STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted 02/20/24 through 02/21/24. Additional information was obtained on 03/25/24. Therefore, the exit date was changed to 03/25/24. Event ID# RODX11. The following intake was investigated: NC00214035. 3 of the 7 complaint allegations resulted in deficiencies. Substandard Quality of Care was identified at: CFR 483.25 at tag F687 at a scope and severity of (H). Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity of (J). Immediate jeopardy began on 2/6/24 and was removed 2/14/24. A partial extended survey was conducted.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		4/11/24

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

Electronically Signed | 04/18/2024

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

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F 656	Continued From page 1 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Resident interviews, the facility failed to implement care plan interventions by not serving her food to her in large bowls for easier management for 1 of 3 residents reviewed for care plans (Resident #1).	F 656	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	

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F 656	Continued From page 2 The finding included: Resident #1 was admitted to the facility on 04/29/18 with diagnoses that included cerebral vascular accident (CVA) with left hemiplegia. A review of Resident #1's physician orders revealed an order dated 09/15/22 to have all her meals served in bowls for independence in self-feeding since the Resident was unable to use her left upper extremity. A review of Resident #1's care plan revised on 03/15/23 revealed a self-care deficit related to left hemiplegia with the goal to maintain her current level of functioning. The goal would be attained by utilizing interventions which included allowing the Resident time to complete tasks and having all her meals served in large bowls due to inability to use her left upper extremity. A review of Resident #1's Care Area Assessment for Activity of Daily Living (ADL) dated 09/22/23 revealed the Resident could eat when her meals were served in bowls for independence in self-feeding due to her diagnoses of CVA. The quarterly Minimum Data Set (MDS) assessment dated 12/14/23 revealed Resident #1 was cognitively intact and had a functional limitation of range of motion of the upper extremity. The MDS also indicated the Resident required set up and clean up assistance for eating with the Resident completing the activity. A review of Resident #1's meal ticket for breakfast on 03/21/24 revealed "all foods served in bowls/food in large bowls" printed on the ticket.	F 656	plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F656 Develop/Implement Comprehensive Care Plan The facility failed to implement care plan interventions by not serving Resident #1 food to her in large bowls for easier management for 1 of 3 residents reviewed for care plans. Resident #1 was admitted to the facility on 04/29/18 with diagnoses that included cerebral vascular accident (CVA) with left hemiplegia. A review of Resident #1's physician orders revealed an order dated 09/15/22 to have all her meals served in bowls for independence in selffeeding since the Resident was unable to use her left upper extremity. A review of Resident #1's care plan revised on 03/15/23 revealed a self-care deficit related to left hemiplegia with the goal to maintain her current level of functioning. The goal would be attained by utilizing interventions which included allowing the Resident time to complete tasks and having all her meals served in large bowls due to inability to use her left upper extremity. A review of Resident #1's Care Area Assessment for Activity of Daily Living (ADL) dated 09/22/23 revealed the Resident could eat when her meals were served in bowls for independence in	

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F 656	Continued From page 3 A review of Resident #1's Kardex (a means of communication specifically for nurse aides to deliver care to the residents) dated 03/21/24 revealed directions "I am unable to use my left upper extremity, please deliver all my meals served in bowls for independent in self-feeding. On 03/21/24 at 9:18 AM an interview and observation were conducted with Resident #1. The Resident was eating her breakfast of oatmeal in a small ceramic bowl and one fried egg on a plate. The Resident explained she did not receive her breakfast in large bowls, which was what she needed in order to feed herself. The Resident continued to explain that she could only use one hand and she needed her food put in large bowls with tall sides so that it was easier for her to be able to feed herself her meals. She stated the tall sides of the bowls allowed her to scoop the food on the spoon and it remained there while she brought the spoon to her mouth. The Resident stated it had taken her a while to eat one of the 2 fried eggs she received for breakfast. She stated it was "hit or miss" as to when she would receive her meals in the large bowls. On 03/21/24 at 9:20 AM an interview was conducted with Cook #1 who plated Resident #1's food on her breakfast tray on 03/21/24. The Cook explained that he was aware that Resident #1 required her meals to be put in large bowls and stated he just missed it that morning and did not put her food in large bowls. The Cook prepared Resident #1 another breakfast tray with large bowls. During an interview with the Assistant Food Service Director on 03/21/24 at 9:23 AM she	F 656	self-feeding due to her diagnoses of CVA. The quarterly Minimum Data Set (MDS) assessment dated 12/14/23 revealed Resident #1 was cognitively intact and had a functional limitation of range of motion of the upper extremity. The MDS also indicated the Resident required set up and clean up assistance for eating with the Resident completing the activity. A review of Resident #1's meal ticket for breakfast on 03/21/24 revealed "all foods served in bowls/food in large bowls" printed on the ticket. A review of Resident #1's Kardex (a means of communication specifically for nurse aides to deliver care to the residents) dated 03/21/24 revealed directions "I am unable to use my left upper extremity, please deliver all my meals served in bowls for independent in self-feeding. On 03/21/24 at 9:18 AM an interview and observation were conducted with Resident #1. The Resident was eating her breakfast of oatmeal in a small ceramic bowl and one fried egg on a plate. The Resident explained she did not receive her breakfast in large bowls, which was what she needed in order to feed herself. The Resident continued to explain that she could only use one hand and she needed her food put in large bowls with tall sides so that it was easier for her to be able to feed herself her meals. She stated the tall sides of the bowls allowed her to scoop the food on the spoon and it remained there while she brought the	

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F 656	Continued From page 4	F 656		

explained that she was aware that Resident #1 required her meals to be served in large bowls and stated she did not notice that her food was not prepared in the large bowls that morning or she would have reminded the Cook to put her food in the bowls.

An interview was conducted with the Occupational Therapist (OT) on 03/21/24 at 4:05 PM. The OT explained that Resident #1 had left sided hemiplegia and therefore could not use both her hands to feed herself therefore having her food served to her in large bowls would enable her to feed herself and increase her self-independence.

During an interview with the Minimum Data Set Nurse on 03/21/24 at 4:20 PM the Nurse explained that when the care plan was written the interventions would be put on the Kardex as well and the nurse aides and staff should adhere to the Kardex for Resident #1's care and needs.

On 03/21/24 at 5:50 PM during an interview with Nurse Aide (NA) #4 she stated she had only worked at the facility 5 or 6 times and was still getting used to the routine. The NA confirmed that she delivered Resident #1's breakfast tray to her and explained that she did not know that Resident #1 should have her meals served in large bowls. When asked if she read the Resident's meal ticket, the NA stated she had not because she could not rely on what was printed on the meal ticket.

An interview conducted with the Director of Nursing (DON) on 03/21/24 at 7:15 PM who explained that she spent a lot of time with Resident #1 and knew that she needed her meals

spoon to her mouth. The Resident stated it had taken her a while to eat one of the 2 fried eggs she received for breakfast. She stated it was "hit or miss" as to when she would receive her meals in the large bowls.

On 03/21/24 at 9:20 AM an interview was conducted with Cook #1 who plated Resident #1's food on her breakfast tray on 03/21/24. The Cook explained that he was aware that Resident #1 required her meals to be put in large bowls and stated he just missed it that morning and did not put her food in large bowls. The Cook prepared Resident #1 another breakfast tray with large bowls.

During an interview with the Assistant Food Service Director on 03/21/24 at 9:23 AM she explained that she was aware that Resident #1 required her meals to be served in large bowls and stated she did not notice that her food was not prepared in the large bowls that morning or she would have reminded the Cook to put her food in the bowls.

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During an interview with the Minimum

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F 656	Continued From page 5 to be served in large bowls for her to be able to feed herself efficiently. The DON indicated if serving the Resident's meals in large bowls was written on the care plan then she expected the care plan to be followed.	F 656	Data Set Nurse on 03/21/24 at 4:20 PM the Nurse explained that when the care plan was written the interventions would be put on the Kardex as well and the nurse aides and staff should adhere to the Kardex for Resident #1's care and needs. On 03/21/24 at 5:50 PM during an interview with Nurse Aide (NA) #4 she stated she had only worked at the facility 5 or 6 times and was still getting used to the routine. The NA confirmed that she delivered Resident #1's breakfast tray to her and explained that she did not know that Resident #1 should have her meals served in large bowls. When asked if she read the Resident's meal ticket, the NA stated she had not because she could not rely on what was printed on the meal ticket. An interview conducted with the Director of Nursing (DON) on 03/21/24 at 7:15 PM who explained that she spent a lot of time with Resident #1 and knew that she needed her meals to be served in large bowls for her to be able to feed herself efficiently. The DON indicated if serving the Resident's meals in large bowls was written on the care plan then she expected the care plan to be followed Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents have the potential to be affected by the alleged practice that require adaptive equipment during meals.	

