the last time was on 02/07/24 day shift. The NA continued to explain that the Resident kept his right hand balled up in a fist and it was hard to clean but she attempted. The NA stated one day when she worked with Resident #63, she told the nurse on the hall (she could not remember which one) that he needed something to be kept in his right hand to keep it from becoming more contracted and the nurse said "they" already knew about it.

An interview was conducted with the Restorative Aide (RA) on 02/08/24 at 10:50 AM who explained that she performed restorative nursing functions such as splints, ambulation, and range of motion on residents that have been released

F 688

Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Director of Clinical Services will report the result of quality monitoring to the Quality Assurance Performance Improvement Committee monthly.

Date of Correction: 3/11/2024

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F 688	Continued From page 34 from skilled therapy services. The RA stated that she did not have, nor did she ever have Resident #63 on restorative nursing caseload. An interview was conducted with the Rehab Manager on 02/07/24 at 4:40 PM who explained that all residents were screened for skilled therapy services every three months and as needed when an issue was identified. The Rehab Manager continued to explain that Resident #63 was last screened by the Physical Therapy Assistant (PTA) in January 2024, but she did not identify any concerns that would warrant the Resident being picked up on caseload. She stated the Resident was last seen by skilled therapy in May 2023 for right wrist pain. The Rehab Manager was informed of Resident #63's right hand staying in a balled-up fist position and how Nurse #7 could not extend his fingers and was asked how the PTA missed seeing his hand. The Rehab Manager explained that when they screened the residents, they were not allowed to touch the resident and just observed to see if they could benefit from a skilled therapy and that it was possible that the PTA did not see the Resident's right hand. During an interview with the Physical Therapist Assistant (PTA) on 02/08/24 at 9:38 AM she explained that when they screened the residents, they were not allowed to touch the residents and could only observe for potential issues and concerns that might benefit from skilled therapy services. The PTA confirmed she screened Resident #63 in January 2024 and when she screened the Resident, she was assessing him for occupational therapy issues as well as physical therapy issues. The PTA stated that she did not identify any concerns with Resident #63	F 688		

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F 688	Continued From page 35	F 688		

and when asked if she noticed the Resident's right hand in a balled fist, the PTA stated she did not notice it and that his hand must have been under the covers. She explained that the residents were screened every 3 months and as needed and stated if the staff knew the resident might have an issue with his hand, they could have notified the therapy department to determine if an evaluation was appropriate.

During an interview with the Medical Director (MD) on 02/08/24 at 2:11 PM the MD stated that she had only been the Medical Director since the summer of 2023 and she had not noticed that Resident #63 kept his right hand in a fist and stated that she would have expected the staff to have identified Resident #63's right hand contracture and had developed a treatment plan for the contracture before now especially since the Resident had been in the facility for several years.

An interview was conducted with the Director of Nursing (DON) on 02/08/24 at 4:25 PM with the Administrator present. The DON explained the residents were screened by skilled therapy every 3 months and as needed. The DON continued to explain that staff should notify management if they observed any issues or concerns so that the residents could get the attention they needed from the skilled therapists. She indicated that they had a lot of new staff, and the staff might have thought someone had already reported the Resident's right hand contracture and it was being followed up on with therapy but regardless the DON indicated the Resident should receive services to treat his right-hand contracture.

An interview was conducted with the

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F 688	Continued From page 36 Occupational Therapist (OT) on 02/08/24 at 9:49 AM and 10:30 AM. The OT explained that she had only been employed by the facility since mid-October 2023 and did not perform his screening in January 2024. If the nursing staff noticed a decline in their condition, it could be reported to the therapy department so they could complete an evaluation on the resident. She stated that she conducted a quick evaluation on Resident #63's right hand that morning and she had ordered him a slim grip splint and palm protector for his right hand. She indicated she was not sure which device would work best, they would have to try both and see which one he tolerated. The OT continued to explain that the Resident needed range of motion to keep his right hand from being contracted if he could tolerate the stretching. She stated that he could not use a resting hand splint because his middle finger was too contracted, and he needed a palm protector to prevent skin breakdown. The OT stated she could not determine how long it took for his hand to contract the way it was because each person was different.	F 688		
F 689 SS=D	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 accidents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff	F 689	1. Smoking materials were removed from	3/11/24

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F 689	Continued From page 37 interviews, and record reviews, the facility failed to ensure that a smoking materials were secured by staff in accordance with their smoking policy for 1 of 3 residents observed for supervision to prevent accidents (Resident #18). Findings included: The facility's smoking policy dated 2/7/20 stated "the center will retain and store matches, lighters, etc. for all residents". Resident #18 was admitted to the facility on 4/17/13 with diagnoses of cardiovascular accident and dementia. Resident #18's Quarterly Minimum Data Set on 1/5/24 revealed the resident was cognitively intact, had clear speech and easily understood others. She had a functional limitation in range of motion on one side of her upper and lower extremity and used a wheelchair for mobility. Resident #18's smoking evaluation dated 1/12/24 indicated the resident was a safe smoker and may smoke in designated areas without supervision. On 2/5/24 10:39 am, Resident #18 was observed self-propelling herself via wheelchair out to the smoking area with 3 other residents that were already smoking. She took out a cigarette from her left breast pocket and lit it with a lighter she took out of her right breast pocket. There were no staff observing the residents smoking. During the interview on 2/5/23 at 10:40 am, Resident #18 stated the staff let them keep their lighters and cigarettes and they could come out to	F 689	resident #18 on 2/5/2024 by Director of Clinical Services. 2. Unit Managers conducted a quality review of current resident rooms that smoke on 2/5/2024 to ensure rooms are free of accident hazards as it pertains to smoking materials. Any concerns noted were addressed as identified. 3. Executive Director/Designee initiated education to all staff to include nursing, therapy, dietary, housekeeping, and administrative staff on 2/5/2024, on the components of this regulation with emphasis on ensuring the environment remains free of accident hazards as it pertains to smoking materials. Newly hired staff will receive this education during orientation. 4. The Executive Director/designee will conduct quality monitoring of 5 residents via observing rooms and interview to ensure rooms are free of accident hazards as it pertains to smoking materials twice weekly for four (4) weeks, then weekly for four (4) weeks, then twice monthly and PRN as indicated. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services,	

