STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT GASTONIA	969 COX ROAD GASTONIA, NC 28054

(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 000	INITIAL COMMENTS A complaint investigation survey along with revisit was conducted 03/26/24 through 03/27/24. Additional information was obtained on 03/28/24; therefore, the exit date was changed to 03/28/24. The following intakes were investigated during the complaint investigation survey: NC00213217, NC00213345, NC00213384, NC00213657, NC00214396, NC00214510, and NC00214700. 6 of the 19 allegations resulted in deficiencies.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews, the facility failed to provide nail care and trim fingernails for 1 of 3 sampled residents (Resident #1) reviewed for activities of daily living (ADL). The findings included: Resident #1 was admitted to the facility on 11/17/23 and readmitted on 02/05/24 with diagnoses which included cerebrovascular accident, hemiplegia, and hypertension. Review of Resident #1's most recent quarterly Minimum Data Set (MDS) assessment dated 02/12/24 revealed he was severely cognitively impaired and required maximal assistance with	F 677	F677 ADL Care for Dependent Residents Facility failed to provide nail care and trim fingernails for 1 resident How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 3/28/24 resident # 1 was provided nail care by facility CNA.	4/2/24

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

Electronically Signed | 04/23/2024

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F 677	Continued From page 1 personal hygiene. An observation and interview with Resident #1 on 03/26/24 at 10:00 AM revealed him lying in bed with his eyes closed. The resident opened his eyes and was able to respond that he was doing well. Resident #1 was able to answer simple questions but unable to carry on a conversation. Observation of his fingernails on both hands revealed his nails were ½ inch beyond the tips of his fingers and he had brown colored debris under the nails on both hands. The resident stated he did not like his fingernails long and would like them to be trimmed but no one had asked him about trimming his fingernails. An observation of Resident #1 on 03/27/24 at 9:20 AM revealed him lying in bed and his fingernails were again observed to be ½ inch beyond the tips of his fingers on both hands and there was brown colored debris under his nails on both hands. He stated the staff still had not trimmed his fingernails. An interview with NA #3 on 03/27/24 at 10:40 AM revealed she frequently cared for Resident #1 from 7:00 AM to 3:00 PM. She stated she usually gave him a bed bath but said she had not noticed his fingernails being long and needing to be trimmed. She stated usually during baths/showers she looked at resident's skin for dry skin, fingernails, toenails, scratches, bruises and to see if they needed to be shaved and either did it or reported it to the nurse for her to take care of the need. NA #3 further stated she had not trimmed Resident #1's fingernails and had not reported to the nurse that his fingernails needed to be trimmed.	F 677	How the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/28/24 regional clinical director (RCD) audited all residents' nails with care provided as needed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/28/24 the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Manager (UM) provided education to licensed nurses and certified nursing assistants (CNA) (including agency) on providing fingernail care on admission and with each nursing interaction as needed. Any licensed nurse or CNA (including agency) who have not received education will not be allowed to work on/after 4/2/24 until education completed. On 3/29/24 the DON added education on providing nail care with showers and as needed to the newly hired licensed nurses and CNAs (including agency). Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

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F 677	Continued From page 2 An interview with NA #7 who was assigned to Resident #1 on 03/27/24 from 7:00 AM to 3:00 PM revealed she had not noticed the resident's fingernails needed to be trimmed and cleaned. She stated this was only the second time she had taken care of the resident and had not noticed his fingernails while in the room providing his care. An interview with Nurse #1 on 03/27/24 at 1:58 PM who was assigned to Resident #1on 03/27/24 from 7:00 AM to 7:00 PM revealed she had taken care of him several times but had not noticed his fingernails needed to be cleaned and trimmed. An observation of his fingernails revealed Nurse #1 agreed the resident needed his fingernails trimmed and cleaned and said she would take care of trimming them for him. Nurse #1 stated she did not know why the Nurse Aides caring for him had not noticed his fingernails and cleaned them and reported to her the nails needed to be trimmed. An interview with the Director of Nursing (DON) on 03/27/24 at 4:52 PM revealed she expected all residents to have their fingernails trimmed as part of their bed bath/shower. She stated the nurses were able to trim fingernails for diabetic residents and the Nurse Aides (NAs) were able to trim the nails for residents that were not diabetic. The DON further stated if the NAs were not comfortable trimming the resident's fingernails, they could tell their nurse and she could trim the resident's nails.	F 677	The (DON), (ADON), and/or unit manager (UM) will audit 10 residents weekly x 12 weeks to ensure nail care has been performed. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 months for additional recommendations. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 4/2/24	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment	F 687		4/2/24

