STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING _____ B. WING _____	R-C 01/24/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey along with a Focused Infection Control survey were conducted on 01/19/22 through 01/20/22. Additional information was obtained offsite through 01/24/22; therefore, the exit date was changed to 01/24/22. Thirteen (13) of the thirty-one (31) complaint allegations investigated were substantiated resulting in deficiencies.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		2/3/22

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

Electronically Signed | 02/11/2022

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to maintain clean hallways on 1 of 4 hallways (200 hall) and failed to dust the overhead lights in 3 of 3 resident rooms (504, 507, and 514). The findings included: a. An observation of the 200 hallway was conducted on 01/19/22 at 10:47 AM. On the wall between rooms 211 and 213 there were 10 dark brown splatters noted on the wall near the baseboard. An interview was conducted with the Environmental Service Director (ESD) on 01/19/22 at 1:59 PM. The ESD stated that they were using a disinfectant solution and magic erasers to clean the walls. She stated that if the walls did not come clean with the cleaning solution, they were putting that wall down on the list of things to be painted. The ESD stated that	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-584 Safe and Clean Environment Corrective action for affected residents. For resident # room 504, 507, 514 and 200 hallways. On 1/19/2022, Housekeeping cleaned rooms and walls identified with deficient practice. Corrective Action for Potentially Affected Residents. All residents have the potential to be affected. All hallways and rooms were	

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F 584	Continued From page 2 following the facility's annual recertification survey they went down each hallway and cleaned the walls to get the brown splatters off the walls. After observing the 10 brown splatters on the wall between 211 and 213 the ESD stated that she believed the areas were coming from the food carts on the hallway but stated she would see if she could get them cleaned again. Housekeeper #1 was interviewed on 01/19/22 at 2:14 PM who confirmed that he was working the 200 hall on 01/19/22. He stated that he had cleaned the rooms on the 200 hall and wiped down the walls on the hallway. He observed the 10 brown splatters on the wall between 211 and 213 and stated he had not tried to clean them off today but stated he would try. A follow up interview was conducted with the ESD on 01/19/22 at 2:42. The ESD stated that the 10 brown splatters were able to be cleaned off the wall between rooms 211 and 213 and added that the walls were cleaned on Monday 01/17/22 but she believed the carts would sling stuff up on the walls and they probably just needed to be painted. The Administrator was interviewed on 01/20/22 at 4:35 PM who stated that the facility had identified the brown splatters on wall between room 211 and 213 and they were working to achieve a more permanent solution for the brown splatters. The Administrator explained that the facility had 2 housekeepers that resigned, 2 that were out sick, and a new director that came to the facility went through training and then never returned so the facility had to go back to the drawing board and start over. She stated that they take 2 steps forward and 4 steps backward and it was taking	F 584	inspected on 1/24/2022, the Interdisciplinary Team completed round on all halls to identify any areas in need of deep cleaning to include dusting sweeping mopping, and decluttering. On 1/24/2022, the hallways and rooms on 100 hall, 200 hall, 300 hall, 400 hall, 500 hall, and 600 halls were cleaned by housekeeping staff to include sweeping, mopping, dusting overbed lights and windowsills, and cleaning walls and base boards on hallways. The blinds, bedside table and over bed table were cleaned. Bathrooms cleaned. Deep cleaning schedule initiated for all rooms and maintenance task list initiated for repairs and painting to ensure a safe, clean, comfortable and homelike environment. Systemic Changes An in-service was provided for housekeeping and maintenance staff on 1/27/2022 by the Environmental Services Director on the expectation for a clean, safe, comfortable and homelike environment. The deep cleaning schedule has been revised to ensure one room per hall (100 hall, 200 hall, 300 hall, 400 hall, 500 hall and 600 hall) per week (6 rooms per week) and walls and high dusting is being done. Additionally, skills check off for housekeeping staff added. Beginning 2/1/2022, Environmental Services Director began completing skills check offs for all housekeeping staff. In addition to this, any newly hired environmental /maintenance staff hired by the facility will receive in-service education related to expectation for safe, clean, homelike environment and deep cleaning schedule. during	