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F 689	Continued From page 38 smoke anytime they wanted to. A review of Resident #18's smoking evaluation completed on 2/5/24 at 4:02 pm determined resident was unsafe due to having a lighter. The resident was informed of the risk of having a lighter. She will require constant supervision while smoking. During an interview on 2/5/24 at 4:07 pm, Nurse Aide #7 stated the residents used to turn in their lighters and staff kept them locked up but that stopped. He was not sure how long ago that was. During an interview on 2/6/24 at 1:14 pm, Medication Aide #1 revealed Resident #18 was an unsupervised smoker. She stated the Resident could understand and follow instructions and should have turned in her lighter. During an interview on 2/7/24 at 10:18 am, Medication Aide #2 stated a staff member was supposed to be present in the smoking area to light the residents' cigarettes and supervise some of them. The residents were not supposed to have lighters with them. The unsupervised residents were supposed to turn them in to staff after smoking. The nursing supervisors used to assign staff to monitor them. During an interview on 2/5/24 at 11:33 am, Nurse #9 stated he was not sure what the smoking policy stated. Nurse #9 thought the residents had to be assessed for safety before they could keep their own cigarettes and lighters. Independent residents could smoke anytime. The others would have to have staff to monitor them and provide aprons for their safety.	F 689	Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Executive Director will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Correction is 3.11.2024	

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F 689	Continued From page 39	F 689		

During an interview on 2/7/24 at 10:28 am, Unit Manager #1 stated they completed a smoking assessment for each resident requesting to smoke. The smoking assessment was completed every 3 months. She stated Resident #18 was deemed a safe smoker during her January smoking assessment, but she still had to turn in her lighter according to the contract she signed. Resident #18 did not have burns on skin and clothes when assessed. All residents were required to give their lighters back.

During an interview on 2/6/24 at 9:43 am, the Director of Nursing (DON) stated the residents who were supervised smokers followed the supervised smoking schedule and all unsupervised residents read/sign a contract that stated they would return their lighter to the nurse after use. The staff did not round/follow the residents to make sure they turned in their lighters. The residents were responsible for following the contract they signed. If staff found them in violation of the policy, the lighters were retrieved, and they became supervised smokers.

During an interview on 02/07/24 at 12:25 pm, the Regional Director of Clinical Services revealed Resident #18 was an unsupervised smoker, but she saw her with a cigarette lighter in her bedroom the afternoon of 2/5/24. Typically, the residents turned in their lighters after smoking. She went with Unit Manager #1 to talk to her but Resident #18 cursed and would not turn in her lighter. She put the resident on 1:1 supervision for a little bit until they could obtain her lighter. She had the Director of Nursing (DON) talk to Resident #18 and got her lighter. The DON explained to the Resident that she could still

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F 689	Continued From page 40 smoke but would have to be supervised and at designated times. Resident #18 was also reminded about the smoking policy agreement she signed. During the follow up interview on 02/08/24 at 3:50 pm, the Director of Nursing (DON) stated the residents should have been turning in cigarette lighters to any nursing staff. They were labeled with the residents' name and were kept in a smoking box in the nurses station.	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	F 690		3/11/24

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F 690	Continued From page 41 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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and Resident interviews, the facility failed to secure a urinary catheter tubing to prevent tension or trauma for 1 of 2 residents (Resident #28) reviewed for urinary catheter. The finding included: Resident #28 was admitted to the facility on 09/30/13 with diagnoses that included neurogenic bladder. Resident #28's care plan dated 04/07/22 indicated the Resident had an indwelling urinary catheter and the goal to remain free from catheter related trauma would be attainted by interventions including keeping the catheter below the bladder and monitoring for signs of discomfort, pain and urinary tract infections. The quarterly Minimum Data Set (MDS) assessment dated 01/02/24 indicated Resident #28 was cognitively intact and had an indwelling urinary catheter. A review of Resident #28's physician orders revealed:	F 690	1. On 2/7/2024 Unit Manager applied a catheter securement device to Resident #28 to secure urinary catheter tubing to prevent tension or trauma. Physician and responsible party were notified. 2. On 2/7/2024 a Quality Review was conducted by Unit Managers and Assistant Director of Nursing of current residents with indwelling urinary catheters to ensure securement device in place to secure urinary catheter tubing to prevent tension or trauma. Any concerns noted were addressed as identified. 3. Director of Nursing and Nurse Management will educate licensed nurses and certified nursing assistant on Indwelling Urinary Catheter securement device by 03/11/2024. Any staff not educated by 3/11/2024 will not be allowed to work until education is completed. Newly hired nursing staff will receive education as part of the orientation process. Licensed Nurses and Certified Nursing Assistants will complete rounds throughout their scheduled shift to	

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F 690 Continued From page 42

*01/15/24 Urinary Catheter #20 French with a 30 milliliters (ml) balloon.

A review of Resident #28's Medication Administration Record (MAR) for 02/2024 indicated the Resident's Catheter Secure Device was initialed by Nurse #5 for 02/07/24 day shift which meant the task was completed.

On 02/07/24 at 1:40 PM during an observation of care that was being provided to Resident #28 by Nurse Aide (NA) #6, the NA turned the Resident onto his left side. In mid turn the Resident hollered "unhook the bag, unhook the bag", meaning move the catheter bag to the opposite side of the bed. The catheter tubing was stretched and was causing tension on the tubing. The NA released the tension from the catheter tubing by repositioning Resident #28 then resumed the care she needed to provide. During the observation it was noted that Resident #28 did not have a catheter securement device to reduce tension on his catheter tubing and reduce trauma to his anatomy.

During an interview with Resident #28 on 02/07/24 at 2:33 PM the Resident explained that the only time he had a catheter securement device to prevent from pulling his catheter tubing was when he was admitted to the hospital. He stated the facility never applied a securement device on his catheter tubing.

An interview was conducted with Nurse #9 on 02/07/24 at 2:49 PM. The Nurse confirmed that he was Resident #28's Nurse on 02/07/24 for the day shift and explained that he had not ensured that Resident #28 had a securement device in place to prevent the catheter tubing from being

F 690

observe for placement of securement.

4. Nurse Management to include Director of Clinical Services, Assistant Director of Clinical Services, and Unit Manager will conduct random audits to observe 5 residents with indwelling urinary catheters for proper placement of securement device twice a week for 4 weeks, then weekly for two (2) months and then monthly for 3 months to ensure accuracy. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Director of Clinical Services will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly.

