STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING _____ B. WING _____	C 10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/07/24 through 10/11/24. Additional information was gathered offsite on 10/14/24, therefore the exit date was changed to 10/14/24. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID#M32K11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 10/07/24 through 10/11/24. Additional information was obtained offsite on 10/14/24; therefore, the exit date was changed to 10/14/24. Event ID# M32K11. The following intakes were investigated: NC00222966, NC00222753, NC00217449, NC00213856, NC00213323, NC00212895, and NC00212703. 11 of the 27 allegations resulted in deficiencies.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other	F 561		11/19/24

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

Electronically Signed | 11/08/2024

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 561	Continued From page 1 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide the resident's preference of showers for 3 of 3 residents reviewed for choices (Resident #17, Resident #189 and Resident #64). The findings included: 1. Resident #17 was admitted to the facility on 11/23/21 with diagnoses which included debility, arthritis, and chronic pain. Resident #17's significant change Minimum Data Set (MDS) assessment dated 08/23/24 revealed she was cognitively intact and required substantial to maximal assistance with showering and bathing. The assessment also revealed Resident #17 had no rejection of care behaviors and according to the assessment, it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath.	F 561	Residents #17, #189, & #64 were identified for not having their shower preferences. On 10/10/24 all residents listed above were interviewed for their choice of shower and/or bath preferences. On 10/10/24, the Director of Nursing/Minimum Data Set (MDS) Coordinator reviewed care plans for the residents listed above and revised the resident care guides for their preferred shower and/or bath preference. On 10/10/24 the DON initiated an audit that included 100% of our residents or resident representatives. This audit is to ensure showers and bed baths are completed according to their preference. This information will be used to updated care plans and care guides as appropriate. On 10/10/24, education was initiated to include all staff, including agency staff, by	

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F 561	Continued From page 2 The shower schedule for the middle hall revealed Resident #17 was scheduled for showers on Tuesday and Friday on 1st shift (7:00 AM to 3:00PM). The documentation of showers in the electronic medical record for Resident #17 for 08/13/24 through 10/11/24 revealed she received showers as scheduled on 08/13/24, 08/16/24, 08/20/24, 08/27/24, 09/03/24, 09/10/24, 09/17/24, 09/20/24, and 09/24/24. On the other days she was scheduled for showers the following was documented: Friday 08/23/24 no shower provided Friday 08/30/24 partial bath provided Friday 09/06/24 no shower provided Friday 09/13/24 no shower provided Friday 09/27/24 no shower provided Tuesday 10/01/24 no shower provided Friday 10/04/24 no shower provided Tuesday 10/08/24 no shower provided Friday 10/11/24 no shower provided An observation and interview on 10/08/24 at 9:23 AM revealed Resident #17 sitting up in her wheelchair and dressed for the day. The Resident's skin was visibly dry and flaky. Resident #17 stated she was not getting her showers two times a week as scheduled and stated she preferred to take showers because the hot water felt good to her arthritis. Resident #17 further stated she had not refused any of her showers and had not been offered showers two times per week, every week and had sometimes gone two weeks without a shower. On 10/10/24 at 4:00 PM a Resident Council	F 561	the Staff Development Coordinator on following resident preferences when performing ADL Care, the use of the resident care guide for determining the resident's choice for a bath and/or shower and skin care. The staff will document refusals of a bath or shower and notify the nurse for appropriate follow-up and documentation. By 11/18/24 all nursing staff working in the building will be educated. Any nursing staff or agency staff that has not been educated by 11/18/24 will be provided with the education on their next scheduled shift. New hires will be educated during their orientation moving forward. Beginning 10/28/24, the Unit Manager started randomly auditing five (5) residents per week for 4 weeks, then (10) residents monthly for 2 months ensure shower and/or baths are offered per the resident's preference and care guide and that any refusals are documented in the electronic medical record. Director of Nursing or Administrator will review bathing/shower audits as completed. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 3 months or until a time determined by the Quality Assurance Performance Improvement (QAPI) members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance.	

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Meeting was held, and Resident #17 was in attendance and again she and others complained about not getting showers during the meeting. She stated that she was not getting her showers two times per week as scheduled.

A telephone interview was attempted several times with agency NA #13 who cared for Resident #17 on 08/23/24 during the 7:00 AM to 3:00 PM shift with voicemail messages left for return call with no response.

A telephone interview on 10/11/24 at 3:55 PM with agency NA #8 revealed she had cared for Resident #17 on 08/30/24 during the 7:00 AM to 3:00 PM shift. She stated she usually tried to give all her showers or bed baths but said sometimes their schedule changed during their shift and showers sometimes got missed. Agency NA #8 further stated the scheduled changed frequently and it was difficult to keep up with showers when changes were made mid-day.

A telephone interview on 10/10/24 at 12:07 PM with Agency Nurse Aide (NA) #3 revealed she had cared for Resident #17 on 09/06/24 during the 7:00 AM to 3:00 PM shift. She stated she couldn't remember why she had not given Resident #17 a shower on that day but said sometimes their assignments were changed during the shift and residents may have missed their showers. Agency NA #3 stated she usually gave all her showers and bed baths unless the schedule was changed and said that happened a lot because staff worked different hours. She further stated the staff worked 4, 8, 12 and 16-hour shifts.

A telephone interview was attempted several

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times with agency NA #12 who cared for Resident #17 on 09/13/24 and 10/11/24 during the 7:00 AM to 3:00 PM shift with voicemail messages left for return call with no response.

An interview on 10/11/24 at 4:42 PM with Unit Manager #2 revealed she was not aware, and no one had told her that Resident #17 was not receiving her showers as scheduled. She stated the NAs should be reporting not getting showers done to the nurse or to her so they could have adjusted the schedule to accommodate the residents. Unit Manager #2 further stated she could have moved NAs around or added them to an assignment to get the resident showers done if she had been told they were not done.

An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed she expected residents to have their bed baths or showers as scheduled. She stated the NAs should report to the nurses or unit managers any residents refusing care or who didn't receive their bed bath or shower as scheduled so they could be accommodated on the next shift or next day. The DON further stated there were changes sometimes to the schedule because they had staff working 4, 8, 12 and 16-hour shifts. She indicated they were trying to cover the schedule with agency staff as they hired their own staff, and it was difficult with using so many agencies to get dependable staff to cover the schedule. The DON further indicated they needed to interview the residents and make sure their preferences were documented correctly.

2. Resident #64 was admitted to the facility on 08/27/23 with diagnoses which included hemiparesis due to cerebrovascular accident

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(CVA) or stroke.

Resident #64's annual Minimum Data Set (MDS) assessment dated 08/13/24 revealed she was moderately cognitively impaired and required partial to moderate assistance with showering and bathing. The assessment also revealed Resident #64 had no rejection of care behaviors and according to the assessment, it was somewhat important to the resident to choose between a tub bath, shower, bed bath or sponge bath.

The shower schedule for the middle hall revealed Resident #64 was scheduled for showers on Wednesday and Saturday on 2nd shift (3:00 PM to 11:00 PM).

The documentation of showers in the electronic medical record for Resident #64 for 08/05/24 through 10/09/24 revealed she received showers on 08/20/24 which was not a scheduled shower day (Tuesday), 09/04/24, 09/11/24, 10/02/24 and 10/07/24 which was not a scheduled shower day (Monday). On the other days she was scheduled for showers the following was documented:

Wednesday 08/07/24	partial bath provided
Saturday 08/10/24	partial bath provided
Wednesday 08/14/24	no shower provided
Saturday 08/17/24	complete bed bath
Wednesday 08/21/24	no shower provided
Saturday 08/24/24	no shower provided
Wednesday 08/28/24	partial bath provided
Saturday 08/31/24	complete bed bath provided
Saturday 09/07/24	no shower provided
Saturday 09/14/24	complete bed bath provided

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Wednesday 09/18/24 no shower provided
Saturday 09/21/24 complete bed bath provided
Wednesday 09/25/24 no shower provided
Saturday 09/28/24 partial bath provided
Saturday 10/05/24 no shower provided
Wednesday 10/09/24 no shower provided

An observation and interview on 10/07/24 at 3:30 PM with Resident #64 revealed her lying in bed and said she had a shower today but prior to that it had been a while since she had one. Resident #64 stated she only got one shower about every 2 weeks and would like to get 2 showers a week as scheduled. She further stated she preferred a shower because the warm water felt good to her, and she felt cleaner after a shower than when she received a bed bath.

A telephone interview was attempted several times with Nurse Aide (NA) #6 who cared for Resident #64 on 08/14/24 and 08/28/24 during the 3:00 PM to 11:00 PM shift with voicemail messages left for return call with no response.

A telephone interview on 10/10/24 at 11:22 AM with agency NA #4 revealed she had cared for Resident #64 on 08/21/24 (along with agency NA #5), 08/31/24, and 09/18/24 during the 3:00 PM to 11:00 PM shift. She stated she usually tried to get all her showers done but sometimes their assignments changed 2 hours into the shift, and she may have been switched to other residents and not gotten her shower done before the assignment changed. Agency NA #4 stated there seemed to be a scheduling problem at the facility because assignments were constantly being changed during the shift.

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A telephone interview on 10/10/24 at 11:50 AM with agency NA #5 who cared for Resident #64 on 08/21/24 (along with agency NA #4), and 09/25/24 during the 3:00 PM to 11:00 PM shift revealed if they were fully staffed, she was able to get her showers done on 2nd shift but if not, she was not able to get all the showers done as scheduled. She stated there were times that staff would just not show up for their shift and would not call and that left them short and on those shifts it was difficult to get all the showers done.

An interview on 10/11/24 at 4:42 PM with Unit Manager #2 revealed she was not aware, and no one had told her that Resident #64 was not receiving her showers as scheduled. She stated the NAs should be reporting not getting showers done to the nurse or to her so they could have adjusted the schedule to accommodate the residents. Unit Manager #2 further stated she could have moved NAs around or added them to an assignment to get the resident showers done if she had been told they were not done.

An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed she expected residents to have their showers as scheduled. She stated the NAs should report to the nurses or unit managers any residents refusing care or who didn't receive their shower as scheduled so they could be accommodated on the next shift or next day. The DON further stated there were changes sometimes to the schedule because they had staff working 4-, 8-, 12- and 16-hour shifts. She indicated they were trying to cover the schedule with agency staff as they hired their own staff, and it was difficult with using so many agencies to get dependable staff to cover the schedule. The DON further indicated they needed to interview

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the residents and make sure their preferences were documented correctly.

3. Resident #189 was admitted to the facility on 06/22/23 with diagnoses which included hemiplegia due to cerebrovascular accident (CVA) or stroke.

Resident #189's annual Minimum Data Set (MDS) dated 06/27/24 revealed it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath.

Resident #189's quarterly MDS dated 07/24/24 revealed she was moderately cognitively impaired but could make her needs known and required setup with showering and bathing. The assessment also revealed Resident #189 had no rejection of care behaviors.

The shower schedule for the middle hall revealed Resident #189 was scheduled for showers on Monday and Thursday on 2nd shift (3:00 PM to 11:00 PM).

The documentation of showers in the electronic medical record for Resident #189 for 08/05/24 through 09/05/24 revealed she received no showers as scheduled during this time. On the days she was scheduled for showers the following was documented:

Monday 08/05/24	no shower provided
Thursday 08/08/24	no shower provided
Monday 08/12/24	complete bed bath provided
Thursday 08/15/24	no shower provided
Monday 08/19/24	no shower provided
Thursday 08/22/24	partial bath provided
Monday 08/26/24	partial bath provided

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Thursday 08/29/24 partial bath provided
Monday 09/02/24 complete bed bath provided
Thursday 09/05/24 no shower provided

Documentation for 09/06/24 through 10/09/24 was not provided for this resident.

An observation and interview on 10/07/24 at 12:38 PM with Resident #189 revealed her sitting up in her wheelchair in her room dressed for the day. The Resident's skin that was visibly dry and flaky. Resident #189 stated she was not getting her showers two times a week as scheduled and stated she preferred to take showers because the hot water felt good to her, and she felt cleaner after a shower and getting her hair washed.

A telephone interview was attempted several times with Nurse Aide (NA) #6 who cared for Resident #189 on 08/08/24, 08/12/24 and 08/26/24 during the 3:00 PM to 11:00 PM shift with voicemail messages left for return call with no response.

A telephone interview on 10/10/24 at 12:07 PM with Agency NA #3 revealed she had cared for Resident #189 on 08/05/24 and 09/05/24 during the 3:00 PM to 11:00 PM shift. She stated she couldn't remember why she had not given Resident #189 a shower on those days but said sometimes their assignments were changed during the shift and residents may have missed their showers. Agency NA #3 stated she usually gave all her showers and bed baths unless the schedule was changed and said that happened a lot because staff worked different hours. She further stated the staff worked 4, 8, 12 and 16-hour shifts.