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F 687	Continued From page 3 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 1 of 3 sampled residents (Resident #1) reviewed for foot care. The findings included: Resident #1 was admitted to the facility on 11/17/23 and readmitted on 02/05/24 with diagnoses which included cerebrovascular accident, hemiplegia, and hypertension. Review of Resident #1's most recent quarterly Minimum Data Set (MDS) assessment dated 02/12/24 revealed he was severely cognitively impaired and required maximal assistance with personal hygiene. Review of a final appointment listing dated 02/05/24 revealed Resident #1 was not seen by the podiatrist on that date. An observation and interview with Resident #1 on 03/26/24 at 10:00 AM revealed him lying in bed with his eyes closed. The resident opened his eyes and was able to respond that he was doing	F 687	F687 Foot Care Facility failed to provide podiatry services and/or toenail care for 1 resident. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 3/29/24 resident # 1 was seen by podiatry and nails were clipped and addressed. How the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/28/24 the Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or Unit Manager (UM) audited all	

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F 687	Continued From page 4 well. Resident #1 was able to answer simple questions but unable to carry on a conversation. Observation of his toes revealed thick, yellow toenails on the 2nd through 4th toes extending ¼ to ½ inch beyond the end of his toes on each foot. The resident stated no one had trimmed his toenails since being at the facility. An observation of Resident #1 on 03/27/24 at 9:20 AM revealed him lying in bed and complained that he wanted a different boot on his left foot so Nurse Aide (NA) #7 who was assigned to Resident #1 from 7:00 AM to 3:00 PM on 03/27/24 came in and changed his boot on the left foot. As she was changing his boot his toenails were again observed to be long, thick, and yellow on the 2nd through 4th toes on each foot and were ¼ to ½ inch beyond the end of his toes. Review of Resident #1's electronic medical record (EMR) revealed there were no progress notes from podiatry in his chart. An interview with NA #3 on 03/27/24 at 10:40 AM revealed she frequently cared for Resident #1 from 7:00 AM to 3:00 PM. She stated she usually gave him a bed bath but said she had not noticed his toenails being long and needing to be trimmed. She stated usually during baths/showers she looked at resident's skin for dry skin, toenails, scratches, bruises and to see if they needed to be shaved and either did it or reported it to the nurse for her to take care of the need. NA #3 further stated she did not trim toenails for residents but said the facility had a podiatrist that came every 3 months to trim toenails.	F 687	residents to ensure toenails were trimmed and podiatry services had been completed if ordered. Identified residents who were identified as needing podiatry services were seen on 3/29/24. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/28/24 DON, ADON, and/or UM provided education to licensed nurses and CNAs (including agency) on toenails are checked and corrected on admission and with each nursing interaction as needed. Any licensed nurse or CNA (including agency) who have not received education will not be allowed to work on/after 4/2/24. On 3/28/24 the DON added this education to the for newly hired or contracted nursing staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The (DON), (ADON), and/or (UM) will audit 10 residents weekly x 12 weeks to ensure toenails have been trimmed or the identified patient has been placed on the center podiatry list. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3	

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F 687	Continued From page 5 An interview with Nurse #1 on 03/27/24 at 1:58 PM who was assigned to Resident #1 on 03/27/24 from 7:00 AM to 7:00 PM revealed she had taken care of him several times but had not noticed his toenails. An observation of his toenails revealed Nurse #1 agreed the resident needed his toenails trimmed by the podiatrist and said she would refer him to the Social Worker (SW) to have his name placed on the list for the podiatrist at his next visit. An interview with the Director of Nursing (DON) on 03/27/24 at 4:52 PM revealed she would have expected the resident's toenails to have been noted during his bed bath/shower or during his weekly skin assessment. She stated she expected the nurses to refer residents to the SW that needed to be seen by the podiatrist.	F 687	for additional recommendations. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 4/2/24	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		4/2/24