Date of correction: 3/11/2024

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F 690	Continued From page 43 pulled or trauma. The Nurse stated that he was in a hurry and did not check it before he checked it off the MAR. On 02/08/24 at 4:16 PM an interview was conducted with the Administrator and Director of Nursing (DON). The DON explained that her expectation was that Nurse #9 should have ensured that Resident #28's securement device was in place before he checked the task off.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §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.	F 761		3/11/24

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F 761	Continued From page 44 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to record opening date for 1 opened vial in 1 of 5 medication cart (100 Hall medication cart), failed to remove expired medication in accordance with the manufacturer's expiration date for 1 of 5 medication cart (100 Hall medication cart), and failed to store drugs in clean and sanitary environment for 1 of 2 medication room refrigerators (north side medication room refrigerator) during medication storage checks. Findings included: a. A medication storage audit was conducted on 2/6/24 at 1:42 pm in the presence of Nurse #6. The following medications were found in 100 Hall medication cart: 1. An opened vial of Lidocaine Hydrochloride 1% 10 milligrams per milliliters (an anesthetic agent that induced insensitivity to pain) without an opening date. 2. An opened bottle of multivitamin containing 174 tablets expired on 10/2023. During an interview on 2/6/24 at 1:42 pm, Nurse #6 confirmed that the multivitamin bottle was the only bottle of its kind in her medication cart. She revealed that she administered mostly multivitamins with minerals on first shift that day. She described the multivitamin as red tablets and the multivitamin with minerals were orange gelcaps. Nurse #6 stated she only started with the facility three weeks ago and did not know why the anesthetic agent did not have a date on it. She	F 761	1. 1 bottle of multivitamin containing 174 tablets that expired on 10/2023 was immediately discarded by the nurse and the opened vial of Lidocaine Hydrochloride 1% 10 milligrams per milliliters was discarded by the nurse on 2/7/2024.The refrigerator located in the north unit medication room was cleaned by housekeeping on 2/7/2024. 2. The Unit Managers performed a quality review of medication carts and medications rooms to ensure medications are labeled, stored, and not expired according to facility policy on 2/7/2024. 3. Licensed nurses re-education started by the Director of Clinical Services on the facility medication storage and labeling policy on 2/7/2024. All licensed nurses will receive education by 3/11/2024 at which time all nurses must be educated prior to working. Newly hired licensed nurses will receive education from the Director of Clinical Services, or designee, regarding the facility medication storage and labeling policy as part of the orientation process. 4. The Director of Clinical Services and/or designee, will conduct a quality review of medication carts, medication storage rooms, and medication refrigerators to ensure proper storage of drugs and biologicals to include removal of expired	

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F 761 Continued From page 45

denied using the vial those days she worked. She stated she would send the anesthetic agent back to the pharmacy since it was used on a resident that received antibiotic injections in January of 2024. Nurse #6 stated all nurses were responsible for cleaning and checking the medication cart and the medication room. She stated she checked her cart once a month.

During a follow up check on 100 Hall medication cart on 2/07/24 at 2:66 pm, the opened vial of Lidocaine was still in the medication cart. Nurse #10 rechecked the vial and stated the resident did not have order for it anymore so the vial should have been sent back to the pharmacy by the nurse or the unit manager when the order ended in January.

b. The medication room audit on the north side of the facility was completed with Unit Manager #2 on 2/6/24 at 2:15 pm. The medication room refrigerator was found to be in an unsanitary condition. Unit Manager #2 confirmed the refrigerator had dried yellowish to brownish sticky liquid at the bottom shelf and bin. There was a resistance felt when opening the bottom bin due to the lip sticking to the upper shelf. The refrigerator grills on the shelf were brownish in color. The door shelves had crumbs and dust. The freezer had a crumpled water bottle with some frozen water inside and a cracked Styrofoam cup with ice covered with brown paper towels. The refrigerator contained insulin vials, insulin injections, eye drops, suppositories, and a liquid anti-seizure medication.

During an interview on 02/06/24 2:16 pm, Unit Manager #2 stated the night nurses completed a checklist nightly stating they checked for expired

F 761

medications, labeling of medications, and cleanliness of refrigerators weekly for four (4) weeks, then monthly for three (3) months. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Director of Clinical Services will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly.

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medications in the medication rooms and medication carts. Nobody was currently assigned to clean the med room refrigerator. The Unit Manager was not sure what was the dried sticky yellowish/brownish liquid in the refrigerator but stated she told the staff not to store their food and drink in there. She took the cracked Styrofoam cup of ice covered by paper towels and the crumpled bottled water with some ice inside the freezer and threw them in the trash can.

During a follow up check on 2/7/24 at 10:48 am of the medication room refrigerator with Unit Manager #2, the refrigerator was observed in the same unsanitary condition. Unit Manager #2 acknowledged it had not been cleaned since we saw it on 2/6/24. She stated nobody was assigned to clean the refrigerator but would have it cleaned that day.

During an interview on 2/6/24 at 2:45 pm, Nurse #9 stated he checked his cart and the medication room when he can. All the nurses should be checking for expiration dates, cleaning the medication carts, and keeping the medication room, including the refrigerator, clean. He stated there was not a definite shift that was assigned to clean the medication cart, the medication room and the refrigerator but knew their unit manager on the south side checked them when she could.

During an interview on 2/7/24 at 4:38 pm, Nurse #7 revealed she worked night shift and recently moved to evening shift. She stated the medication carts were checked by all nurses and the unit managers checked the medication rooms. The nurses should check the carts all the time, especially when they receive new supplies or discontinued medications. Nurse #7 thought

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the unit managers also checked the carts and the medication room twice a week. She stated no shift was mainly responsible for checking the medication carts for expired medications. Nurse #7 stated the vial of Lidocaine should have been labelled with the date it was opened by the nurse who used it the first time. The vial should have been returned to the pharmacy by the nurse who was working when the order ended. She stated there was a return bin in the medication room where the nurses put all medications that needed to go back to the pharmacy.

During an interview on 2/8/24 at 3:50 pm, the Director of Nursing (DON) stated the night shift nurses had a checklist that included checking for expired medications and supplies. The expired medications and supplies were supposed to be returned to the pharmacy. She stated she would assign staff to clean the medication room refrigerators weekly. She would also include checking on the refrigerators during management rounds in the mornings.