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A telephone interview on 10/10/24 at 11:57 AM with agency Nurse Aide (NA) #2 revealed she had cared for Resident #189 on 08/19/24 during the 3:00 PM to 11:00 PM shift. She stated she was not sure why she had not given Resident #189 a shower on that day but said sometimes their assignments were changed during the shift. She further stated it could have been that she originally had the resident and then was reassigned to another set of residents. Agency NA #2 indicated she always tried to give her showers and if she was not able to it was because the assignments were changed or there was not enough time during her shift to get it done. She also indicated there were times when staff called out or didn't show up and there was not enough time in the shift to give showers because of the increased workload.

A telephone interview on 10/10/24 at 11:22 AM with Agency NA #4 revealed she had cared for Resident #189 on 08/22/24 during the 3:00 PM to 11:00 PM shift. She stated she usually tried to get all her showers done but sometimes their assignments changed 2 hours into the shift, and she may have been switched to other residents and not gotten her shower done before the assignment changed. Agency NA #4 stated there seemed to be a scheduling problem at the facility because assignments were constantly being changed during the shift.

A telephone interview was attempted several times with agency NA #15 who cared for Resident #189 on 08/29/24 during the 3:00 PM to 11:00 PM shift with voicemail messages left for return call with no response.

A telephone interview was attempted several

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F 561	Continued From page 11 times with agency NA #7 who cared for Resident #189 on 09/02/24 during the 3:00 PM to 11:00 PM shift with voicemail messages left for return call with no response. An interview on 10/11/24 at 4:42 PM with Unit Manager #2 revealed she was not aware, and no one had told her that Resident #189 was not receiving her showers as scheduled. She stated the NAs should be reporting not getting showers done to the nurse or to her so they could have adjusted the schedule to accommodate the residents. Unit Manager #2 further stated she could have moved NAs around or added them to an assignment to get the resident showers done if she had been told they were not done. An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed she expected residents to have their preferred showers as scheduled. She stated the NAs should report to the nurses or unit managers any residents refusing care or who didn't receive their shower as scheduled so they could be accommodated on the next shift or next day. The DON further stated there were changes sometimes to the schedule because they had staff working 4-, 8-, 12- and 16-hour shifts. She indicated they were trying to cover the schedule with agency staff as they hired their own staff, and it was difficult with using so many agencies to get dependable staff to cover the schedule. The DON further indicated they needed to interview the residents and make sure their preferences were documented correctly.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 565		11/19/24

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PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE ROAD KERNERSVILLE, NC 27284

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F 565	Continued From page 12 §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address	F 565	On 10/30/24 the NHA completed a review of resident council grievances for January, March, April, June, July, and August, and	

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F 565	Continued From page 13 repeated concerns and/or suggestions voiced by residents during Resident Council meetings for 6 of 10 months reviewed (January 2024, March 2024, April 2024, June 2024, July 2024, and August 2024). Findings included: Review of the Resident Council Minutes for the period 09/25/23 through 09/20/24 revealed the following: a. The Resident Council meeting minutes dated 01/31/24 revealed under New Business there were noted resident concerns about not receiving showers, staff turning off call lights and not providing care, ice not being passed daily, and better customer service. b. The minutes from the Resident Council meeting held on 02/16/24 were not available for review. c. The Resident Council meeting minutes dated 03/22/24 revealed the section for old business noted resident concerns with showers not being given or in a timely manner, staff turning off call lights and not answering them, and better customer service. There was no indication of the facility's response to these concerns listed under old business. Under New Business there were noted residents were unhappy with certain pictures being taken down, nursing assistants being disrespectful, not changing sheets, or making resident beds, not picking up trays or telling residents their names, and not receiving showers on time. d. The Resident Council meeting minutes dated	F 565	followed up with the resident council on their completion/resolution. On 10/30/24, the Nursing Home Administrator (NHA) spoke with the resident council president to schedule a resident council meeting for 10/31/24 to address resident concerns/grievances. This meeting was held on 10/31/24. The NHA will ensure follow up to any concerns and/or grievances voiced during this meeting will be addressed, and the resolution will be communicated to the resident council. Beginning November 6, 2024, the NHA will attend weekly resident council meetings to review any unresolved business weekly x 4 weeks and then monthly thereafter for 2 months. On 10/14/24 the Administrator completed an in-service for the Activities Director on the correct forms to use for the Resident Council Meeting Minutes. They were educated to include any grievances or concerns from the council meeting in the minutes. This is to be taken to the IDT for resolution as appropriate. The concerns will be followed up on and shared by the next resident council meeting. Inservice training be completed with any new activity person that may be hired. The Administrator will audit resident council grievances weekly for 4 weeks and then monthly x 2 months utilizing Grievance Audit Tool. This audit is to ensure all resident council grievances and concerns are being recorded appropriately in the meeting minutes for review at each meeting. The Administrator will address all concerns identified during the audit to	

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F 565	Continued From page 14 04/19/24 revealed no indication that the minutes from the Resident Council meeting held on 03/22/24 were read, approved, revised and/or resolved. Further review revealed the section for old business noted residents were unhappy with certain pictures being taken down, nursing assistants being disrespectful and not changing their sheets or making their beds, not picking up their trays, not telling residents their names, and not receiving showers on time. There was no indication of the facility's response to these concerns. Under New Business there were noted resident concerns with showers, staff not picking up resident trays, wipes not being replaced in resident rooms, resident beds not being made, 3rd shift staff turning off call lights and not coming back in a timely manner for care, and dietary not providing correct utensils. e. The minutes from the Resident Council meeting held on 05/19/24 were not available for review. f. The Resident Council meeting minutes dated 06/21/24 revealed section for old business noted about showers given on time and call lights answered in a timely manner. There was also no indication of the facility's response to concerns voiced during the 05/19/24 resident council meeting. g. The Resident Council meeting minutes dated 07/19/24 revealed no indication that the minutes from the Resident Council meeting held on 06/21/24 were read, approved, revised and/or resolved. Further review revealed the section for old business noted no improvements to prior complaints. Under New Business there was noted resident concerns of housekeeping throwing	F 565	include re-training of Activities Director. The Administrator will present the findings of the Resident Council Grievance Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. Date of Alleged Compliance: 11/19/2024	

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away cups with herbs in them and giving plants too much water, nursing assistants were changing air conditioning temperatures in resident rooms and residents were cold, dietary concerns of correct food for diets, receiving utensils on tray, ice cream being served melted, and facility staff not being friendly.

h. The Resident Council meeting minutes dated 08/19/24 revealed no indication that the minutes from the Resident Council meeting held on 07/19/24 were read, approved, revised and/or resolved. Further review revealed, the section for old business noted "the complaints that were staff related have somewhat improved." Under New Business there was noted resident concerns of medications being passed late, resident not receiving their pain medication for 4 days, nursing assistants talking too much, resident bed linens not being changed more than once a month and their beds not being made daily, and missing clothing items.

A Resident Council group interview was conducted on 10/09/24 at 4:00 PM. During the interview, Residents #3, #17, #38, #45, #57, and #66, who attend Resident Council meetings regularly, all stated they felt facility staff did not really address their concerns or suggestions because the only response they typically received from staff, if they received one at all, was "we are working on it," "it has been addressed," or "we spoke with staff" but never any satisfactory resolution and some of the issues continued to happen. Resident #45, who was the Resident Council President, added they understood some of the concerns they voiced couldn't be fixed right

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away but it would be nice to receive some form of communication back as to what was being done. The residents all agreed they would like to know they were being heard and receive feedback from the administration on the efforts that had been made or attempted to resolve their concerns and/or suggestions.

During an interview on 10/09/24 at 4:45 PM, the Activity Director (AD) confirmed she attended and recorded the minutes for the Resident Council monthly meetings. The AD explained she had been told by the previous Administrator that when residents voiced concerns and/or suggestions during the monthly meetings, to write them under new business on the Resident Council minutes and inform him or the previous Director of Nursing (DON) of the concerns and they would "look into them." She stated she never received an actual response back from the previous Administrator or the previous DON as to how the concerns had been resolved other than being told "it had been addressed" or they "were working on it." She revealed most of the same concerns were mentioned during the meetings each month and she continued to document those concerns in the Resident Council minutes and inform the current Administrator and DON. The AD stated the previous DON attended some of the Resident Council meetings prior to her leaving and during those meetings the residents addressed their concerns with nursing staff directly to her. The previous DON stated she would take care of those concerns but never informed the AD if or how those concerns were addressed or resolved. The AD revealed moving forward she would prefer to write any concerns or suggestions from Resident Council meetings on a grievance form so she could have some form of a paper trail

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showing the concerns had been reviewed and were being addressed.

A telephone interview with the previous Director of Nursing (DON) on 10/10/24 at 11:11 AM revealed she had been employed at the facility from April 2024 until the first week of September 2024. She stated during her employment at the facility she had attended Resident Council meetings but could not recall which dates she had attended, or any specific resident concerns or resolutions discussed during the meetings.

The former Administrator was unable to be interviewed.

During an interview on 10/11/24 at 4:30 PM, the current Administrator revealed he began his employment at the facility around the middle of August 2024. He stated that he could not speak to the process of former Administration, but his preference would be for the AD to complete grievance forms for any concerns/suggestions brought up during Resident Council meetings. The Administrator revealed once the grievance forms from Resident Council meetings were completed, they would be given to him as he was the "grievance officer" and he would distribute them out to the responsible departments for their review. He stated once the grievances were resolved, the departments would write out their resolution on the grievance form and those would be distributed back to the AD for review at the following Resident Council meeting. He also stated that moving forward with this process would help with making sure any grievances or suggestions from Resident Council were being addressed and the departments responsible were being held accountable.

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		11/19/24

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F 580	Continued From page 19 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to notify the NP and MD that a resident was completely out of her narcotic pain medication resulting in her missing 14 consecutive doses for 4 ½ days for 1 of 3 residents reviewed for notification (Resident #17). The findings included: Resident #17 was admitted to the facility on 11/23/21 with diagnoses which included debility, arthritis, and chronic pain. The physician's order dated 10/25/23 revealed Resident #17 had an order to receive one tablet of oxycodone-Acetaminophen oral tablet 5-325 milligrams (mg) (oxycodone with acetaminophen) or Percocet (a type of opioid analgesic consisted of oxycodone/acetaminophen that acted on the central nervous system to relieve pain) by mouth three times a day for pain. The medication was scheduled to be given at 8:00 AM, 2:00 PM and 8:00 PM. The Medication Administration Record (MAR) for	F 580	On 10/10/21, it was discovered that on 8/1/24 – 8/5/24, the Percocet was not administered, the provider was not notified for interventions. On 10/11/24 a pain assessment was completed to address the current level of pain to see if intervention was needed. The provider was notified of the omission with no new orders given at that time. On 10/21/24, Resident #17 continued their regularly scheduled visits at the pain clinic. On 10/11/24, all residents with a BIMS of 13 or greater were interviewed related to their satisfaction with the effectiveness of their current pain management interventions. Providers notified of any areas of concern. On 10/11/24 all resident with BIMS of 12 or less had pain assessments completed with no adverse findings. On 10/11/24, the Director of Nursing initiated education to all licensed nursing staff on notification of changes to physician/nurse practitioner. Licensed nurses and medication aides educated on following the appropriate notification process when a resident did not receive	

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F 580	Continued From page 20 August 2024 revealed Resident #17 had not received her medication the following dates and times: - August 1 8:00 AM, 2:00 PM and 8:00 PM - August 2 8:00 AM, 2:00 PM and 8:00 PM - August 3 8:00 AM, 2:00 PM and 8:00 PM - August 4 8:00 AM, 2:00 PM and 8:00 PM - August 5 8:00 AM and 2:00 PM for a total of 14 doses missed. The August 2024 MAR revealed on the following dates and times, Agency Nurse #3 had taken care of Resident #17 and had not administered her Percocet: - August 1 at 8:00 AM and 2:00 PM - August 3 at 8:00 AM, 2:00 PM and 8:00 PM - August 4 at 8:00 AM and 2:00 PM A telephone interview was attempted with Agency Nurse #3 on 10/10/24 at 3:15 PM; however, the number had been disconnected and Nurse #3 was no longer employed through the Agency. The August 2024 MAR revealed on the following dates and times, Nurse #2 had taken care of Resident #17 and had not administered her Percocet: - August 2 at 8:00 AM and 2:00 PM - August 5 at 8:00 AM and 2:00 PM A telephone interview on 10/10/24 at 4:00 PM with Nurse #2 revealed she couldn't recall the specifics but said generally if a resident does not have their medication, she typically contacts the pharmacy and then if a script was needed, she contacted the NP to send an electronic script to the pharmacy for the medication. Nurse #2 stated she couldn't recall if they had oxycodone with acetaminophen in their narcotic Emergency	F 580	their medication as ordered. Nurses, medication aides and agency staff will be in-serviced by 11/18/24, any nurse, medication aide or agency that has not received the education by 11/18/24 will be provided the education prior to their next shift. This education will be part of the orientation process for all newly hired nurses and medication aides. On 11/06/24, the Director of Nursing will audit progress notes for MD/NP notification of narcotic medications not administered to residents weekly x 4 weeks then monthly x 2 months. Director of Nursing or Administrator will review MAR audits and whether the provider was notified as appropriate weekly for 4 weeks, and then monthly for 2 months. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 3 months or until a time determined by the Quality Assurance Performance Improvement (QAPI) members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance.	