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F 656	Continued From page 6	F 656	The Administrator completed audit of all resident with order for adaptive equipment. Rounding completed to ensure adaptive equipment placed on meal tray per plan of care. No other residents identified as not having adaptive equipment on meal tray per plan of care. Adaptive equipment to be added to tasks for certified nursing assistants to document for each meal. Systemic Changes: On 4/9/2024 Education was provided to the facility Minimum Data Set (MDS) Coordinator who participate in development and revision of care plans. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident requiring adaptive equipment for all meals. A comprehensive person-centered care plan will include meeting with residents, family and/or power of attorney. MDS Staff Signatures were collected to ensure staff acknowledgment utilizing policy and procedure. Any MDS staff not in serviced by 4/10/2024 will not be allowed to work until education completed. Newly Hired MDS staff will be educated policy and procedure develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident requiring adaptive equipment for all meals. Monitoring Procedure to ensure that the plan of correction is effective and that	

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F 656	Continued From page 7	F 656	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. To ensure compliance, beginning the week of 4/15/2024, the administrator or designee will monitor compliance by reviewing 5 residents nutritional CarePlan and observe two meal trays to ensure that adaptive equipment is being provided during meals per residents plan of care. This will be done on weekly basis for 4 weeks then monthly for 2 months. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: ¿¿¿¿4/11/2024	
F 679 SS=H	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan	F 679		4/11/24

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F 679	Continued From page 8 and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, activity calendar and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 6 of 7 residents reviewed for activities (Residents #1, #2, #3, #4, #5 and #6). The residents expressed not being able to leave the facility for over a year made them feel like they had lost some of their independence, felt terrible, isolated, confined, sad, trapped, and they missed getting out and socializing with a group and seeing people outside the facility. The findings included: A review of the March 2023 through March 2024 activity calendars revealed activities for inside of the facility during the week and on the weekends. There were no activities scheduled for outside of the facility for any of these months. Observation on 03/20/24 at 9:30 AM revealed the facility was located within a business and residential area and was within a 1 to 3-mile radius of shopping complexes with various retail stores, restaurants, local and commercial coffee shops, fast food restaurants, grocery stores and a	F 679	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F679 Activities Meet Interest/needs of Each Resident The facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important for them to attend group activities outside of the facility for 6 of 7 residents. Corrective action for resident(s) affected by the alleged deficient practice: For resident #1 -Outside activity scheduled for 4/26/2024 and resident invited to attend For Resident #2- Outside activity scheduled for 4/26/2024 and resident	

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F 679	Continued From page 9 commercial super center. a. Resident #1 was admitted to the facility on 04/29/18. An annual Minimum Data Set (MDS) assessment dated 09/22/23 indicated Resident #1 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #1 was cognitively intact. An interview with Resident #1 on 03/20/24 at 11:39 AM revealed there had not been a scheduled group activity outside of the facility in years and they had discussed it during resident council meetings each month and were told there was no transportation for the residents to be taken on outings outside the facility. She stated group activities outside of the facility were important to the residents that were able to go and participate because it allowed them some independence, socialization with the group and outside world, and helped with their overall mental and physical health. Resident #1stated not being able to leave the facility in over a year and participate with a group in activities outside the facility had made her feel as though she had lost some of her own independence and was having to rely on someone else to do her personal shopping that she enjoyed doing herself. She further stated she had gone out from time to time on the municipal bus system but it wasn't the same going alone as going with a group and had friends at the facility that wanted to get out as well. Resident #1 said it was very important to her to be able to go out and socialize with a group outside the facility.	F 679	invited to attend For Resident #3- Outside activity scheduled for 4/26/2024 and resident invited to attend For Resident #4- Outside activity scheduled for 4/26/2024 and resident invited to attend For Resident #5- Outside activity scheduled for 4/26/2024 and resident invited to attend For Resident #6- Outside activity scheduled for 4/26/2024 and resident invited to attend Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who express desire to attend activities outside of the facility have the potential to be affected by the alleged deficient practice: Beginning 4/1/2024, the Administrator and Activities Director interviewed all current residents with a BIMS of 13 or higher regarding their preferences for outside activities. The Activities Director updated resident care plans to reflect their preference for outside activities. On 4/1/2024, the Activities Director scheduled outside facility activity and placed on activity calendar. Also, for residents with BIMS of 12 or less, the Administrator and Activities Director reviewed and updated activities care plans. This was completed by 4/10/2024. Measures /Systemic changes to prevent	

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F 679	Continued From page 10 b. Resident #2 was admitted to the facility on 06/15/22. An annual MDS assessment dated 05/24/23 indicated Resident #2 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #2 was cognitively intact. An interview with Resident #2 on 03/20/24 at 4:29 PM revealed there had not been a scheduled group activity outside of the facility since she had been admitted and they had discussed it during resident council meetings several times and were told there was no transportation for the residents to be taken on outings outside the facility. She stated the residents had been told by administration but could not recall who, if they wanted to go on activities outside the facility, they would have to make the arrangements and secure transportation on their own for the activity. Resident #2 stated not being able to leave the facility since being admitted and participating with a group in activities outside the facility had made her feel sad and like she no longer had any independence in any aspect of her life. She further stated she had gone out from time to time with family but would love to be able to go out with friends at the facility as a group and enjoy the outside world if only for a couple of hours to feel like a normal person. Resident #2 explained that she was one of the younger residents at the facility and it was important to her to get out and shop and socialize with other residents and said it was very important to her to get out of the four walls of the facility and socialize with a group. c. Resident #3 was admitted to the facility on	F 679	reoccurrence of alleged deficient practice: Beginning 4/9/2024, the Administrator began education to all full time, part time, and PRN (as needed) activity staff on the following: " Activities Program Policy to include resident□s preferences for outside activities This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to the above identified staff who direct activities in the facility. Any Activity staff who does not receive scheduled in-service training by 4/10/2024 will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 4/15/2024, The Administrator or designee will monitor compliance utilizing the F679 Quality Assurance Tool for Activities to ensure resident preferences are being honored related participating in outside activities. This will be completed weekly x 4 weeks then monthly x 2 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the	

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F 679	Continued From page 11 10/12/23. An admission MDS assessment dated 10/24/23 indicated Resident #3 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #3 was cognitively intact. An interview with Resident #3 on 02/20/24 at 4:00 PM revealed there had not been a scheduled group activity outside of the facility since he had been admitted and said he had attended resident council meetings occasionally and they had discussed it during the meetings and were told there was no transportation. He stated he used to compose music for symphonies all over the world and traveled to lots of different countries to hear his music played by the symphonies. Resident #3 further stated he would love to get out of the facility surroundings and be able to go with a group to a restaurant, movie or to listen to music or anything to get him out of the four walls of the facility. He said it had been difficult to be confined to a small space with four walls after traveling the world and said he was uplifted and encouraged by talking about getting out of the facility and socializing with a group and getting out in the real world with other people. d. Resident #4 was admitted to the facility on 12/02/20. An Annual MDS assessment dated 02/09/24 indicated Resident #4 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #4 was cognitively intact.	F 679	Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/11/2024	

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An interview with Resident #4 on 02/21/24 at 7:35 PM revealed there had not been a group activity outside of the facility in years and said she had attended resident council meetings monthly and they had discussed it during the meetings and were told there was no means of transportation for residents to go on outings. She stated she thought it would be wonderful to go out of the facility on group outings and said she felt like it would lift their spirits to get out of the same four walls they are confined to on a regular basis. Resident #4 further stated it was very important to her to get out and socialize with other residents in a group and was important to her to be able to go outside the facility to socialize with the outside world.

e. Resident #5 was admitted to the facility on 06/17/19 and readmitted on 02/17/22.

An Annual MDS assessment dated 01/17/24 indicated Resident #5 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #5 was cognitively intact.

An interview with Resident #5 on 03/21/24 at 7:00 PM revealed there had not been a group activity outside of the facility in years and said she had attended resident council meetings monthly and they had discussed it during the meetings and were told there was no means of transportation for residents to go on outings. She stated her roommate and she had brought it up themselves several times during meetings and other residents had brought it up as well and nothing had been done. Resident #5 further stated not

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being able to get out of the facility had made her feel sad and isolated from the outside world and said she would love to get out and go to a restaurant to eat or a coffee shop to have coffee and donuts or do anything just to be outside the facility and socialize with a group.

f. Resident #6 was admitted to the facility on 02/21/20 and readmitted on 03/04/21.

An Annual MDS assessment dated 02/14/24 indicated Resident #6 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #6 was cognitively intact.

An interview with Resident #6 on 03/21/24 at 7:00 PM revealed there had not been a group activity outside of the facility since her admission and said she had attended resident council meetings monthly and they had discussed it during the meetings and were told there was no means of transportation for residents to go on outings. She stated she knew for a fact that she had asked several times during meetings about going out with a group to a movie, coffee shop, or restaurant but said nothing was ever done about taking them out. Resident #6 said she would love to be able to get out and go with a group on an outing and said not being able to do so made her feel terrible and isolated from the outside world. She further stated she would love the opportunity to go out to eat or do anything outside the facility's four walls and would love to be able to do it with a group from the facility. Resident #6 indicated she thought it would be great for all of them mentally and emotionally to get out of the facility and enjoy themselves at a restaurant,

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theater, or coffee shop.