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F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		3/11/24

§483.60(c) Menus and nutritional adequacy. Menus must-

§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;

§483.60(c)(2) Be prepared in advance;

§483.60(c)(3) Be followed;

§483.60(c)(4) Reflect, based on a facility's

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F 803	Continued From page 48 reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on an observation of the lunch meal tray line, staff interviews and record review, the facility failed to provide the correct portion size of pureed food and large portions according to the planned menu for 1 of 1 meal observations. This practice had the potential to affect 2 residents on pureed diets and 12 residents who received large portions. The findings included: During a continuous observation of the lunch meal tray line on 02/08/24 from 12:11 PM until 12:35 PM, cook #1 plated pureed black-eyed peas and pureed chicken with a 2-ounce serving utensil. Additionally, Cook #1 plated a four-ounce serving of stewed tomatoes for a large portion. Review of the menu revealed the following portions were to be served on 02/08/24 for the lunch meal: - Pureed black-eyed peas - 4-ounce serving. - Pureed chicken - 4-ounce serving.	F 803	1. The District Dietary Manager immediately provided the correct scoop size and ordered additional utensils/scoops. 2. The District Dietary Manager and Dietary Manager reviewed resident meal slips and the menu observing the tray line for proper portion size and no other resident was affected. 3. The Dietary Manager (DM) was in-serviced by District Dietary Manager on HCSG Policy 006. Dietary Manager or designee (when DM is not in facility) to observe/monitor tray line for proper serving size¿portions according to menu. The Dietary Staff will be in-serviced before 3/11/2024 by the Dietary Manager on the proper portion size and following the menu. Any new dietary employees will also be in-serviced by the Dietary Manager on proper portion size and	

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F 803	Continued From page 49 - Large portion - one and one third serving. An interview with Cook #1 occurred on 02/08/24 at 12:37 PM. Cook #1 stated that she used the menu to know the portion of foods to serve, but sometimes the correct serving utensil was not available. Cook #1 stated that she did not locate a 4-ounce serving utensil for the pureed black-eyed peas or pureed chicken when she set up the lunch tray line. She also stated that she was aware of the correct serving size for a large portion, but that a large portion of stewed tomatoes would not fit in the bowl she used to serve the stewed tomatoes. An interview with the Dietary Manager on 02/08/24 at 12:40 PM revealed she and the District Dietary Manager were responsible for monitoring the tray line for correct portions and the cooks were responsible for using the correct size utensil to serve foods according to the menu. The District Dietary Manager stated in an interview on 02/08/24 at 12:43 PM that the facility provided large portions equivalent to one and one third serving and that residents should receive correct portions of foods per the menu. A phone interview with the Registered Dietitian (RD) occurred on 02/08/24 at 01:07 PM. The RD stated that she conducted monthly kitchen audits which included observing the portions of foods served. The RD stated that she had not identified concerns with portions of pureed foods served per the menu during her monthly audits, but that she had re-educated dietary staff on the correct portion to serve to residents who received large or double portions.	F 803	following the menu. 4. The Dietary Manager will monitor the tray line weekly. The Dietary Manager will present findings from weekly monitoring of the serving line to the Executive Director Monthly. The Executive Director will present the findings to the Registered Dietician for any recommendations for three (3) months. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Executive Director will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Correction will be 3.11.2024	

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F 803	Continued From page 50 The Administrator stated in an interview on 02/08/24 at 05:31 PM that residents should receive the correct portion of food per the menu.	F 803		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to serve a prescribed double portion protein therapeutic diet to Resident #80, a Resident at risk for nutritional decline, for 1 of 2 sampled residents reviewed for physician ordered therapeutic diets. The findings included: Resident #80 was admitted to the facility on 8/22/23. Diagnoses included end stage renal disease, stage IV (ESRD), anemia in chronic kidney disease, dependence on renal dialysis, elevation of levels of liver transaminase levels, and protein calorie malnutrition, among others. A Care Area Assessment dated 8/22/23 recorded Resident #80 was at potential nutritional risk regarding the requirement of a therapeutic diet for ESRD management.	F 808	1. Resident #80 was immediately offered a second sandwich, however, resident declined stating he drinks his Nepro for protein. 2. The dietary manger will complete a 100% audit of resident diet orders to ensure each resident's diet card is accurate according to the physician order by 3/11/2024. Dietary Staff (including manager) in-serviced by District Manager on HCSG Policy 008 and HCSG policy 007. Dietary staff will be in-serviced regarding tray card accuracy including the parameters for residents on double portion protein therapeutic diet by 3/11/2024. Any new dietary employees will be in-serviced by Dietary Manager as part of the orientation process.	3/11/24

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A diet order for Resident #80 dated 8/25/23 recorded a (brand name) high protein shake twice daily (BID) for additional calories and ESRD, 8 ounces BID.

A diet order for Resident #80 dated 9/6/23 recorded a renal diet, regular texture regular/thin liquids consistency, fluid restriction per dialysis, 32 ounces, per day, double portion protein with each meal, additional sandwich with dinner meal, and dialysis lunch bag.

The care plan for Resident #80, revised 9/6/23, identified a potential nutritional problem, regarding therapeutic diet restrictions for ESRD. Interventions included, to provide and serve the therapeutic diet as ordered.

A quarterly Minimum Data Set assessment dated 1/5/24 assessed Resident #80 with adequate hearing, impaired vision with corrective lenses, understood, understands, clear speech, intact cognition, no swallowing problems, no dental problems, no changes in weight status, at risk for malnutrition and the diagnoses of ESRD.

A Complete Blood Count (CBC) with Differential and Comprehensive Metabolic Panel (CMP) test result (lab tests regarding blood cells) dated 1/31/24, for Resident #80, recorded the test results for albumin (a protein made in the liver) was 3.53 grams/deciliter (g/dl), with a normal range of 3.50 - 5.70 g/dl.