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Kit but stated she felt like if they had she would have given it from the Emergency Kit. She further stated she could not recall notifying the NP or MD that the resident was completely out of her pain medication.

The August 2024 MAR revealed on August 4 at 8:00 PM Agency Nurse #4 had taken care of Resident #17 and had not administered her Percocet on that day and time.

A telephone interview was attempted several times with Agency Nurse #4 without success.

Review of Resident #17's significant change MDS dated 08/23/24 revealed she was cognitively intact and received scheduled pain medication and no as needed pain medication. The assessment also revealed the resident had almost constant pain at a level of 10 out of 1-10.

An interview on 10/10/24 at 10:03 AM with Resident #17 revealed she had gone 4 ½ days the first of August without receiving her pain medication as ordered. She stated during that time she had an increase in her pain level to an 8 on a scale of 1-10, instead of her usual pain level of 0 to 3 with her pain medication. She stated the staff (couldn't remember names) kept telling her it was on order and had not come from the pharmacy and said one nurse (couldn't remember name) finally told her it was too soon to refill her prescription for her pain medication.

An interview on 10/10/24 at 4:35 PM with the MD revealed she was not aware Resident #17 had completely ran out of her pain medication. The MD stated she or the NP should have been notified the resident was completely out of her

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F 580	Continued From page 22 pain medication so they could have ordered pain medication to cover her while awaiting her order from the pharmacy. She further stated she was familiar with Resident #17 and her chronic pain and her concern with her not receiving her pain medication for over 4 days would have been her increased intensity in pain. A telephone interview on 10/11/24 at 2:04 PM with the NP revealed she was not aware that Resident #17 had completely ran out of her pain medication. The NP stated had she known she could have ordered additional pain medication and potentially other modalities such as heat to help with her pain. The NP further stated her concern with Resident #17 not receiving her pain medication would have been her increased intensity in pain making it difficult to get the pain back under control. An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed it her expectation that residents received their medications as ordered by the providers. The DON stated the nurses or Unit Manager #2 should have contacted the NP or MD to obtain orders for pain medication and utilized other modalities such as heat to assist the resident in managing her pain.	F 580		
F 602 SS=G	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 602		11/19/24

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F 602	Continued From page 23 any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents, staff, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to protect a resident's right to be free from misappropriation of controlled medications for 1 of 3 residents reviewed for misappropriation of resident's property (Resident # 17). As a result of not getting her pain medication, Resident #17 had an increase in her pain of a level 8 on a scale of 1 to 10 which was increased from her usual pain level of 0 to 3 when getting her medication as prescribed. Resident #17 described the pain as constant aching and throbbing pain in her right hip and throbbing pain in her mouth. The findings included: The facility's Abuse, Neglect, or Misappropriation of Resident Property Policy, last revised on 03/10/17, revealed in part the facility would do whatever is in its control to prevent misappropriation of resident's property. Resident #17 was admitted to the facility on 11/23/21 with diagnoses which included debility, arthritis, and chronic pain. The physician's order dated 10/25/23 revealed Resident #17 had an order to receive one table of oxycodone-Acetaminophen oral tablet 5-325 milligrams (mg) (oxycodone with acetaminophen) or Percocet (a type of opioid analgesic consisted of oxycodone/acetaminophen that acted on the central nervous system to relieve pain) by mouth three times a day for pain. The medication was	F 602	The resident's medication was replaced at the facilities expense on 8/5/24. On 10/10/24, the Nursing Home Administrator completed an initial report to the state for drug diversion/misappropriation of property. The police were notified on 10/10/24. On 10/10/24, an audit of all medication carts was completed by unit managers to reconcile narcotic cards, declining count sheets for accuracy and shift change control count sheets. There were no concerns identified. On 10/10/24, an audit of the pharmacy integrated order alerts was completed by the DON to determine if any controlled substances were ordered early. No concerns were identified. On 10/10/24, in-service education was initiated by the Staff Development Coordinator/Unit Manager for all staff on abuse, neglect, and misappropriation of resident property. Education to be completed by 11/18/24. After 11/18/24 all staff not educated will be provided with the education on their next scheduled shift. New hires will be educated during orientation. On 10/28/24 an audit of the narcotic count will be completed by the Unit Manager/Clinical Care Coordinator weekly x 4 weeks, then monthly x 2 months to ensure compliance. Any areas of concern will be addressed by the DON at that time. Director of Nursing or Administrator will	

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F 602	Continued From page 24 scheduled to be given at 8:00 AM, 2:00 PM and 8:00 PM. A Packing Slip dated 07/11/24 from the Pharmacy revealed Oxycodone/Acetaminophen tablets 5-325 mg tablets, 90 tablets were received for Resident #17 and signed for by Agency Nurse #1. The declining narcotic count sheets indicated Resident #17 had 2 sheets for a total of 60 tablets instead of 3 sheets for a total of 90 tablets as received and signed for by Agency Nurse #1 on 07/11/24. The sheets had been altered at the top indicating there were 2 sheets (1 of 2 sheets and 2 of 2 sheets) received instead of 3 sheets (1 of 3 sheets, 2 of 3 sheets and 3 of 3 sheets) as indicated from the pharmacy at the top of the sheet as well as the packing slip from the pharmacy indicating 90 tablets with 3 sheets received. The declining narcotic count sheets indicated the last dose given was on 07/31/24 at 8:00 PM. There was no page 3, and 30 tablets were unaccounted for, for Resident #17. A telephone interview on 10/11/24 at 9:56 AM with Agency Nurse #1 who had signed for Resident #17's medications on 07/11/24 revealed she could not recall signing for the medications but stated if her signature was on the document then she had signed them in. She stated she did not remember how many tablets there were or how many declining count sheets there were attached to the medications. Nurse #1 further stated she did not recall altering the declining count sheets to say 1 of 2 sheets and 2 of 2 sheets instead of 1 of 3, 2 of 3 and 3 of 3 sheets from the pharmacy. She denied knowing anything about one of the sheets and one of the cards of medication going missing. Nurse #1 denied taking the medications	F 602	review medication cart audits weekly to ensure narcotic count is correct x 4 weeks and then monthly x 2 months. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 3 months or until a time determined by the Quality Assurance Performance Improvement (QAPI) members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. Date of Alleged Compliance: 11/19/2024	

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and sheet and denied knowing anything about anyone else taking the medications or sheet.

Review of Resident Council Meeting Minutes dated 08/19/24 revealed during the meeting when residents were asked about New Business concerns, Resident #17 stated in the meeting that she had not received her pain medications for 4 days.

The MAR for August 2024 revealed Resident #17 had not received her medication the following dates and times:
- August 1 8:00 AM, 2:00 PM and 8:00 PM
- August 2 8:00 AM, 2:00 PM and 8:00 PM
- August 3 8:00 AM, 2:00 PM and 8:00 PM
- August 4 8:00 AM, 2:00 PM and 8:00 PM
- August 5 8:00 AM and 2:00 PM for a total of 14 doses missed.

Review of Resident #17's significant change MDS dated 08/23/24 revealed she was cognitively intact and received scheduled pain medication and no as needed pain medication. The assessment also revealed the resident had almost constant pain at a level of 10 out of 1-10.

An interview on 10/10/24 at 10:03 AM with Resident #17 revealed she had gone over 4 ½ days the first of August without receiving her pain medication as ordered. She stated during that time she had an increase in her pain level to an 8 on a scale of 1-10, instead of her usual pain level of 1-3 with her medication. Resident #17 described a constant aching and throbbing pain in her right hip and constant pain in her joints due to arthritis. Additionally, Resident #17 stated she had three teeth extracted during this time which further increased her pain and described her

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mouth pain as a throbbing pain in her mouth. She stated the staff (couldn't remember names) kept telling her it was on order and had not come from the pharmacy and said one nurse (couldn't remember name) finally told her it was too soon to refill her prescription for her pain medication. Resident #17 said they didn't offer her any other medication or treatment for her pain during those 4 ½ days she went without her scheduled pain medication.

A telephone interview on 10/10/24 at 12:12 PM with the Pharmacy Manager stated on 07/11/24 90 tablets and 3 medication sheets were sent to the facility for Resident #17. The Pharmacy Manager stated they had received a new electronic script on 08/02/24 for Resident #17 but it was too early to refill because the 07/11/24 order should have lasted until 08/10/24. She further stated on 08/04/24 they received another electronic script, and it was still too early to refill the medication so on 08/05/24 they received approval from Unit Manager #2 to refill the medication and to bill the facility and send the medication out on special delivery. The Pharmacy Manager explained the medication had gone out on the afternoon of 08/05/24 to the facility and that usually their medication runs occurred during the night hours. She further explained that 90 tablets had been sent to the facility for Resident #17 along with 3 narcotic declining count records.

Review of an invoice from the Pharmacy dated 08/31/24 revealed on 08/05/24 90 pills were sent to the facility and billed to the facility for Resident #17.

A telephone interview on 10/10/24 at 2:42 PM

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with the former Director of Nursing (DON) revealed she had been the interim DON at the facility in August of 2024. She stated no one had reported to her that any resident was missing Percocet or any other medications. The former DON further stated she remembered vaguely that someone had run out of their pain medication but said she had been told it was because the physician had increased the dosage of medication not that there were medications missing. She indicated she did not authorize any medications being paid for by the facility while there and no one had told her that narcotics were missing while she was interim DON at the facility.

An interview on 10/10/24 at 4:35 PM with the Medical Director (MD) revealed she was not aware of missing medications for Resident #17 until just before this interview. She stated she was familiar with Resident #17 and her chronic pain and her concern with her not receiving her pain medication for over 4 days would have been her increased intensity in her pain. The MD further stated it seemed as though someone with access had diverted the medications belonging to Resident #17 and she would be mindful in the future of requests for refilling narcotic medications early.

A telephone interview on 10/11/24 at 2:04 PM with the Nurse Practitioner (NP) revealed she was not aware that Resident #17 was missing medications or that she had completely ran out of her medications. The NP stated it seemed as though someone had diverted her pain medication, and she would pay better attention to early requests for narcotic medication refills.

A telephone interview on 10/11/24 at 2:46 PM with

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F 602	Continued From page 28 the Consultant Pharmacist revealed they did monthly controlled substance inspections at the facility and looked in the books to ensure the count on the declining sheets matched the card count. She stated they looked at the carts and medication rooms for dates on medications, expired meds, and ensure medications were being stored appropriately. The Consultant Pharmacist further stated they might find a missed signature from time to time on medication sheets but had not noticed any medication sheets being altered or missing or missing cards of medication. She indicated it was unlikely they would have found an error such as this on their cart and medication room inspections because they spot checked the carts and medication rooms and this error would have been hard to identify with their current process. The Consulting Pharmacist further indicated an error like this should have been reported to the Medical Director and the pharmacy and should have been documented they were notified. An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed it was the expectation of the DON that resident's medications were not taken and unaccounted for and that residents received their medications as ordered by the providers. The DON stated she had been through all the files and was not able to locate the 3rd declining count sheet received on 07/11/24 for Resident #17. She further stated they could only assume the medications and sheet had been taken by one of the nurses with access to the medications and sheet.	F 602		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		11/19/24

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§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30

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days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to

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F 623	Continued From page 31 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the Regional Ombudsman when residents discharged or transferred from the facility for 6 of 6 months (April 2024, May 2024, June 2024, July 2024, August 2024, and September 2024). Findings included: Review of the facility's Admission/Discharge report for the period 04/01/24 to 09/30/24 revealed there were 149 residents who were discharged home, transferred to the hospital, or transferred to another nursing facility. During an interview on 10/09/24 at 12:03 PM, the Social Worker (SW) revealed since starting her employment in October 2023, she had not sent notifications to the Regional Ombudsman when residents discharged or transferred from the facility and wasn't aware that she needed to do so.	F 623	Audit completed for 6 of 6 months (April 2024, May2024, June 2024, July 2024, August 2024, and September 2024). All discharge notifications have been sent to the Ombudsman. On 10/14/24, the Nursing Home Administrator (NHA completed an audit of the last 30 days to ensure all discharges have been sent to the Ombudsman. On 10/14/24, the NHA initiated an in-service to the Social Worker related to our discharge process, and notification to the Ombudsman. This Includes all residents being issued a 30-day notice and monthly notifications of facility-initiated discharges. Per the Ombudsman's request the social worker will notify the Ombudsman of facility-initiated discharges on a monthly basis. The notification will be sent to the administrator as well. Any 30-day notice of discharges will be sent to the	