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F 584	Continued From page 3 them some time to get things done and cleaned appropriately. b. An observation of the overbed lights in room #504 was made on 01/19/22 at 10:49 AM. There was a buildup of dust when you would run your hand over the top of the lights, the dust would fall from your hand to the floor. An observation of the overbed lights in room #507 was made on 01/19/22 at 10:51 AM. There was a buildup of dust when you would run your hand over the top of the lights, the dust would fall off your hand to the floor. An observation of the overbed lights in room #514 was made on 01/19/22 at 10:55 AM. There was a buildup of dust when you would run your hand over the top of the lights, the dust would fall from your hand to the floor. An interview was conducted with the Environmental Service Director (ESD) on 01/19/22 at 1:59 PM. The ESD stated that dusting of each room was done daily including the top of the overbed lights. She explained that the dust was built up and dusting with feather duster just didn' get the dust off, the housekeepers must use a wet cloth to get the buildup of dust off. She further explained that most of the housekeeping staff was still new and they were still working to get the rooms up to par. The ESD observed the dust on the overbed lights in rooms #504, #507, and #514 and she stated she continued to train the housekeepers how to do things correctly and again get the rooms up to her expectations. Housekeeper #2 was interviewed on 01/19/22 at 2:22 PM who confirmed she was working on the	F 584	orientation. Quality Assurance The Administrator or designee will monitor this issue using the Survey QA tool for Monitoring Safe, Clean Homelike Environment. The monitoring will include observing rooms using the room inspection audit tool to be completed by the Administrator or designee 5 x weekly x 4 then monthly x 3. Findings will be reviewed in the Quality of Life Quality Assurance Committee meeting weekly x 4 then monthly x 3 or until resolved. Date of Compliance: 2/3/2022	

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F 584	Continued From page 4 500 hall on 01/19/22. She explained how she cleaned each room and if no resident was in the bed, she would wipe the overbed lights off each day. Housekeeper #2 stated that she did not feel comfortable dusting if the resident was in the room and added if the resident had a visitor, she would let them visit and try to come back to that room later in the day. She added she would go back and dust room #504. #507, and #514 later that day. The Administrator was interviewed on 01/20/22 at 4:35 PM. The Administrator explained that the facility had 2 housekeepers that resigned, 2 that were out sick, and a new director that came to the facility went through training and then never returned so the facility had to go back to the drawing board and start over. She stated that they take 2 steps forward and 4 steps backward and it was taking them some time to get things done and cleaned appropriately.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:	F 607		2/3/22

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F 607	Continued From page 5 Based on record review and facility staff interviews, the facility failed to implement abuse policies and procedures and thoroughly investigate when they received an allegation of staff to resident abuse for 1 of 1 resident reviewed for abuse (Resident #3). The Findings Included: A review of the facility's policy entitled "Abuse Prohibition" last revised in January 2021 revealed under the section "Procedures for Investigations" that "the administrator, or designee, will investigate any reports of abuse ... All reports of resident verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property shall be promptly and thoroughly investigated by facility management". Resident #3 was recently readmitted to the facility on 03/23/21. A review of Resident #3's most recent quarterly Minimum Data Set Assessment dated 10/18/21 revealed Resident #3 to be moderately impaired for daily decision making with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #3 required extensive assistance with bed mobility, transfer, locomotion on and off the unit, dressing, personal hygiene, and bathing. She was totally dependent with toilet use. A review of Resident #3's electronic progress notes revealed a note dated 12/16/21, written by the Social Worker, that read "SW [Social Worker] followed up with resident's [family member] pertaining to her wanting additional follow from an	F 607	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. □ F607 Policies for Abuse & Neglect of Resident Corrective action for resident(s) affected by the alleged deficient practice. On 12/10/2021 resident was interviewed by Nursing Supervisor (B.M). Resident denied the allegation that she was hit by staff and stated that she was trying to get back at CNA because CNA would not give resident a soda. Investigation proved that there was no actual abuse and a continuation of previously care planned behaviors of the resident. Corrective action for residents with the potential to be affected by the deficient practice On 1/27/2022, the administrator and corporate clinical nurse completed a 100 % audit of all current grievances to ensure that there were no outstanding grievances that fell under reportable abuse category that was not reported. On 2/2/2022 the QA Nurse Consultants and Unit Managers interviewed residents with BIMS greater than 12 for any concerns with care. No	

