STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345000	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF BISCOE	401 LAMBERT ROAD BISCOE, NC 27209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was completed on 3/4/24 to 3/7/24. The facility was found out of compliance with the CFR 483.73, Emergency Preparedness at E0039. Event #OSFD11.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or	E 039		3/28/24

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

Electronically Signed | 03/29/2024

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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functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section

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is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed

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messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared

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questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions

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designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop

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exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises

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to test the emergency plan at least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises

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E 039	Continued From page 8 to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to participate in a full-scale community based exercise as part of their	E 039	1. Facility had an actual fire community response on January 18, 2024 that was used as a full scale drill and involved local	

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E 039	Continued From page 9 Emergency Preparedness (EP) program. The findings included: A review of the facility's EP manual revealed the facility had no evidence of conducting a full-scale exercise that was community based in the past year. During an interview with the Administrator on 3/6/24 at 2:45 PM, she indicated there had not been a full-scale exercise since the COVID-19 outbreak several years ago. She indicated the failure was related to scheduling conflicts with the county and would work on coordinating with the local police and emergency officials to schedule a community-based exercise to test their EP plan.	E 039	fire department, police services, EMS, and staff. The Administrator completely forgot while being interviewed by the Surveyor that the drill occurred. 2. Emergency preparedness book reviewed to ensure no other areas of deficient practice by Administrator on 3/20/2024. – no issues noted. 3. Prevention to ensure deficient practice does not occur again: Division Vice President educated Administrator on 3/20/24 on importance of maintaining emergency preparedness exercises. 4. Ongoing compliance monitoring: Division Vice President of Operations/designee will audit Emergency Preparedness exercises/drills monthly x 3 months. The Administrator will review the Emergency Preparedness Manual and update as needed monthly for 3 months. Administrator will report results in QAPI x 3 months.	
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was completed 3/4/24 to 3/20/24. Five of the 16 complaint allegations resulted in a federal deficiency. See #NC00209735, NC00208439, NC00205869, NC00207603, NC00205141, N00206197, NC00202813 and NC00199328. See Event # OSFD11 dated 3/7/24. Additional information was obtained on 3/20/24. Therefore, the exit date wa changed to 3/20/24.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		3/28/24

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§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the

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F 550	Continued From page 11 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to treat a resident with dignity and respect when Nurse Aide #2 spoke to a resident (Resident #2) in a disrespectful manner. This was for 1 of 2 residents reviewed for dignity. The findings included: Resident #2 was admitted to the facility on 9/6/10. An initial allegation report dated 2/21/23 documented that Resident #2 reported Nurse Aide (NA) #2 was verbally abusive to him on 2/20/23, when he needed toileting hygiene assistance. NA #2 was an agency NA who was removed from the schedule and terminated immediately on 2/21/23. A written statement from Nurse #3 (on duty 7:00 PM to 7:00 AM) dated 2/20/23 indicated that he overheard bickering from NA #2 and Resident #2 using bad language to each other. NA #2 left the building and Nurse #3 approached Resident #2 who stated NA #2 wouldn't clean his buttocks after a bowel movement. She stated to him that he could do it himself and cursed at him. NA #3 assisted Resident #2 with his toileting hygiene. A written statement from NA #2 (who was on duty 3:00 PM to 11:00) dated 2/21/23 read that on 2/20/23 Resident #2 was in the bathroom. She went to help him but couldn't get to him. "I handed him the wipes, he got mad, bent over, and patted his buttocks and said to kiss his ass".	F 550	1. Resident #2 – On February 21, 2023 resident #2 reported to administrator that there was a dignity concern with Nurse Aide on the previous evening. Nurse aide was discharged on 2/21/23. Head to toe assessment completed on 2/22/23 and resident included in weekly audits x 4 weeks. Responsible party notified of situation. 2. All residents are at risk for same deficient practice. Skin sweep performed on all other cognitively impaired residents by nurses and interviews completed on cognitively intact residents by nurses. Completion 2/22/23. 3. Prevention to ensure deficient practice does not occur again: Director of Nursing (DON)/designee provided education to all staff about dignity and resident rights. Education will be provided to all new hires during orientation. Education completed 3/28/24. 4. Ongoing compliance monitoring: DON/Designee to perform random interviews of 5 cognitive residents weekly x 12 weeks and staff/resident observations for 5 cognitively impaired residents x 12 weeks to ensure staff is treating residents with dignity. Results to be reported in QAPI x 3 months by the DON.	

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AUTUMN CARE OF BISCOE	401 LAMBERT ROAD BISCOE, NC 27209

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NA #2 left the room and reported to the nurse what happened. Later that evening Resident #2 called "me a stupid bitch and I said that is why you are going to have an itchy ass tonight".

A written statement from Nurse #1 (who was the nurse on duty 7:00 AM to 7:00 PM) dated 2/21/23 read that NA #2 came to the desk talking very loudly stating Resident #2 told her to "kiss his ass because she wouldn't clean his ass". She stated, "since the resident could stand up, he could wipe his own ass".

An Interdisciplinary Departmental Team (IDT) meeting was completed on 2/22/23 regarding Resident #2 interaction with NA #2.

The investigative report dated 2/27/23 documented that the facility investigation into the incident revealed the exchange did not rise to the level of abuse but was inappropriate. Resident #2 reported that NA #2 called him names, cursed at him, and told him he could provide toileting hygiene himself when he was in the need for assistance after toileting. He was assisted with hygiene from a different staff member as he didn't want NA #2 back in his room.

An annual Minimum Data Set (MDS) assessment dated 1/24/24 indicated Resident #2 was cognitively intact and displayed no behaviors. He required moderate assistance with toileting hygiene.

An interview occurred with Resident #2 on 3/5/24 at 1:50 PM who was able to recall the incident that occurred on 2/20/23. He explained he was in the bathroom and needed assistance with toileting hygiene. The NA came in, was on her

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F 550	Continued From page 13 phone and told him if he could stand, he could "wipe his own ass". He couldn't recall what else was said but stated the incident made him very mad and he felt she was rude and disrespectful. Resident #2 stated he didn't want her back in his room that evening, so another NA assisted him with his needs. On 3/5/24 at 2:02 PM, an interview occurred with Nurse #1 who recalled the incident on 2/20/23. She stated NA #2 came to the nurse's station, was very loud and stated, "I'm not going to wipe his ass, he can do it himself". Nurse #1 stated she went to Resident #2 who stated the aide spoke to him rudely and he didn't want her back in the room. Another NA assisted Resident #2 with his needs. The incident was reported to the Administrator. The Administrator was interviewed on 3/6/24 at 10:23 AM and was able to recall the details of the incident that occurred on 2/20/23. She stated when she arrived to work on 2/21/23 she was made aware of the incident between Resident #2 and NA #2 and initiated the investigation. Resident #2 reported to her that NA #2 cursed at him and wouldn't help him with toileting hygiene. During the interviews it was reported that staff overheard Resident #2 and NA #2 cursing at each other. She was an agency employee and was removed from the schedule. The Administrator stated she would expect staff to treat residents with dignity and respect at all times. Multiple phone calls were placed to NA #2 and Nurse #3 without success.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		3/28/24

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F 584	Continued From page 14 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 15 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews of residents and staff, the facility failed to provide a clean, home-like environment in the main dining room as evidenced by a dirty, sticky floor and a dirty window and failed to repair a leaking roof. Findings included: 1 On 3/4/24 at 12:00 pm the initial resident dining observation was done. The entryway floor with vending machines, food serving cabinets and entry into the kitchen was noted to have a moderate amount of brown soil which was sticking to the shoe. This was a high-traffic area with staff, residents, and visitors walking. The window in this area had a large amount of spider webs with black soil affecting visibility to the outside. On 3/5/24 at 1:30 pm an observation was done of the dining room and the floor and window remained the same. On 3/6/24 at 1:35 pm an observation was done of the dining room and the floor and window remain unchanged. On 3/6/24 at 1:54 pm an interview was conducted with the lead Housekeeper. She stated housekeeping was responsible to clean the floor and dust in the main dining room each day. She stated the floor was mopped each day. She stated she was not aware the floor had not been	F 584	1. All residents are affected if homelike environment not present. Room 212 ceiling was repaired on 3/12/24. Dining room floors and window cleaned on 3/8/24. 2. All resident areas are at risk for deficient practice. Other resident care areas inspected for ceiling integrity and cleanliness by the Administrator and Maintenance Director and repairs made if noted on 3/8/24. 3. Prevention to ensure deficient practice does not occur again: Administrator completed education with maintenance director regarding timely contact of vendors if leaks occur on 3/21/2024. Housekeeping employees educated by the Administrator on expectations for mopping and dusting frequency on 3/21/2024. Facility renovation began on 3/18/24 to include walls, doorways, and floors. Education will be provided to all new hires during orientation. 4. Ongoing compliance monitoring: Administrator/designee will perform random audits of resident care and common areas weekly x 12 weeks for cleanliness and disrepair. Administrator will report results in QAPI x 3 months.	