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F 623	Continued From page 32 During an interview on 10/09/24 at 10:16 AM, the Administrator revealed he had spoken with the SW and she had not been contacting the Regional Ombudsman to notify them of any resident discharges or transfers. The Administrator stated both he and the SW had no excuse as to why notifications were not sent to the Regional Ombudsman but they should be done anytime a resident discharged or transferred from the facility and there would be a process moving forward.	F 623	Ombudsman upon initiation of the 30-day notice. The NHA will review all transfer notifications monthly to ensure all discharges have been sent appropriately to the Ombudsman. All 30-day notices will be reviewed at the time they are issued, and monthly with the notification of all other discharges. Administrator will audit discharge notifications weekly for 4 weeks, and monthly for 2 months. Results of the audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 3 months or until a time determined by the Quality Assurance Performance Improvement (QAPI) members for sustained compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		11/19/24

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F 657	Continued From page 33 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, residents and staff interviews, the facility failed to invite residents to participate and provide input in care planning for 2 of 3 sampled residents (Residents #82 and #13). Findings included: 1. Resident #82 was admitted to the facility on 08/21/24 with diagnoses that included gout (type of arthritis that causes severe pain, swelling, redness and tenderness in joints), hypertension, severe protein-calorie malnutrition, and osteoarthritis of knee. The admission Minimum Data Set (MDS) assessment dated 08/27/24 revealed Resident #82 had intact cognition. Review of Resident #82's electronic medical record revealed no evidence he was invited to attend a care plan meeting to discuss and provide input regarding his plan of care following the completion of the admission MDS assessment dated 08/27/24. Review of the facility's Care Plan Meeting	F 657	On 10/31/2024, Resident #13 was invited to participate in a care plan meeting to provide input on his plan of care, which was held on 11/01/2024. Resident #82 is no longer in the facility. Prior to discharge the resident/responsible party was provided the opportunity to provide input into the discharge on 10/23/24. He was discharged on 10/26/24. On 11/05/24 an audit was completed of all resident care plan meetings to ensure that all residents and/or responsible party have been invited to participate and provide input during their individual care plan meetings. The Social Worker will address all concerns identified during the audit to include scheduling of a care plan meeting to provide the residents with an opportunity to participate and provide input on their care plans. The Nursing Home Administrator (NHA) will review the Care plan audit tool weekly for compliance. On 10/30/2024, the NHA conducted an in-service with Social Worker on Care Plans with emphasis on the need to provide residents with the opportunity to	

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F 657	Continued From page 34 Schedules for the period August 2024 - October 2024 revealed a care plan meeting with Resident #82 was not listed on the schedules. During an interview on 10/07/24 at 4:18 PM, Resident #82 did not recall being invited to participate in any care plan meetings since being admitted to the facility. During interviews on 10/09/24 at 12:02 PM and 10/10/14 at 10:27 AM, the Social Worker (SW) verified a care plan meeting had not been held with Resident #82 following the completion of his admission MDS assessment dated 08/27/24. The SW explained when she started her employment in October 2023, the previous SW had not wanted to train her and there was a lot that she did not know or was trained to do. The SW explained at the time, she really didn't have a process for ensuring care plan meetings were scheduled which resulted in care plan meetings falling through the cracks. She stated now, the process was for the receptionist to schedule the meeting and the SW would keep track of the meetings on a monthly calendar and facilitate the care plan meeting. The SW stated that sometimes the families of residents did not want the resident to attend the meeting so she did not invite the resident at the families' request. The SW stated she was unaware that residents should be invited and provided the opportunity participate in their care plan meeting but she would make sure she invited residents going forward. During an interview on 10/11/24 at 5:52 PM, the Administrator stated the SW was responsible for keeping track of the care plan meeting schedule and he expected the initial care plan meeting to	F 657	participate in their care plan meetings for their input related to their plan of care. Any newly hired social worker will be educated on facilitating resident participation in care plan meetings. The Director of Nursing/Unit Manager/Clinical Coordinator will conduct record review weekly x 4 weeks then monthly x 2 month for resident participation with care plan meetings. This audit is to ensure resident is invited to his or her care plan. NHA will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 2 months to ensure all concerns were addressed. This audit will be reviewed by the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months.	

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be conducted within 72-hours of a resident's admission to the facility and then completed quarterly. The Administrator stated the care plan meetings should be conducted with the entire Interdisciplinary Team (IDT) present to provide information related to the resident's progress with each discipline. If the IDT member was not able to attend the care plan meeting, he expected the IDT member to provide the information to the SW for her to review with the resident and/or their representatives during the care plan meeting.

2. Resident #13 was admitted to the facility on 08/09/24 with diagnoses that included rhabdomyolysis (breakdown of muscle tissue), hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, and diabetes.

The admission Minimum Data Set (MDS) assessment dated 08/22/24 revealed Resident #13 had intact cognition.

Review of Resident #13's electronic medical record revealed no evidence he was invited to attend a care plan meeting to discuss and provide input regarding his plan of care following the completion of the admission MDS assessment dated 08/22/24.

Review of the facility's Care Plan Meeting Schedules for the period August 2024 - October 2024 revealed no care plan meeting was scheduled for Resident #13 until October 24, 2024.

During an interview on 10/07/24 at 12:28 PM,

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Resident #13 stated that he had not been invited to participate in any care plan meetings since being admitted to the facility.

During interviews on 10/09/24 at 12:02 PM and 10/10/14 at 10:27 AM, the Social Worker (SW) verified a care plan meeting had not been held with Resident #13 following the completion of his admission MDS assessment dated 08/22/24. The SW explained when she started her employment in October 2023, the previous SW had not wanted to train her and there was a lot that she did not know or was trained to do. The SW explained at the time, she really didn't have a process for ensuring care plan meetings were scheduled which resulted in care plan meetings falling through the cracks. She stated now, the process was for the receptionist to schedule the meeting and the SW would keep track of the meetings on a monthly calendar and facilitate the care plan meeting. The SW stated that sometimes the families of residents did not want the resident to attend the meeting so she did not invite the resident at the families' request. The SW stated she was unaware that residents should be invited and provided the opportunity participate in their care plan meeting but she would make sure she invited residents going forward.

During an interview on 10/11/24 at 5:52 PM, the Administrator stated the SW was responsible for keeping track of the care plan meeting schedule and he expected the initial care plan meeting to be conducted within 72-hours of a resident's admission to the facility and then completed quarterly. The Administrator stated the care plan meetings should be conducted with the entire Interdisciplinary Team (IDT) present to provide

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F 657	Continued From page 37 information related to the resident's progress with each discipline. If the IDT member was not able to attend the care plan meeting, he expected the IDT member to provide the information to the SW for her to review with the resident and/or their representatives during the care plan meeting.	F 657		
F 660 SS=E	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and	F 660		11/19/24

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resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident

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F 660	Continued From page 39 information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family and staff interviews, the facility failed to have a discharge planning process in place that incorporated the resident in the development of a discharge care plan that addressed the resident's discharge goals and post-discharge needs for residents who wished to discharge to the community for 3 of 4 sampled residents (Residents #82, #13 and #137). Findings included: 1. Resident #82 was admitted to the facility on 08/21/24 with diagnoses that included gout (type of arthritis that causes severe pain, swelling, redness and tenderness in joints), hypertension, severe protein-calorie malnutrition, and osteoarthritis of knee. The admission Minimum Data Set (MDS) assessment dated 08/27/24 revealed Resident #82 had intact cognition with a discharge goal to return to the community. The MDS noted an active discharge plan was in place for Resident #82. The Social Service admission assessment dated 08/28/24 noted Resident #82's discharge goal was to return to the community. Review of Resident #82's comprehensive care plan, last reviewed/revised 10/09/24, revealed no discharge care plan.	F 660	On 10/28/2024, 10/23/24 and 11/04/2024, the Social Worker met with resident #13, #82 and #137 to ensure that a discharge planning process incorporated the resident in the development of a discharge care plan that addresses the residents discharge goals and post discharge needs, respectively. Resident #13 participated in a discharge care plan meeting on 10/28/24. Resident #137 participated in a discharge care plan meeting on 10/09/24. Resident #82 participated in a discharge care plan meeting on 10/23/24; he was discharged on 10/26/24. On 11/04/2024, Social Worker initiated review of all current residents to ensure that a discharge planning process incorporated the resident in the development of a discharge care plan that addresses the residents discharge goals and post discharge needs. The audit will be completed by 11/12/24. On 10/18/2024, the Nursing Home Administrator educated Social Worker on incorporating the resident with the development and implementation of an individualized discharge plan that focuses on the resident’s discharge goals and while facilitating a safe transition to post discharge care, and reduction of avoidable readmissions. Administrator will an audit of all new	

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F 660	Continued From page 40 During an interview on 10/07/24 at 4:18 PM, Resident #82 expressed his goal was to return home as soon as he was able. Resident #82 revealed that since being admitted to the facility, he did not recall having a discussion with facility staff regarding his discharge goals, plans or rehab progress. During an interview on 10/09/24 at 12:03 PM, the Social Worker (SW) explained when residents were first admitted to the facility, she met with the resident and/or Responsible Party (RP) to introduce herself, complete the initial assessment and then held a 72-hour care plan meeting with the resident/RP to discuss their goals. The SW stated after the initial 72-hour care plan meeting, she tried to visit with the resident weekly but didn't document the conversations. The SW stated she had not developed a discharge care plan for Resident #82 or any other resident. She stated care plans were completed by the MDS Coordinator. During an interview on 10/09/24 at 12:20 PM, the MDS Coordinator explained the development of a resident's comprehensive care plan was an Interdisciplinary Team effort and discharge care plans normally fell on the SW to complete. The MDS Coordinator stated she had not developed or completed any resident's discharge care plan. During an interview on 10/09/24 at 3:50 PM and follow-up interview on 10/11/24 at 5:52 PM, the Administrator stated for residents who admitted to the facility for short-term rehab, the discharge planning process should begin upon admission, updated based on the resident's progress and remain ongoing until the resident discharged. In	F 660	admissions weekly for 4 weeks, then monthly x 2 months utilizing the Discharge Planning Audit, related to incorporating the resident in their discharge care plan. Director of Nursing or Administrator will review audits and share results of audit with the Quality Assurance Performance Improvement (QAPI) members for 3 months or until a time determined by the Quality Assurance Performance Improvement (QAPI) members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. Alleged Compliance date 11/19/24	

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addition, he expected the initial care plan meeting to be held with the resident/RP within 72-hours to discuss the resident's overall goals. The Administrator explained that a discharge care plan should be developed as part of the discharge planning process that incorporated the resident's goals and wishes and updated based on the resident's therapy progress, goals and care needs.

2. Resident #13 was admitted to the facility on 08/09/24 with diagnoses that included rhabdomyolysis (breakdown of muscle tissue), hemiplegia (complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side, and diabetes.

The admission Minimum Data Set (MDS) assessment dated 08/22/24 revealed Resident #13 had intact cognition with a discharge goal to return to the community. The MDS noted an active discharge plan was in place for Resident #13.

Review of Resident #13's comprehensive care plan, last reviewed/revised 08/26/24, revealed no discharge care plan.

During an interview on 10/07/24 at 12:28 PM, Resident #13 stated he wanted to return home but was not sure when that would be. Resident #13 stated no one at the facility has talked with him about his discharge goal, plans or needs.

During an interview on 10/09/24 at 12:03 PM, the Social Worker (SW) explained when residents were first admitted to the facility, she met with the

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resident and/or Responsible Party (RP) to introduce herself, complete the initial assessment and then held a 72-hour care plan meeting with the resident/RP to discuss their goals. The SW stated after the initial 72-hour care plan meeting, she tried to visit with the resident weekly but didn't document the conversations. The SW stated she had not developed a discharge care plan for Resident #13 or any other resident. She stated care plans were completed by the MDS Coordinator.

During an interview on 10/09/24 at 12:20 PM, the MDS Coordinator explained the development of a resident's comprehensive care plan was an Interdisciplinary Team effort and discharge care plans normally fell on the SW to complete. The MDS Coordinator stated she had not developed or completed any resident's discharge care plan.

During an interview on 10/09/24 at 3:50 PM and follow-up interview on 10/11/24 at 5:52 PM, the Administrator stated for residents who admitted to the facility for short-term rehab, the discharge planning process should begin upon admission, updated based on the resident's progress and remain ongoing until the resident discharged. In addition, he expected the initial care plan meeting to be held with the resident/RP within 72-hours to discuss the resident's overall goals. The Administrator explained that a discharge care plan should be developed as part of the discharge planning process that incorporated the resident's goals and wishes and updated based on the resident's therapy progress, goals and care needs.