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F 761	Continued From page 6 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to secure medications stored at the bedside for 1 of 2 residents reviewed for medication storage (Resident #15). Findings included: Resident #15 was re-admitted to the facility on 9/30/23 with diagnoses that included shortness of breath and chronic obstructive pulmonary disease (COPD). A quarterly Minimum Data Set (MDS) assessment dated 2/9/24 indicated Resident #15 was moderately cognitively impaired. A review of Resident #15's March 2024 Physician's Order Summary revealed he was prescribed the following medication on 9/30/23: Symbicort Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Dihydrate)- 2 puffs inhale orally 2 times a day for COPD. The document did not reveal a current order for Albuterol AER HFA (an inhaled medication used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing and chest tightness) or Resident #15.	F 761	F761 Label/Storage of Drugs and Biologicals Facility failed to secure medications stored at bedside for one resident. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 3/26/24 the facility nurse removed inhalers from bedside of resident #15 and secured on medication cart. How the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/29/24 the Infection Control Nurse (IC) audited all resident rooms for medications at bedside. No additional findings.	

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F 761	Continued From page 7 An observation was made on 3/26/24 at 11:15 AM which revealed two inhalers placed on a bedside table to the left of Resident #15's bed. Resident #15 was laying in bed at the time of the observation with his eyes closed and did not respond when this writer spoke to him for an attempted interview. Close observation of the inhalers revealed one inhaler included a label with the medication name 1) Albuterol AER HFA and the second was labeled 2) Symbicort 160/4.5. Neither inhaler container contained Resident #15's name or instructions on the label for administration visibly displayed. An observation and interview with Nurse #6 on 3/26/24 at 12:07 PM revealed she was the medicating nurse for the 100 hall on day shift. She observed the inhalers on Resident #15's bedside and stated he did not administer them himself and that they should not have been left in his room. She said she was unsure why they were not secured on the medication cart after administration unless it was by accident. Nurse #6 removed the medication from Resident #15's room and took them to the medication cart and secured them until she could speak to her supervisor. An interview with the Director of Nursing (DON) on 3/27/24 at 3:33 PM revealed she expected nurses to observe a resident while medications were administered and remove all medications and their unused portions from the resident's room after administration for safety. The DON stated all medications should be properly labeled and secured in the medication carts when not being directly administered to a resident and in the direct observance of a nurse.	F 761	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/28/24 the Director of Nursing (DON) provided education to licensed nurses (including agency) on medication storage including not keeping medications at bedside unless self-administration assessment was in place. Any licensed nurse (including agency) who have not received education will not be allowed to work on/after 4/2/24 until education complete. On 3/28/24 the DON added education on medication storage to the newly hired licensed nurses (including agency). Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or Unit Manager (UM) will audit 10 resident rooms to ensure no medications at bedside weekly x 12 weeks. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for additional recommendations. Administrator will review the results of weekly audits to ensure any issues	

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F 761	Continued From page 8	F 761	identified are corrected. Completion date: 4/2/24	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, and test tray the facility failed to provide palatable food that was appetizing in temperature for 6 of 6 residents reviewed for food palatability (Resident #9, Resident #10, Resident #11, Resident #12, Resident #13, and Resident #14) . This practice had the potential to affect other residents on all halls. Findings included: a. Resident #9 was re-admitted to the facility on 5/24/23. A quarterly Minimum Data Set (MDS) assessment dated 1/12/24 revealed Resident #9 was cognitively intact. An interview was conducted with Resident #9 on	F 804	F804 Palatable Food Facility failed to provide palatable food that was appetizing in temperature for 6 residents. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 3/28/24 Regional Clinical Director (RCD) completed lunch observation for resident #9, 10, 11, 12, 13, and 14 with no concerns noted with palatability, temperature and indicated satisfaction with their meals with no residents denying	4/2/24