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F 607	Continued From page 6 occurrence [Resident #3] shared with her. SW advised that I followed up with Administrator and was informed that Resident [#3] was interviewed by an RN supervisor. Resident [#3] shared that what she told her [family member] did not occur. [Family Member] was provided with information to guide her if she needed to call and share similar concerns." During an interview with Resident #3's Family Member on 01/19/22 at 11:32 AM she reported she had spoken to Resident #3 via telephone in December 2021 and Resident #3 reported that NA #5 had hit her and asked for Family Member to come get her. Family Member stated she reported the allegation and was told later that they spoke with Resident #3 and she denied the incident. Family Member reported she did not believe they investigated the allegation as "[Resident #3] wouldn't lie". During an interview with NA #5 on 01/19/22 at 1:35 PM, she reported she was aware of an allegation of abuse voiced against her by Resident #4. She denied hitting Resident #4 and stated she was unsure why she stated she had hit her. NA #5 also reported she was not suspended during any investigation and no one from the facility interviewed her regarding the allegation. While NA #5 stated she had not provided care to Resident #4 when the allegation was made, she verified that she did provide care to Resident #4 later that day. An interview with Nurse Supervisor #1 on 01/19/22 at 3:15 PM revealed he remembered receiving a text message from the Administrator asking him to check out and speak to Resident #4 because she had alleged, she was hit by	F 607	concerns voiced by residents. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/27/2022, the Director of Nursing (DON) and Quality Assurance (QA) Nurse Consultant began educating 100% of facility staff and agency staff on the Abuse Prohibition Policy. All training is to be completed by 2/1/2022. If training is not completed, the employee will not be allowed to work until completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning 2/7/2022, the Administrator or designee will monitor compliance utilizing F-tag 607 Abuse and Neglect Reporting of Alleged Violations monitoring QA tool. Observation will include review of daily notes and grievances for 5 residents daily x 4 then weekly x 3, and then monthly x 2. The ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed as no longer necessary for compliance with reporting abuse and neglect. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 2/3/2022	

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F 607	Continued From page 7	F 607		

Nurse Aide #5. He stated he immediately went to Resident #4's room and assessed her. He stated there was no noted bruising, redness, or swelling and when he questioned Resident #4 about the allegation, she denied being hit by anyone and that she was "just mad" at NA #5. Nurse Supervisor #1 then relayed the information to the Administrator and was told he did not need to do anything further regarding the investigation.

During an interview with the Administrator on 01/19/22 at 3:30 PM, she reported she was aware of an allegation of abuse that was reported by Resident #3's family member. She stated when she received the information regarding the allegation, she had Nurse Supervisor #1 go speak to Resident #3. She reported Resident #3 told Nurse Supervisor #1 that she was not hit by NA #5 and that she was just angry with her. She reported since Resident #3 had a history of telling mistruths and "the fact that it [the allegation] came from her [family member] and not the resident" the facility stopped the investigation. She also reported the investigation was not fully completed due to the information gathered by Nurse Supervisor #1. The Administrator verified that NA #5 was not suspended or removed from the facility. The Administrator stated at the facility, if they receive an allegation of abuse from a 3rd party source, and the resident in question was deemed alert and oriented, they interviewed the resident. She stated only when the resident verified the allegation, the facility then began a full abuse investigation as laid out in their abuse policies and procedures. The Administrator insisted since Resident #3 was alert and oriented and she did not verify the allegation of abuse, she was not required to complete a full abuse investigation.

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to obtain a clarification order for medication to be administered via a gastrostomy tube or by mouth and failed to administer medications as ordered for 1 of 3 residents with a gastrostomy tube (Resident #3). The findings included: Resident #3 readmitted to the facility on 03/23/21 with diagnoses that included dysphagia. The quarterly Minimum Data Set (MDS) dated 10/18/21 indicated that Resident #3 was moderately cognitively impaired for daily decision making and required one person assistance with eating. The MDS further revealed that Resident #3 had a feeding tube and received a mechanically altered and therapeutic diet. Review of Resident #3 ' s physician orders dated 01/01/22 through 01/31/22 included the following: Metformin (treat diabetes) 1000 milligrams (mg) by mouth one time a day, Desmopressin Acetate (treat diabetes insipidus) 0.1 mg give 2 tablets by mouth twice a day, Levetiracetam (treat epilepsy) 100 mg/milliliter (ml) give 5 ml by mouth two times a day, Potassium Chloride 20 milliequivalents (meq) give 2 packets by mouth twice a day, and Quetiapine Fumarate (treat	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 Professional Standards Corrective action for resident(s) affected by the alleged deficient practice: On 1/19/2022 the Director of Nursing notified the MD and clarified resident # 3 orders to accurately state the route of medication administration as per care plan. Corrective action for residents with the potential to be affected by the deficient practice On 1/24/2022 the Quality Assurance (QA) Nurse Consultant completed a 100 % audit of all current residents who have orders for feeding tubes in order to validate that the residents order i accurately reflects the route in which they should receive medications. The results of the audit were 4 of 5 resident orders were	2/3/22