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mopped since before Monday and was sticky. She stated she would mop the floor now and clean the dirty window. Housekeeping and maintenance manage cleaning the facility windows.

2.
A vendor estimate dated 10/3/23 to repair the areas of active leak or the entire roof was obtained by the facility and a copy was provided on 3/7/24.

E-mail communication dated 10/16/23 between the facility Administrator and Corporate Office documented there were roof leaks that affected the following areas (copy provided 3/7/24):

" Resident rooms 109 202, 206, 209, 212, 301, 302, 2307, 310, 401, 402, 403, 406, 407, 410, 412, 502, 503, 504, 506, 507, 508, 510, 516, 608 614, 620, 622, and 625.
" 600 nurses' station
" 600 nutrition room
" 600 medication room
" 600 living room
" 600 soiled utility room
" Director of Nursing's office
" Unit manager's room
" Conference room
" Laundry room vents
" Front dining room

A capital purchase request dated 10/16/23 was provided to the Corporate Office for roof repair or replacement by the Administrator and copy provided on 3/7/24. The facility had leaking areas patched by the vendor.

On 03/06/24 at 12:20 pm an interview was

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conducted with the Maintenance Manager. The Manager stated he was the only person completing repairs. The roof has been leaking for months in the past and patched by the vendor. He was currently waiting for the entire roof replacement bid to be approved by the home office. There was currently other random roof leaks after patches were placed that he was fixing.

On 3/7/24 at 9:00 am an interview was conducted with the Administrator. She stated that the Corporate Office was provided the vendor quote for patch and repair and approved patch repair and there had been "new leaks that had popped up throughout the building." The Corporate Office was aware of the leaks and had the roof replacement estimate, but there was no decision at present. The facility maintenance staff had attempted to repair the leaks, but there were new leaks. She stated new areas of leak had opened recently and residents had to be moved to other rooms. There was a current roof leak in resident Room 212, which had leaked before. The Administrator stated the roof needed to be replaced, patching the roof was not working at this time.

On 3/7/24 at 9:30 am an observation was completed of resident Room 212. It was raining and there was a small amount of water on the floor next to the outer wall. The ceiling above had a small area of stain and small blister in the drywall.

On 3/7/24 at 10:00 am an observation of resident rooms on Halls 100 - 600 was completed. The rooms were checked for roof leak and none were observed.

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F 584	Continued From page 18 On 3/7/24 at 9:30 am an interview was conducted with Resident #24. The resident resided in Room 212. The resident stated the roof was leaking again. She had been moved from another room before when the roof was leaking. The ceiling was coming down and no one had come to repair the leak. On 3/7/24 at 9:35 am an interview was conducted with Resident #58. Resident #58 resided in room 212. She stated the ceiling was stained and sagging and there was a small amount of water leaking onto the floor near the window and this was not the first time. An observation revealed the leak was in front of the drawers where the residents' clothes were stored. On 3/20/24 at 9:40 am an interview was conducted with the Administrator. The Administrator stated the Corporate Office made the decision of how to manage the roof leak. The roof leak was patched last week, resident room 212 no longer had a leak, and future leaks would be patched. The roof would not be replaced at this time.	F 584		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews of residents and staff, the facility failed to provide dependent residents with nail care for	F 677	1. Resident #14, 20, 35, 61, 76 and 92 – all residents received nail care on 3/7/24. 2. All residents are at risk for deficient	3/28/24

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F 677	Continued From page 19 6 of 6 residents reviewed for activities of daily living (ADL) [Resident #s 14, 20, 35, 61, 76, and 92]. Findings included: 1. Resident #14 was admitted to the facility on 9/26/14 with the diagnosis of Parkinson's disease. Resident #14 had a care plan for activity of living deficit. He required assistance as needed and help with his dentures. Review of Resident #14's ADL sheets for February and March 2024 revealed the staff did not document set up for shower, he had periodic staff assistance with toilet use on all shifts, and there was no documentation of nail care or refusal of care. A review of Resident #14's nurses' notes for February and March 2024 documented the resident required set up help with meals and showers. Showers were scheduled on Tuesday and Friday. On 03/04/24 at 10:40 am Resident #14 was observed to have long dirty nails and was interviewed. The nails had dirt underneath and around the cuticles that was brown to black. The resident was alert and oriented, he looked at his long, dirty nails and shrugged his shoulders and said it's okay. "I am independent with most things." The resident had limited dexterity to his hands, with gross movement to pick up items. The resident had limited range of movement to his neck and torso and sat in his wheelchair leaning over to his left leaning on the side arm.	F 677	practice. All dependent resident nails assessed and nail care offered to all dependent residents by nurses and aides beginning on 3/5/24. Nail care provided by aides and the nurses provided nail care for those with diabetes. Completed 3/7/24 3. Prevention to ensure deficient practice does not occur again: Director of Nursing/designee completed education with nursing nurses and aides on 3/26/24. All of nursing re-educated on residents receiving nail care on shower days, PRN, and to document refusals. Education will be provided to all new hires during orientation. Education completed 3/26/24. 4. Ongoing compliance monitoring: DON/designee will audit nail care on 10 residents weekly for 12 weeks. Results to be reported in QAPI x 3 months by the DON.	

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On 3/4/24 at 10:55 am an interview was conducted with Nurse #4. Nurse #4 stated she was assigned to Resident #14 and knew him well. She stated the resident refused to have his nails cut, but the nails/hands should be washed when he was set up for his shower or meal. The resident "was set in his ways." Nurse #4 was not aware the resident had soiling around the nail cuticle and underneath and his nails were long.

On 3/5/24 at 11:20 am an observation was completed of Resident #14. His nails remained in the same condition.

On 3/5/24 at 2:50 pm Nursing Assistant (NA) #5 was interviewed. NA #5 stated she was assigned to all halls. The residents were to have nail care as needed unless unable then the nurse was to be informed of the resident's needs. Resident's nails were cared for during bathing or showers. If the resident refused, the nurse was to be informed. The NA did not know why some of the residents on Hall 500 had long dirty nails and would check. If the nails were long and dirty, the care was not done and should have been reported to the nurse.

On 2/5/24 at 3:24 pm an interview was conducted with Nurse #4. Nurse #4 stated she was assigned to Hall 500 residents. She stated if the residents' nails were long and dirty, care was not completed, and the NA had not informed her. Nurse #4 stated Resident #14 would probably not allow staff to cut his nails, but his hands/nails should be washed. The resident had not refused care before. She expected the NA to provide nail care with the shower or bath and as needed or let the nurse know if unable or the resident refused.

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On 3/6/24 at 8:45 am an observation was completed of Resident #14. His nails were observed to be cut and clean this morning. Resident #14 commented staff assisted him with his nails.

On 3/6/24 at 2:05 pm an observation was done of Resident #14. He used his hands to feel through the wheelchair pocket and it was noted that his fine dexterity was limited and had gross use of his fingers.

On 3/6/24 at 10:40 am an interview was conducted with Nurse Consultant #2. She stated facility staff noticed some issues with the residents' nail condition and directed the staff to audit all residents' fingernails and provide care around 5:00 pm yesterday, 3/5/24.