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F 804	Continued From page 9 3/26/24 at 2:00 PM which revealed she resided on the 200 hall. She stated she received a meal for lunch and although the taste was acceptable, the temperature was cold. Resident #9 stated that she often received food items that were not the correct temperature. b. Resident #10 was re-admitted to the facility on 3/19/24. A quarterly Minimum Data Set (MDS) assessment dated 2/28/24 revealed Resident #10 was cognitively intact. An interview was conducted with Resident #10 on 3/26/24 at 2:05 PM which revealed she resided on the 200 hall. She stated she received chicken on her lunch tray that was cold today. Resident #10 stated that she and other residents had voiced concerns about food in the past and although the taste had improved the temperature had not been consistent. c. Resident #11 was admitted to the facility on 9/15/23. A quarterly Minimum Data Set (MDS) assessment dated 2/13/24 revealed Resident #11 was cognitively intact. An interview was conducted with Resident #11 on 3/26/24 at 2:12 PM which revealed he resided on the 400 hall. He stated he received a lunch meal which contained chicken which was of a cool temperature and lima beans which contained no juices. Resident #11 said it did not do any good to continue to complain about the food because he had voiced concerns about food in the past and it did not change. He stated, "I gave up trying."	F 804	any concerns/indicating satisfaction with meal. How the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/28/24 RCD completed breakfast and lunch observations and interviews with no concerns for cold food. On 3/29/24 RCD completed lunch and dinner observations and interviews with no concerns for cold food. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/28/24 Director of Nursing (DON) provided education to licensed nurses and CNAs (including agency) on passing trays timely to ensure food is warm and palatable. Any licensed nurse or CNA (including agency) who have not received education will not be allowed to work on/after 4/2/24 until education is completed. On 3/28/24 the DON added education to the orientation of newly hired or contracted nursing staff.	

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F 804	Continued From page 10 d. Resident #12 was re-admitted to the facility on 10/16/23. A quarterly Minimum Data Set (MDS) assessment dated 1/2/24 revealed Resident #12 was cognitively intact. An interview was conducted with Resident #12 on 3/26/24 at 2:18 PM which revealed she resided on the 400 hall. She stated she received a lunch tray which contained chicken that was of a temperature cool enough she was concerned to eat it because she thought it may not have been fully cooked. She stated she and other residents had expressed concerns related to food multiple times and although the taste of the food had improved, at times, there was no consistency for meal with taste or proper temperature. e. Resident #13 was re-admitted to the facility on 10/13/23. A quarterly Minimum Data Set (MDS) assessment dated 1/7/24 revealed Resident #13 was cognitively intact. An interview was conducted with Resident #13 on 3/26/24 at 2:29 PM which revealed he resided on the 300 hall. He stated he received a lunch tray that was cold. He said most of the time he and the other residents either must eat it, go hungry, or use what little money they are given each month to order food for delivery to have good food. He stated the meals delivered from the kitchen were very inconsistent with temperature ranging from cold to barely above lukewarm but never hot enough to need to wait to let it cool and never contained steam from the plate. Resident	F 804	On 3/28/24 the dietary manager (DM) provided education to dietary staff on serving food per temperature recommendations. This education was completed on 3/28/24. On 3/28/24 the DM added this education to orientation for newly hired/contracted dietary staff. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing (DON), Assistant Director of Nursing (ADON), and/or unit manager (UM) will audit/interview 10 residents weekly x 12 weeks to ensure meals have been served at appropriate temperature and are palatable. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for additional recommendations. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 4/2/24	

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#13 said at times he asks the nurse aides to re-heat a meal in the microwave, but he knows there are not enough of them to re-heat everyone on the halls meals when he is not the only one who received a meal that was cold.

f. Resident #14 was re-admitted to the facility on 3/8/24.

A 5-day Minimum Data Set (MDS) assessment dated 3/12/24 revealed Resident #14 was cognitively intact.

An interview was conducted with Resident #14 on 3/26/24 at 2:40 PM which revealed he resided on the 300 hall. He stated he received a lunch tray that was cold and he was only able to eat the potatoes. Resident #14 stated the meat was cold and staff was unable to identify what was being served and the lima beans were cold, dry, colorless, and contained no juices. Resident #14 chuckled and said the lima beans looked like they were taken right out of a plastic bag from the grocery store and laid on the plate without cooking.