A review of the Resident Council Meeting minutes from October 2023 through March 2024 revealed no indication in the minutes that group outings were discussed during the meetings.

An interview with the Activity Director (AD) on 03/21/24 at 9:16 AM revealed she had been the director for 2 years. She stated she oversaw setting up the resident council meetings and usually recorded the minutes for the meeting. The AD stated the resident council met monthly and stated the residents in attendance were very vocal about their issues at the facility and would often seek her out in between meetings to let her know about issues affecting them at the facility. She stated a resident had just recently discussed activities being provided for them outside of the facility with her but it was not during the resident council meeting and she had reported this to the Administrator (could not remember exactly when). She further stated when she discussed it with the Administrator, she gave the AD some ideas for activities to inquire about and told her to let her know what she found out about the suggestions. The AD further said they had looked at activities right around the area where they were and had contacted a playhouse that offered live plays and musicals and were working on planning for the residents to attend an event in May but said none of the details had been finalized for the event. The AD indicated they did not have any activities planned outside of the facility for March or April of 2024, just the one they were working on for May. She further indicated before COVID in 2020 there were group outings outside of the facility at least monthly but since 2020 they had not been outside the facility

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on a group outing. The AD said there was a van at the facility but she was not sure if it was operational or if they had a driver for the van. She also said some of the residents had expressed an interest in getting out and shopping but said if they needed something she usually collected their money and did their shopping for them. The AD admitted she knew it was not the same but said she ordered out for them monthly at the restaurant of their choice, collected their money, and delivered their meals to them.

An interview with the Administrator on 03/21/24 at 9:41 AM revealed she had been the Administrator since August 2023 and said the residents had just recently mentioned wanting to go and see a live play and that they were working on the details of the event in May but all the arrangements had not been finalized. She stated there were no group outings planned on the March or April calendars and to her knowledge had not been any group outings planned since she had been at the facility but said they could try to schedule something for the residents to do in April if they could work out the details. The Administrator further stated they had taken the residents outside but had not taken them off campus yet and said they would have to get consent from family, guardians, power of attorney for the residents that were not their own responsible party to see if they agreed for the residents to go on outings outside of the facility. She indicated it was just recently brought to her attention by one of the residents and the Activities Director that the residents wanted to go on group outings and she had made it a priority to plan a group outing for May. The Administrator further indicated it was her goal to provide the residents with outings of their choice but there were details that had to be resolved. The Administrator stated

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F 679	Continued From page 16 the facility had a van but she was not sure if it was in proper working condition and if they had a driver for the van and these were some of the details, they had to work out to provide the residents with group outings.	F 679		
F 687 SS=G	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide podiatry services and/or toenail care for 2 of 2 sampled residents (Resident #3 and Resident #1) reviewed for foot care. Resident #3 reported difficulty getting his socks on every morning and having to walk differently due to the condition of his toenails and reported the big toenails on both feet were ingrown. The findings included: 1. Resident #3 was admitted to the facility on 10/12/23 with diagnoses which included hypertension and diabetes mellitus type II with complications.	F 687	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F687 Foot Care Corrective action for affected residents. For Resident #3-On 4/9/2024, Podiatrist was contacted and resident to be seen in	4/11/24

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F 687	Continued From page 17 Resident #3's most recent quarterly Minimum Data Set (MDS) assessment dated 01/24/24 revealed he was cognitively intact and was independent with personal hygiene. Review of a visit summary dated 03/08/24 revealed Resident #3 was not seen by the podiatrist on that date and was not on the list of residents not seen on that date. An observation and interview with Resident #3 on 03/20/24 at 4:00 PM out in the courtyard revealed he needed to be seen by the podiatrist to have his toenails cut. Resident #3 described them as growing over the back of his toes and said he had a difficult time putting on his socks and was walking differently because the toenails were long and bothering the back of his toes. He stated he was admitted to the facility in October of 2023 and had not seen the podiatrist since he had been admitted to the facility. Review of Resident #3's electronic medical record revealed there were no progress notes from podiatry in his chart. An observation of Resident #3 on 03/21/24 at 8:55 AM revealed his toes on the left foot had nails that extended ¼ inch to ½ inch beyond the tip of his toe. The 2nd toenail had grown over the top of the toe and extended into the skin of the back of the toe on both feet. Resident #3 stated he had ingrown toenails of both big toes on both feet that were painful and affected the way he walked. He further stated the condition of his toenails was new since his admission to the facility and had steadily worsened. Observation of his big toes on both feet revealed both big	F 687	facility on 4/17/2024 For Resident #1- On 4/9/2024, Podiatrist was contacted and resident to be seen in facility on 4/17/2024 Corrective action for potentially affected residents. All current residents have the potential to be affected by the alleged deficient practice Beginning 4/9/2024, the Social Worker audited all current residents to ensure that they have been seen or will be seen by the podiatrist per their consent. Any resident identified as not being seen by the podiatrist in the past 90 days was placed on podiatry list. Podiatrist was contacted and scheduled to visit facility on 4/17/2024 This process will be completed by 4/10/2024. On 4/9/2024, the nurse managers audited all current residents to establish which residents had diagnosis of Diabetes Mellitus and reviewed podiatry list to ensure residents to be seen by podiatrist. Any consenting resident with diagnosis of Diabetes Mellitus that was not on podiatry list was added to be seen by Podiatrist on 4/17/2024. Additionally, all current resident was assessed by Director of Nursing and Unit Managers for issues with foot care. The results of the audit revealed no residents identified with any acute signs or symptoms of infection or in need of immediate treatment. This process was completed by 4/10/2024. Systemic changes On 4/9/2024, the Director of Nursing began an in-service education to all full time, part time, and as needed nurses and	

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F 687	Continued From page 18 toenails were curving, growing inward on the sides of both big toes and the nails had a yellowish tint. He stated he had mentioned it to the NA who takes care of him but could not recall her name. Resident #3 further stated he would love to see the podiatrist and get his toenails trimmed so he could walk without that pain and the pain from his ingrown toenails. He stated they only hurt when he walked but he still walked because he liked to be out of his room. A telephone interview with NA #3 on 03/21/24 at 6:18 PM who had taken care of Resident #3 on the 7:00 AM to 3:00 PM shift on 03/20/24 and 03/21/24 revealed she had noticed his toenails 2 weeks ago and mentioned it to Nurse #3 who said the podiatrist would be coming soon. NA #3 stated she did not cut anyone's toenails and especially not residents who were diabetic. An interview with Nurse #2 on 03/21/24 at 6:26 PM revealed she was the primary nurse for Resident #3 and frequently took care of him 7:00 AM to 7:00 PM. She stated no one had reported his toenails to her or if they had she couldn't remember it and said she had not noticed them being long. Nurse #2 observed Resident #3's toenails and agreed they needed to be trimmed and he needed to be seen by the podiatrist. She stated she would refer Resident #3 to the podiatrist to be seen on his next visit. A telephone interview with Nurse #3 on 03/21/24 at 6:48 PM revealed she didn't recall anyone mentioning Resident #3's long toenails to her and said if they had she didn't remember it. She stated she had not noticed his toenails or that they needed to be trimmed but said he should be seen by the podiatrist since he was diabetic.	F 687	CNA□s. Topics included: NAIL CARE *Inspecting nails at least daily for long or jagged nails. *Notifying Nurse if diabetic resident has long, ingrown or jagged nails Additionally, the Director of Nursing in serviced the Social Workers regarding scheduling regulatory podiatry visits and ensuring all consenting residents are placed on list to be seen. The Director of Nursing will ensure that any Licensed Nurse or Certified Nursing Assistant, or Social Worker who has not received this training by 4/10/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff or Social Worker who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Podiatry Services. The monitoring will include reviewing 5 residents weekly to ensure they are being seen by podiatry services per regulatory requirements. This will be completed weekly for 4 weeks then monthly times 2	

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F 687	Continued From page 19 An interview with the Director of Nursing (DON) on 03/21/24 at 7:21 PM revealed that she thought it was the responsibility of the Social Worker to put diabetic residents on the list for the podiatrist. She stated these residents should be seen by the podiatrist every 3 months on a routine basis and said she would have expected Resident #3 to have been included on the list to be seen every 3 months. A follow-up telephone interview with the Social Worker on 03/21/24 at 8:11 PM revealed the podiatry office sees all long-term care residents admitted to the facility and accept referrals from nursing and residents who need to be seen. She stated once they are seen the podiatrist puts them in the rotation of residents to be seen every 3 months. The Social Worker stated she could not explain why Resident #3 had been left off the rotation but said she and the Administrator were in the process of setting up a conference call with the podiatry office about their concerns with residents not being seen during visits. An interview with the Administrator on 03/21/24 at 8:34 PM revealed she expected all diabetic residents and other residents with toenail concerns to be seen by the podiatrist. 2. Resident #1 was admitted to the facility on 04/29/18 and readmitted on 06/15/22 with diagnoses which included peripheral vascular disease, neuropathy, and diabetes mellitus type II with complications. Review of Resident #1's electronic medical record (EMR) revealed a note dated 11/22/23 and signed by the podiatrist on 11/26/23. The	F 687	months or until resolved. Quality of Life/Quality Assurance Committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 4/11/2024	

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resident was seen by the podiatrist on 11/22/23 and he trimmed her nails to patient's tolerance. The note stated there were no signs of infection and non-professional treatment would be hazardous to the resident. There was a recommendation for follow-up as medically necessary but no sooner than 60 days.