3. Resident #137 was admitted to the facility on 09/27/24 with diagnoses that included right pubis

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fracture (one of the bones in the pelvis), multiple myeloma (cancer of the plasma cells) and chronic pain.

The Nursing Admission Assessment completed on 09/27/24 revealed that Resident #137 was able to communicate her needs and be understood. Resident #137 required supervision or touching assistance with eating and substantial/maximal assistance with all other self-care tasks, bed mobility and transfers.

The Social Service admission assessment dated 10/01/24 noted Resident #137's discharge goal was to return to the community.

An interview was conducted with Resident #137 and her family member on 10/07/24 at 3:50 PM. Both Resident #137 and her family member stated that her goal was to receive therapy services and discharge home as soon as possible. Both Resident #137 and the family member expressed that staff had not met with them to discuss Resident #137's discharge goals, plans or treatment needs. Both Resident #137 and the family member stated the only discussion they have had with staff thus far was regarding her insurance right after Resident #137 first admitted to the facility.

An interview was conducted with Resident #137's Responsible Party (RP) on 10/09/24 at 9:25 AM with Resident #137 and her family member present. The RP stated no one had met with him or Resident #137 to discuss her discharge plans and voiced frustration over the lack of communication regarding Resident #137's therapy progress. The RP stated he received a call from facility staff about a week ago and a

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F 660	Continued From page 44 care plan meeting was scheduled for 10/24/24 which would be almost a month since she was admitted to the facility. The RP explained Resident #137's rehab stay was covered for the first 20 days and starting day 21, she would have to start paying a copay and they had planned on her returning home before that. During an interview on 10/09/24 at 12:03 PM, the Social Worker (SW) explained when residents were first admitted to the facility, she met with the resident and/or RP to introduce herself, complete the initial assessment and then held a 72-hour care plan meeting with the resident/RP to discuss their goals. The SW stated she did not conduct a 72-hour care plan with Resident #137 or her RP and was not sure what happened, it just fell through the cracks. The SW stated she had not developed a discharge care plan for Resident #137 or any other resident. During an interview on 10/09/24 at 3:50 PM and follow-up interview on 10/11/24 at 5:52 PM, the Administrator stated for residents who admitted to the facility for short-term rehab, the discharge planning process should begin upon admission, updated based on the resident's progress and remain ongoing until the resident discharged. In addition, he expected the initial care plan meeting to be held with the resident/RP within 72-hours to discuss the resident's overall goals. The Administrator explained that a discharge care plan should be developed as part of the discharge planning process that incorporated the resident's goals and wishes and updated based on the resident's therapy progress, goals and care needs.	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		11/19/24

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F 677	Continued From page 45 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, and resident, family member, and staff interviews, the facility failed to clean and trim nails on both hands of a dependent resident and failed to shave chin hairs on a dependent resident for 1 of 3 dependent residents reviewed for activities of daily living (Resident #43). The findings included: Resident #43 was readmitted on 04/19/23. Her diagnoses included diabetes mellitus type II, osteoporosis, and dementia. Resident #43's Care Area Assessment for activities of daily living (ADL) dated 07/14/24 revealed she needed assistance from staff with all activities of daily living due to her diagnoses of dementia, hemiplegia following a stroke affecting her left non-dominant side and osteoporosis. Resident #43's quarterly Minimum Data Set (MDS) assessment dated 09/11/24 revealed she was moderately cognitively impaired but was able to make her needs known. The assessment also revealed Resident #43 required substantial to maximal assistance with showering and bathing and required partial to moderate assistance with personal hygiene. The resident had no behaviors of rejection of care.	F 677	On 10/9/24 the Unit Manager observed that resident #43's nails were trimmed and were free of debris and chin hair had been trimmed. On 10/18/24, the Director of Nursing (DON) and Unit Manager (UM) completed an audit of ADL care of all dependent residents to include nail care and facial hair. This audit is to ensure all residents were assisted with ADL care. If care is refused, that it is documented in the electronic record. The DON/UM addressed any concerns identified during the audit on 10/18/24. On 10/15/2024, the Unit Managers and Staff Development Coordinator (SDC) initiated an in-service with all licensed nurses, medication aides and certified nursing assistants regarding ADL care with emphasis on ensuring nails are clean and trimmed per resident preference and facial hair groomed per resident preference for all dependent residents. In-services will be completed by 11/18/24. After 11/18/24 any licensed nurse, Medication aides or certified nursing assistants, to include agency staff who have not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired licensed nurses, medication aides, certified nursing	

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F 677	Continued From page 46 Review of Resident #43's care plan last revised on 10/05/24 revealed she had a focus area for requiring assistance with activities of daily living (ADL) related to left sided hemiplegia from previous stroke. The interventions included in part, bed mobility required substantial to maximal assistance, showers/bathing required substantial to maximal assistance and personal hygiene required partial to moderate assistance from staff. An observation on 10/07/24 at 3:43 PM revealed Resident #43 resting in her bed eating crackers with her nails noted to be ¼ inch beyond the end of her fingers with brown debris under all the nails on both her hands. Resident #43 was also noted to have visible white chin hairs that were ¼ inch long on her chin. An interview with the resident revealed she did not like her nails to be long and would like for them to be trimmed and cleaned on both hands and said she didn't like having chin hairs and would like for someone to trim them off her chin for her. Resident #43 stated her family member usually had to trim her nails and the chin hair off her chin because the staff at the facility didn't offer to do it for her. She further stated her family member had not been able to come to the facility to visit her because she had fallen and broken her arm. A telephone interview on 10/11/24 at 3:55 PM with Agency Nurse Aide (NA) #8 revealed she had taken care of Resident #43 on 10/07/24 during the 7:00 AM to 3:00 PM shift and had given her a complete bed bath. Agency NA #8 stated she knew Resident #8 had long nails, but she was not used to taking care of her, so she didn't trim her nails. She further stated she had not reported to Unit Manager #2 that her nails were long and needed trimming. Agency NA #8 said she did not	F 677	assistants and agency staff will be in-serviced during orientation for ADL care. The UM and SDC will audit with Nail and Facial Hair Audit Tool for 10 residents a week for 4 weeks, then 10 residents a month for 2 months to ensure all concerns are addressed. The DON will review the Nail and Facial Hair Audit Tool weekly x 4, then monthly x 2 months to ensure all concerns are addressed. The DON will share the results of ADL Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months to determine trends and/or issues that may need further interventions put into place and to determine the need for further monitoring.	

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F 677	Continued From page 47	F 677		

usually trim chin hairs on women and said she had not asked Resident #43 if she wanted her chin hairs trimmed and had not reported to Unit Manager #2 that her chin hairs needed to be trimmed. She indicated she was not aware she was expected to trim chin hairs on women.

An observation on 10/08/24 at 4:32 PM revealed Resident #43 resting in her bed and her nails were still long with brown debris under them and she still had visible white chin hairs on her chin. She stated she had received a bed bath on 10/07/24 but her nails had not been trimmed and she had not had her chin hairs shaved during her bath.

Review of the shower schedule revealed Resident #43 was scheduled for showers/bed baths on Monday and Thursday on 2nd shift (3:00 PM to 11:00 PM).

An interview on 10/09/24 at 3:15 PM with Nurse Aide (NA) #11 revealed she had taken care of Resident #43 on 10/08/24 and 10/09/24 during the 7:00 AM to 3:00 PM shift and stated she had not noticed Resident #43's nails being long or being dirty on both her hands. NA #11 stated she had not given her a bath on the days she had cared for her and had not paid attention to her nails or the hair on her chin. She stated usually resident's nails are trimmed and they are shaved on their shower days, and she had not provided Resident #43's shower when she cared for her on 10/08/24 and 10/09/24. NA #11 further stated she believed Resident #43 was diabetic and her nails would have to be trimmed by the nurse but said she had not reported her nails needing to be trimmed to Unit Manager #2.

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F 677	Continued From page 48 An observation on 10/09/24 at 3:03 PM revealed Resident #43 lying in bed with her family member at her bedside. Her nails were trimmed and cleaned, and her chin hairs had been shaved. The family member stated she had trimmed and cleaned the brown debris from under Resident #43's nails and shaved her chin hairs because the staff at the facility would not do it even though she had requested the resident's nails to be trimmed and kept clean and her chin hairs shaved from her face. The family member further stated she had not been able to visit for 3 weeks because she had fallen and broken her arm and had to heal herself. She indicated to her knowledge the facility staff had never offered to trim Resident #43's nails or shave the chin hairs from her face, so she tried to do it, but it had been difficult today with her broken arm. An interview on 10/10/24 at 2:54 PM with Unit Manager #2 revealed she was not aware, and no one had told her that Resident #43's nails were long and needed to be trimmed. She stated her nails would have to be trimmed by a nurse since she was diabetic but the NAs caring for her should keep them clean and they shouldn't have brown debris under the nails. Unit Manager #2 further stated that shaving residents both male and female was part of their routine when giving residents bed baths or showers and said Resident #43 should have been shaved on Monday when she received her bed bath. She indicated she was not aware the resident's family member had requested the resident be shaved and her fingernails trimmed but said it should be part of her routine ADL care and her family member should not have to trim her fingernails or shave her chin hairs. She further indicated that should be done by the facility staff.	F 677		

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F 677	Continued From page 49 An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) revealed she expected residents to have their nails trimmed and cleaned and be shaved as part of their bed bath or shower. She stated the NAs should report to the nurses or Unit Managers any diabetic residents with nails that needed to be trimmed, and they should be trimming the other resident's nails. The DON further stated all residents that wanted to be shaved male or female should be shaved as part of their ADL care.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to apply compression wraps daily per the physician's order for 1 of 1 resident (Resident #57) reviewed for edema (swelling). Findings included: Resident #57 was admitted to the facility on 09/28/23 with diagnoses that included lymphedema (chronic condition that causes swelling, most often in the arms or legs, due to a	F 684	On 10/07/24, nursing staff applied the compression wraps as ordered for resident #57 with documentation captured on the TAR. On 10/12/2024, all resident treatment orders were audited for application of compression wraps. All residents had their wraps applied per physician's order. There were no abnormal findings. On 10/11/24, the Staff Development Coordinator initiated an in-service with all nurses and agency staff on application of	11/19/24

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F 684	Continued From page 50 buildup of lymph fluid). The quarterly Minimum Data Set (MDS) assessment dated 07/06/24 revealed Resident #57 had intact cognition. She required substantial/maximum staff assistance with lower body dressing and received application of nonsurgical dressings other than to feet. It was further noted that Resident #57 had not rejected care during the MDS assessment reference period. An active physician's order dated 08/23/24 for Resident #57 read in part, apply compression garments (wraps) in the morning daily for 8 to 12 hours. Remove at night and elevate legs. Every shift for lymphedema of bilateral lower extremities. Review of the staff progress notes for October 2024 revealed no entries related to Resident #57 refusing application of the compression wraps. An observation and interview was conducted with Resident #57 on 10/07/24 at 4:08 PM. Resident #57 was sitting up in her motorized wheelchair, there was swelling noticed to both lower legs and she had no compression wraps applied. A rolling walker was placed at the end of Resident #57's bed and lying on the seat of were two compression wraps. Resident #57 stated she was supposed to wear the compression wraps on her lower legs due to edema and never refused to have them applied. Resident #57 explained she couldn't put them on herself and staff did not consistently apply them for her. Resident #57 stated staff did not apply the compression wraps on Thursday (10/3/24) or Friday (10/04/24) and had yet to apply them today (10/07/24).	F 684	compression wraps as ordered by the physician/nurse practitioner, documentation of application, and documentation for refusal of treatment. Any licensed nursing staff or agency staff not in serviced on by 11/18/24 will be in serviced before their next scheduled shift. Any newly hired nursing staff will be educated on the application of compression wraps during the orientation process. On 10/28/2024 an audit will be completed for all residents with compression wraps was completed by the Unit Manager (UM) to be completed 3 times weekly x 4 weeks, then 4 times monthly x 2 months.(This audit is to ensure all residents with compression wraps are completed and documented. The DON will address any concerns identified during the audit to include re-training of nursing staff. The Director of Nursing will present the findings of the Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to determine further needs and address as appropriate.	

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F 684	Continued From page 51	F 684		

Review of Resident #57's Treatment Administration Record (TAR) for October 2024 revealed the compression wraps were initialed as applied daily except for 10/03/24 and 10/04/24. Further review revealed Nurse #5 initialed the TAR as applying the compression wraps on 10/07/24.