2.
Resident #20 was admitted to the facility on 10/23/23 with the diagnoses of schizoaffective disorder and weakness.

A review of Resident #20's ADL sheets for February and March 2024 documented he received a bath with assistance from staff almost every day. No refusals were documented. There was no nail care documented.

Resident #20's care plan dated 2/13/24 documented Resident #20 had an ADL self-care deficit. Staff were to assist with ADL care as needed.

Resident #20's quarterly Minimum Data Set dated 2/13/24 documented his cognition was intact. The resident had little interest in doing things

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every day, was depressed, and had trouble falling asleep 2 to 6 days per week. The resident was moving and speaking slowly, had no behaviors, and no rejection of care.

On 03/4/24 at 2:08 pm an observation was completed of Resident #20. His nails were long and dirty under the nail bed and around the cuticle.

On 3/5/24 at 12:30 pm an observation was completed of Resident #20 and his nails remained unchanged. Some nails had jagged edges, especially on his dominant hand the second finger.

On 3/5/24 at 2:50 pm Nursing Assistant (NA) #5 was interviewed. NA #5 stated she was assigned to all halls. The residents were to have nail care as needed unless unable then the nurse was to be informed of the resident's needs. Resident's nails were cared for during bathing or showers. If the resident refused, the nurse was to be informed. The NA did not know why some of the residents on Hall 500 had had long dirty nails and would check. If the nails were long and dirty, the care was not done and should have been reported to the nurse.

On 2/5/24 at 3:24 pm an interview was conducted with Nurse #4. Nurse #4 stated she was assigned to Hall 500 residents. She stated if the residents' nails were long and dirty, care was not completed, and the Nursing Assistant (NA) had not informed her. Nurse #4 stated Resident #20 had not refused care and should have had nail care when assisted with his shower. She expected the NA to provide nail care with the shower or bath and as needed or let the nurse

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know if unable or the resident refused.

On 3/7/24 at 10:15 am Resident #20 was interviewed. The resident was able to state "yes" when asked if staff assisted him with nail care last evening. The resident was slow to respond.

On 3/6/24 at 10:40 am an interview was conducted with Nurse Consultant #2. She stated facility staff noticed some issues with the residents' nail condition and directed the staff to audit all residents' fingernails and provide care around 5:00 pm yesterday, 3/5/24.

3.
Resident #61 was admitted to the facility on 1/31/24 with the diagnosis of dementia.

A review of Resident #61's weekly skin assessment dated 2/29/24 documented no skin issues with no mention of fingernails.

Resident #61's care plan dated 1/31/24 documented an ADL self-care deficit and to assist with ADLs as needed.

Resident #61's admission Minimum Data Set dated 1/31/24 documented he had a moderately impaired cognition. The resident had no refusal of care and bathing required maximal assistance and all other care required partial-moderate assistance of 1 staff.

A review of Resident #61's ADL for February and March 2024 documented he required bathing assistance with part of the bathing by 1 staff member. The resident had Tuesday and Friday showers scheduled. He required total dependence for most days and 1-day partial

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assistance. March 2024 bathing varied from dependence to assistance by 1-staff member. There was no documentation of nail care or refusal.

On 3/05/24 at 1:29 Resident #61 was observed sitting in his wheelchair in the front lobby. The resident was alert to self and situation. The resident's nails were noted to be long, broken (right pointer finger) and dirty under the nails and fingers. The resident was interviewed and stated he would like nail care. He had "no nail care since he got here" (1/31/24).

On 3/5/24 at 2:50 pm Nursing Assistant (NA) #5 was interviewed. NA #5 stated she was assigned to all halls. The residents were to have nail care as needed unless unable then the nurse was to be informed of the resident's needs. Resident's nails were cared for during bathing or showers. If the resident refused, the nurse was to be informed. The NA did not know why some of the residents had had long, dirty nails on Hall 500 and would check. If the nails were long and dirty, the care was not done and should have been reported to the nurse.

On 2/5/24 at 3:24 pm an interview was conducted with Nurse #4. Nurse #4 stated if the residents' nails were long and dirty, care was not completed, and the NA had not informed her. Nurse #4 stated residents should have had nail care when assisted with their shower or bath. She expected the NA to provide nail care with the shower or bath and as needed or let the nurse know if unable.

On 2/7/24 at 10:20 am an observation was completed of Resident #61. He was sitting in his

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wheelchair on the hall. His nails were cleaned, and some were cut.

On 3/6/24 at 10:40 am an interview was conducted with Nurse Consultant #2. She stated facility staff noticed some issues with the residents' nail condition and directed the staff to audit all residents' fingernails and provide care around 5:00 pm yesterday, 3/5/24.

4.
Resident #76 was admitted to the facility on 4/14/22 with the diagnosis of dementia.

Resident #76's annual Minimum Data Set dated 2/11/24 documented the resident had a severely impaired cognition, no psychosis, no behavior, or refusal of care. The resident was dependent for personal care.

The documented care plan dated 2/12/24 for Resident #76 revealed she had an ADL care deficit.

On 03/04/24 at 12:35 pm an observation was done of Resident #76. Resident #76 was dressed and sitting in her wheelchair in her room. Her nails were long and dirty, and she was unable to state whether she wanted them to be cut and cleaned. The resident was pleasantly confused but oriented to self.

A review of Resident #76's orders revealed she was receiving longevity care as of 9/25/23 (managed palliative care).

A review of ADL documentation for February and March 2024 revealed Resident #76 received bathing each day and one shower on 3/5/24

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during March and bathing each day during February 2024. The resident was dependent of 1 staff for care with no refusals and no behaviors. There was no documentation of nail care.

The multi-disciplinary meeting for Resident #76 on 2/14/24 documented the resident no longer had behaviors or refusal of care.

Physician note dated 2/14/24 documented Resident #78 was seen for her regulatory visit. The resident had a history of late onset Alzheimer's dementia without behavioral disturbances. Staff reported no new behaviors or concerns.

A review of Resident #78's ADL documentation for February 2024 revealed she was bathed every day. The resident was dependent and had showers on Tuesday and Friday. There was no nail care, behaviors, or refusals documented.

On 3/5/24 at 2:50 pm Nursing Assistant (NA) #5 was interviewed. NA #5 stated she was assigned to all halls. The residents were to have nail care as needed unless unable then the nurse was to be informed of the resident's needs. Resident's nails were cared for during bathing or showers. If the resident refused, the nurse was to be informed. The NA did not know why some of the residents had had long, dirty nails on Hall 500 and would check. If the nails were long and dirty, the care was not done and should have been reported to the nurse.

On 2/5/24 at 3:24 pm an interview was conducted with Nurse #4. Nurse #4 stated if the residents' nails were long and dirty, care was not completed, and the NA had not informed her.

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Nurse #4 stated residents should have had nail care when assisted with their shower or bath. She expected the NA to provide nail care with the shower or bath and as needed or let the nurse know if unable. Nurse #4 stated Resident #78 had not refused care, no longer had behaviors and would not be able to make her needs known due to dementia.

On 3/6/24 at 10:40 am an interview was conducted with Nurse Consultant #2. She stated facility staff noticed some issues with the residents' nail condition and directed the staff to audit all residents' fingernails and provide care around 5:00 pm yesterday, 3/5/24.

On 3/6/24 at 11:10 am Resident #76 was observed. She had some remaining brown soil under her fingernails, a couple of nails were cut, and the soil around the cuticle was gone.

5.
Resident #92 was admitted to the facility on 11/30/23 with diagnosis of ataxia, muscle wasting of the hands, and other nervous system deficit. Resident #92's admission Minimum Data Set dated 12/7/23 documented his cognition was intact and he had no behavior or refusal of care. The resident required partial/moderate assist with personal hygiene.

Resident #92's quarterly MDS dated 2/21/24 and due 3/8/24 documented no behaviors or refusal of care.

Resident #92's care plan dated 2/21/24 documented he had an ADL deficit secondary to hand atrophy and ataxia. ADL assistance was needed for personal care and meal set up. The

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resident wore bilateral splints to wrist/hand for carpal tunnel and muscle wasting, which was removed during the day, and used adaptive utensils for meals.