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F 658	Continued From page 9 psychosis) 50 mg by mouth two times a day. An observation of Nurse #2 was made on 01/19/22 at 12:28 PM. Nurse #2 was observed to prepare Resident #3's medications in a medicine cup. Once all the medications were in a medication cup Nurse #2 crushed the medications and placed them in a cup and added a small amount of water to the cup. Nurse #2 proceed to Resident #3's bedside with 4 small water cups, one that contained the crushed medication and 3 others that contained tap water. Nurse #2 was observed to administer the cup of medication via Resident #3's gastrostomy tube followed by the 3 cups of water. Nurse #2 was interviewed on 01/19/22 at 3:55 PM. Nurse #2 confirmed that she had prepared Resident #3 ' s medication which included Metformin, Potassium Chloride, Levetiracetam, Desmopressin, and Quetiapine. She stated that she had crushed up the medication and put them in a water cup and added a little bit of water to it before administering them via Resident #3's gastrostomy tube. Nurse #2 stated that Resident #3 had been at the facility for years and she had taken her medication by mouth initially but then early in 2021 she was in the hospital and returned with the feeding tube (gastrostomy tube) and initially could not take anything by mouth, so we were giving her medication via the feeding tube. Nurse #2 confirmed that she had been administering Resident #3 ' s medication via her feeding tube for a while and just had not noticed that the order still stated by mouth. Nurse #2 stated she would need to speak to the Nurse Practitioner and get a clarification order for Resident #3's medications.	F 658	accurate. 1 of 5 was inaccurate. On 1/20/2022 the QA Nurse corrected 1 resident record. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/27/2022, the QA Nurse Consultant began educating all full time, part time, and prn nurses, medication aides, nurse aides and agency staff on the following topics: on professional standards on the importance of making sure resident medications are administered via appropriate route per MD orders. If training is not completed, the employee will not be allowed to work until completed. In addition to this, any newly hired or agency nurse utilized by the facility will receive this in-service education during orientation. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On Beginning 2/7/2022, the Director of Nursing or designee will monitor compliance utilizing F-tag 658 Professional Standards monitoring QA tool. Observation will include observations of medication provided via G-tube for 5 residents weekly x 4 then monthly x 3. The ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed as no longer necessary. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 658	Continued From page 10 The Nurse Practitioner (NP) was interviewed on 01/19/22 at 5:06 PM. The NP stated that Resident #3 had her gastrostomy tube for about a year and she really did not have a preference of how she took her medications. She stated that she could take them orally, but it may be safer and easier to give them via her tube and she was not sure why the staff choose to administer the medications via her gastrostomy tube. She stated that the way physician orders were written was the way the medications were to be administered and stated she would have to talk to the staff and get a clarification order in place for Resident #3's medications. The Director of Nursing (DON) was interviewed on 01/20/22 at 10:45 AM. The DON stated that Resident #3 readmitted to the facility from the hospital in March of 2021 with the gastrostomy tube and had a nothing by mouth order, but her medications were ordered by mouth. She could not explain how the orders had been overlooked but stated likely "human error." The DON stated that the staff should have obtained a clarification order for the medications to be administered either through the gastrostomy tube or orally and administer the medications as ordered.	F 658	Date of Compliance: 2/3/2022	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and Resident interviews, the facility failed to	F 677	The statements made on this plan of correction are not an admission to and do	2/3/22

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F 677	Continued From page 11 provide incontinence care for 1 of 3 residents (Resident #1) who was dependent on facility staff for activities of daily living. The findings included: Resident #1 was admitted to the facility on 10/24/20 with diagnoses that included hypertension, diabetes mellitus and chronic obstructive pulmonary disease. A review of Resident #1 Care Area Assessment (CAA) for Incontinence dated 10/14/21 revealed the Resident was always incontinent and required extensive assistance with toileting which put her at risk for pressure ulcers and other skin impairments. A review of Resident #1's care plan dated 12/29/21 revealed the Resident was at risk for skin breakdown and urinary tract infections related to incontinence. The interventions included to checking for incontinence every two hours and as needed, providing the Resident with incontinence care after every incontinent episode and using a clean wipe with each stroke during perineal care. The quarterly Minimum Data Set (MDS) assessment dated 01/04/22 revealed Resident #1 was cognitively intact and required extensive assistance of one staff for bed mobility and toileting. The MDS also indicated Resident #1 was occasionally incontinent of bladder and bowel and had no behaviors of rejection of care. a. An interview and observation of Resident #1 on 01/19/22 at 11:25 AM revealed the Resident was lying in bed and explained that she was waiting	F 677	not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-677 ADL Care Provided for Dependent Residents Corrective Action for Affected Residents For resident# 1 incontient care provided by CNA on 1/19/2022 Corrective Action for Potentially Affected Residents All residents who need assistance with toileting have the potential to be affected by this alleged deficient practice. On 1/27/2022 and 1/28/2022, Nurse Managers audited all current residents for toileting and incontinent care needs. Any resident identified with toileting or incontinent needs were promptly toileted or care provided by the assigned CNA. Systemic Changes On 1/27/2022 the Director of Nursing began in-servicing all current full time, part time and PRN Nurses and CNA's and agency staff this in-service included the following topics: "ADL Care for Dependent Resident "Performing Incontinent/Perineal Care per Plan of Care "UTI Prevention	