Resident #1's most recent quarterly Minimum Data Set (MDS) assessment dated 12/14/23 revealed she was cognitively intact and required substantial to maximal assistance of one staff member with personal hygiene.

Review of Resident #1's care plan dated 03/07/24 revealed a focus area for the resident having diabetes mellitus type II and being at risk for complications. The interventions included inspecting feet daily for open areas, sores, pressure areas, blisters, edema or redness and report to nurse if noted, among others.

Review of Resident #1's electronic medical record revealed she had been seen by podiatry on their visit on 11/22/23 but had not been included on the list of residents seen on 03/08/24 which had been 3 ½ months since she was last seen by podiatry. Review of a visit summary from the podiatrist dated 03/08/24 revealed Resident #1 was not seen by the podiatrist on that date and was not on the list of residents not seen on that date.

An observation of Resident #1 on 03/20/24 at 11:39 AM revealed her lying in bed and her right leg was extended out of the covers and her right foot was observed with the 2nd through 4th toes noted with nails extending ¼ to ½ inch beyond the tip of her toes. The 5th toenail was noted to

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be so long that it had grown inverted past the front of her toe and onto the skin of her foot. The resident stated she did not feel the toenail digging into her skin because she had neuropathy and could not feel anything on her foot. Resident #1 further stated she had been seen by podiatry services several months ago but had not seen them since and was not sure when they had been back to the facility or why she had not seen by them since 11/22/23.

An observation was made of Resident #1 on 03/21/24 at 9:43 AM and she was in bed with a gown on and her toenails remained long and the 5th toenail remained inverted and growing past her toe and onto the skin of the top of her foot.

An interview with the Social Worker (SW) on 03/21/24 at 11:00 AM revealed she was responsible for setting up appointments with ancillary services for the residents. She stated the services included podiatry, dental, auditory and optometry. The Social Worker explained that the podiatry office had access to their resident population and diagnoses and devised and sent to her a list of residents that needed to be seen based on their diagnoses. She said she didn't know why Resident #1 had been left off the list but said if nursing had referred the resident to her, she could have added her to the list of residents to be seen but that had not happened before the visit on 03/08/24. The SW indicated once residents were on the list they should be in the rotation to see the podiatrist every 3 months and said she wasn't sure how Resident #1 had been left off the list for 03/08/24 and the list for 03/29/24.

A phone interview with NA #2 on 03/21/24 at 6:06

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PM revealed she had taken care of Resident #1 on 03/21/24 from 7:00 AM to 3:00 PM and said she saw the resident's foot out of the covers but really didn't notice her toenails. NA #2 stated no one had mentioned her toenails being long and needing cut to her but said she didn't cut toenails and especially not on residents with diabetes.

An interview with Nurse #1 on 03/21/24 at 6:40 PM revealed she took care of Resident #1 from 7:00 AM to 7:00 PM on 03/20/24 and 03/21/24 and said no one had mentioned the resident's toenails needing cut to her. She stated they had a podiatrist who came in every 3 months and that Resident #1 should have been seen by the podiatrist since she was diabetic. Nurse #1 observed Resident #1's toenails and agreed they needed to be cut by the podiatrist. She further stated she would make sure the resident got added to the next podiatry visit scheduled.

An interview with the Director of Nursing (DON) on 03/21/24 at 7:21 PM revealed that she thought it was the responsibility of the Social Worker to put diabetic residents on the list for the podiatrist. She stated these residents should be seen by the podiatrist every 3 months on a routine basis and said she would have expected Resident #1 to have been included on the list to be seen every 3 months.

A follow-up telephone interview with the Social Worker on 03/21/24 at 8:11 PM revealed the podiatry office sees all long-term care residents admitted to the facility and accepts referrals from nursing and residents who need to be seen. She stated once they are seen the podiatrist puts them in the rotation of residents to be seen every 3 months. The Social Worker stated she could

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F 687	Continued From page 23 not explain why Resident #1 had been left off the rotation but said she and the Administrator were in the process of setting up a conference call with the podiatry office about their concerns with residents not being seen during visits. An interview with the Administrator on 03/21/24 at 8:34 PM revealed she expected all diabetic residents and other residents with toenail concerns to be seen by the podiatrist.	F 687		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and Resident, transportation company staff, insurance manager, facility staff, Wound Physician and Medical Director interviews, the facility failed to secure Resident #1 and her wheelchair to the vehicle according to the manufacturer's instructions to prevent her from sliding forward from the wheelchair during a contracted van transport. When the driver applied the brakes in traffic it caused Resident #1 to slide forward from the wheelchair, her face on the back of the driver's seat and pinning her right kneecap on the van floor. Resident #1 was taken to the hospital for evaluation and a computed tomography (CT) scan of her head and spine resulted negative and	F 689	Past noncompliance: no plan of correction required.	

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three x-ray views of the right knee resulted negative. The Resident was returned to the facility the same day. The Resident had moderate to severe pain and her right kneecap developed a blister that resulted in an open wound that continued to require treatment and had not healed as of the survey. This deficient practice had the likelihood of causing serious injury for 1 of 3 residents (Resident #1) reviewed for accidents.

The findings included:

The undated manufacturer's instructions for the securement system used in the contracted transportation service vans used to transport residents who were seated in the wheelchairs for transports was made up of four retractors, one occupant lap belt, one occupant shoulder belt and floor anchorages. The instructions read in part "9. Non WC19 Wheelchairs (A wheelchair that does not meet a voluntary industry standard that establishes minimum design and performance requirements for wheelchairs that are occupied by users traveling in motor vehicles.): attach shoulder belt pin connector to pin on rear retractor closest to wall. Occupant restraint shoulder and pelvic belt must not be held away from the occupant's body by wheelchair components. 10. Attach the pelvic belt pin connector to pin on rear retractor closest to the aisle. 11. Pull the shoulder belt over occupant's chest and buckle shoulder belt pelvic connector to removable pelvic belt. 12. Adjust shoulder belt height so that shoulder belt rests on shoulder. After the occupant and vehicle are secured, the occupant is ready for transportation."

Resident #1 was admitted to the facility on

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04/29/18 with diagnoses that included cerebral vascular accident with left side hemiplegia (paralysis of one side of the body) and left above the knee amputation, pain and diabetes mellitus.

The quarterly Minimum Data Set (MDS) assessment dated 12/14/23 revealed Resident #1 was cognitively intact and had functional impairment of range of motion on one side of her upper and lower extremities. The MDS indicated the Resident also received routine and as needed pain medication.

During an interview with Nurse Aide (NA) #5 on 03/20/24 at 11:45 AM the NA explained that she was the one who got Resident #1 ready for her doctor's appointment on 02/06/24 and the Resident had no complaints of feeling dizzy or sick or she would have informed the nurse. The NA continued to explain that she transferred Resident #1 into the manual wheelchair that she normally used when she had out of the facility appointments.

A review of a Nurse Progress Note dated 02/06/24 at 1:22 PM written by Nurse #4 revealed, the Resident #1 left out of the facility for appointment in stable condition alert and oriented.

An interview was conducted with Nurse #4 on 03/20/24 at 7:45 PM who reported that she was the Nurse on duty on 02/06/24 when Resident #1 went out of the facility for a doctor's appointment via the transportation van. The Nurse explained that she did not remember Resident #1 having any complaints of being dizzy or sick before she left for the appointment. She stated Van Driver #1 was always good about asking if the residents

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were okay for the transportation before he took them off the floor and she specifically remembered that the Van Driver asked her that day about Resident #1 before he took her off the floor and she told him that Resident #1 was okay to go to her appointment.

A review of a written verbal statement from Resident #1 dated 02/08/24 witnessed and signed by the Director of Nursing revealed Resident #1 stated that she was correctly strapped in the wheelchair by the Van Driver. When she was questioned regarding the top strap being pulled across her and being secured in the wheelchair the Resident stated yes, the top strap was fastened and secured. The Resident stated she felt the Van Driver had secured her safely in the wheelchair and van. She stated the wheels were locked on the wheelchair. Resident #1 stated that at no time did she feel dizzy, and she was looking down because she had just made a phone call and was about to make another call. At that moment when she was looking through her contacts the Van Driver slammed on the brakes suddenly causing her to be thrown forward and pinned with the right side of her face hitting the back of the driver's seat. She stated her right knee was pinned on the floor of the van with her right leg turned backwards. The Resident stated she yelled to call 911. She continued, the Owner of the van service was the first to arrive on the scene and the Owner and the Van Driver started conversing in a language she did not understand. She stated the Owner and the Van Driver then cut the seatbelt and shortly after that the paramedics arrived and all of them removed her from the van then lowered her onto the ground and slid her onto the stretcher. The Resident stated the paramedics transported her

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to the hospital with no further issues. The Resident verbalized discomfort to her right lower extremity and the right side of her face in route to the hospital.