A Nutritional Review dated 2/7/24, completed by the Registered Dietitian (RD), recorded Resident #80 received a renal diet, regular texture, 32-ounce fluid restriction, double portion protein with each meal, additional sandwich with dinner

F 808

3. Dietary Manager (DM)/Designee (when DM is not in facility) to monitor service line and check trays for correct diets.¿ District Manager to follow up to¿validate all proper therapeutic diets are being followed and served¿during facility visits.¿District Manager and Dietary Manager will follow up weekly with the Registered Dietician (RD).¿

4. The Dietary Manager will monitor the tray line weekly. The Dietary Manager will present findings from weekly monitoring of the serving line to the Executive Director Monthly. The Executive Director will present the findings to the Registered Dietician for any recommendations for three (3) months. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Executive Director will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly for three months.

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meal, and (brand name) high protein shake BID. The RD recorded that Resident #80 tolerated the current diet. The RD recorded that the current lab results from 1/31/24 were reviewed and that there were no new concerns voiced from a conversation with the dialysis center RD.

Resident #80 was interviewed and observed on 02/05/24 at 12:53 PM in his room having lunch. The tray card on his lunch meal tray recorded "Renal, Double Protein Portions." Resident #80 received 1 portion of chicken pot pie. Resident #80 stated that he often received one serving of meat for his meals, but his tray card recorded that he should get two servings. He further stated, "I have my shake which gives me extra protein." Three bottles of a (brand name) high protein shake were observed on his over bed table.

Resident #80 was interviewed and observed on 02/07/24 at 12:30 PM in his room having lunch. The tray card on his lunch meal tray recorded "Renal, Double Protein Portions, 2 Sandwich, Open Faced Roast Pork Sandwich." Resident #80 received one slice of bread and one slice of roast pork. Resident #80 stated that he did not receive double portions of the protein for lunch and that he usually did not receive double portions of protein with his meals. Resident #80 stated that he had not complained and stated, "staff just drop off my tray and leave." He further stated that he thought the high protein shake was the additional protein he was supposed to get. One bottle of a (brand name) high protein shake was observed on his over bed table.

Nurse Aide (NA) #1 was interviewed on 02/07/24 at 12:42 PM. NA #1 stated that she often took breakfast and lunch meals to Resident #80. NA

F 808

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#1 stated that Resident #80 was alert and oriented and fed himself independently, so she just took his meal tray in his room and placed the tray on his over bed table. NA #1 further stated that she did not set up his meal tray or remove the lid from his meal to see what he received because he was independent with his meals and did not require staff assistance to set up his meals.

An interview with Cook #1 occurred on 02/08/24 at 12:37 PM. Cook #1 stated that she used the menu to know the portion of foods to serve, but that sometimes the correct serving utensil was not available. She also stated that she was aware of the correct serving size for a large/double portion, but that sometimes the large/double portion would not fit.

An observation of the lunch meal for Resident #80 with the Dietary Manager (DM) occurred on 02/07/24 at 12:35 PM. The DM observed the lunch meal Resident #80 received and reviewed his lunch meal tray card. The DM stated Resident #80 had a diet order for double protein portions with meals and that he should have received 2 open faced roast pork sandwiches with his lunch meal. The DM stated that the District Dietary Manager monitored the lunch meal tray line that day (02/07/24) for accuracy. The DM stated, "It was an error we missed." The DM further stated that when meal trays were delivered by the nursing staff, they should compare the meal delivered to the tray card to identify any discrepancy and notify dietary staff if an error was found. The DM stated that it was the responsibility of dietary staff to follow the diet order when plating foods.

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The District Dietary Manager was interviewed on 02/07/24 at 12:44 PM. She stated that she was in the manager's office talking to a family member at the start of the lunch tray line that day (02/07/24) and did not see the tray for Resident #80 plated. She stated that the tray line was usually monitored by the DM for accuracy to ensure residents receive the correct diet per order. The District Dietary Manager stated that nursing should compare the meal received to the tray card for accuracy and let the kitchen know if there was an error and that dietary staff should follow the diet order when plating foods.

A phone interview with the Registered Dietitian (RD) occurred on 02/08/24 at 01:07 PM. The RD stated that she conducted monthly kitchen audits which included observing the portions of foods served. The RD stated that she had re-educated dietary staff on the correct portion to serve residents with diet orders for large and double portions. The RD stated that she recommended double protein portions in September 2023 for Resident #80 for extra protein because the goal was to keep his albumin level 3.0 g/dl or higher. The RD stated that his albumin was currently within the goal as his last albumin lab result was 3.53 g/dl on 1/31/24. The RD stated that she wanted Resident #80 to continue receiving double protein portions with each meal to maintain that goal.

The Director of Nursing (DON) was interviewed on 02/08/24 at 2:33 PM. The DON stated that dietary staff should provide residents with food per diet order. The DON stated that nursing staff should remove the lid from the meal, even for residents who ate independently to compare foods received with the diet order to make sure

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the resident received the correct foods. The DON stated that she would not expect a nurse aide to be able to identify correct portion sizes but that the nurse aide should recognize if the wrong food items were received or if a food item was missing and let dietary staff know.

The Administrator stated in an interview on 02/08/24 at 05:31 PM that residents should receive portions of food per the menu and per their diet order.

F 809 SS=E

Frequency of Meals/Snacks at Bedtime
CFR(s): 483.60(f)(1)-(3)

Completion date: 3/11/24

§483.60(f) Frequency of Meals
§483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.

§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.
This REQUIREMENT is not met as evidenced by:
Based on resident interviews and staff interviews, the facility failed to offer and deliver

Plan of correction:

1. Residents #78, #6, #69, #84, #60, #81, #34, #7, #25, and #27 are now being

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evening snacks to 10 of 12 residents (#78, #6, #69, #84, #60, #81, #34, #7, #25, #27) reviewed for evening snacks.

The findings included:

During an interview on 2/8/24 at 3:33 PM the Dietary Manager revealed she responded to resident council grievance in September 2023 by adding more evening snacks each night and nursing staff would sign off on receiving the snacks.

A review of the December 2023 Resident Council Minutes revealed under "New Business", Residents were "still" not receiving snacks at night and under "Old Business", Residents would like to have snacks at night.

A review of the January 2024 Resident Council Minutes revealed under, "New Business", Residents were "still" not receiving snacks at night and under "Old Business", Residents would like to have snacks at night.

During an interview on 2/6/24 at 2:21 PM the Activities Director indicated she completed resident council grievances and passed them onto the Social Worker who assigned the grievances to department heads. If she did not receive an update from a department head and if resident council attendees indicated the concern/ issue continued, she would add the concern to the resident council minutes for the next month and re-submit a grievance.