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F 677	Continued From page 12 on Nurse Aide (NA) #2 to get her up for the day. Resident #1 continued to explain that she had her heaviest urination first thing in the morning. The Resident explained NA #2 came into her room earlier and told her she would be back to get her up between 11:30 AM and 12:00 PM. At 11:46 AM during the conversation the Resident pushed her call light for assistance and at 11:48 AM. At 12:05 PM Resident #1's call light remained unanswered and the Surveyor intervened and located the Nurse Aide responsible for the Resident that shift. 12:06 PM NA #2 entered the Resident's room to inquire what she needed, and the Resident told the NA that she needed to get up for the day. The NA proceeded to get the Resident up using the sit to stand lift and transferred the Resident to the bathroom. The Resident's bed had 3 paper incontinent pads on it and the top pad was so heavily wet with urine it was completely yellow from corner to corner. The Resident's brief was removed in the bathroom and was yellow from corner to corner because it was so saturated with urine. When the NA tossed the brief in the bathroom trashcan it made a thud sound. Resident #1 had no skin breakdown or redness noted. On 01/19/22 at 12:10 PM during an interview with Nurse Aide (NA) #2 she explained that when she was in the Resident's room earlier that morning to check on her the Resident requested to be gotten out of bed between 11:30 AM and 12:00 PM but she got busy assisting other residents and got behind. The NA acknowledged the Resident's brief and incontinent pad on her bed was soaked with urine and explained that she knew Resident #1 was a heavy wetter and was told by a third shift staff (who she could not identify) that the Resident's brief was changed at 7:00 AM. The NA	F 677	If training is not completed, The Director of Nursing will ensure that any Nurse or CNA who has not received this training will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance Beginning 2/7/2022, The Director of Nursing or designee will monitor this issue using the F-677 Quality Assurance Tool for Monitoring ADL Care for Dependent Residents. The monitoring will include reviewing a sample of at least 5 residents for toileting and incontinent care needs. This will be completed 3 x weekly for 2 weeks then monthly times 2 months or until resolved by to ensure their needs are met. Quality of Life/Quality Assurance Committee. Reports will be given by the Director of Nursing to the monthly Quality of Life-QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 2/3/2022	

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continued to explain that she had not changed Resident #1's brief since coming on duty but stated she should have changed Resident #1's brief earlier when she was in her room earlier. The NA indicated her job was hard because there was not enough staff to make rounds on the residents every two hours.

Attempts to contact the 11:00 PM - 7:00 AM Nurse Aide #4 who worked on 01/18/22 were unsuccessful.

b. On 01/20/22 at 2:40 PM an observation was made of Resident #1 who was in bed and had dinner meal tray still in her room. The Resident explained she was wearing the same wet brief that she had on after she had her first large voiding that morning. She continued to explain that Nurse Aide (NA) #3 came into her room earlier and she requested to be gotten up around 12:00 PM but when the Nurse Aide came back with her dinner tray she told Resident #1 she had to finish passing out the meal trays and feed some people before she could get her up.

At 2:53 PM on 01/20/22 an interview was conducted with Nurse Aide #3 who explained that she changed Resident #1's brief around 7:45 AM and went back to check on her around 11:30 AM but she did not want to get up until 12:00 PM. The NA continued to explain when she took the Resident her dinner tray, she told the Resident she had to pass out the trays and feed the residents who needed assistance and she would get her up after she finished. The NA stated she got caught up assisting other residents with incontinent care and could not get back to Resident #1. The NA explained she was working as fast as she could, but she had two halls to

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attend to and could not get it all done.

On 01/20/22 at 3:10 PM observation of multiple staff into assist Resident #1 out of bed and into the bathroom using the sit to stand lift. The incontinent pad on the Resident's bed was saturated with urine and the brief the Resident wore was saturated with urine from corner to corner and stuck to the Resident's skin. The brief was so heavily saturated with urine that the inner material was bunching, and the brief made a thud sound when it was discarded in the trashcan.

During an interview with the Corporate Quality Assurance Nurse on 01/20/22 at 3:30 PM the CQAN explained that Nurse Aide #3 checked on Resident #1 earlier that morning, but the Resident denied being wet and needing to be changed. The CQAN stated the expectation was that incontinent residents be checked every two hours and as needed.

Attempted to interview the Director of Nursing but was unsuccessful.