On 03/20/24 at 10:00 AM an interview was conducted with Resident #1 who explained that she was being taken to her doctor's appointment by the transportation company van in a manual wheelchair and as far as she knew Van Driver #1 strapped her in with the seatbelt and shoulder harness and buckled the wheelchair down appropriately because she could not tell that anything was different. She stated she had ridden with the Van Driver before and had no problems with the transport, but she always thought that he drove too fast. The Resident continued to explain that she was looking down at her phone to call her family member when all the sudden the Van Driver slammed on the brakes and she and her phone flew up to the front of the van pinning the right side of her face against the back of the driver's seat and her right kneecap against the floor of the van with her leg bent behind her. The Resident stated she did not know why the Van Driver slammed on the brakes because she was looking down and he never said anything before he slammed on the brakes. Resident #1 reported she screamed to call 911 and let them know that she was in an accident, but the Van Driver called his boss (the Owner of the company), and the Owner showed up to the accident before the ambulance got to the accident. She stated they kept pulling on her coat collar saying let me see you, but she could not turn over because she was face forward and still strapped to the wheelchair. She stated the Owner finally cut the seatbelt that released her. The Resident continued to explain that the ambulance got to the accident about 20

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minutes later and all the while her right knee was burning while pressing against the van floor. She reported when the ambulance got to the accident, they asked the Owner and Van Driver what happened, and the Owner stated she slid out of her wheelchair and the Van Driver was going to pull over to the side because she complained of being dizzy. She stated she knew that was not true, because why would she end up face forward up front if she just slid out of the wheelchair, but she did not say anything to the contrary. The Resident explained that they sat her up and laid her down and rolled her over on a slide pad then put her onto the stretcher. She stated they took her to the hospital where they did a CT scan of her head and right knee and there were no broken bones. She stated she returned to the facility late that night. Resident #1 reported that she did have pain in her knee and the facility was good to give her pain medication when she requested it to relieve the pain.

During an interview with Van Driver #1 on 03/20/24 at 4:45 PM the Van Driver explained that on the afternoon of 02/06/24 he was scheduled to transport Resident #1 to a doctor's appointment and when he went to pick her up, she complained of being dizzy. He stated he checked with the Nurse before he took her off the hall and the nurse reported the Resident was okay to go to the appointment. The Van Driver reported that he secured Resident #1 into the van by the anchors and seatbelts the way he normally secured a resident in the van and started to the doctor's office. About 3 miles away he heard Resident #1 say, "Help me" and he pulled over off the road and when he got to where he could open the door, he saw that the Resident had slid out of the wheelchair and was pressing her head against

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the back of the driver's seat and her right leg was extended out to the side. He stated the wheelchair was still attached to her and the wheelchair was still anchored down. The Van Driver stated he called 911 and then he called the Owner of the company who arrived at the van before the emergency services arrived. He stated the Resident would not let them help her up, so the Owner cut the seatbelt off her and moved the wheelchair in order to be able to roll her over onto the stretcher when the emergency services got there. He stated they rolled her onto a cloth then transferred her over onto the stretcher and took her to the hospital. The Van Driver explained the facility immediately suspended the transport services by the company until the van could be inspected and the Van Drivers including the Owner were retrained by a representative of the facility. He indicated they endured weekly audits, and the audits were still going on.

At 5:05 PM on 03/20/24 an interview and observation were made of Van Driver who reenacted how he secured Resident #1 into the van on 02/06/24 afternoon. The Van Driver utilized a random individual as a passenger in a wheelchair and secured the wheelchair to 4 floor anchors then applied a seatbelt and the shoulder strap to the individual. The Van Driver "rocked" the wheelchair to ensure it was safely secured to the anchors and ensured the individual could not slide out from under the seatbelt. When the Van Driver was asked how Resident #1 slid out of the wheelchair if she was securely strapped in the Van Driver brought his hands up to his chest and gestured that he did not know. The Van Driver was asked why he slammed on his brakes, and he stated he did not slam on his brakes because nothing was wrong. The Van Driver stated

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everything was fine until Resident #1 stated, "Help me." When asked about the discrepancies in his explanation of the accident and Resident #1's explanation of the accident the Van Driver again brought his hands up to his chest and stated "Ma'am, I don't know."

Interviews were conducted with the Owner of the transportation company on 03/20/24 at 3:00 PM and 5:54 PM. The Owner stated that his transportation service for the facility was suspended on 02/06/24 immediately after the van incident for about 3 weeks when Resident #1 slid out of her wheelchair during a transport in one of his vans that was being driven by the Van Driver. He explained that before he could resume transportation for the facility, he along with his Van Drivers had to be retrained and the van that was used during the incident had to be inspected by the facility's Insurance Manager who did not find anything wrong with the seatbelts. He stated all the drivers of the vans had to be randomly audited for loading and unloading the passengers correctly and safely before the facility would reinstate their service and the random audits were still ongoing. The Owner continued to explain that the Van Driver had to perform a reenactment of how he secured Resident #1 in the wheelchair and the Insurance Manager determined that the driver did not secure the Resident in the wheelchair correctly. The Owner stated that he personally felt that the Van Driver secured Resident #1 in the wheelchair correctly because if he did not hook her up correctly, she would have fallen out of the wheelchair as they were driving out of the facility's parking lot because of so many turns they had to make in order to get to the doctor's office. The Owner explained that when he hired Van Driver #1

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almost a year ago, the Van Driver was given 3 weeks of training before he was released to transport residents solo and there were no concerns with his performance. The Owner continued to explain that he remembered specifically that he told Van Driver #1 the morning of the transport to make sure Resident #1 was safely strapped in her wheelchair because she had a tendency to take naps and lean forward in the wheelchair. The Resident has even dropped her phone and had tried to pick it up during transport before. When the Van Driver was still at the facility, he called the Owner and reported that Resident #1 looked dizzy, and the Van Driver was told to check with the Nurse before he left with the Resident and the Resident told the Van Driver that she was only tired. Then about 3 miles into the transport the Van Driver called the Owner and reported that Resident #1 stated, "Help me", help me" and when he looked in the rear-view mirror she had started to slide out of the wheelchair and the Resident stated it was choking her. The Van Driver had to get through the traffic light and pull over. When the Van Driver pulled over, he got out and opened the side door of the van and found Resident #1 had already slid out of her wheelchair. The Van Driver called the Owner who told the Van Driver to call 911 which he did. The Owner stated that he arrived at the scene before the emergency services got there and found Resident #1 lying face forward on the van floor where she landed (she had not been moved from where she landed) and up against the back of the driver's seat and her seat belt was not on her it was lying underneath her. He stated he thought Resident #1 had removed the seatbelt that went across her belly because it was laying underneath her. He stated he had to cut the left front anchor strap to free the Resident up enough for them to

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roll her over and onto the stretcher.

A review of an Incident Report dated 02/06/24 at 1:50 PM completed by Long Term Care Support Nurse revealed the Van Driver called this Nurse to report that while transporting Resident #1 to her doctor's appointment, the Resident complained of not being able to breathe and was feeling dizzy. The Van Driver pulled over and the Resident was leaning over in her chair. The Van Driver had to cut the seat belt to lower the Resident to the floor then called 911. The Resident was taken to the local hospital by ambulance.

During an interview with the Long Term Care Support Nurse on 03/20/24 at 4:30 PM the Nurse explained that on the day of the accident she received a phone call from the Owner of the transportation company who reported that he was still trying to figure out what happened but there was a van accident and Resident #1 fell over forward out of her wheelchair and he had to cut the seatbelt because where the seatbelt was positioned on her, it was pressing into her. He said the Resident landed on one side and her knee landed on the floor of the van. The Nurse continued to explain that she immediately reported the accident to the Administrator. The Nurse stated a short while after that the owner of the transportation van came to the facility with the wheelchair that Resident #1 was sent to the appointment in. The Nurse reported the Owner of the transportation company explained that he received a phone call from the driver of the van who reported that he put the brakes on quickly and Resident #1 fell over face first. When the owner arrived at the van, he had to cut the seatbelt off her to relieve the pressure because

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she complained of the strap hurting her. The Nurse stated when Resident #1 returned to the facility she had a blister on her right kneecap that burst, and she was currently being seen by the Wound Physician.

A review of Resident #1's emergency room visit on 02/06/24 3:02 PM revealed a CT scan of her head and spine resulted negative for injury and three x-ray views of the right knee resulted negative for fractures.