A review of the Resident #98's medical chart revealed he had no pain to his hands; he had muscle atrophy and splints at night for carpal tunnel and was receiving therapy services for hand rehab and used adaptive utensils to eat.

On 3/6/24 at 11:00 am Resident #92 was interviewed. He stated staff cleaned and cut his nails last evening (3/5/34), and he observed staff provide nail care to his roommate as well. The resident had no pain in his hands and accepted care.

On 3/5/24 at 2:50 pm Nursing Assistant (NA) #5 was interviewed. NA #5 stated she was assigned to all halls. The residents were to have nail care as needed unless unable then the nurse was to be informed of the resident's needs. Resident's nails were cared for during bathing or showers. If the resident refused, the nurse was to be informed. The NA did not know why some of the residents had had long, dirty nails on Hall 500 and would check. If the nails were long and dirty, the care was not done and should have been reported to the nurse.

On 2/5/24 at 3:24 pm an interview was conducted with Nurse #4. Nurse #4 stated she was assigned to and familiar with Resident #92. The resident had pain in his hands and she would need to see if the resident would allow nail cut. The resident had not refused care. All residents should have their hands and nails washed. If the residents' nails were long and dirty, care was not

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completed, and the NA had not informed her. Nurse #4 stated residents should have had nail care when assisted with their shower or bath. She expected the NA to provide nail care with the shower or bath and as needed or let the nurse know if unable.

On 3/6/24 at 10:40 am an interview was conducted with Nurse Consultant #2. She stated facility staff noticed some issues with the residents' nail condition and directed the staff to audit all residents' fingernails and provide care around 5:00 pm yesterday, 3/5/24.

6. Resident #41 admitted on 8/9/22 with diagnoses of a cerebral vascular accident (CVA),right side hemiparesis and Diabetes.

Review of Resident #41's annual Minimum Data Set dated 2/3/24 indicated he had severe impairment, exhibited no behaviors and was dependent on staff assistance with personal hygiene.

Review of Resident #41's comprehensive care plan included a care plan revised on 12/12/23 for staff to check his skin to his right hand with hygiene, before splint placement and removal. There was also a care plan last revised on 10/28/22 for Resident #41's for noncompliance with shaving, weights, showers and medications.

Review of Resident #41's cumulative Physician orders included an order dated 1/16/24 for a resting hand splint to his right hand for a contracture.

An observation on 3/4/24 at 10:51 AM of Resident #41. He was sitting in a wheelchair in

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his room. The fingernails to his left hand were long and jagged. Resident #41 opened his right contracted hand slightly enough to observe his fingernails longer than the nails to his left hand. His nails were touching his palm but there was no evidence of any injuries.

An observation on 3/5/24 at 9:30 AM was completed of Resident #41. He was lying in bed. The nails to his left hand had been trimmed but his contracted right hand remained unchanged.

An interview was completed on 3/5/24 at 9:40 AM with nursing assistant (NA) #6. He stated Resident #41 was a diabetic so the nurses were responsible for trimming his fingernails. He stated he had reported the appearance of Resident #41's fingernails sometime last week or the week before to a nurse but he was unable to recall which nurse it was. NA #6 stated normally the aides completed nail care after showers or bathing and Resident #41 was known to refuse his showers. He stated he was not aware of his refusals of nail care.

An observation on 3/6/24 at 10:25 AM was completed of Resident #41. He was sitting in a wheelchair in his room. The fingernails to his right contracted hand were unchanged.

Another observation was completed on 3/6/24 at 10:30 AM with the assistant Director of Nursing (ADON) of Resident #41's fingernails on his right hand. The ADON observed his fingernails and confirmed they appeared long. The ADON assessed his palm for injuries and asked if he would allow her to trim his nails and he replied "yes." The ADON confirmed Resident #41 was diabetic and stated the nurses were responsible

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for trimming his fingernails and his fingernails should have not been in the condition observed.

An interview was completed on 3/6/24 at 10:32 AM with Nurse #8. She stated nurses trim fingernails of all diabetic residents. She stated this was her first day working in a while and that she did not notice the appearance of Resident #41's fingernails this morning.

An interview was completed on 3/6/24 at 10:40 AM with Nurse Consultant #2. She stated the facility noticed some issues with nailcare and she told the staff to audit all the residents fingernails on 3/5/24. Nurse Consultant #2 stated she expected Resident #41's fingernails to have been trimmed yesterday.

A telephone interview was completed on 3/6/24 at10:52 AM with Nurse #6. She confirmed she worked with Resident #41 on 3/4/24 and 3/5/24 from 7:00 AM to 7:00 PM. She stated she did not notice his fingernails on either day. Nurse #6 stated she thought an aide trimmed his nails one day last week. When questioned why an aide would trim Resident #41's fingernails, she did not recall that he was diabetic. When questioned if anyone asked her to audit fingernails on 3/5/24, she stated she was not aware of any directive to audit resident fingernails yesterday.

A telephone interview was completed on 3/6/24 at 1:54 PM with Nurse #9. She stated she worked 7:00 PM to 7:00 AM on 3/5/24 with Resident #41. She stated she was not aware of any directive to audit resident fingernails. She stated Resident #41 was known to refuse assistance with his activities of daily living (ADLs) and nail care.

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F 677	Continued From page 32 An interview was completed on 3/7/24 at 9:50 AM with the Administrator. She stated it was her expectation that the nurses provide nail care on Resident #41's hands as indicated on observation.	F 677		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		3/28/24

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F 690	Continued From page 33 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 record review, resident, Physician and staff interviews, the facility failed to act on a hospital discharge order for a nephrology follow up appointment for Resident #60 that resulted in her requiring antibiotics to treat UTIs on 5/26/23, 10/11/23, 10/28/23, 1/18/24 and 2/25/24. This was for 1 of 2 residents reviewed for urinary tract infections (UTIs). The findings included: Resident #60 was admitted on 3/13/23 with cumulative diagnoses of congestive heart failure and chronic kidney disease. Review of Resident #60's hospital discharge summary dated 3/13/23 included an order for a nephrology consult in 2-4 weeks. Resident #60 was care planned on 10/12/23 for current and/or a history of UTIs. Interventions included antibiotics as ordered. Review of Resident #60's electronic medical record read she was treated for UTIs on 5/26/23, 10/11/23, 10/28/23, 1/18/24 and 2/25/24. Review of Resident #60's quarterly Minimum Data Set dated 2/25/24 indicated she was cognitively intact, dependent on staff for toileting, moderate staff assistance with personal hygiene and always incontinent of bladder. Review of Resident #60's electronic medical record from 3/13/23 to 3/6/24 did not include any	F 690	1. Resident #60 □ New orders received on 3/6/24 to attempt catheter voiding trial. Voiding trial unsuccessful and catheter reinserted. Urology consult completed on 3/20/24 with orders for Flomax and bethanechol and voiding trial successful at this time with catheter removed. Nephrology consult scheduled for 6/27/24 to ensure appropriate services to prevent recurring urinary tract infections. 2. All residents are at risk for deficient practice. Director of Nursing (DON) audited all admissions and re-admissions since January 1, 2024 and reviewed discharge summary for any appointments or referrals requested. No other missed appointments. Admission/readmission process list implemented to ensure solutions are sustained. Completed 3/22/24. 3. Prevention to ensure deficient practice does not occur again: On 3/20/24, the Regional Director of Clinical Services re-educated Director of Nursing and nurse admin staff on reviewing all new admission/readmission paperwork within 48 hours to ensure that all appointments have follow up. Floor nurses were not educated due to nursing management completing all audits. Education will be provided to all new Nurse Management during orientation. 4. Ongoing compliance monitoring:	

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F 690	Continued From page 34 documentation of any nephrology or urology consultations. An interview was completed on 3/5/24 at 1:40 PM with Resident #60. She stated she had a history of UTIs that caused her dysuria (painful urination). She stated she was not experiencing dysuria at present and was recently treated with an antibiotic for a UTI. She stated she did not recall seeing a nephrologist or urologist for her history of UTIs. Review of Resident #60's March 2024 Physician orders included an order dated 3/5/24 for a renal ultrasound due to urinary retention. Review of a nursing note dated 3/6/24 at 12:53 AM read Resident #60 displayed an altered mental status and complained of discomfort to her suprapubic area. The on-call Physician was notified and new orders were given for a post void in and out catheterization. Review of a nursing note dated 3/6/24 at 1:20 AM read a post void in and out catheterization was completed with the result of 700 cubic centimeter (cc) of urine drained. The note read the on-call Physician ordered Resident #60's Physician to be notified of her post void results. Review of Resident #60's March 2024 Physician orders include new orders dated 3/6/24 for a urinary catheter placement and a urology consult. An interview was completed on 3/6/24 at 11:35 AM with the Physician. She stated Resident #60 had a history of UTIs and urinary retention. The Physician stated she expected any orders for consultation with a nephrologist or urologist be	F 690	DON/designee will audit all new admission discharge instructions during clinical morning meetings to ensure follow up appointments are scheduled 5 days per week for 12 weeks. DON to report results in QAPI x 3 months.	