During an interview on 10/11/24 at 10:04 AM, the Wound Nurse revealed he worked the medication cart on 10/03/24 when he was on-call and could not recall if he had offered to apply Resident #57's compression wraps. He stated if he had, it would not have been until late in the afternoon. The Wound Nurse stated Resident #57 had told him that her compression wraps were not applied last Thursday (10/03/24) or Friday (10/04/25) and typically didn't get applied when he or the weekend Wound Nurse were not working.

During a telephone interview on 10/11/24 at 12:54 PM, Nurse #5 revealed she had offered to apply Resident #57's compression wraps on 10/04/24 but she had refused. Nurse #5 stated she had meant to document the refusal on Resident #57's TAR but she must have got distracted and forgot.

During a telephone interview on 10/11/24 at 1:43 PM, Nurse #6 revealed she was assigned to do treatments on 10/07/24 but did not have Resident #57 on her list of treatments completed that day. Nurse #5 confirmed it was her initials that were noted on Resident #57's TAR for 10/07/24 and explained it was initialed as completed by mistake because she did not apply Resident #57's compression wraps that day.

During an interview on 10/11/24 at 4:25 PM, the

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F 684	Continued From page 52 Director of Nursing (DON) stated Resident #57 did not typically refuse to have her compression wraps applied by staff, she might delay having them put on until after her shower but not refuse completely. The DON was unaware Resident #57's compression wraps were not applied by staff on 10/3/24, 10/04/24 or 10/07/24. She stated she would expect for the physician order to be followed and if the treatment nurse was not doing treatments, hall nurses were responsible for checking the TAR and completing treatments.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		11/19/24

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F 690	Continued From page 53 prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to secure an indwelling urinary catheter tubing to prevent tension or trauma for 1 of 3 residents reviewed for urinary catheter (Resident #63). The finding include: Resident #63 was admitted to the facility on 07/01/24 with diagnoses that included benign prostatic hyperplasia (enlarged prostate which can cause urinary obstruction). The admission Minimum Data Set assessment dated 07/06/24 revealed Resident #63's cognition was moderately impaired and had an indwelling urinary catheter. Review of Resident #63's care plan revised 07/10/24 that addressed the use of an indwelling urinary catheter related to benign prostatic hyperplasia. The goal that he would be free of urinary tract infections would be attained by utilizing interventions that include following catheter care policies and procedures and abiding by enhanced barrier precautions.	F 690	On 10/11/24, the Unit Manager placed a stat lock indwelling catheter securing device to the indwelling urinary catheter to prevent tension or trauma for resident #63. On 10/15/2024 residents with urinary catheter bags were observed for a securement device for their indwelling urinary catheter by the DON. No areas of concern identified. On 10/15/2024 the Staff Development Coordinator initiated an in-service with all nurses, medication assistants and nursing assistants, to include agency and contract staff on ensuring catheter bags are secured by a leg strap or catheter securing device applied to the indwelling urinary catheter. All staff will be in serviced by 11/18/2024. After 11/18/2024, all staff not in serviced will be in serviced before their next scheduled shift. All new hires will be in serviced during the orientation process. All residents with indwelling urinary catheters will be observed weekly x 4 weeks, then monthly x 2 months for utilizing the catheter securement device.	

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F 690	Continued From page 54 Review of Resident #63's physician order dated 08/20/24 indicated indwelling urinary catheter due to benign prostatic hyperplasia. On 10/07/24 at 12:56 PM during an observation and interview with Resident #63 while sitting up in his wheelchair, the Resident wore pants, and the catheter tubing was threaded down his left pant leg and the catheter bag was contained in a catheter bag holder which was hooked to the wheelchair bars. When the Resident was asked if the catheter tubing had a stabilizing device attached to his leg to prevent pulling on the tubing he replied, "sometimes but not now, I don't always have one." On 10/08/24 at 10:42 AM Nurse Aide (NA) #1 and Medication Aide (MA) #1 was in Resident #63's room to provide morning care. Before providing catheter care it was noted that there was no stabilizing device in place to prevent pulling or trauma related to the catheter. The MA located the Wound Nurse who came into the Resident's room and applied a sure lock tape on the Resident's left thigh and secured the catheter tubing during the observation. During interviews with the Wound Nurse and MA #1 on 10/08/24 at 10:42 AM the MA explained that sometimes the staff remove it when they give him a shower and when the MA was asked if Resident #63 had a shower that morning the MA indicated he had not. The MA and Wound Nurse stated there should be a stabilizing device in place for every indwelling urinary catheter. An interview was conducted with the Director of Nursing (DON) on 10/11/24 at 10:11 AM. The DON explained that every catheter should have a	F 690	The DON will address all concerns identified during the audit. The Director of Nursing will present the findings of the Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to look for trends and issues. The QAPI Committee will determine the duration needed to ensure lasting compliance.	

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F 690	Continued From page 55 stabilizing device in place to prevent trauma caused by pulling on the catheter tubing.	F 690		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents, staff, Nurse Practitioner (NP), and the Medical Director (MD), the facility failed to ensure a resident's pain was assessed and that she received her pain medication to treat acute throbbing mouth pain from teeth being extracted and chronic constant aching and throbbing pain in her right hip for 1 of 3 residents reviewed for pain management (Resident #17). As a result of the resident not getting her pain medication as prescribed, her pain level increased to an 8 on a scale of 1 to 10 when her usual pain level was 0 to 3 when taking her pain medication as prescribed three times a day. The findings included: Resident #17 was admitted to the facility on 11/23/21 with diagnoses which included debility, arthritis, and chronic pain. The physician's order dated 10/25/23 revealed Resident #17 had an order to receive one tablet of oxycodone-Acetaminophen oral tablet 5-325 milligrams (mg) (a type of opioid analgesic	F 697	On 10/21/24, Resident #17 attended her regularly scheduled pain management appointment for follow-up. New orders were received and implemented at the facility. The resident was educated on the new orders received from the pain clinic with no concerns voiced at this time. On 10/11/24, all residents with a BIMS of 13 or greater were interviewed related to their satisfaction with the effectiveness of their current pain management interventions. Providers notified of any areas of concern and notified when physician orders are not followed. On 10/11/24 all resident with BIMS of 12 or less had pain assessments completed with no adverse findings. On 10/11/24, the Director of Nursing initiated education to all nursing staff on notification of changes to physician/nurse practitioner to include new onset pain and/or unresolved pain. On 10/11/24 Education was initiated by the Staff Development Coordinator (SDC)/Clinical Care Coordinator to all	11/19/24

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F 697	Continued From page 56 consisted of oxycodone/acetaminophen that acted on the central nervous system to relieve pain) by mouth three times a day for pain. The medication was scheduled to be given at 8:00 AM, 2:00 PM and 8:00 PM. Review of Resident #17's Nurse Practitioner progress note dated 07/01/24, Resident #17's arthritis was described as polyosteoarthrits of multiple joints including right hip, left hip, bilateral knees and shoulders. According to the note the resident was being followed by the local pain clinic for assistance in managing her pain. Resident #17's topical pain patch was changed from as needed to scheduled one time a day to help with pain. Review of the physician's orders for August 2024 revealed Resident #17 was on the following medications for pain in addition to the oxycodone-acetaminophen oral tablet 5-325 mg by mouth three times a day: - Salonpas Pain Relieving External Patch 4% (Lidocaine) apply to right hip topically one time a day for hip pain with a start date of 07/02/24. Patch scheduled for 9:00 AM - Acetaminophen oral tablet give 1000 mg by mouth two times a day for chronic pain give as an alternating dose with oxycodone/acetaminophen with start date of 10/18/23. Tablets scheduled at 11:00 AM and 5:00 PM. - Diclofenac sodium external gel 1% (topical) apply 2 grams to left and right hip for arthritic pain two times daily. Scheduled for day and evening. - Diclofenac sodium external gel 1% (topical) apply 2 grams to right shoulder for arthritic pain two times daily. Scheduled for day and evening. Review of a dental care note dated 08/01/24 for	F 697	licensed nurses and agency staff on proper pain management by. This will be completed by 11/18/24. After 11/18/24, licensed nurses and agency staff not educated will be educated prior to their next scheduled shift. An audit of fifteen residents weekly with complaints of pain will be completed by the Unit Manager/ Clinical Care Coordinator to review for appropriate interventions by review of the resident assessment and monitoring of progress notes for 15 residents a week times x 4 weeks, then 15 residents a month x 2. Any areas of concern will be addressed by nursing leadership. Director of Nursing or Administrator will review weights and vitals summary audits weekly for 4 weeks, and then monthly for 2 months looking for trends or unresolved pain. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 3 months or until a time determined by the Quality Assurance Performance Improvement (QAPI) members for sustained compliance.	

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Resident #17 she had three teeth extracted on 08/01/24 at 12:46 PM. Teeth #9, #10, and #11 were extracted under local anesthetic and sutures placed for closure that would dissolve in 5 days. Resident #17 was given antibiotics prior to the dental appointment but no pain medication was administered.

Review of Resident Council Meeting minutes dated 08/19/24 revealed during the meeting when residents were asked about New Business concerns, Resident #17 stated that she had not received her pain medications for 4 days the beginning of August 2024.

The Medication Administration Record (MAR) for August 2024 revealed Resident #17 had not received her medication of oxycodone-acetaminophen 5-325 mg one tablet by mouth at 8:00 AM, 2:00 PM and 8:00 PM the following dates and times, the blocks on the MAR for these dates and times was blank and there was no indication of what her pain level was on these dates and times:
- August 1 8:00 AM, 2:00 PM and 8:00 PM
- August 2 8:00 AM, 2:00 PM and 8:00 PM
- August 3 8:00 AM, 2:00 PM and 8:00 PM
- August 4 8:00 AM, 2:00 PM and 8:00 PM
- August 5 8:00 AM and 2:00 PM for a total of 14 doses missed

Continued review of the MAR revealed on the following dates and times, Nurse #3 had taken care of Resident #17 and had not administered her Percocet and there was no indication of what her pain level was on these dates and times:
- August 1 at 8:00 AM and 2:00 PM
- August 3 at 8:00 AM, 2:00 PM and 8:00 PM
- August 4 at 8:00 AM and 2:00 PM

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A telephone interview was attempted with Nurse #3; however, the number had been disconnected and Nurse #3 was no longer employed through the agency.

Continued review of the MAR revealed on August 1 and August 2 at 8:00 PM Medication Aide (MA) #2 had taken care of Resident #17 and had not administered her Percocet on those days and times and there was no indication of what her pain level was on those dates and times.

An interview on 10/10/24 at 3:31 PM with MA #2 revealed she did not recall the evening she cared for Resident #17 but stated usually if there were no medications available for a resident, she reported it to the nurse supervising her and the nurse would contact the pharmacy or the physician for orders. MA #2 stated if it was not signed out then she had not given the medication. She further stated she could not recall if the resident had complained of pain with not getting her narcotic medication.

Continued review of the MAR revealed on the following dates and times, Nurse #2 had taken care of Resident #17 and had not administered her Percocet on those dates and times and there was no indication of what her pain level was on those dates and times:
- August 2 at 8:00 AM and 2:00 PM
- August 5 at 8:00 AM and 2:00 PM

A telephone interview on 10/10/24 at 4:00 PM with Nurse #2 revealed she couldn't recall the specifics but stated generally if a resident does not have their medication, she typically contacted the pharmacy and then if a script was needed,

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she would contact the Nurse Practitioner to send an electronic script to the pharmacy for the medication. Nurse #2 stated she couldn't recall if they had oxycodone with acetaminophen in their narcotic Emergency Kit but stated she felt like if they had she would have given it from the Emergency Kit. She further stated she could not recall if the resident had complained of pain with not getting her narcotic medication and could not recall if she had complained of mouth pain from having her teeth extracted.

Continued review of the MAR revealed on August 4 at 8:00 PM Nurse #4 had taken care of Resident #17 and had not administered her Percocet on that day and time and there was no indication of what her pain level was at that time or if she had any acute mouth pain from her teeth being extracted.

A telephone interview was attempted several times with Nurse #4 without success.

Continued review of the MAR revealed on August 5 at 8:00 PM when Resident #17 received her pain medication her pain level was 8 on a scale of 1-10.

The Emergency Medication Kit for Controlled Substances revealed there were no Percocet in the kit at the facility available to administer to residents.

Review of the nursing progress notes revealed the following:
- 08/02/24 at 11:54 PM resident verbalized she's in constant pain in her right hip at a level of 10 for the last 5 days and level 8 while talking with this nurse.

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- 08/03/24 at 03:56 AM resident awake at intervals tonight. Inquired about pain medications and informed it was on order and awaiting pharmacy to send it.

A telephone interview was attempted several times with Nurse #7 who wrote the above progress notes without success.

Review of Resident #17's significant change MDS dated 08/23/24 revealed she was cognitively intact and received scheduled pain medication but no as needed (prn) pain medication. The assessment also revealed the resident had almost constant pain at a level of 10 out of 1-10.