An interview with Nurse Aide #6 on 3/26/24 at 2:22 PM revealed she had been employed on day shift for approximately 4 months and often heard from residents that their meals were cold when they received them. NA #6 stated she has attempted at times to heat up a few residents' meals in the microwave; however, there are just too many residents who complain that their meals are cold at once and there is no way to get them all heated up every meal because it takes too much time making trips back and forth to the microwave. NA #6 stated she has never seen food hot enough to have steam visible from the

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tray when she lifts the insulated cover to serve it to a resident.

A kitchen tour was conducted just prior to the meal service line for the lunch meal on 3/26/24 at 12:15 PM. The test tray was scooped from the steam table in the kitchen following the last resident meal for the 200 hall and was plated by the Dietary Training Manager and delivered to the 200 hall along with the trays for the 200 hall. At 1:00 PM., the lunch meal cart was delivered to the 200 hall from the kitchen in a metal enclosed cart and staff began passing meal trays to residents. When the last tray was delivered to the resident at 1:11 PM, the test tray was sampled. The Dietary Training Manager carried the test tray into the conference room. The plate contained an insulted metal base and the insulated dome lid. The Dietary Training Manager opened the dome lid to reveal no steam from the food. The items were sampled by the surveyor and Dietary Training Manager with taste having good flavor and texture aside from the cornbread which was unevenly cooked with portions being overly cooked and hard and dry and other portions mushy and dough like. The items were cool to lukewarm in temperatures.

An interview with the Dietary Training Manager on 3/26/24 at 1:11 PM revealed she believed the food was lukewarm during the testing due to the fact it took time to pass out the trays by staff on the 200 hall and the meal tray was not able to be placed inside the insulated metal cart due to space. The Dietary Training Manager acknowledged the meal would need to have been heated up before serving this meal to a resident and agreed there was not visible steam coming from the plate when the insulated cover was

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F 804	Continued From page 13 lifted. The Dietary Training Manager stated she believed the metal insulated base warmer, plate warmers, and the insulated dome lid systems were utilized during the lunch meal, and she is unsure why the meal did not stay hotter than it did. An interview with the Administrator on 3/27/24 at 3:33 PM revealed she expected all residents to be served foods at a temperature acceptable to the resident.	F 804		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		4/2/24

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(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

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F 842	Continued From page 15 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain complete and accurate medical records related to wound treatments for 1 of 3 residents (Resident #5) reviewed for wounds. The finding included: Resident #5 was admitted to the facility on 01/29/24 with diagnoses that included pyoderma gangrenosum (a rare condition that causes large, painful sores to develop on the skin, most often the legs). Review of Resident #5's physician orders revealed an order dated 02/01/24 to cleanse left lateral medial thigh with soap and water, pat dry, apply non stick contact layer of oil emulsion gauge to wound bed, place calcium alginate on top then cover with ABD pad and secure with tape daily. Resident #5 was discharged home on 02/16/24. A review of Resident #5's Treatment Administration Record (TAR) for 02/2024 revealed of the 15 days Resident #5 resided in the facility in the month of February, 4 days were not documented as the Resident receiving the ordered treatment. The days were: 02/01/24, 02/03/24, 02/11/24 and 02/15/24. An interview was conducted with Nurse #5 on 03/26/24 at 9:10 PM who worked on Resident #5's hall on 02/15/24. The Nurse explained that she worked all the halls at the facility and could not be sure if she worked with Resident #5 on	F 842	F842 Resident Records The facility failed to maintain complete and accurate medical records related to wound treatments of 1 resident How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #5 was discharged from facility on 2/16/24. How the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/28/24 the Director of Nursing (DON) audited the treatment administration records (TARs) for missing documentation. No negative resident outcomes related to holes in TAR no omissions in documentation identified or noted. Address what measures will be put into place or systemic changes made to	