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F 690	Continued From page 35 scheduled and completed as ordered. An interview was completed on 3/6/24 at 1:52 PM with the Administrator. She stated Resident #60's nephrology appointment order from the hospital discharge paperwork dated 3/13/23 was never done and there was new orders obtained today for a urology consultation. A telephone call was attempted on 3/6/24 at 3:37 PM with Nurse #5 who no longer worked at the facility. Nurse #5 entered Resident #60's admission orders on 3/13/123 into the electronic medical record. The surveyor was unable to leave a message for Nurse #5 to return the call. An interview was completed on 3/7/24 at 9:50 AM with the Administrator. She stated she expected all admission orders to be entered into the electronic medical record correctly with a careful review of all hospital discharge orders to ensure no orders were missed.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		3/28/24

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F 692	Continued From page 36 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, Responsible Party, Physician and staff interviews, the facility failed to provide dietary supplements as ordered (Residents #84 and #67) for 2 of 6 residents reviewed for nutrition. The findings included: 1. Resident #84 was admitted to the facility on 12/20/22 with diagnoses that included dementia, protein-calorie malnutrition, and adult failure to thrive. A review of Resident #84's physician orders included an order dated 4/24/23 for Magic Cup (a high calorie and protein dessert cup) twice a day with lunch and dinner. An annual Minimum Data Set (MDS) assessment dated 12/27/23 indicated Resident #84 had moderately impaired cognition and required setup assistance for eating. Her weight was coded as 94 pounds. A review of Resident #84's active care plan, last reviewed 1/10/24, included a focus area for increased nutrition/hydration risk related to: received a mechanically altered diet and severe malnutrition requiring high calorie supplements.	F 692	1. Resident #67 and #84 were provided supplements as ordered. Both residents reviewed by Registered Dietician to ensure supplements are printing on meal tickets to ensure delivery on meal trays on 3/6/24. 2. All residents are at risk for deficient practice. All resident meal tickets were compared to MD orders to verify accuracy on 3/20/24 by administrator. Completed 3/20/24 3. Prevention to ensure deficient practice does not occur again: On 3/7/24, Regional Registered Dietician completed education with Dietary Manager. Manager educated on how to pull report in Point Click Care and ensure information on supplements is correct on meal cards. Education will be provided to all new hires during orientation. Education completed 3/7/24. 4. Ongoing compliance monitoring: Administrator or designee will review 10 meal tickets weekly x 12 weeks to ensure supplements are on meal tickets and delivered on meal trays. Administrator will report results to QAPI x 3 months.	

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The interventions included provide diet as ordered and provide supplements per order.

On 3/4/24 at 12:34 PM, an observation was made of Resident #84 while she was sitting on the side of the bed with her lunch tray. The meal ticket read that she should have a Magic Cup and soft sandwich present with meal tray. Neither one of these items were present on the lunch tray.

Another observation of Resident #84 occurred on 3/5/24 at 12:35 PM, as she was sitting on the side of the bed with her lunch tray. The meal ticket read that a Magic Cup and soft sandwich should be present but neither of those items were present on the meal tray.

An interview occurred with Nurse Aide (NA) #1 on 3/5/24 at 12:42 PM who set up the lunch tray for Resident #84. She stated she noticed the Magic Cup wasn't present on the tray but not the soft sandwich. NA #1 explained that those items would be placed on the meal tray from the kitchen staff and was told last week that Magic Cups were not in stock. She added she would call the kitchen to get those items for Resident #84.

The Dietary Manager (DM) was interviewed on 3/5/24 at 3:01 PM. She reviewed Resident #84's meal ticket and stated there should be a Magic Cup and soft sandwich on her meal tray at lunch and dinner. She was unaware these items had been missing from the lunch tray on 3/4/24 and 3/5/24. The DM added that Magic Cups were in stock and there were no issues with having it available. The dietary aide was responsible for putting these items on the tray when the meals were being plated.

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Another interview occurred with the DM on 3/6/24 at 8:15 AM, who stated the Dietary Aides "just forgot" to put those items on the meal tray for Resident #84 on 3/4/24 and 3/5/24. She stated that each meal ticket should be reviewed at the time of plating to ensure that items are not forgotten.

An interview occurred with Dietary Aide #1 on 3/6/24 at 9:27 AM. She explained that any additional items such as Magic Cups and sandwiches are placed on the meal tray based on the meal ticket and that it was an oversight not to have sent those items to Resident #84 on 3/4/24 and 3/5/24.

The Physician was interviewed on 3/6/24 at 11:40 AM and stated that she would expect the facility to provide supplements on meal trays as ordered to give Resident #84 the option to consume those items.

The Administrator was interviewed on 3/7/24 at 9:03 AM and stated she would expect supplements and additional items listed on the meal ticket to be present as ordered and indicated.

2. Resident #67 was admitted on 1/9/24 with a diagnosis of a fractured left humerus.

Resident #67 was care planned on 1/11/24 for increased nutrient needs related to inadequate oral intake and being underweight. Weight gains were desirable for greater than 90 pounds (lbs.). Resident #67 was prescribed a regular diet. Interventions included serving supplements as ordered.

Review of Resident #67's January 2024 Physician

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orders included an order dated 1/11/24 for a house supplement twice daily.

Her admission Minimum Data Set dated 1/15/24 indicated she had moderate cognitive impairment and required set up only for meals.

Review of a weight warning note dated 2/6/24 read Resident #67 had unplanned weight loss, her oral intake remained inadequate and her weight continued to decline. The note read she was on a house supplement for weight loss that was increased to three times daily with a trial of fortified pudding with her lunch daily.

Review of Resident #67's March 2024 Physician orders included an order dated 2/6/24 for a regular diet with fortified pudding with her lunch daily and weekly weights.

An observation was completed on 3/4/24 at 12:40 PM. Resident #67 was eating in her room without staff assistance. Observation of her meal tray appeared that she had eating approximately 25% and there was no fortified pudding on her tray. Her Responsible Party (RP) was in the room . He stated he had not noticed any weight loss for Resident #67 and stated she had always had a minimal appetite prior to her admission. He stated Resident #67's dominant hand was her right one and that the humerus fracture was to her left arm

Another observation was completed on 3/5/24 at 12:55 PM. She had eaten approximately 50% of her meal with no observed fortified pudding on her tray. Observation of her tray ticket did not include the fortified pudding with her lunch.

An interview was completed on 3/5/24 at 1:20 PM

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with Nurse #4. She stated the nurses gave Resident #67 her house supplement three times a day in the morning, afternoon and at bedtime. Nurse #4 stated most days she does not finish the house supplement and other days she would drink most of it. Nurse #4 stated Resident #67 had a poor oral appetite since admission and apparently that was not unusual for her according to her family.

An interview was completed with the dietary manager (DM) on 3/5/24 at 3:00 PM. She stated the fortified pudding was not listed on her tray ticket because she had not received an order for it and was not aware that it was to be added to her lunch tray.