An interview was conducted with the Administrator on 01/22/22 at 1:05 PM. The Administrator explained that Resident #1 was in her right mind and she had to believe the Resident when she tells the aides that she was not wet when they check on her. The Administrator agreed that incontinent care should be provided after every incontinent episode. The Administrator continued to explain that if the nurse aides get tied up assisting other residents and was not able to go back to the Resident #1 when they were supposed to then the nurse aides should have communicated that to the nurse and the nurse should have gotten help from someone

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F 677	Continued From page 15 else to get the Resident up. She stated if that cannot happen then they should be directing other resources to help out and indicated that they should be educating the staff to use better communication regarding their workload.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff and Nurse Practitioner interviews, the facility failed to apply a hand splint for contracture management as ordered by the physician for 1 of 3 residents (Resident #6) reviewed for choices. The findings included: Resident #6 was admitted to the facility on	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	2/3/22

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F 688	Continued From page 16 07/07/18 with diagnoses that included arthritis. Review of the physician orders for Resident #6 revealed an order written on 10/07/21 for Resident #6 to wear a left-hand finger extension splint for up to 6 hours during the day as tolerated for contracture management for treatment of left-hand contracture. The care plan for Resident #6 initiated on 12/22/16 and revised on 11/16/21 revealed a focus area for musculoskeletal status related to a left-hand contracture. The goal was for the resident to remain free of complications related to a contracture. Interventions included application of a left-hand splint as ordered. The annual Minimum Data Set (MDS) assessment completed on 01/03/22 indicated Resident #6 was cognitively intact. She had impairment to her upper and lower extremities and required extensive assistance of one staff member with most activities of daily living (ADL). Resident #6 had no behaviors or rejection of care. Resident #6's Nurse Aide Kardex/care guide revealed a task that stated to stretch the resident's fingers in the left hand before applying the splint so she could wear it for 8 hours or as tolerated. An observation completed on 01/19/22 at 10:59 AM revealed Resident #6's left-hand splint was not on. There was a sign on the closet in Resident #6's room that noted the splint was to be on her hand during the day along with a picture of how the splint was to be applied.	F 688	deficiencies cited have been or will be corrected by the date or dates indicated. F688 Increase/Prevent Decrease in ROM/Mobility Corrective action for affected residents. On 1/20/2022, the occupational therapist replaced split closure strap and applied left hand splint to resident #6 left hand. Corrective action for potentially affected residents. Residents who utilize a splint for contractures have the potential to be affected. On 1/27/2022, the QA Nurse Consultant audited all current residents with order for splints to ensure they were wearing splints and if any splints were noted to be misplaced a therapy referral was completed. Once it was determined who needed a splint, brace, palm guard, or hand roll replaced a therapy referral was completed. This process was completed by 1/28/2022. Systemic changes On 1/27/2022, the Director of Nursing began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: " The importance for applying splints, palm guards, hand rolls as ordered by the MD. " What to do and who to notify if resident refuses to wear splint " What to do when the device cannot be located. Nurse Managers will monitor residents requiring splints and compliance of use	

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F 688	Continued From page 17 An interview was conducted on 01/19/22 at 11:00 AM with Resident #6. During the interview she stated she was supposed to have a left-hand splint on during the day, but staff had not been applying the splint. Resident #6 stated the splint had been missing for several months and she had told staff she didn't have it. She stated she wanted the splint because she felt like she needed it and it made her hand feel more comfortable. An observation was completed on 01/19/22 at 1:38 PM of Resident #6. She was lying in bed with no splint on her left hand. No left-hand splint was observed in the room. An observation was completed on 01/19/22 at 3:33 PM of Resident #6. She was lying in bed with no splint on her left hand. No left-hand splint was observed in the room. Medication Aide #1 was interviewed on 01/19/22 at 3:40 PM regarding Resident #6. She stated she was not aware of the splint and had never seen Resident #6 with a splint on her left hand. An interview conducted on 01/19/22 at 4:26 PM with Nurse #1 revealed she thought Resident #6 used to have a splint to her left hand but didn't think the resident used it. She stated the Nurse Aides on the hall would be responsible for applying the splint or the Medication Aide. An interview conducted on 01/19/22 at 4:40 PM with Nurse Aide #1 revealed she was caring for Resident #6 on the 100 halls. She stated she had never seen a left-hand splint in Resident #6's room nor was she aware the resident needed a splint. The interview revealed she had not noticed	F 688	related plan of care daily and report in Clinical Meeting for review to include notifying MD of noncompliance and complete therapy referral and updating plan of care. Additionally, monitoring will increase to ensure compliance. The Director of Nursing will ensure that any Nurse or CNA who has not received this training will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Quality Assurance Beginning 2/7/2022, The Director of Nursing or designee will monitor this issue using the F688 Quality Assurance Tool for Splint and Contracture. The monitoring will include reviewing a sample of at least 5 residents who require a splint or brace to ensure it is applied and removed per MD orders. This will be completed 5 x weekly for 4 weeks then monthly times 2 months or until resolved to ensure their needs are met by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated	