A review of a Nurse Progress Note dated 02/07/24 at 6:32 AM written by Nurse #5 revealed, Resident #1 returned to the facility at 12:00 midnight via medic transport. The Resident was alert and oriented times three and verbally responsive. She was treated in the emergency room for a fall that included a CT scan of her head and x-ray to her right knee that showed negative fractures. The Resident complained of pain in the right knee of 9/10 with a rating of nine with the highest rating of ten and was relieved after pain medication was given. Her skin assessment revealed fluid filled blisters to her right kneecap and no other new areas noted.

Attempts were made to interview Nurse #5, but the attempts were unsuccessful.

A review of Resident #1's physician orders revealed:

- an order on 02/06/24 for Oxycodone HCL 5 milligrams (mg) by mouth every 12 hours as needed for moderate to severe pain.

A review of Resident #1's 02/2024 and 03/2024 Medication Administration Record indicated

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Resident required the as needed pain medication less than once a day. There were several days in a row when there was no pain medication administered.

- an order on 03/06/24 to cleanse right knee with wound cleanser and apply a debriding agent and oil emulsion and cover with gauze border dressing once a day.

On 03/20/24 at 10:20 AM an observation was made of Resident #1's right kneecap wound treatment and assessment conducted by the Wound Physician. When the dressing dated 03/19/24 was removed the entire right kneecap was an open wound that had brown necrotic tissue and yellow slough with a small amount of brown drainage. The wound measured 6.9 centimeters (cm) x 8.0 cm x 0.1 cm. The wound bed was 60% with 30% necrosis (dead tissue) and 10% granulation (healthy tissue).

An interview was conducted with the Wound Physician on 03/20/24 at 10:30 AM. The Wound Physician explained that Resident #1's wound resulted from a fall that started out as a fluid filled blister and when he first consulted on the wound on 02/07/24 he ordered skin prep to be applied daily and keep pressure off the knee. He stated after a few visits the blister opened to a wound that required a daily dressing change and then required a daily debriding agent to soften the necrotic tissue so that it could be removed easier with the scalpel.

During an interview with the Nurse Practitioner (NP) on 03/25/24 at 8:05 AM the NP confirmed that she was informed of the van incident that involved Resident #1 on the evening of 02/06/24.

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The NP explained that she was told that the Resident was being transported to a doctor's appointment and had "come" out of her wheelchair in the van and was taken to the emergency room. They determined that she had no fractures, but she had one intact blister to her right kneecap. The blister did eventually open and now she was being followed by the Wound Physician who consulted with her weekly. The NP stated that on 02/29/24 she had to increase Resident #1's pain medication from every 12 hours as needed to every 6 hours as needed and that seemed to manage her pain.

An interview was conducted with the Director of Nursing (DON) on 03/20/24 at 3:20 PM. The DON explained that she was notified of the van accident involving Resident #1 by the Long-Term Care Support Nurse. She was told that Resident #1 would be transferred to the hospital for evaluation and that the family member and Physician were already notified. The DON reported that when she spoke with Resident #1 the following day the Resident explained that as far as she knew the van driver had strapped her in the wheelchair correctly but when he suddenly hit the brakes, she fell forward. Then, when she interviewed the Resident again on 02/08/24 for her statement the Resident reported the same thing that she fell forward out of the wheelchair and pinned her head up against the back of the driver's seat and pinned her right knee against the floor of the van. The Resident stated the van Owner was the first one to arrive at the accident and the van Owner cut the seatbelt off her before the emergency services arrived and took her to the hospital. The DON continued to explain that they did scans of her head and right knee and there were no fractures, but she did have a blister

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on her right kneecap that developed into an open wound and was currently being treated weekly by the Wound Physician. She reported the transportation service with that particular company was immediately halted pending investigation and training for several weeks.

During an interview with the Administrator on 03/20/24 at 3:35 PM the Administrator explained that the Owner of the transportation company came into her office on the afternoon of 02/06/24 and reported that he received a phone call from Van Driver #1 who reported that Resident #1 was on the floor of the van, and he instructed the Van Driver to call 911. The Owner informed the Van Driver that he was close by, so the Owner arrived before the emergency services arrived at the scene. The Owner stated that when he arrived Resident #1 was leaning face down on the left side close to the driver's seat and he had to cut the seatbelt off to be able to lay the Resident down to release her from the wheelchair so the emergency services could get her on the stretcher to take her to the hospital. The Administrator stated Resident #1 returned to the facility the same day and did not have any fractures. The Administrator explained the corporate Insurance Manager who conducts the training for our company, conducted the investigation and determined through reenactment that the Van Driver did not properly place the retractors and the seatbelt system was not properly applied to Resident #1 for the transport. The Owner of the company and the Van Driver were retrained correctly on the securement system in the vans and weekly audits were done at random by the facility's medical supply clerk who is trained in van transportation, to ensure loading and unloading the residents

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were correctly done and was ongoing. The Administrator continued to explain that the residents who were transported by the van company before the incident were interviewed about the safety of the service and there were no complaints from the residents about their being unsafe for their transports. Residents who were currently transported by the transportation service continue to be interviewed about their safety and there have been no concerns brought forward.

An interview was conducted with the Insurance Manager on 03/20/24 at 7:00 PM. The Manager explained that he had over 20 years of experience of training the company's van drivers as well as the incident investigator. He continued to explain that on 02/08/24 he met with the Owner of the company and the Van Driver and had the Van Driver reenact the incident using the exact same wheelchair that was used during the transport. The Van Driver demonstrated how he secured the resident in the wheelchair by the anchors and the seatbelts, and the Manager stated when the Van Driver finished, he determined that the Van Driver did not apply the seatbelt correctly by the standards of the company and the resident slid out from under the seatbelt. The Manager stated the seatbelt had to be applied correctly in order to restrain an individual in the seat and the individual slid out from under the seatbelt because it was not applied correctly. He stated the Resident did not release the seatbelt, she just slid out from underneath it. After that the Manager stated he showed the Van Driver how to set it up correctly and told the Owner to obtain the instruction manual for the securement system used in the van and retrain the drivers on the correct way to secure the individual in the wheelchair. The

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Manager explained the transportation service was immediately suspended for at least 3 weeks until they could produce a substantial training log to support the training in the correct way the seatbelt system should be applied, and weekly auditing was still being conducted by the facility. The Manager stated during the reenactment it was determined that the anchors were not placed properly but it did not have anything to do with the incident.

The Administrator was informed of immediate jeopardy on 03/21/24 at 11:39 AM.

The facility provided the following Corrective Action Plan with a compliance date of 02/16/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 2/6/2024, around 1:25 pm, Facility transport driver (contracted) arrived at the facility to transport with Resident #1 to an endocrinology appointment. Resident was loaded into transport van via wheelchair. Wheelchair was secured, shoulder harness applied in addition the seatbelt was secured to her person. At approximately 1:35 pm, driver left facility with resident in route to appointment. At approximately 1:45 pm, driver slammed on brakes causing resident to fall forward from wheelchair and land in floor with face against back of driver's seat. Immediately driver pulled over vehicle and called emergency medical for assistance. Driver then called transport company and owner arrived and assisted driver in cutting seatbelt to provide resident comfort from seatbelt harness. At approximately 2:50 pm, Emergency Medical

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Services arrived and transported resident to hospital for evaluation and treatment.

On 2/6/2024, the Administrator immediately suspended the transport driver and company pending investigation. During the re-enactment it was discovered that the seatbelt system was not properly applied and the wheelchair retractors were not properly placed.

On 2/6/2024, the Director of Nurses notified Resident #1's responsible party and the Medical Director of the van incident.

On 2/7/2024, facility scheduled all transports with outside transportation service for the following week. Also, Resident #1's wheelchair was taken out of use and placed in Administrator's office for inspection.

On 2/7/2024 at 12:00 midnight, Resident #1 returned to facility with no new orders.

On 2/14/2024, transport van and Resident #1's wheelchair was inspected by Risk Management Insurance Manager. The inspection revealed no malfunctioning components of van's seatbelts or wheelchair.

On 2/14/2024, transport driver was re-educated on how to properly apply the seatbelt system and the wheelchair retractors according to the Restraint Manufacturer Manual and the need to make sure residents are fully secured prior to transport.

On 2/14/2024, Administrator concluded the van incident investigation and based on investigation findings the root cause of incident was due to lack

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of knowledge of the contracted transport driver and not properly applying the seatbelt system and the wheelchair retractors, this was identified by the Risk Management Insurance Manager During re-enactment.

On 2/14/2024, a Quality Assurance and Performance Improvement meeting was held with the Interdisciplinary Team to review findings of investigation with no additional findings.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Beginning 2/7/2024, the Administrator and Director of Nursing identified residents that would be potentially impacted by the deficient practice by completing facility transportation audits for all current resident that had appointments in the past three months that had been transported by the outside transport van and asked if they had any issues or concerns when the transport driver transported them to or from an appointment. The results of the audit revealed no other residents identified with any issues or concerns with transports to or from appointments and that they had been secured with a seatbelt and felt safe.