Review of Resident #67's weights since admission revealed weight loss from 71.6 lbs. on 2/5/24 to 67.1 lbs. on 3/6/24.

An interview was completed on 3/6/24 at 11:20 AM with nursing assistant (NA) #4. She stated Resident #67's assistance with meals varied. She stated the nurses gave her a house supplement and that she had not seen fortified pudding on Resident #67's lunch tray. NA #4 stated Resident #67 had never had much of an appetite since admission.

An interview was completed on 3/6/24 at 11:35 AM with the Physician. She stated Resident #67 had a poor appetite with had poor oral intake since admission. She stated the facility reach out to her RP who stated that was not unusual for Resident #67. The Physician stated she expected any order for supplements were acted on and provided.

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F 692	Continued From page 41 An interview was completed on 3/6/24 at 12:10 PM with Nurse Consultant #1. She stated the facility identified what happened with the order for the fortified pudding. She stated the original order was entered into the electronic medical record inaccurately and that Resident #67 had never received the fortified pudding with her lunch. An interview was completed on 3/7/24 at 9:50 AM with the Administrator. She stated Resident #67 should have received the fortified pudding with her lunch tray as ordered.	F 692		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interviews, Medical Director interview, and record review, the facility failed to prevent a significant medication error for 1 of 2 residents reviewed for medication administration when Depakote (valproic acid) Delayed Release (DR) 125 milligrams (mg), (manages bipolar disorder) was not administered per orders for Resident #26. The findings included: Resident #26 was admitted to the facility on 02/03/23. Her relevant diagnosis included bipolar disorder, anxiety, and depression. The most recent Minimum Data Set (MDS) coded as an admission assessment on 02/07/24 revealed Resident #26 was cognitively intact. No	F 760	1. Resident #26 □ Depakote was removed from medication cart on 3/5/24 and placed in return to pharmacy bin. Depakote order clarified with provider and placed in the eMAR on 3/5/24. Medication pulled from backup Omnicell per physician order and administered to resident #26 on 3/5/24. Medication received from pharmacy on 3/6/24, compared to physician order in eMAR, and placed on medication cart. 2. All residents are at risk for deficient practice. Director of Nursing (DON) audited all resident medication orders and compared to medications available on hand for each resident currently in the facility. Completed 3/7/24. 3. Prevention to ensure deficient	3/28/24

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F 760	Continued From page 42 behaviors coded and no rejection of care were coded. Record review of active medications revealed an order dated 01/03/24 that read Depakote (valproic acid) Oral Tablet DR 125 mg, give 1 tablet by mouth two times a day related to bipolar disorder. The Medication Administration Record (MAR) for February 2024 revealed Depakote (valproic acid) 125mg DR by mouth twice a day was administered. The MAR for March 2024 revealed Depakote (valproic acid) 125mg DR by mouth twice a day was administered from 03/01/24 through 03/04/24. An observation and interview were made on 03/05/24 at 8:39 AM with Nurse #1 during the medication pass. As she prepared medications for Resident #26 an observation was made of one bubble pack card of Depakote (valproic acid) 250 mg DR. tablets. These were the only Depakote (valproic acid) tablets observed on the medication cart for Resident #26. She stated she administered Depakote (valproic acid) 125 mg sprinkles capsule on 03/04/24, however there were no Depakote (valproic acid) 125 mg sprinkle capsules available on the medication cart. Further inspection of the Depakote (valproic acid) 250 mg tablet cards revealed 4 out of 30 tablets were missing. Nurse #1 retrieved the correct dose of 125 mg of Depakote (valproic acid) from the facility back up system and administered it. Pharmacy medication delivery summary for Resident #26 revealed Depakote (valproic acid) 250 mg tablets were received on 02/01/24 and on 03/01/24.	F 760	practice does not occur again: On 3/22/24, DON/designee began re-educating all nurses and medication aides on medication rights to include right dose. Medication administration competencies were completed for all nurses and medication aides prior to returning to work by the DON, Assistant Director of Nursing and shift supervisors. Education will be provided to all new hires during orientation. All nurses and med aides will not be able to work on a cart unless a medication competency is performed. Education completed 3/27/24. 4. Ongoing compliance monitoring: DON/designee will audit medications delivered from pharmacy and compare to MD order. Audits will be completed for 3 medications 5 x weekly for 12 weeks. Results of audits will be reported in QAPI x 3 months by the DON.	

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Valproic Acid level (measures the amount of valproic acid in the blood) report for Resident #26 dated 03/06/24 revealed the resident had a level of 22.4 micrograms (mcg)/milliliter (ml), the reference range was 50.0-100.0 mcg/ml.

On 03/05/24 at 9:39 AM an interview was conducted with Nurse #1. She stated she called the pharmacy to clarify the order on 03/04/24 for Depakote (valproic acid) 125 mg DR tablets and they did not have the correct order. She then stated Depakote (valproic acid) 125 mg DR tablets will arrive at the facility this evening.

An interview and observation were conducted on 03/06/24 at 10:44 AM with Nurse #7, she stated she had worked at the facility full time for approximately one year. She indicated she regularly worked first shift (7:00 AM-7:00 PM) on the 400 hall, and the Depakote (valproic acid) 250 mg DR tablets was the dosage that pharmacy had been delivering for Resident #26. She further stated she administered the Depakote tablets that were in the medication cart, which was Depakote 250 mg. She verified the name of the medication compared to the Medication Administration Record (MAR) but stated she did not look at the dosage prior to pulling the medication. An observation conducted with Nurse #7 in the medication room revealed 2 medication cards located in a tote that read, return to pharmacy. Nurse #7 verified the medication cards for Resident #26 were labeled Depakote 250mg tablets and those were the cards that were in the medication cart available for use until they were removed from the medication cart on 3/4/24.

An interview was conducted on 03/06/24 at 11:35

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AM with the Medical Director. She stated the medications should always be administered per order and staff should compare the medication to the Medication Administration Record (MAR) for accuracy. She also stated she would be ordering a valproic acid level to ensure Resident #26 was at therapeutic level. She further stated no abnormal behaviors had been reported regarding Resident #26.

An interview was conducted on 03/06/24 at 1:17 PM with the Director of Nursing (DON). She stated she was not aware the pharmacy had sent the incorrect dose of Depakote to Resident #26 until the error was brought to her attention. She stated nurses were to follow the rights of medication administration when administering any medication, which included the correct dose.

A phone interview was conducted on 03/06/24 at 2:52 PM with the Pharmacy Manager. She stated she did not know why Depakote (valproic acid) 250 mg was sent to the facility on 02/01/24 or 03/01/24. She verified the order they had on file was Depakote (valproic acid) 125 mg twice a day since October 2023. She also stated the facility had not reported the error to them. She indicated when the facility notifies them of an error, they immediately initiate an investigation to include root cause analysis, interviews, and education.

An interview was conducted on 03/06/24 at 3:41 PM with the Director of Nursing (DON). She stated that the medications should be given per order.

A phone interview was conducted on 03/06/24 at 5:34 PM with Nurse #10. She verified she worked 03/03/24 and 03/04/24 from 7:00 PM-7:00 AM.