During interviews on 2/7/24 at 2:15 PM during a Resident Council Meeting, Residents #78, #6, #69, #84, #60, #81, #34, #7, #25, #27 who were

offered snacks. All residents will be offered a bedtime snack based on dietary restrictions.

2. Snacks will be available at the nursing station for any resident who may request an additional snack. Staff will document all snack offers and refusal on a snack audit tool. Snack offering will be monitored during daily Mock Survey rounds.

3. All Nursing staff will be educated on offering a bedtime snack to all residents by 3/11/2024. Newly hired staff will receive education as part of the orientation process. Dietary Staff (including manager) in-serviced by District Manager on HCSG Policy 010 through HCSG Policy 011. Dietary Manager or designee (when DM is not in facility) will use the snack delivery monitoring sheet to be signed nightly when snacks are delivered. District Manager will help monitor consistency during their visits to the facility. Dietary Manager will follow up daily with Director of Clinical Services on the passing of the snacks. Dietary Manager will utilize the snack label for residents.

4. Director of Clinical Services and/or Administrative Nurses will review the snack audit tool five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly for four (4) weeks. Any identified areas of concern will be addressed and corrected by the Director of Clinical Services and/or Dietary Manager. The Executive Director

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F 809	Continued From page 57 identified as alert and oriented revealed staff did not offer or provide evening snacks. They further revealed they met with the Dietary Manager during the food committee meeting about the concern and they were reassured they would receive snacks. During an interview on 2/7/24 at 2:15 PM during a Resident Council Meeting, Resident #84, further revealed if snacks were delivered to the nurse's station, there were never enough for all residents who may have wanted a snack. During an interview on 2/7/24 at 2:15 PM during a Resident Council Meeting, Resident #81, further revealed Resident Council Members' concerns had been reported in almost every resident council meeting and their concerns were not resolved. During an interview on 2/7/24 at 2:15 PM during a Resident Council Meeting, Resident #34, who was identified as alert and oriented, revealed staff did not offer or provide evening snacks. Resident #34 further revealed she observed an unnamed nurse aide eating snacks intended for residents. During an interview on 2/7/24 at 3:35 PM Nurse #5 indicated she worked the evening shift at times and observed Nurse Aides passing out evening snacks to residents. During an interview on 2/7/24 at 3:34 PM Nurse Aide (NA) #4 revealed when he worked the evening shift, he passed out snacks to residents when they requested them and that there were never enough snacks to pass out to all of his residents.	F 809	will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum of one direct care giver. The Director of Clinical Services will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Correction will be 3.11.2024	

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F 809	Continued From page 58 During an interview on 2/8/24 at 2:56 PM NA #3 indicated she worked on the 100 hall once or twice weekly and that sometimes dietary staff bring snacks to the nurse's station and sometimes they do not bring snacks. NA #3 further indicated she had never been able to distribute snacks to all of her residents because there were never enough delivered from dietary. NA #3 stated residents not receiving snacks was an on-going issue and that some residents had to go to the snacks machine and spend their own money on snacks and juice. During an interview on 2/8/24 at 3:40 PM the Dietary Manager stated she was made aware of three incidents during food committee meetings in December 2023 and November 2023 when snacks were not delivered to the units. During an interview on 2/8/24 at 3:55 PM the Director of Nursing indicated the concerns with snacks had been brought to her attention and she believed the process that was put in place (nursing staff signing off on the delivered snacks) had resolved the concern. She further indicated she was not aware of any recent complaints that residents were not receiving snacks. Her expectation was that all residents should be offered evening snacks. During an interview on 2/8/24 at 1:18 PM the Administrator revealed his expectation was for staff to offer evening snacks to all residents.	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		3/11/24

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F 812	Continued From page 59 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on an observation, staff interviews and record review, the facility failed to wash dishes in hot water and sanitize dishes per manufacturer recommendations in a quaternary sanitizing solution of at least 100 parts per million (ppm). This had the potential to affect 89 of 89 residents. The findings included: An observation of the Dietary Manager (DM) washing dishes (pots, sheet pans, whisks) in a three-compartment sink occurred on 02/08/24 at 12:15 PM. The water in the wash sink was cold to touch. The concentration of the quaternary sanitizing solution was less than 50 parts per million (ppm). The water in the sanitizing sink was above the "WATER FILL LINE." Per manufacturer recommendations the concentration of quaternary sanitizing solution should be at least 100 ppm.	F 812	1. Three-compartment sink was emptied and filled to water line with correct concentration of the quaternary sanitizing solution of at least 100 parts per million (ppm). All residents had the potential to be affected by deficient practice. 2. Dietary Staff (including manager) in-serviced by District Manager on HCSG Policy 022 and HCSG Policy 023. Education to include proper usage of Three-Compartment Sink. Any staff not educated by 3/11/2024 will not be allowed to work until education is completed. Newly hired staff will receive education as part of the orientation process. District Dietary Manger reviewed Three-Compartment Sink Log for	

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The DM stated on 02/08/24 during the observation that she set up the three-compartment sink earlier that morning to wash the dishes from the breakfast meal, and that she checked the quaternary sanitizing solution which registered above 100 ppm at the time. The DM stated that she did not recall what time she completed this task. The DM stated that she used the same water to wash the lunch dishes that she used earlier that morning to wash, rinse and sanitize the dishes from the breakfast meal. She also stated that she did not check the concentration of the quaternary solution in the sanitizing sink before she washed dishes from the lunch meal. The DM stated that the concentration of the quaternary sanitizing solution should be at least 100 ppm, and that the water in the sanitizing sink should not be above the water fill line. The DM stated that she should have reset the sinks to wash the dishes from the lunch meal.

The Administrator stated in an interview on 02/08/24 at 5:31 PM the dietary staff should wash and sanitize dishes per the manufacturer instructions.

F 812

accuracy. No issues identified.

3. Dietary Manager will monitor/ensure all staff follow the proper technique when using the 3-compartment sink. Dietary Manager or designee will check water fill line and sanitizing solution to ensure water level is acceptable and sanitizing solution meets manufacturer recommendations of no less than 150 parts per million and no more than 400 parts per million at the water fill line. District Manager to validate that the temp log is being completed appropriately during their facility visits.