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F 688	Continued From page 18 the picture on the resident's closet of the splint. An interview conducted with the Rehabilitation Director on 01/20/22 at 9:43 AM revealed she had received a referral originally dated 12/29/21 on 01/19/22 regarding Resident #6's left hand splint. She stated the left-hand splint was missing and the referral was given to her by the Nurse Consultant from the facility. She stated the delay in giving the referral to therapy must have been due to an oversight. The Rehabilitation Director stated splints were medically necessary and Resident #6's left hand splint was ordered because she had a flexion contracture in her 5th digit on her left hand. She stated the splint was being placed on Resident #6's hand as a preventive measure to prevent the contracture from worsening. The interview revealed she observed no worsening of Resident #6's contracture from the splint not being applied. On 01/20/22 at 11:35 AM the surveyor and Nurse Consultant completed an observation of Resident #6. There was no left-hand splint observed in Resident #6's room nor was there a left-hand splint applied to the resident's hand. An interview was conducted with Resident #1 on 01/20/22 at 11:40 AM with the Corporate Nurse Consultant present. Resident #6 stated she had not seen her left-hand splint, nor had it been applied at any time during the day. She stated she had not had the splint in a long time. The interview revealed she would not refuse for the splint to be applied. She stated she wanted the splint on her hand because it made her hand feel better.	F 688	as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 2/3/2022	

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A follow up interview with the Nurse Consultant conducted on 01/20/22 at 11:50 AM revealed the left-hand splint had been found in the resident's room and was missing a strap. She stated an Occupational Therapist had the splint and was fixing it.

An interview conducted on 01/20/22 at 12:00 PM with Occupational Therapist (OT) #1 revealed Resident #6 wasn't currently on her caseload however she had been notified her left-hand splint had been found with a strap missing. She stated Resident #6's left hand was contracted, and the splint was created to prevent her finger from pushing into her inner hand causing skin breakdown. The interview revealed Resident #6 was supposed to be wearing the splint 6 hours during the day. OT #1 stated she had just been notified of the missing strap this morning. She stated without the strap the splint would not have stayed on the resident's hand. OT #1 stated she observed no skin breakdown on Resident #6's hand from not wearing the splint. She stated when she fixed the strap and applied it to Resident #6's hand the resident stated to her, "Good, I want to keep it on".

An interview conducted on 01/20/22 at 4:21 PM with Resident #6 revealed the left had splint had been applied by the OT. She stated she was happy to have her left-hand splint on and the splint made her hand feel more comfortable. Resident #6 stated, "thank you for your help".

An interview conducted on 01/20/22 at 4:35 PM with the Director of Nursing (DON) revealed Resident #6's left hand splint should have been applied as the Physician ordered. The DON stated she had never seen the resident wearing a

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F 688	Continued From page 20 left-hand splint and was unaware that she had orders for one. After reviewing Resident #6's care plan and Nurse Aide care guide she stated staff should have been applying the splint daily.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide a routine daily dressing to a gastrostomy tube as ordered for 1 of 3 residents reviewed with a gastrostomy tube (Resident #3). The findings included:	F 693	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of	2/3/22

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F 693	Continued From page 21 Resident #3 readmitted to the facility on 03/23/21 with diagnoses that included dysphagia. A physician order dated 03/25/21 read, post-surgical wound of the left abdomen (gastrostomy tube site), clean left abdomen with wound cleanser, pat dry and apply protective dressing once daily and as needed. The quarterly Minimum Data Set (MDS) dated 10/18/21 indicated that Resident #3 was moderately cognitively impaired for daily decision making and required one person assistance with eating. The MDS further revealed that Resident #3 had a feeding tube and received a mechanically altered and therapeutic diet. Review of the Treatment Administration Record (TAR) dated 01/01/22 through 01/31/22 revealed that the daily dressing had been completed on 01/01/22 through 01/05/22, 01/10/22 through 01/11/22, and 01/13/22 through 01/16/22. An observation of Resident #3 was conducted on 01/19/22 at 11:59 AM. Resident #3 had a gastrostomy tube on her left side of her abdomen that had a dressing that was dated 01/15/22. An observation and interview were conducted with Nurse #2 at 12:28 PM. Nurse #2 was observed to provide Resident #3 with a water flush via her gastrostomy tube and confirmed that the dressing in place was dated 01/15/22. Nurse #2 stated that it was a daily dressing that was completed each morning at 6:00 AM before the start of her shift. Nurse #3 was interviewed on 01/20/22 at 10:15	F 693	correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-tag 693 Tube Feeding management Corrective action for resident(s) affected by the alleged deficient practice: on 1/20/2022, floor LPN changed resident # 3 G-tube dressing and assessed the gastric tube stoma site. Nominal skin breakdown or signs and symptoms of infection noted. On 1/20/20/2022, the Director of Nursing notified the medical provider and new orders were obtained for cleaning skin/stoma with soap and water and monitor for redness. Dressing was discontinued as it was not needed. Corrective action for residents with the potential to be affected by the deficient practice: All resident with Gastric tubes have potential to be affected. On 1/24/2022 the QA nurse consultant who reviewed all current residents with gastric tubes, observing the MD order and G-tube site. The results of the audit were 5 residents with feeding tubes were identified and all have feeding tube care orders. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/27/2022, the QA Nurse consultant, interim DON and RN supervisor began educating all full time, part time, and prn nurses, medication aides, nurse aides and agency staff on the following topics:	