On 2/7/2024, all appointments scheduled for the following week were scheduled with outside transportation service.

On 2/14/2024, after concluding investigation, the Quality Assurance Committee convened to discuss the van incident and the status of the investigation. There were no additional findings at that time.

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F 689	Continued From page 41 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 2/7/2024 the Administrator in-serviced the contracted transport driver on the facility transportation safety education policy and on how to properly apply the seatbelt system and the wheelchair retractors according to the Restraint Manufacturer Manual. On 2/14/2024, skills checkoff includes driver ensuring resident wears seatbelt, and how to apply seatbelt properly according to the facility transport education policy. Inservice was also done on securing the wheelchair and how to attach the retractors as well has how to apply the seatbelt properly this was derived from the Restraint Manufacturer Manual. This was completed with the Owner of the transportation company by our Risk Management Insurance Manager. The transportation company Owner will ensure that any newly hired transportation staff will receive this training prior to transporting residents. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator/Designee will monitor 5 residents for safe transports using the Quality Assurance (QA) Tool for Van Safety starting 2/16/2024. This will be completed weekly for 4 weeks and monthly for 2 months. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting.	F 689		

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F 689	Continued From page 42 " Include dates when corrective action will be completed. 2/17/2024 Immediate jeopardy removal date is 2/14/2024. The Administrator is the individual responsible for compliance with this action plan. On 03/21/24 the facility's correction action plan for immediate jeopardy removal was validated by the following: The facility provided documentation to support their corrective action plan including education provided to the transportation owner and van driver that included return demonstration and weekly auditing logs that included safely loading and unloading resident transports. The plan included documentation of resident interviews of safe transport by the transportation company with no concerns identified. The documentation included information submitted to the Quality Assurance Committee and the monitoring is ongoing, which is now on a monthly basis. An observation was conducted of the Van Driver and the Owner of the company who both demonstrated the correct method of securing a wheelchair to the 4-point wheelchair securement system including the seatbelt and shoulder harness. The facility's date of 02/17/24 for the corrective action plan was validated on 03/21/24.	F 689		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804		4/11/24

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F 804	Continued From page 43 Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, and test tray the facility failed to provide palatable food that was appetizing in temperature for 2 of 3 residents on the 500 Hall (Resident #1 and Resident #8) reviewed for food palatability. This practice had the potential to affect other residents on the 500 Hall. The findings included: A kitchen observation of the breakfast meal before being plated on 03/21/24 at 8:15 AM along with the Food Service Director. On 03/21/24 at 8:35 AM the breakfast meal cart was delivered to 500 Hall from the kitchen. The first breakfast tray was removed from the enclosed cart at 8:40 AM and the last breakfast tray removed from the cart at 8:59 AM. The test tray which had an insulated dome lid and bottom was taken to the nearest nourishment room at 9:00 AM. A test tray of grits, scrambled eggs and sausage was tested along with the Food Service Director at 9:00 AM on 03/21/24. Butter was placed on the grits that did not melt. The taste test yielded the food was not hot and at best was room temperature. The Director remarked the food was	F 804	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F804 1. For dietary services, a corrective action was obtained on 03/21/2024. Based on observations, record reviews, resident and staff interviews, and test tray the facility failed to provide palatable food that was appetizing in temperature for 2 of 3 residents on the 500 Hall (Resident #1 and Resident #8) reviewed for food palatability. A kitchen observation of the breakfast meal before being plated on 03/21/24 at 8:15 AM along with the Food Service Director. On 03/21/24 at 8:35 AM the breakfast meal cart was delivered to 500	

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cold because the food sat on the hall too long before it was passed out by the staff. When the Director was asked what could be done to ensure the food was hot when it was delivered to the residents, she stated the food could be passed out to the residents faster when the meal cart arrived on the halls.

1a. Resident #1 was admitted to the facility on 04/29/18.

Review of Resident #1's medical record revealed an order dated 06/16/22 for limited concentrated sweets, regular texture and regular liquids.

The quarterly Minimum Data Set (MDS) assessment dated 12/14/24 revealed Resident #1 was cognitively intact.

On 03/21/24 at 9:18 AM an interview and observation were conducted with Resident #1. The Resident was eating her breakfast of oatmeal in a small ceramic bowl and one fried egg on a plate. The Resident explained that her breakfast did not taste good because it was cold by the time the staff brought her tray to her. She reported that since her oatmeal was cold, she had the staff put some flavored creamer in it to give it flavor. The Resident continued to explain that she received her breakfast cold every morning.

1b. Resident #8 was admitted to the facility on 11/18/15.

A review of Resident #8's medical record revealed an order dated 08/12/16 for regular diet, regular consistency and regular liquids.

Hall from the kitchen. The first breakfast tray was removed from the enclosed cart at 8:40 AM and the last breakfast tray removed from the cart at 8:59 AM. The test tray which had an insulated dome lid and bottom was taken to the nearest nourishment room at 9:00 AM.

A test tray of grits, scrambled eggs and sausage was tested along with the Food Service Director at 9:00 AM on 03/21/24. Butter was placed on the grits that did not melt. The taste test yielded the food was not hot and at best was room temperature. The Director remarked the food was cold because the food sat on the hall too long before it was passed out by the staff. When the Director was asked what could be done to ensure the food was hot when it was delivered to the residents, she stated the food could be passed out to the residents faster when the meal cart arrived on the halls.

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F 804	Continued From page 45 The quarterly Minimum Data Set (MDS) assessment dated 12/31/24 revealed Resident #8 was cognitively intact. During an interview with Resident #8 on 03/21/24 at 9:12 AM the Resident was sitting up in bed feeding himself his oatmeal. The Resident explained that his breakfast was cold when he received it. The Resident stated that he felt the meal cart sat on the hall too long before the staff delivered his tray to him. He continued to explain that when the staff brought the meal cart to the hall, they parked it outside his room door, and he could hear them unloading the cart. He stated that because it took the staff so long to deliver his tray was why he thought his meals were almost always cold when he got his tray. An interview was conducted with the Director of Nursing (DON) at 7:15 PM on 03/21/24. The DON explained the nurse aides could have been in resident rooms when the meal cart was brought to the hall, but they should be aware when the meal cart was brought to the hall so that they could deliver the trays while the food was hot. She stated no one should have to eat cold food. During an interview with the Administrator on 03/21/24 at 8:31 PM she explained that she conducted test trays about every other month that included taking food temperatures and taste tests. She stated she had not encountered a problem with the procedure. The Administrator indicated the residents were entitled to receive hot meals.	F 804	not taste good because it was cold by the time the staff brought her tray to her. She reported that since her oatmeal was cold, she had the staff put some flavored creamer in it to give it flavor. The Resident continued to explain that she received her breakfast cold every morning. 1b. Resident #8 was admitted to the facility on 11/18/15. A review of Resident #8's medical record revealed an order dated 08/12/16 for regular diet, regular consistency and regular liquids. The quarterly Minimum Data Set (MDS) assessment dated 12/31/24 revealed Resident #8 was cognitively intact. During an interview with Resident #8 on 03/21/24 at 9:12 AM the Resident was sitting up in bed feeding himself his oatmeal. The Resident explained that his breakfast was cold when he received it. The Resident stated that he felt the meal cart sat on the hall too long before the staff delivered his tray to him. He continued to explain that when the staff brought the meal cart to the hall, they parked it outside his room door, and he could hear them unloading the cart. He stated that because it took the staff so long to deliver his tray was why he thought his meals were almost always cold when he got his tray. An interview was conducted with the Director of Nursing (DON) at 7:15 PM on 03/21/24. The DON explained the nurse aides could have been in resident rooms when the meal cart was brought to the hall, but they should be aware when the meal cart was brought to the hall so that	

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F 804	Continued From page 46	F 804	they could deliver the trays while the food was hot. She stated no one should have to eat cold food. During an interview with the Administrator on 03/21/24 at 8:31 PM she explained that she conducted test trays about every other month that included taking food temperatures and taste tests. She stated she had not encountered a problem with the procedure. The Administrator indicated the residents were entitled to receive hot meals Dietary Manager met with residents #1, and #8 to review dietary concerns and complaints. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 03/21/2024, the Dietary Service Director completed a verbal in-service to discuss with meal procedures with Cooks and Dietary aides and nurses/assistant nursing staff. Test Trays will be incorporated more often until food complaints reduce or resolve completely. Residents mentioned above will be interviewed and monitored on a regular basis to ensure food delivered is per expectations.	