Review of Resident #17's care plan last revised on 09/14/24 revealed a focus area for chronic pain related to impaired mobility, leukemia, diabetes mellitus, type II, arthritis and coronary artery disease. The interventions included in part, administering pain medication as per MD orders and note effectiveness, and notify physician if pain management is not effective.

An interview on 10/10/24 at 10:03 AM with Resident #17 revealed she had gone several days, like over 4 days without receiving her pain medication as ordered. She stated during that time she had an increase in her pain level to an 8 instead of a 0 to 3 with her medication. She described having a constant aching, throbbing pain in her right hip and aching pains throughout her body due to arthritis in her joints. Resident #17 also described a throbbing pain in her mouth due to her teeth being extracted and being without her pain medication. She stated the staff (couldn't remember names) kept telling her it was on order and had not come from the pharmacy

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and one nurse (couldn't remember name) finally told her it was too soon to refill her prescription for her pain medication. Resident #17 said they didn't offer her any other medication or treatment for her pain during those 4 ½ days she went without her scheduled pain medication. The resident further said it made it difficult without her pain medication to get up during the day and found herself lying back down and sleeping more during the day and then having trouble sleeping at night. Resident #17 indicated she had not been offered ice or heat to help with her constant pain and had used her topical Biofreeze (topical pain relief product that uses menthol to soothe minor muscle and joint pain), patch and topical gel but none of them really helped the pain she had like her pain medication.

A telephone interview on 10/10/24 at 12:12 PM with the Pharmacy providing medications to the facility revealed during a conversation with the Pharmacy Manager that on 07/11/24 90 tablets were sent to the facility for Resident #17. The Pharmacy Manager stated they had received a new electronic script on 08/02/24 and 08/04/24 for Resident #17 but it was too early to refill because the 07/11/24 order should have lasted until 08/10/24. Then on 08/05/24 they received an approval from Unit Manager #2 to refill the medication and to bill the facility and send the medication out on special delivery. The Pharmacy Manager explained the medication had gone out on the afternoon of 08/05/24 to the facility.

An interview on 10/10/24 at 4:35 PM with the Medical Director (MD) revealed she was not aware that Resident #17 had missed 14 consecutive doses or her narcotic medication for

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chronic pain until just before this interview. She stated she was familiar with Resident #17 and her chronic pain and the acute pain she had suffered getting her teeth pulled during this time and her concern with the resident not receiving her pain medication for over 4 days would have been her increased intensity in her pain. The MD further stated the facility staff should have told the Nurse Practitioner that she was out of her pain medication so she could have given orders for something else in the meantime while awaiting her medication from the pharmacy. The MD indicated it should have been made clear to the Nurse Practitioner that the resident was completely out of her medications and not that she just needed a refill script. The MD further indicated Resident #17 should have had her medication to keep her pain at a level that was manageable.

A telephone interview with the Nurse Practitioner (NP) caring for Resident #17 revealed she was unaware the resident had gone over 4 days in a row without her pain medication and had missed 14 consecutive doses. She stated she tried to stay on top of ordering her medications due to her chronic pain but said she had not been notified that she was completely out or had not received her medications for over 4 days. The NP stated she was surprised the resident had not mentioned it to her unless she just didn't see her during that time. She further stated her concern with Resident #17 not receiving her medications for that period would have been the increase in intensity of her pain because of the chronic nature of her pain and the acute pain she suffered getting her teeth extracted. The NP stated she should not be going that long without her medicine and that she would have expected

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F 697	Continued From page 63 the nursing staff to have called her and told her she was out of her medicine and not just that she needed a refill prescription. An interview on 10/11/24 at 6:10 PM with the Director of Nursing (DON) and Administrator revealed it was the expectation of the DON that resident's pain medications were administered as ordered by the providers. The DON further stated the nurses should have made it clear to the Nurse Practitioner that Resident #17 was out of her pain medication so the NP could have ordered additional medication to relieve the resident's acute pain from her teeth being extracted and chronic pain she was suffering in her hip and other joints.	F 697		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		11/19/24

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F 842	Continued From page 64 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 65 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain accurate Treatment Administration Records (TAR) for 1 of 4 residents reviewed for pressure ulcers (Resident #238). The findings include: a. Review of Resident #238's medical record revealed a physician order dated 02/17/2024 to cleanse sacral pressure ulcer with wound cleanser and pat dry then apply non-adhesive pad then cover with foam dressing every day and as needed. Review of Resident #238's 02/2024 TAR revealed there was no documentation on 02/27/2024 to indicate the treatment was completed as ordered. An interview was conducted with former Wound Nurse #1 on 10/09/2024 at 7:01 AM who was assigned to perform pressure ulcer treatments on 02/27/2024. Wound Nurse #1 explained that she remembered Resident #238 and when she performed the Resident's admission skin assessment on 02/16/2024 the Resident had a stage II pressure ulcer on her sacrum. Wound Nurse #1 reported she worked Monday through Friday, but she was also responsible to take call which meant if she was called into work during the week after her first shift, she was scheduled off the following day and the pressure ulcer	F 842	On 10/09/2024 it was identified that Resident #238 did not have appropriate documentation on her TAR on 2/27/2024. Resident #238 discharged from the facility on 5/20/24. On 10/31/2024 an audit of all residents Treatment Administration Record (TAR) was completed by the Director of Nursing (DON) for required documentation. Any discrepancies will be addressed by the DON and immediately corrected as indicated to include appropriate documentation or completion of prescribed treatment. On 10/21/24 the Unit Managers/Staff Development Coordinator initiated education to all nurses and medication aides, regarding appropriate documentation for Treatment Administration Record to include appropriate documentation and completion of prescribed treatment. All licensed Nurses, Medication Aides and agency staff will be educated by 11/18/24. After 11/18/24 all staff not in serviced will be in serviced before their next scheduled shift. All newly staff and agency staff will be educated during the orientation process.	

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F 842	Continued From page 66 treatments were left up to the nurse on the hall to perform. Wound Nurse #1 stated she could not verify whether 02/27/2024 was one of those days she was off or whether she forgot to initial for the treatment. She indicated it was possible that she overlooked initialing it. Review of Resident #238's 03/2024 TAR revealed there was no documentation on 03/15/2024, 03/20/2024, 03/25/2024 and 03/29/2024 to indicate the treatment was completed as ordered. An interview was conducted with former Wound Nurse #1 on 10/09/2024 at 7:01 AM who was assigned to perform pressure ulcer treatments on 03/15/2024. Wound Nurse #1 explained that she could not confirm whether she was scheduled to perform the treatments on 03/15/2024 and stated it was possible she forgot to initial for the treatment. An interview was conducted with Nurse #8 on 10/10/2024 at 2:31 PM who worked on 03/20/2024 and 03/29/2024 first shift. Nurse #8 explained she vaguely remembered Resident #238 and did not recall whether she performed the pressure ulcer treatment or not. The facility was unable to identify the initials of the nurse who worked the hall on 03/25/2024 first shift in order to obtain an interview. Review of Resident #238's 04/2024 TAR revealed there was no documentation on 04/10/2024 to indicate the treatment was completed as ordered. An interview was conducted with Nurse #8 on 10/10/2024 at 2:31 PM who worked on 04/10/2024 first shift. Nurse #8 explained she	F 842	The Unit Manager or Clinical Care Coordinator will complete audits with TAR Audit Tool for 10 residents a week for 4 weeks, then 10 residents a month x 2 months to audit TAR's for accuracy of documentation. The DON will review the TAR Audit Tool weekly x 4 weeks and monthly x 2 months to ensure all concerns were addressed. The DON will forward the results of TAR Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. The QAPI Committee will meet and review the ADL Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further monitoring.	

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vaguely remembered Resident #238 and did not recall whether she performed the pressure ulcer treatment or not.

b. Review of Resident #238's medical record revealed a physician order dated 04/24/2024 to cleanse sacral pressure ulcer with wound cleanser and apply crushed metronidazole (antibiotic) and collagenase ointment (used to debride) then cover with a silver fortified dressing and an island dressing every day.

Review of Resident #238's 04/2024 TAR revealed there was no documentation on 04/25/2024 to indicate the treatment was completed as ordered.

An interview was conducted with Nurse #8 on 10/10/2024 at 2:31 PM who worked on 04/25/2024 first shift. Nurse #8 explained she vaguely remembered Resident #238 and did not recall whether she performed the pressure ulcer treatment or not.

c. Review of Resident #238's medical record revealed a physician order dated 05/03/2024 to cleanse sacral pressure ulcer with wound cleanser and apply calcium alginate and cover with dry dressing every day.

Review of Resident #238's TAR for 05/2024 revealed there was no documentation that indicated the treatment was completed on 05/09/2024.

An interview was conducted with Nurse #8 on 10/10/2024 at 2:31 PM who worked on 05/09/2024 first shift. Nurse #8 explained she vaguely remembered Resident #238 and did not recall whether she performed the pressure ulcer

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F 842	Continued From page 68 treatment or not. An interview was conducted with the Director of Nursing (DON) on 10/11/2024 at 11:28 AM. The DON explained that "if it is not documented, then it was not done" because when staff initialed for the treatment it indicated the treatment was done. She indicated if the treatment was not completed for whatever reason, then there should be documentation to support the reason why the treatment was not done.	F 842		
F 880 SS=E	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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		11/19/24

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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.

§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

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F 880	Continued From page 70 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to implement infection control policies and procedures when the Wound Nurse did not follow the procedure for dressing change for a wound (Resident #25). In addition, Nurse Aide (NA) #11 failed to remove soiled gloves and perform hand hygiene after incontinence care and before she touched the resident, bed linens and the bed control (Resident #25), the Wound Nurse did not follow enhanced barrier precautions (EPB) while applying stabilizing devices to indwelling catheters for two residents (Resident #60 and Resident #63), Nurse #9, failed to follow enhanced barrier precautions while administering intravenous antibiotics into a central venous catheter (Resident #139) and NA #1 did not follow EPB when providing catheter care (Resident #63). The deficient practice occurred for 4 of 5 staff observed for infection control practices (Wound Nurse, Nurse Aide (NA) #11, Nurse #9, and NA #1). The findings included: 1. Review of the facility's policy and procedure on clean dressings last revised on 10/31/18 revealed the following procedure: - Provide for clean field on overbed table by using wax paper, paper towel, etc. - Place clean supplies on the clean field. - Place trash receptacle within easy reach. - Don gloves, remove, and dispose of old dressing in the trash receptacle. - Cleanse the wound. Cleanse from the inside	F 880	On 10/09/2024, The wound care nurse immediately returned to resident #25 and provided wound care per facility infection control standards. The bed linens were changed for cleanliness. The room environment was cleaned and sanitized by housekeeping staff to meet compliance with infection control practices. Wound Nurse was provided education related to infection control practices with wound care and Enhanced Barrier Precautions (EBP). Nurse #9 identified was provided education on the use of EBP precautions. The nurse aide #11 was provided education on hand hygiene and EBP precautions. Nurse aide #1 will be educated on removing of soiled gloves and hand hygiene on their next scheduled work shift. On 10/09/2024, the nurse followed Enhanced Barrier Precautions (EBP) while replacing a securement device for the indwelling catheters for resident #60 and #63. On 10/22/24, the central line was discontinued for resident #139. On 10/9/24 the DON audited all residents on EBP to ensure compliance with EBP practices. Any discrepancies identified will be addressed by the DON at that time. On 10/9/24, The Staff Development Coordinator/Clinical Care Coordinator initiated education to all staff, including agency staff, on Enhanced Barrier Precautions and handwashing to be completed by 11/18/24. All staff and	

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F 880	Continued From page 71 working out. If additional cleaning is needed, use another 4 x 4 gauze. Never use the same 4 x 4. - Discard sponges used for cleaning the wound in the trash receptacle/bag. - Remove and dispose gloves in trash receptacle/bag. - Wash your hands. - Don clean gloves. Apply clean dressing. - Secure dressing with tape. - Date and initial the dressing. - Remove and dispose of gloves in trash receptacle/bag. - Wash hands. - Remove supplies and trash from the resident's room. - Dispose of removed trash properly. An observation of wound care was made on 10/09/24 at 09:50 AM. The Wound Nurse washed his hands with soap and water, donned a clean gown and gloves and placed a barrier down on the overbed table that had not been cleaned. After placing all the supplies on the barrier, he doffed his gloves, sanitized his hands, and donned clean gloves. He assisted Nurse Aide (NA) #11 with turning Resident #25 on his side and the resident had a large amount of stool between his buttock cheeks and there were smears of stool on the brief underneath the resident. The Wound Nurse removed the old dressing and discarded the dressing in the trash bag. He doffed his gloves, sanitized his hands, and donned new gloves and cleaned the outer portion of the wound with normal saline (NS). He then proceeded to clean the wound bed with NS. He doffed his gloves, sanitized his hands, and donned new gloves and proceeded to apply an antifungal and a corticosteroid cream to the outer edges of the wound. The Wound Nurse then	F 880	agency staff not in serviced by 11/18/2024 will be in serviced before their next scheduled shift. All new hires will be educated during the orientation process. The nursing leadership will observe staff providing direct resident care by using the Infection Control/Enhanced Barrier Precaution Audit Tool to ensure they are wearing and discarding PPE appropriately and proper hand hygiene for 5 residents a week for 4 weeks, then monthly for two months. The Director of Nursing/Clinical Care Coordinator will observe staff while performing 5 wound treatments weekly x 4 weeks, then 5 wound treatments a month x 2 months to ensure compliance with infection control practices. The Director of Nursing will forward the results of Infection Control/Enhanced Barrier Precautions Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months. The QAPI Committee will meet and review the Infection Control/Enhanced Barrier Precaution Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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applied moisture barrier cream (used to treat minor skin irritations) to the wound edges and peri wound area. He doffed his gloves, sanitized his hands and donned clean gloves and applied a hydrogel that helps maintain a moist wound environment conducive to healing to the wound bed and packed it with a solution-soaked gauze used to prevent and treat infection. As the Wound Nurse was packing the solution-soaked gauze in the wound the end of the gauze fell out of the wound onto the stool smeared brief and the Wound Nurse proceeded to pack it back into the wound. The Wound Nurse applied the bordered gauze dressing to the wound and Resident #25 was turned onto his back.