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F 842	Continued From page 16 02/15/24 but stated if she did, she would like to think that she completed the treatment and signed off on the TAR. An interview was conducted with Nurse #2 on 03/26/24 at 9:15 PM who confirmed she worked on 02/01/24. The Nurse explained that there was a wound nurse who normally completed the treatments but there were times when no one was scheduled to do the treatments and the nurse on the hall had to do the treatments. Nurse #2 continued to explain that she did remember completing Resident #5's treatment on 02/01/24 but could not remember if she signed off on the treatment. On 03/26/24 at 9:17 PM an interview was conducted with Nurse #4 who confirmed she worked with Resident #5 on 02/15/24. The Nurse explained that she did recall completing Resident #5's wound treatment around the middle of February but could not say whether she signed off on the TAR. Attempts were made to interview Nurse #3 but the attempts were unsuccessful. On 03/26/24 at 2:45 PM an interview was conducted with Unit Manager (UM) #2 who explained that the facility recently hired a full-time wound nurse but before that the treatments were completed by the hall nurses. The UM stated the treatments should be treated like medications and they should be signed off for as soon as they were completed. During an interview with the Director of Nursing (DON) on 03/26/24 at 12:00 PM the DON explained that until recently the Unit Managers	F 842	ensure that the deficient practice will not recur: On 3/28/24 the DON provided education to licensed nurses on completion of TAR. Any licensed nurse not educated on 4/2/24 will not be allowed to work until education complete. This education was added to the orientation for newly hired or contracted licensed nurses on 3/28/24 by DON. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON, Assistant Director of Nursing (ADON), and/or Unit Manager (UM) will review 10 residents weekly to ensure no missing documentation is present on MAR/TAR x 12 weeks. Clinical team will review MAR and TAR documentaiton for all residents five times a week for four weeks to ensure there is no missing documentation. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for additional recommendations. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 4/2/24	

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F 842	Continued From page 17 and the hall nurses were responsible for completing the treatments. She stated it was possible that some of the treatments could have been completed but regardless she stated they should have been documented as being completed. The DON also stated that they tried to call the nurses back in to complete their documentation. An interview conducted with the Administrator on 03/27/24 at 3:00 PM revealed the Administrator stated her background was clinical and she knew the nurses should sign off on their treatments when they completed the treatments.	F 842		
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	F 867		4/2/24

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F 867	Continued From page 18 §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions 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.	F 867		

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§483.75(e) Program activities.

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

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

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The 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

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F 867	Continued From page 20 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, and staff interviews, and a test tray, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following a recertification and complaint investigation that occurred on 02/01/24, a complaint investigation that occurred on 06/26/23 and a recertification and complaint investigation survey that occurred on 10/03/22 for a deficiency that was cited in the area of Activities of Daily Living for Dependent Residents (F677), a recertification and complaint investigation survey that occurred on 02/01/24, a recertification and complaint investigation survey that occurred on 04/15/21 for a deficiency cited in the area of Label/Storage of Drugs Biologicals (F761), a recertification and complaint investigation survey that occurred on 02/01/24 in the area of Palatable Food (F804), a recertification and complaint investigation survey that occurred on 10/03/22, a recertification and complaint investigation survey that occurred on 04/15/21 for a deficiency that was cited in the area of Resident Records - Identifiable Information (F842), a recertification and complaint investigation survey that occurred on 02/01/24, a complaint investigation survey that	F 867	F867 QAA How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility received repeated deficiency tags F677, F761, F804, F842, and F880 Appropriate plans of correction implemented for each deficiency with repeat cite. How the facility will identify other residents having the potential to be affected by the same deficient practice; On 3/29/24 the interdisciplinary team (IDT) met and determined the root cause for repeat deficiency F677 to be Lack of auditing for continued follow up and staff failure to identify needed ADL care for dependent residents.	