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F 760	Continued From page 45 She stated she was familiar with Resident #26's medication orders. She indicated she normally compares the medication card with the Medication Administration Record (MAR) but there was a possibility that she did not verify the Depakote (valproic acid) dosage amount. She verified she did not withdraw any medications from the backup system for Resident #26, she administered the Depakote tablet that was in the medication cart. An interview was conducted on 03/07/24 at 9:12 AM with the Administrator. She stated she expects nurses to administer medications following the rights of medication administration, which includes the ordered dose.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		3/28/24

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F 761	Continued From page 46 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with resident and staff, the facility failed to assure that medications were secure and inaccessible to unauthorized staff and residents when the nurse left the medications at bedside for 1 of 2 residents (Resident #25). The facility also failed to date multi-use medications upon opening in 2 of 2 medication carts (400 hall and 500 hall medication carts) reviewed for medication storage. Findings included: 1. Resident #25 ' s was admitted to the facility on 08/01/22 with diagnosis that included hypertension, chronic kidney disease, anxiety, depression, restless legs syndrome, polyneuropathy, and essential tremors. Resident #25 ' s quarterly Minimum Data Set (MDS) assessment indicated her cognition was moderately impaired. No behaviors or rejection of care were coded. On 03/04/24 at 10:00 AM an observation was made of medications in a medication cup sitting on Resident #25 ' s bedside table. Resident #25 stated the pills had been on the table since before breakfast. Observed breakfast plate sitting on bedside table and Resident #25 stated she had completed her breakfast a while back. She stated	F 761	1. Resident #25 □ medication removed from bedside on 3/4/24 by Director of Nursing (DON). Head to toe assessment completed by Director of Nursing on 3/4/24 and no adverse effects noted to resident. Nurse re-educated on 3/4/24 for safe medication practices by DON. 2. Other residents at risk for same deficient practice: All residents are at risk for deficient practice. Director of Nursing (DON) audited all resident rooms on 3/4/24 to ensure no additional residents had medications at bedside/unsecured. 3. Prevention to ensure deficient practice does not occur again: DON/Assistant Director of Nursing re-educated all nurses and medication aides on proper medication storage. Education will be provided to all new hires during orientation. Education completed 3/20/24. 4. Ongoing compliance monitoring: DON/designee will use the facility map to complete a total building audit to ensure no unsecured medications one time a week for 12 weeks. Interview 5 alert residents weekly to ensure meds received and 5 observations of non-alert residents to identify change of baseline that may indicate not receiving medications x12	

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F 761	Continued From page 47 she did not know why the pills had been left there, as she did not ask the nurse to leave them. She did not indicate she was going to take the medications. An observation and interview were conducted on 03/04/24 at 10:01 with AM the Director of Nursing (DON). The DON approached this surveyor in front of Resident #25 ' s doorway and asked if this surveyor needed assistance. The surveyor explained there was a cup of medications at the bedside for Resident #25. The DON verified the medications were at bedside and retrieved them. She stated Nurse #1 should have observed Resident #25 taking the medications and they should not be left at bedside. The DON gave the medications to Nurse #1 as she approached her in the hall. An interview was conducted on 03/04/24 at 10:02 AM with Nurse #1. She verified she was the nurse that left Resident #25 ' s morning medications on the bedside table for her to take. She stated another resident was in the hall and was attempting to stand up unassisted, so she sat the medications on the table and went to assist the other resident. She further stated she forgot to return to the room to administer the medications after she assured the other resident was safe. She administered the medications to the resident with surveyor and DON present. She further stated the medications should be secured and Resident #25 did not have an order to self-administer medications. The medications left in the medication cup at bedside included the following: extra strength acetaminophen 500 milligram (mg) 2 tablets, senna-s 8.6/50mg 1 tablet, cranberry capsule	F 761	weeks. Med storage audit weekly on med carts and medication storage areas weekly x 12 weeks. Results to be reported in QAPI x 3 months by Director of Nursing.	

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250mg, vitamin-D 1000 units 2 capsules, famotidine 20mg 1 tablet, ferrous gluconate 324mg 1 tablet, Norvasc 2.5mg 1 tablet, gabapentin 100mg 2 capsules, buspirone 5mg 1 tablet, Lisinopril 20mg 1 tablet, Zoloft 25mg 1 tablet, and Zoloft 50mg 1 tablet.

An interview was conducted with the Director of Nursing (DON) on 03/06/24 at 1:17 PM. She stated medications should not be left at bedside unsecure unless the resident has an order for self-administration.

An interview was conducted with the Administrator on 03/07/24 at 9:12 AM. She was unaware the medications were left unattended for an extended amount of time. She indicated medications should be locked in the medication cart or taken by the resident in the presence of the nurse and should not be left at bedside.

2. An observation was conducted on 03/04/24 at 11:05 AM of the 400 Hall medication cart in the presence of Nurse #1. The observation revealed no opened date on the following multi-dose medications:

a. One multi-dose open foil package of Levalbuterol 1.25 milligram (mg) nebulizer inhalation solution vials. The manufacturer ' s recommendation was to discard 7 days after opening.

b. Two multi-dose open foil packages of Ipratropium Bromide/Albuterol Sulfate 0.5mg/3ml inhalation vials. The manufacturer ' s recommendation was to discard 7 days after opening.

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Nurse #1 verified the medications were not dated and she removed them from the medication cart and discarded them. She revealed she knew the foil packages were to be dated when they were opened. She indicated nurses were to write the date on all multi-dose medications upon opening and check dates on all medications prior to administration to make sure they were not expired. She then stated she did not realize the medications were not dated. She further stated that the nurses should be checking the medication carts daily prior to administration.

3. An observation was conducted on 03/04/24 at 11:15 AM of the 500 Hall medication cart in the presence of the Assistant Director of Nursing (ADON). The observation revealed no opened date on two multi-dose open foil packages of Ipratropium Bromide/Albuterol Sulfate 0.5mg/3ml inhalation. The manufacturer ' s recommendation was to discard 7 days after opening.

The ADON stated she reviews the medication carts every Monday to check for expired and/or undated medications. She also stated she knew the foil packages were to be dated when they were opened.

An interview was conducted with Nurse #4 on 03/04/24 at 11:23 AM. She verified she was the nurse for the 500 hall. She stated she did not know the foil packages for nebulizer solution vials were to be dated when they were opened. She indicated she was a new nurse and had not been told she needed to date the multi-use packages.

An interview was conducted with the Director of Nursing (DON) on 03/06/24 at 1:17 PM. She stated nurses were to date multi-dose

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F 761	Continued From page 50 medications upon opening and they should be checking for dates daily prior to administration.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews of staff, the facility failed to: 1) label, date and discard expired food items observed in the walk-in refrigerator for 1 of 1 refrigerator observed; 2) enforce hair restraint during meal preparation and food plating in the kitchen for 2 of 4 staff observed; 3) keep milk at 41 degrees Fahrenheit or below during meal service; and 4) repair the kitchen ceiling which was observed to have paint and drywall flaking and peeling above the cooking, serving, preparation and general areas of the kitchen.	F 812	1. All residents are at risk for deficient practice. Ceiling in food prep area was repaired on 3/6/24. All foods were discarded, labelled or dated at time deficient practice was noted by Regional Dietician (RD). All employees directed to apply hairnets appropriately at time of deficient practice on 3/5/24 by RD. Milk was discarded by RD on 3/7/24 when noted. 2. All residents are at risk for deficient practice. Regional Registered Dietician	3/28/24

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F 812	Continued From page 51 Findings included: 1. On 3/4/24 at 10:00 am the initial kitchen observation was conducted with the Dietary Manager. During observation of the walk-in refrigerator, the following was observed to be expired or not dated and opened: " Turkey sandwich meat had no date, was opened, and the plastic was not covering the meat. " Cooked ham was wrapped in plastic and labeled with a discard date of 3/2/24, which was expired. " Shredded cheese was opened and not dated. " Sliced cheese was not completely wrapped and not dated. " There were 2 containers of chocolate pudding. One had a discard date of 2/28/24 and one had a discard date of 3/1/24 respectively. Both items were expired. On 3/4/24 at 10:00 am an interview was conducted with the Dietary Manager. The Dietary Manager stated the Cook was responsible for discarding expired food and labeling food items. The Cook was not available for interview during the survey. The Dietary Manager stated all opened food should be dated after opening and all food checked daily for expiration and discarded accordingly. On 3/7/24 at 10:20 am the Administrator was interviewed. The Administrator stated she was not aware opened and expired food was not discarded or label dated for the discard date. The cook was responsible for daily food check and labeling.	F 812	completed a thorough audit of kitchen storage areas to ensure proper dating and labelling on 3/7/24. No other deficient practice found. 3. Prevention to ensure deficient practice does not occur again: Administrator completed education with maintenance director regarding timely contact of vendors if leaks occur on 3/21/2024. Dietary staff re-educated on proper storage, labelling, and dating of foods and proper application of hair nets by Regional Dietician and Administrator 3/8/2024. Education will be provided to all new hires during orientation. Education completed 3/22/24. 4. Ongoing compliance monitoring: Administrator/designee will perform “administrator/dietary audit form” weekly x 12 weeks. Results to be reported in QAPI x 3 months by Administrator.	