4. Executive Director and/or designee, will monitor Three Compartment Sink to ensure water level and sanitizing solution are within acceptable range five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly for four (4) weeks. Any identified areas of concern will be addressed and corrected by the Dietary Manger and/or District Dietary Manager. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager,

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F 812	Continued From page 61	F 812	Minimum Data Set Nurse, and a minimum of one direct care giver. The Executive Director will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly for three months. Date of correction: 3/11/2024	
F 867 SS=F	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,	F 867		3/11/24

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including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to 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;

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F 867	Continued From page 63 consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms 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;	F 867		

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F 867	Continued From page 64 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 8/31/21, the complaint investigation survey completed on 1/19/22, the recertification and complaint investigation survey completed on 7/15/22, and the complaint investigation survey completed on 5/25/23. This failure occurred for four repeat deficiencies cited for resident, family, group and response, accuracy of assessments, food procurement, and increase, prevent decrease in range of motion and mobility that was subsequently recited on the current recertification and complaint investigation survey of 2/12/24. The continued failure of the facility during five federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F565: Based on record review, resident interviews and staff interviews the facility failed to provide updates or resolutions to group grievances (evening snacks, better meal choices, transportation to outings, and cold food) that were brought to Resident Council meetings for 4 of 4 months reviewed (October, November,	F 867	1. The Executive Director held a Quality Assurance Performance Improvement meeting on 2/23/2024 with the Interdisciplinary Team (IDT) including the Director of Clinical Services, Social Services, Dietary Manager, Admissions Director, MDS Coordinator, Activities Director, Medical Records Director, and Business Office Manager focusing on the areas of F565 Resident/Family/Group and Response; F641 Accuracy of Assessments; F688 Increase/Prevent Decrease in ROM/Mobility; F812 Food Procurement, Store/Prepare/Serve Sanitary 2. During the Quality Assurance Performance Improvement on 2/23/2024 the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. 3. The Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Regional Director of Clinical Services will	

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F 867	Continued From page 65 December of 2023, and January 2024). During the complaint investigation survey completed on 05/25/23 the facility failed to resolve dietary concerns voiced by residents during 6 of 7 Resident Council meetings reviewed related to providing foods per resident preference, snacks, and palatable foods (September 2022, October 2022, November 2022, February 2023, March 2023, and April 2023). F641: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for Gradual Dose Reduction for 2 of 5 residents (Resident #15 and Resident #20) reviewed for unnecessary medications. During the recertification and complaint investigation survey completed 7/15/22 the facility failed to accurately record the weight on a Minimum Data Set (MDS) assessment for 1 of 4 sampled residents reviewed for MDS accuracy. During the complaint investigation survey completed on 01/19/22 the facility failed to accurately code an admission Minimum Data Set (MDS) assessment related to scheduled pain medication regimen for 1 of 6 sampled residents reviewed for MDS accuracy. During the recertification and complaint investigation survey completed 08/31/22 the facility failed to correctly code Minimum Data Sets (MDSs) for 4 of 9 residents reviewed for MDS accuracy. A Resident was incorrectly coded for altered behaviors on an admission MDS dated 06/10/2021. A Resident was not accurately coded	F 867	attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities will be corrected as identified by the Executive Director. ¿ 4. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by IDT members each month for 12 months. The QAPI Committee will evaluate the effectiveness and amend as needed. Date of Correction will be 3.11.2024	

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HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

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F 867	Continued From page 66	F 867		

for rejection of care on a quarterly MDS dated 07/19/2021. A Resident had a quarterly MDS dated 05/20/2021 that was coded incorrectly for rejection of care. A Resident was coded incorrectly for vision on both an annual MDS dated 04/26/2021 and a quarterly MDS dated 07/27/2021.

F688: Based on observations, record review, and staff and Medical Director interviews, the facility failed to identify and develop a treatment plan for a resident with a right-hand contracture. This was evident for 1 of 3 residents (Resident #63) reviewed for range of motion.

During the recertification and complaint investigation survey completed 7/15/22 the facility failed to apply bilateral lower leg splints for 1 of 1 resident reviewed for contractures/limited range of motion.

F812: Based on an observation, staff interviews and record review, the facility failed to wash dishes in hot water and sanitize dishes per manufacturer recommendations in a quaternary sanitizing solution of at least 100 parts per million (ppm). This had the potential to affect 89 of 89 residents.

During the complaint investigation survey completed on 01/19/22 the facility failed to maintain clean kitchen tile throughout the kitchen. This practice resulted in unsanitary conditions in the kitchen.

The Administrator stated in an interview on 02/08/24 at 05:16 PM that the QAA committee meets monthly with all department managers to review standing agenda items, current facility

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F 867	Continued From page 67 trends and any systemic issues identified. He stated that if the QAA committee identified any gaps in the QAA process or identified new concerns, the QAA committee would conduct audits and discuss revisions to the process. The Administrator further stated that he attributed repeat deficiencies regarding resident, family, group, and response, to the need for improvement in relaying information to Resident Council about how the facility addressed their concerns; accuracy of assessments, to a recent change in staff in the MDS department and increase, food procurement to staff education and turnover and prevent decrease in range of motion and mobility related to education and staff turnover.	F 867		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		3/11/24

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F 883	Continued From page 68 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to administer the Influenza vaccination (Resident #63) and failed to offer and administer the Pneumococcal vaccination	F 883	]1. Resident #63 was assessed and offered the Influenza vaccine. Influenza was administered on 2/7/2024. Medical Director and Responsible Party were	