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F 867	Continued From page 21 occurred on 12/08/21 and a recertification and complaint investigation survey that occurred on 04/15/21 for a deficiency cited in the area of Infection Control (F880) and these were subsequently recited on the current follow up and complaint investigation survey of 03/28/24. The repeat deficiencies during six consecutive 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: F677: Based on observations, record reviews, resident and staff interviews, the facility failed to provide nail care and trim fingernails for 1 of 3 residents (Resident #1) reviewed for activities of daily living. During the recertification and complaint investigation survey completed on 02/01/24, the facility failed to provide showers to a dependent resident reviewed for activities of daily living. During the complaint investigation survey completed on 06/26/23, the facility failed to provide incontinent care on dependent residents that would prevent residents from soaking through their briefs, turn sheets and fitted sheets for 2 of 4 residents reviewed for activities of daily living (ADL). During the recertification and complaint investigation survey completed on 10/03/22, the facility failed to provide a dependent resident with their preferred method of bathing and the number of showers per week.	F 867	On 3/29/24 the interdisciplinary team (IDT) met and determined the root cause for repeat deficiency F761 to be a Lack of auditing for continued follow up related to ensuring that the medication storage was compliant to include medications at bedside without appropriate self-administration assessments. On 3/29/24 the interdisciplinary team (IDT) met and determined the root cause for repeat deficiency F804 to be lack of follow up and resolutions related to residents voicing food concerns to drive root cause analysis discussions. On 3/29/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F842 to be lack of auditing for continued follow-up including a comprehensive clinical team meetings that reviewed discrepancies related to documentation. On 3/24/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F880 to be an ineffective infection control education system with ongoing monitoring in addition to the need for education with return demonstration for infection control practices.	

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F 867	Continued From page 22 F761: Based on observations, record review, resident and staff interviews, the facility failed to secure medications stored at the bedside for 1 of 2 residents reviewed for medication storage (Resident #15). During the recertification and complaint investigation survey completed on 02/01/24, the facility failed to date opened multi-dose vials of medications in 1 of 3 medication administration carts. During the recertification and complaint investigation survey completed on 04/15/21 the facility failed to remove 14 blister cards (contained 265 tablets) and 1 bottle (contained 500 tablets) of expired medications. F804: Based on observations, record review, resident, and staff interviews, and test tray, the facility failed to provide palatable food that was appetizing in temperature for 6 of 6 residents (Resident #9, Resident #10, Resident #11, Resident #12, Resident #13, and Resident #14) reviewed for food palatability. This practice had the potential to affect other residents on all halls. During the recertification and complaint investigation survey completed on 04/15/21, the facility failed to serve food that was appetizing temperature for residents reviewed for food palatability. F842: Based on record review and staff interviews the facility failed to maintain complete and accurate medical records related to wound treatments for 1 of 3 residents (Resident #5) reviewed for wounds.	F 867	On 3/29/24 Quality Assessment and Assurance committee and IDT will review reviewed previous Quality Assessment and Assurance minutes to determine trends and opportunities for improvement including repeat deficiencies. As a result of this audit root cause were identified for F677, F761, F804, F842, and F880. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/29/24 the Regional Clinical Director (RCD) and Regional Director of Operations (RDO) educated the center administrator on the QAA committee process to include root cause analysis and identification of system opportunities. The center Administrator will preview past three survey cycles to ensure that center remains in substantial compliance with those areas previously cited. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will audit results of plan of correction audits weekly x 12 weeks.	

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F 867	Continued From page 23 During the recertification and complaint investigation survey completed on 02/01/24, the facility failed to maintain complete and accurate medical records related to a resident's blood sugar. During the recertification and complaint investigation survey completed on 10/03/22, the facility failed to document in the medical record a resident's death. F880: Based on record review, observations, and staff interviews, the facility failed to implement their hand hygiene/handwashing policy as part of their infection control policy, when the Treatment Nurse did not perform hand hygiene according to the facility ' s policy and procedure when providing wound care to 1 of 3 residents (Resident #1) reviewed for wound care. During the recertification and complaint investigation survey completed on 02/01/24, the facility failed to implement their infection control policies for the safe handling of soiled laundry when 1 of 5 staff members (Laundry Staff) failed to follow standard precautions during the infection control observation. During the complaint investigation survey completed on 12/08/21, the facility failed to follow CDC guidelines when staff failed to wear eye protection while performing direct care during a COVID-19 pandemic. During the recertification and complaint investigation survey completed on 04/15/21, the facility failed to follow infection control policies and procedures by not sanitizing the injection site with antiseptic pad.	F 867	RCD and/or RDO will audit Quality Assurance monthly x 3 months to ensure procedures are implemented and monitored. Completion date: 4/2/24	

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F 867	Continued From page 24 During a telephone interview with the Administrator on 03/28/24 at 4:34 PM, she revealed they had been discussing everything associated with the recertification plan of correction following their survey of 02/01/24 and were working closely with corporate consultants on the plans. She stated they had initiated using agency staff for nurses and nurse aides to help fill shifts related to their vacancies and the agency staff had been educated just as their staff had on the plan of correction. Additionally, she reported they were trying to schedule staff consistently on halls to care for residents. The Administrator further stated they would need to provide additional education on documentation to be sure they took credit for the work they were doing for each resident.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		4/2/24