An interview on 10/09/24 at 11:41 AM with the Wound Nurse revealed he had been doing wound care at the facility for 4 months and did all the wound care in the building both pressure and non-pressure wounds. He stated he had forgotten to clean the overbed table prior to placing his wax paper down and he forgot to put a clean chuck pad under Resident #25 prior to providing the wound care. The Wound Nurse further stated he realized that he should have tossed the gauze when it fell out of the wound onto the resident's brief but was nervous about being observed and just continued with the wound care.

An interview on 10/11/24 at 6:34 PM with the Director of Nursing (DON) who was also the Infection Preventionist revealed it was her expectation for the Wound Nurse to follow infection control guidelines and wound care guidelines while providing wound care. She stated they were auditing staff to ensure they were following infection control guidelines and

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procedures and said she would be adding the Wound Nurse and wound care to the auditing tool. The DON/IP further stated she thought the Wound Nurse was nervous about being observed doing wound care.

2. Review of the facility's policy on Handwashing revised 04/2023, indicated personnel are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by acceptable standards of practice. The policy read in part: Personnel should wash their hands:
- After contact with blood, bodily fluids, secretions, excretions, & equipment or articles contaminated by them.
- After removing gloves before performing procedures in which a normally sterile part of the body is entered.
- Before and after touching wounds.
- When otherwise indicated to avoid transfer of microorganisms to other residents and environments.
- When indicated between tasks and procedures to prevent cross contamination of different body sites.

An alcohol-based hand sanitizer may be used for handwashing unless the hands are visibly soiled. The hands should be free of dirt and organic material when using an alcohol-based hand sanitizer. The hands should be washed with soap and water after exposure to blood or body fluids.

An observation of incontinence care was made on 10/09/24 at 10:13 AM and revealed Nurse Aide (NA) #11 wearing a gown and gloves proceeded to clean stool from Resident #25's buttocks and made sure he was thoroughly clean.

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With the same gloves on, she adjusted the resident in bed, touching his linens and pillow under his legs and bed controls. She then touched his catheter bag, clean pants and pushed his catheter bag through his pants. In the meantime, his top sheet had fallen on the floor behind his bed, and she walked behind the bed and lifted the sheet up off the floor and placed it on his bed. After getting his pants pulled up on him, she placed the sheet that had fallen on the floor over the resident and then touched his bed controls again with the same gloves to put his bed in low position. NA #11 doffed her gown and gloves without sanitizing her hands and put on a single glove, collected the trash bag and left the room.

An interview on 10/09/24 at 3:12 PM with NA #11 revealed she had only taken care of Resident #25 a couple of times. NA #11 stated she realized after she left the room that she should have doffed her gloves after cleaning the resident, sanitized her hands and donned clean gloves prior to touching him and anything in his environment. She further stated she was nervous about being observed providing care and just forgot to change her gloves. NA #11 indicated she should have gotten the resident a clean sheet as well since his had fallen onto the floor.

An interview on 10/11/24 at 6:34 PM with the Director of Nursing/Infection Preventionist (DON/IP) revealed she expected all staff to follow the infection control procedures and guidelines when providing incontinence care and any care to residents. She stated she would be providing additional education to the NAs on infection control procedures and guidelines and would likely be monitoring them to ensure they are

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following the guidelines while providing care to the residents. The DON/IP further stated they would provide additional one on one training as the need was identified.

3. Review of the facility's policy on Enhanced Barrier Precautions (EBP) revised 06/14/24, indicated EBP are used in conjunction with Standard Precautions to reduce the risk of Multi Drug Resistant Organism (MDRO) transmission during high-contact resident care activities. Includes use of both gown and gloves. EBP are meant to be in place for the duration of the resident's stay or until resolution of a wound or discontinuation of an indwelling medical device.

Review of the facility's policy on Handwashing revised 04/2023, indicated personnel are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by acceptable standards of practice. Personnel should wash their hands: After contact with blood, bodily fluids, secretions, excretions, & equipment or articles contaminated by them. After removing gloves before performing procedures in which a normally sterile part of the body is entered.

a. On 10/08/25 at 10:15 AM an observation was made of Nurse #9 who went into Resident #139's room to administer an intravenous (IV) antibiotic through a central venous catheter (CVC, a long flexible tube inserted into a vein in the neck, chest, arm or groin that leads to the large vein which empties into the heart). Posted on the Resident's door was a sign for Enhanced Barrier Precautions that indicated all healthcare personnel should don gloves and gowns when providing care of high contact resident care

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activities that included device care or use including central lines. Nurse #9 applied gloves and gathered the IV antibiotic, normal saline flush syringe and alcohol pads before she entered Resident #139's room. The Nurse proceeded to sanitize the catheter tip and flushed the normal saline into the CVC before she connected the IV antibiotic to the catheter.

b. An observation was made on 10/08/24 at 11:20 AM of Nurse #9 disconnecting Resident #139's IV antibiotic from her central venous catheter. The Nurse sanitized her hands and donned gloves and gathered a normal saline syringe and alcohol pads before she went into the Resident's room. Nurse #9 sanitized the catheter tip then removed the IV antibiotic and flushed the normal saline then sanitized the catheter tip a second time.

An interview was conducted with Nurse #9 on 10/08/24 at 2:39 PM. While standing outside of Resident #139's door the Nurse was asked to explain the EBP sign posted on the Resident's door. Nurse #9 explained that Resident #139 had multiple wounds on her coccyx and heels and had to be under EBP. The Nurse was asked if having a central venous catheter warranted being under EBP and Nurse #9 stated "no." The Nurse was asked to read the sign, and she then stated "yes, I guess it does." Nurse #9 stated she usually wore the gown, but she had not worn the gown with Resident #139. When asked why not, the Nurse stated she really had no reason to offer.

An interview was conducted with the Weekend Supervisor on 10/08/24 at 3:11 PM. The Supervisor explained she had only been employed by the facility for three weeks and was

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still learning her duties. She continued to explain that if Resident #139 had a CVC, then Nurse #9 should have followed the EBP sign on the door. She indicated Nurse #9 might need further education on infection control.

c. On 10/08/24 at 10:42 AM an observation was made of Nurse Aide (NA) #1 and Medication Aide (MA) #1 going into Resident #63's room to provide urinary catheter care. It was noted that there was no Enhanced Barrier Precaution sign or Personal Protective Equipment (PPE) posted on the Resident's door. The two staff donned gloves but did not don gowns. After the MA noticed Resident #63 did not have a stabilizing device in place for his urinary catheter, she removed her gloves and left the room to inform the Wound Nurse about the Resident needing a stabilizing device. The MA never returned to the room. In the meantime, NA #1 emptied Resident #63's catheter bag and disposed of the urine in the commode. NA #1 then removed her gloves and without sanitizing or washing her hands she donned another pair of gloves. At this time the Wound Nurse entered the room wearing only gloves and proceeded to attach the stabilizing device on Resident #63's left thigh. The Wound Nurse removed his gloves, washed his hands and left the room. NA #1 then proceeded to perform catheter care on the Resident and when she was finished, she removed her gloves and washed her hands before she left the Resident's room.

An observation was made on 10/08/24 at 3:00 PM of the Enhanced Barrier Precaution sign and PPE tower was posted on Resident #63's door.

An interview was conducted with NA #1 on 10/08/24 at 3:02 PM as she stood outside

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Resident #63's door. NA #1 explained she had been at the facility for about 6 months and received infection control training when she was hired. When asked how she knew if a resident was on any kind of infection control precaution, she responded the precaution sign should be posted on the door. The NA pointed at the EBP sign on Resident #63's door and stated that sign was not on the Resident's door earlier when she rendered care to him because if the sign had been on the door, she would have donned the appropriate PPE meaning a gown as well as the gloves because the Resident had a catheter. The NA was asked if she should have done anything different during the morning care of Resident #63 the NA explained she should have washed her hands after she emptied his urinary bag and removed her gloves and before she donned another pair of gloves.

An interview was conducted with the Weekend Supervisor on 10/08/24 at 3:11 PM. The Supervisor explained that anytime you remove gloves you should wash your hands before donning more gloves so NA #1 should have washed or sanitized her hands after she removed her gloves and before she donned new gloves. She stated a resident who had a urinary catheter should be on EBP which indicated to use the PPE of gown and gloves. The Supervisor reported she did not know who was responsible for posting the precaution signs and PPE, but the Director of Nursing was responsible for the infection control program.

On 10/08/24 at 3:48 PM during an interview with the Medical Supply Clerk, she explained that she posted the EBP sign and PPE on Resident #63's door earlier that afternoon and was asked to post

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them by Nurse #10.

During an interview with the Wound Nurse on 10/08/24 at 4:29 PM the Nurse explained that he had only been doing the wound treatments for a few months. When asked about if Resident #63 was on EBP he stated he could not remember if the precaution sign was on the door, but he should have worn a gown and gloves because the Resident had a urinary catheter. When asked what he wore when he applied the stabilizing device to Resident #63 the Wound Nurse explained he only wore gloves and not the gown because he was told if the reason you were coming in contact with the resident did not last longer than 15 minutes then you did not have to wear the gown. The Wound Nurse implied he was told that by the Director of Nursing.

An interview was conducted with Nurse #10 on 10/08/24 at 7:47 PM who explained that she just started back to work at the facility that week. The Nurse stated she was asked by the Director of Nursing earlier in the afternoon (10/08/24) to have the Medical Supply Clerk post the EBP sign and PPE on Resident #63's door.

d. An observation was made of the Wound Nurse applying a stabilizing device for Resident #60's indwelling urinary catheter on 10/08/24 at 4:24 PM. The door was open to the Resident's room which had an EBP sign posted, and the PPE tower mounted on the Resident's door. The Wound Nurse was noted to be wearing gloves and no gown during the procedure.

An interview was conducted with the Wound Nurse on 10/08/24 at 4:29 PM. The Wound Nurse was asked about what kind of precautions was

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posted on Resident #60's door and he replied EBP which meant he should have worn gloves and a gown. When asked why he did not wear a gown the Nurse explained that he was told that if the reason he was coming in contact with the resident did not last longer than 15 minutes then you did not have to wear a gown. The Wound Nurse implied he was told that by the Director of Nursing.

During an interview with the Director of Nursing (DON) who was also the Infection Preventionist on 10/08/24 at 4:50 PM the DON explained that she had only been employed at the facility for about 4 weeks and had not yet put any new systems into place regarding infection control nor had she conducted any education on infection control. The DON remarked that you would think that Nurse #9 wound follow the directions of the EBP sign posted on Resident #139's door before she administered medication to Resident #139's CVC. She reported that she conducted an audit for the precaution signs and found that Resident #63 had an indwelling urinary catheter and did not have an EBP sign or PPE posted on his door, so she instructed Nurse #10 to have a sign placed on the Resident's door. The DON stated she did not have a routine monitoring for handwashing but indicated NA #1 should have washed her hands after she removed her gloves and before she donned new gloves after she emptied Resident #63's catheter. She stated both NA #1 and the Wound Nurse should have worn a gown when they worked with Resident #63 and Resident #60 because the residents had an indwelling urinary catheter. The DON voiced that she did not inform the Wound Nurse that if the encounter with the resident lasted no longer than 15 minutes then they did not have to wear gowns

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F 880	Continued From page 81 that the Wound Nurse must be getting it confused with COVID contact time. She stated it looked like she would need to educate on infection control sooner than later.	F 880		