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F 804	Continued From page 47	F 804	3. Systemic changes The Dietary Manager, Cooks and Dietary aides and nurses/assistant nursing staff. were In-service using the policy and procedure of meal tray preparation by the administrator. Education was provided to all full time, part time, and as needed staff on 4/9/2024. Topics included: " Meal objectives and procedures " Test Tray completion " Palatable food appetizing in Temperature. Test Trays will be completed to ensure satisfactory dining experience. Dietary Manager will attend resident council as invited and follow up with any food complaints as identified. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any dietary staff who does not receive scheduled in-service training by 4/10/2024 will not be allowed to work until training has been completed. 4. Quality Assurance monitoring procedure. Beginning the week of 4/15/2024. The Dietary Service Director or designee will complete a test tray for two meals daily 3 x week x 2 weeks, then weekly x 2 weeks, and then monthly x 2 months. Monitoring	

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F 804	Continued From page 48	F 804	will include reviewing food items for appearance and taste as well as visiting with residents when complaints are received. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manage. Date of Compliance: 4/11/2024	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Resident interviews the facility failed to serve her food to her in large bowls for easy management for 1 of 3 residents reviewed for choices. The finding included: Resident #1 was admitted to the facility on 04/29/18 with diagnoses that included cerebral vascular accident (CVA) with left hemiplegia.	F 810	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be	4/11/24

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F 810	Continued From page 49 A review of Resident #1's physician orders revealed an order dated 09/15/22 to have all her meals served in bowls for independence in self-feeding since the Resident was unable to use her left upper extremity due to assist during the task of (eating). A review of Resident #1's care plan revised on 03/15/23 revealed a self-care deficit related to left hemiplegia with the goal to maintain her current level of functioning. The goal wound be attained by utilizing interventions which included allowing the Resident time to complete tasks and having all her meals served in large bowls due to inability to use her left upper extremity. A review of Resident #1's Care Area Assessment for Activity of Daily Living (ADL) dated 09/22/23 revealed the Resident could eat when her meals were served in bowls for independence in self-feeding due to her diagnoses of CVA. The quarterly Minimum Data Set (MDS) assessment dated 12/14/23 revealed Resident #1 was cognitively intact and had a functional limitation of range of motion of the upper extremity. The MDS also indicated the Resident required set up and clean up assistance for eating with the Resident completing the activity. A review of Resident #1's meal ticket for breakfast on 03/21/24 revealed "all foods served in bowls/food in large bowls" printed on the ticket. On 03/21/24 at 9:18 AM an interview and observation were conducted with Resident #1. The Resident was eating her breakfast of oatmeal in a small ceramic bowl and one fried egg on a plate. The Resident explained she did	F 810	corrected by the dates indicated. F810 Assistive Devices- Eating Equipment/Utensils Corrective action for resident(s) affected by the alleged deficient practice: On 4/9/2024, The Administrator verbally in-serviced Dietary Manager, Cooks, Dietary Aides, MDS, Rehab, CNAS and licensed nurses on 4/10/2024 regarding ensuring appropriate adaptive equipment is placed on meal tray for residents. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents who require adaptive equipment for meals have the potential to be affected by the alleged deficient practice. The Administrator completed audit of all resident with order for adaptive equipment. Rounding completed to ensure adaptive equipment placed on meal tray. No other residents identified as not having adaptive equipment on meal tray. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The Dietary Manager, Cooks and Dietary Aides were in-serviced using the policy and procedure on meal tray preparation on 4/9/2024 by the Administrator. Staff Signatures were collected to ensure staff acknowledgment utilizing policy and procedure. Any dietary staff not in serviced by 4/10/2024 will not be allowed to work until education completed. Newly Hired staff will be educated policy and procedure on meal tray preparation during	

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F 810	Continued From page 50	F 810		

not receive her breakfast in large bowls, which was what she needed in order to feed herself. The Resident continued to explain that she could only use one hand and she needed her food put in large bowls with tall sides so that it was easier for her to be able to feed herself her meals. She stated the tall sides of the bowls allowed her to scoop the food on the spoon and it remained there while she brought the spoon to her mouth. The Resident stated it had taken her a while to eat one of the 2 fried eggs she received for breakfast. She stated it was "hit or miss" as to when she would receive her meals in the large bowls.

On 03/21/24 at 9:20 AM an interview was conducted with Cook #1 who plated Resident #1's food on her breakfast tray on 03/21/24. The Cook explained that he was aware that Resident #1 required her meals to be put in large bowls and stated he just missed it that morning and did not put her food in large bowls. The Cook prepared Resident #1 another breakfast tray with large bowls.

During an interview with the Assistant Food Service Director on 03/21/24 at 9:23 AM she explained that she was aware that Resident #1 required her meals to be served in large bowls and stated she did not notice that her food was not prepared in the large bowls that morning or she would have reminded the Cook to put her food in the bowls.

An interview conducted with the Director of Nursing (DON) on 03/21/24 at 7:15 PM who explained that she spent a lot of time with Resident #1 and knew that she needed her meals to be served in large bowls for her to be able to

orientation.

Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Beginning the week of 4/15/2024, the Administrator will begin monitoring using the F810 QA Tool to ensure residents have the appropriate adaptive equipment on the tray prior to giving to resident 5 x a week for 2 weeks, then b weekly x 2 weeks, then monthly x 2 months to ensure compliance and identify areas of improvement as needed. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Performance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, Maintenance Director, Environmental Services Director, and the Dietary Manager
Date of Compliance: 4/11/2024

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F 810	Continued From page 51 feed herself efficiently. The DON stated if it is on her meal ticket then the bowls should have been utilized.	F 810		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		4/11/24

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F 867	Continued From page 52	F 867		

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

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

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

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

§483.75(e) Program activities.

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

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F 867	Continued From page 53 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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F 867	Continued From page 54 Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation survey that occurred on 11/19/21, and the recertification and complaint investigation survey that occurred on 03/10/23 This failure was for two deficiencies that were originally cited in the areas of Development and Implementation of Comprehensive Care Plans (F656) and Nutritive Value/Appearance, Palatability/Preferred Temperature of Food (F804) and were subsequently recited on the current complaint investigation survey of 03/25/24. The repeat deficiencies during multiple surveys of record show a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F656: Based on observation, record review, staff and Resident interviews, the facility failed to implement care plan interventions by not serving (Resident #1) her food to her in large bowls for easier management for 1 of 3 residents reviewed for care plans. During the recertification and complaint investigation survey conducted 11/19/21, the facility failed to develop a care plan for right-hand splint management for 1 of 1 resident reviewed for positioning. F804: Based on observations, record reviews, resident and staff interviews, and test tray the	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilitys allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 QAPI/QAA Improvement Activities Corrective action for resident(s) affected by the alleged deficient practice: Based on observations, record reviews, resident, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 11/19/21 and for the recertification and complaint investigation survey conducted on 03/10/23. This failure was for two deficiencies that were originally cited in the areas of Development/Implementation of Comprehensive CarePlan (F656) and Nutritive Value/Appearance, Palatability Preferred Temperature of Food (804) that were subsequently recited on the current recertification and complaint investigation survey of 03/25/24. The repeat deficiencies during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA	

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F 867	Continued From page 55 facility failed to provide palatable food that was appetizing in temperature for 2 of 3 residents on the 500 Hall (Resident #1 and Resident #8) reviewed for food palatability. This practice had the potential to affect other residents on the 500 Hall. During the recertification and complaint investigation survey conducted 03/10/23, the facility failed to provide meals that were palatable for 5 of 5 residents sampled for food palatability. The residents complained the food was cold, unseasoned, and overcooked. During the recertification and complaint investigation survey conducted 11/19/21, the facility failed to provide food that was appetizing for 8 of 8 residents reviewed for food palatability. The residents complained the food was cold, butter did not melt on food and food was hard. A telephone interview on 03/25/24 at 3:20 PM with the Administrator revealed the QAPI committee meets monthly with department heads, administrative staff, the Medical Director, and at least quarterly the Pharmacist and Registered Dietician attend in person or by phone. She reported she felt like the issues that kept occurring were a result of not having consistent staff in department head positions. The Administrator stated they had changes in administration, in MDS Coordinators and in other leadership positions but that had now stabilized and hopefully the Process Improvement Plans (PIPs) they were putting into place would reflect positive changes moving forward.	F 867	program Corrective action for residents with the potential to be affected by the alleged deficient practice: "Corrective action has been taken for the identified concerns in the areas of: Development/Implementation of Comprehensive CarePlan (F656) "Corrective action has been taken for the identified concerns in the areas of: Nutritive Value/Appearance, Palatability Preferred Temperature of Food (F804) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 4/9/2024/ to review the deficiencies from the 3/20/2024-3/25/2024 complaint investigation survey and reviewed the citations. On 4/ 9/2024, the Regional Clinical Nurse Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 4/ 9/ 2024 the Regional Clinical Nurse Consultant completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Unit Managers, Health Information Manager, Maintenance Director, Environmental Services Manager, and the Dietary Manager, on	

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the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies.
This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above.
This will be reviewed by the Quality Assurance process to verify that the change has been sustained.
Any of the above identified staff who does not receive scheduled in-service training by 4/10/2024 will not be allowed to work until training has been completed.

Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
Beginning the week of 4/15/2024, The Regional Director of Operations or Regional Nurse Consultant will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee.
Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate.
Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	C 03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 57	F 867	laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/11/2024	