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F 880	Continued From page 25	F 880		

staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 26 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to implement their hand hygiene/handwashing policy as part of their infection control policy, when the Treatment Nurse did not perform hand hygiene according to the facility ' s policy and procedure when providing wound care to 1 of 3 residents (Resident #1) reviewed for wound care. The findings included: The facility ' s policy entitled Handwashing/Hand Hygiene which is part of their Infection Control Policies and Procedures last revised 08/2019 under Policy Interpretation and Implementation read in part: 7. Use an alcohol-based hand rub (ABHR) containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; g. Before handling clean or soiled dressings, gauze pads, etc.,; k. After handling used dressings, contaminated equipment, etc.,;	F 880	F880 Infection Control Facility failed to implement their hand hygiene/handwashing policy as part of their infection control policy when the treatment nurse did not perform hand hygiene according to facility□s policy and procedure when providing wound care to 1 resident How corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 3/28/24 the Regional Clinical Director (RCD) reviewed infections for past month, including resident # 1 with no negatives potentially related to the hand hygiene observation. Treatment nurse was provided education on handwashing and competency was validated by Regional Clinical Director on 3/38/24. How the facility will identify other residents	

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F 880	Continued From page 27 m. After removing gloves; 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. An observation of wound care by the Treatment Nurse was made on 03/26/24 at 3:30 PM. The Treatment Nurse sanitized her hands, donned clean gloves and removed the old dressing from Resident #1 ' s sacral wound which had a small amount of serous drainage on the dressing. With the same gloves on she proceeded to cleanse the wound with wound cleanser-soaked gauze, doffed her gloves, sanitized her hands, and donned new gloves and patted the wound dry. With the same gloves on, she proceeded to apply ointment around the wound bed and then applied medicated gel to the wound bed and then covered with normal saline moistened gauze and petroleum jelly-treated gauze was applied over the saline gauze and then an ABD (abdominal) pad applied and taped. With the same gloves on the Treatment Nurse adjusted the resident up in bed and positioned him with pillows and placed his covers over him. She doffed her gloves, sanitized her hands and donned clean gloves and collected her supplies and left the room. An interview was conducted with the Treatment Nurse on 03/27/24 at 12:12 PM. When asked the Treatment Nurse stated she should have doffed her gloves, sanitized her hands and donned new	F 880	having the potential to be affected by the same deficient practice; All residents with wounds have potential to be affected. On 3/28/24 the RCD reviewed infections for past month to ensure no trends related to wounds or site of infection. No trends noted. On 3/29/24 the RCD observed the treatment nurse during wound rounds to ensure infection control and hand hygiene policies were followed with no negative findings. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 3/28/24 Director of Nursing (DON) provided education all staff on how and when to perform hand hygiene. This education was added to the orientation for newly hired or contacted staff on 3/29/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The administrator, DON, ADON, and/or UM will observe 10 hand hygiene occurrences weekly x 12 weeks to ensure	

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F 880	Continued From page 28 gloves after removing the old dressing and before cleansing the wound and said she should have sanitized her hands and changed her gloves before adjusting the resident in bed and touching his pillows and linens on his bed. The Treatment Nurse further stated it was an oversight on her part. An interview with the Infection Preventionist on 03/27/24 at 4:37 PM revealed she agreed the Treatment nurse should have doffed her gloves, sanitized her hands and donned new gloves after removing the old dressing and before cleansing the wound. She also agreed the Treatment Nurse should have doffed her gloves, sanitized her hands and donned new gloves before positioning the resident in bed and touching the resident ' s bed linens. An interview with the Director of Nursing (DON) revealed she would have expected the Treatment Nurse to follow the policy and procedure for Hand Hygiene while performing wound care and said she felt like the Treatment Nurse was probably nervous about being watched.	F 880	hand hygiene policy is followed to include wound care/treatment observations. Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for additional recommendations. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Completion date: 4/2/24	