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2.On 3/4/24 at 10:00 am an observation was completed of dietary staff. The Dietary Manager (DM) was noted to have multiple hair braids half-way down her back. She had a hair net on her scalp only and not over her braids as evidenced by free movement and a lack of netting during movement throughout the kitchen and storage initial observation. Food was being prepped at this time.

On 3/4/24 at 12:20 pm an observation was completed of lunch food plating by the Dietary Manager. The Dietary Manager was observed from the kitchen door during dining room meal observation to have long braids that were not covered by a hair net. The braids were observed to swing freely and the scalp was covered with a hair net.

On 3/4/24 at 12:25 pm an observation and interview was done with Dietary Aide #2. Dietary Aide #2 was observed to assist lunch plating and was present during meal prep. He had long curls approximately 12 inches down his back and not in a hair net. His hair net covered the scalp only. Dietary Aide #2 stated he was not aware a hair net was required to cover his curls.

The facility in-service for protecting food during preparation documented (no date) hair restraints as part of physical contamination prevention.

On 3/5/24 at 3:10 pm the Dietary Manager was interviewed. The Dietary Manager stated she was not aware that braided or tied hair (all hair) was required to be placed in a hair net while in the kitchen for all staff. The Dietary Manager stated she was aware Dietary Aide #2 had long curls not inside of a hair net and would follow up.

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On 3/7/24 at 10:20 am the Administrator was interviewed. The Administrator stated she was not aware that dietary staff had not covered all hair with a hair net. All hair was required to be covered.

3.On 3/4/24 at 12:20 pm the temperature check for the lunch meal was observed. After all hot food was checked and reheated as needed, dietary staff was requested to check a milk carton that had been sitting for 15 minutes on a metal tray with ice on top. The drinks were taken from the refrigerator at 12:05 pm and placed on the tray. The staff had not checked any of the cold drinks and were ready to plate. The Corporate Dietary Consultant was asked to check the temperature of a carton of milk, and it recorded 44.5 degrees Fahrenheit after three rechecks. The Consultant commented that the milk temperature had not met the 41 degrees criteria and the cold drinks would need to be returned to the refrigerator.

On 3/7/24 at 10:20 am the Administrator was interviewed. The Administrator stated she was not aware milk cartons stored on ice after being taken out of the refrigerator during plating had not met the temperature criteria and would follow up with the DM.

4. On 3/6/24 at 12:05 pm an observation and interview was conducted with the Dietary Manager (DM) and Corporate Dietary Consultant. The kitchen ceiling was observed to be peeling in several areas of the kitchen including over the food preparation area, food plating area, steam

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F 812	Continued From page 54 table, and steam oven, as well as general areas. The Dietary Manager stated she had notified maintenance early last week that the kitchen ceiling needed maintenance which had not been completed to date (3/6/24). The Corporate Dietary Consultant acknowledged the peeling ceiling areas were over open food areas which was a potential for physical food contamination. On 3/6/24 at 12:20 pm an observation and interview was done with the Maintenance Manager. The Maintenance Manager stated he was provided information early last week that the ceiling in the kitchen needed repair but had no time to evaluate the situation. During observation of the kitchen ceiling, the Maintenance Manager stated the areas of ceiling paint that was peeling was larger and more significant than he thought. He stated that it would need to be fixed immediately because the ceiling was peeling over food preparation areas. The Maintenance Manager stated he was notified last week the kitchen needed maintenance, but the areas were large and involved several areas. He commented that this had been a problem for a while (before early last week). On 3/7/24 at 10:20 am the Administrator was interviewed. The Administrator stated she was not aware the kitchen ceiling needed repair and would follow up with the Maintenance Manager.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data	F 867		3/28/24

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collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

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

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

§483.75(d)(1) The facility must take actions

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aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

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

§483.75(e) Program activities.

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

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

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F 867	Continued From page 57 number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following recertification survey dated 10/31/22 for three deficiencies in the areas of safe/clean/comfortable/homelike environment (584), quality of care (690) and label/store drugs	F 867	1. The facility failed to maintain an effective Quality Assurance Performance Improvement (QAPI) program due to receiving citation F584, F690, F761 during annual survey on 10/31/22 and F677 during annual survey on 10/21/21. These citations were received again during annual survey 3/4/24. All residents still reside in the facility and have no negative outcomes as a result of deficient practice.	

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F 867	Continued From page 58 and biological's (761). The facility also failed to maintain implemented effective procedures and monitor the interventions that the committee put into place following recertification survey dated 10/21/21 for one deficiency in the area of quality of life (677). The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross referenced to: F584: Based on observations, record review, and interviews of residents and staff, the facility failed to provide a clean, home-like environment in the main dining room as evidenced by a dirty, sticky floor and a dirty window and failed to repair a leaking roof. During a recertification survey dated 10/31/22 the facility failed to clean the Packaged Terminal Air Conditioner (PTAC) units (a type of heating and air conditioning system used in a single living space) in residents' rooms. F690: Based on record review, resident, Physician and staff interviews, the facility failed to act on a hospital discharge order for a nephrology follow up appointment for Resident #60. This was for 1 of 2 residents reviewed for urinary tract infections (UTIs). During a recertification survey dated 10/31/22 the facility failed to follow up on a laboratory results for a resident reviewed for urinary tract infections (UTIs). F761: Based on record review, observations and interviews with resident and staff, the facility failed	F 867	2. All residents are at risk for deficient practice. The findings of homelike environment, medication storage, nail care, and urinary appointments will be reviewed weekly by the QAPI committee in morning stand up meetings to ensure compliance with the implemented measures. The facility Quality Assurance and Performance Improvement committee conducted a root cause analysis on 3/27/24 to determine steps to implement and sustain systemic correction as it relates to F584 with the root cause of effective rounding by Administrator/Maintenance Director for cleanliness and need for repairs; F677 with a root cause of nail care not performed during showers/prn and there was not a place/trigger for CNAs to document nail care and CNAs were not reporting refusals to Nurses to address; F690 with a root cause of admission reviews by nursing administration not completed due to nursing administration not in place and agency nurses working on the floor; and F761 with a root cause of nurse was distracted by a resident with a high risk for falls. 3. Prevention to ensure deficient practice does not occur again: Regional Director of Clinical Services educated the administrator on the federal regulation of Quality Assurance Performance Improvement on 3/20/24. The administrator then educated all interdisciplinary team members on the federal regulation of Quality Assurance Performance Improvement on 3/21/24. All new interdisciplinary team members	

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F 867	Continued From page 59 to assure that medications were secure and inaccessible to unauthorized staff and residents when the nurse left the medications at bedside for 1 of 2 residents (Resident #25). The facility also failed to date multi-use medications upon opening in 2 of 2 medication carts (400 hall and 500 hall medication carts) reviewed for medication storage. During a recertification survey dated 10/31/22 the facility failed to discard expired multi-dose inhaler and to date multi-dose inhalers and protein supplements. F677: Based on observation, record review and interviews of residents and staff, the facility failed to provide dependent residents with nail care for 6 of 6 residents reviewed for activities of daily living (ADL) [Resident #s 14, 20, 35, 61, 76, and 92]. During a recertification survey dated 10/21/21 the facility failed to trim and clean dependent residents' nails and failed to ensure a resident was free from unwanted facial hair. An interview was completed on 3/7/24 at 9:50 AM with the Administrator. She stated the repeat citations were likely due to staff turnover during the pandemic.	F 867	will receive this same education prior to completion of orientation. 4. Ongoing compliance monitoring: Beginning 3/27/24 a Quality Assurance Performance Improvement meeting form will be completed weekly to show compliance for the plan of correction for F584, F677, F690 and F761 for 12 weeks. The results of the audits will be forwarded to the facility Quality Assurance meeting by the Administrator or designee for 3 months.	