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F 883	Continued From page 69 (Resident #15, Resident #59 and Resident #68) to 4 of 5 residents reviewed for immunizations. The findings included: 1. Resident #63 was admitted to the facility on 05/07/21. Resident #63's quarterly Minimum Data Set (MDS) assessment dated 11/02/23 revealed the Resident did not receive the Influenza vaccine in the facility for the year's Influenza season and the Influenza vaccine was not offered. A review of Resident #63's electronic medical record revealed the consent to administer the Influenza vaccination was given by the responsible party on 11/28/23 but there was no record that the Influenza vaccine was given to Resident #63. An interview was conducted with the Infection Preventionist (IP) on 02/07/24 at 10:29 AM who reviewed the Resident #63's medical record and stated that she was not sure why the Resident did not receive the Influenza vaccination especially since the consent to administer the vaccination was given. The IP continued to review the medical record and stated it looked like the Resident's last Influenza vaccination was given in 2022. An interview was conducted with the Director of Nursing (DON) on 02/08/24 at 2:46 PM. The DON explained that they had an issue getting in touch with Resident #63's responsible party to give the consent for the Influenza vaccination and by the time they received the consent to administer the vaccination, "it just fell through the cracks".	F 883	notified. Resident #15 was assessed and offered the Pneumococcal vaccine. The Pneumococcal vaccine was ordered and will be administered upon arrival. Medical Director and Responsible Party were notified. Resident #59 was assessed and offered the Pneumococcal vaccine. The Pneumococcal vaccine was ordered and will be administered upon arrival. Medical Director and Responsible Party were notified. Resident #68 was assessed and offered the Pneumococcal vaccine. The Pneumococcal vaccine was ordered and will be administered upon arrival. Medical Director and Responsible Party were notified. 2. All residents who have not been assessed and offered the influenza vaccine for the 2023/2024 flu season have the potential to be affected by the alleged deficient practice. All residents who have not been assessed and offered the pneumococcal vaccine have the potential to be affected by the alleged deficient practice. On 2/29/24 The Director of Clinical Services/Assistant Director of Clinical Services (Infection Preventionist)/Unit Managers completed a 100% audit of all pneumococcal and influenza vaccines to assess any residents who were eligible and didn□t receive the pneumococcal and influenza vaccine. Any residents who were not vaccinated were assessed and offered the pneumococcal and influenza vaccine according to facility policy. The Director of Clinical Services/Assistant Director of Clinical Services (Infection	

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F 883 Continued From page 70

During an interview with the Administrator, Director of Nursing and the Regional Clinical Director on 02/08/24 at 3:56 PM. The Administrator stated they should be providing Influenza and Pneumococcal vaccinations according to the state regulations.

2. a. Resident #15 was admitted to the facility on 06/22/21.

Resident #15's quarterly Minimum Data Set (MDS) assessment dated 12/19/23 revealed the Resident's Pneumococcal vaccination was not up to date and the vaccine was not offered.

A review of Resident #15's electronic medical record revealed there was no record of the Resident's Pneumococcal vaccination history in the medical record.

An interview was conducted with the Infection Preventionist (IP) on 02/07/24 at 10/34 AM. The IP stated she did not know why Resident #15's Pneumococcal vaccination status not addressed.

b. Resident #59 was admitted to the facility on 12/15/21.

A review of Resident #59's quarterly Minimum Data Set (MDS) assessment dated 01/17/24 revealed the Resident's Pneumococcal vaccination status was not up to date and the vaccination was not offered.

A review of Resident #59's electronic medical record revealed there was no record that the Pneumococcal vaccination had been offered to the Resident.

F 883

Preventionist)/Unit Managers followed up with the residents and any family representatives for any residents who were identified as not receiving the pneumococcal and influenza vaccine during this audit to provide education for the vaccine. Residents who consented to the pneumococcal and influenza vaccine have been vaccinated and their medical record has been updated as of 03/11/2024. Residents who declined the pneumonia and influenza vaccine have the declination updated in their electronic medical record according to the facility policy as of 03/11/2024.

3. The Director of Clinical Services, Infection Preventionist, and the Unit Managers were re-educated on the immunization policy and procedures by the Regional Director of Clinical Services. The education included the following topics: Education to the resident or resident's representative of the benefits and potential adverse side effects of the vaccinations. Obtaining of consent for administration of the vaccinations. Uploading the consent or declination in Point Click Care (PCC). Obtaining a physician□s order to administer the vaccinations.
Administration of the vaccines.
Documentation of the vaccinations in the resident□s immunization record in PCC.
On 3/1/2024 the Director of Nursing /Nurse Management team began education of all full time, part time and as needed nurses and agency nurses on the Pneumococcal and Influenza

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An interview was conducted with the Infection Preventionist (IP) on 02/07/24 at 10:01 AM who explained that she did not know how the Infection Control program was managed before she recently took over the position so she could not offer why the Pneumococcal vaccination was not offered to Resident #59.

c. Resident #68 was admitted to the facility on 12/11/23.

A review of Resident #68's admission Minimum Data Set (MDS) assessment dated 12/15/23 revealed the Resident's Pneumococcal vaccination status was not up to date and the vaccine was not offered.

A review of Resident #68's electronic medical record revealed there was no record that the Pneumococcal vaccination had been offered to the Resident.

An interview with the Infection Preventionist (IP) on 02/07/24 at 10:58 AM revealed that the IP explained that she did not know why the facility was not currently addressing the Pneumococcal vaccinations.

An interview was conducted with the Director of Nursing on 02/08/24 at 2:56 PM. The DON explained that the Pneumococcal vaccinations were not given to anyone because they were trying to audit to determine the Pneumococcal vaccination status on all the residents and then administer the vaccinations to the residents.

During an interview with the Administrator, Director of Nursing and the Regional Clinical

F 883

administration process. The in-service will be completed by 03/11/2024 at which time all nurses must be in-serviced prior to working. The Director of Clinical Services will ensure that that any of the above identified staff who does not complete the in-service training by 03/11/2024 will not be allowed to work until the training is completed. The in-service will be incorporated into the new employee facility orientation Director of Clinical Services/ADON (Infection Preventionist)/Unit Managers.

4. The Director of Clinical Services/ADON (Infection Preventionist)/Unit Managers will monitor the immunization process for pneumococcal and influenza vaccines by observing five (5) residents utilizing the Immunization Audit Tool during the Daily Clinical Meeting Monday through Friday for compliance of the facility policy. This audit will be completed weekly for a period of four (4) weeks and then monthly for a period of three (3) months. The Executive Director will introduce the plan of correction to the Quality Assurance Performance Improvement Committee on 3/4/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Clinical services, Assistant Director of Clinical Services, Unit Manager, Director of Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, Minimum Data Set Nurse, and a minimum

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F 883	Continued From page 72 Director on 02/08/24 at 3:56 PM. The Administrator stated they should be providing Influenza and Pneumococcal vaccinations according to the state regulations.	F 883	of one direct care giver. The Director of Clinical Services will report the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement Committee monthly. Date of Correction will be 3.11.2024	