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F 693	Continued From page 22 AM. Nurse #3 confirmed that she had worked 01/17/22, 01/18/22, and 01/19/22 on third shift. She stated she worked wherever she was needed. Nurse #3 stated that if she was not working with Resident #3, a lot of times she would change her gastrostomy tube dressing because there would be Medication Aide (MA) assigned to care for Resident #3 and they were not able to change those dressings. Nurse #3 could not recall if she had worked with Resident #3 since 01/15/22 but recalled changing her dressing that day. She added that she thought Nurse #4 had worked with Resident #3 earlier in the week and may have changed her dressing. Nurse #4 was interviewed on 01/20/22 at 10:29 AM. Nurse #4 stated that she had worked on third shift earlier in the week but stated she could not state if she cared for Resident #3 or not because they had MA that passed mediations and the nurses would split covering the MAs assigned hallway. She stated she had not changed Resident #3's gastrostomy tube dressing but stated maybe Nurse #3 had done it or maybe Nurse #5 had done it. An attempt to speak to Nurse #5 was made on 01/20/22 at 10:39 AM and was unsuccessful. The Director of Nursing (DON) was interviewed on 01/20/22 at 10:45 AM. The DON stated that she expected Resident #3's dressing to be changed daily as ordered. She added that MAs were able to change the dressing as well so if there was a MA on the hall then she expected the MA to change the dressing as ordered.	F 693	Management and Caring for G-tubes. The Director of Nursing will ensure that any licensed nurse or nurse aide II who has not receive education will not be allowed to work until training completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On 2/7/2022, the DON or designee will monitor compliance utilizing the F-tag 693 tube feeding management Quality Assurance monitoring tool. Monitoring will include 3 residents with G-tubes, site observations, and dressing changes/stoma care is completed per doctor order. Monitoring will be completed 2 x week x 4 weeks then monthly x 3 months. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance (QA) Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Manger, Wound nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager Date of Compliance: 2/3/2022	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		2/3/22

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F 725	Continued From page 23 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, Nurse Practitioner and staff interviews, the facility failed to provide sufficient staff to provide incontinence care for 1 of 3 residents (Resident #1) reviewed for activities of daily living (ADL). The findings included: This tag is cross referred to:	F 725	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of	

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F 725	Continued From page 24 1. F677: Based on observations, record reviews, and staff and Resident interviews, the facility failed to provide incontinence care for 1 of 3 residents (Resident #1) who was dependent on facility staff for activities of daily living. An interview on 01/19/22 at 2:27 PM with Nurse Aide (NA) #6 revealed "staffing was horrible." NA #6 stated incontinence care was done maybe 2 times per shift on the 7:00 AM to 3:00 PM shift and said sometimes barely get to everybody. NA #6 stated the Nurses were not able to assist because they were busy doing their own duties for the residents. An interview on 01/19/22 at 2:45 PM with NA #2 revealed "staffing was bad." NA #2 stated incontinence care was done 1 to 2 times in the 7:00 AM to 3:00 PM shift and tried to do those who were "heavy wetter" more often by sometimes just could not get to them. An interview on 01/19/22 at 2:57 PM with NA #7, NA #5, NA #8, and NA #9 revealed "staffing was horrible." The NAs stated some days they had 26 plus residents each on the 7:00 AM to 3:00 PM shift and were not able to do incontinence care by maybe 1 to 2 times per shift. The NAs stated it was difficult to know what to do first because there were residents who could not put on their light and there were residents who used their call light and would be upset when you told them you had to come back because you were assisting another resident. The NAs further stated they struggled in these situations with who to take care of first. The NAs indicated the Nurses were not able to help because they were busy with their own work and said other staff did not offer to	F 725	compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F725- SUFFICIENT STAFFING Corrective action for affected residents. For resident # 1: on 1/19/2022 Incontinent care provided by CNA Corrective action for potentially affected residents. On 1/24/2022, a 100% review of staffing ratios and assignments were completed by the Director of Nursing, Administrator, and Nurse Management team. The review revealed facility staffing insufficient for the facility based on ratios and acuity. On 1/21/2022, the Administrator initiated contracts with staffing agency to supplement current permanent staff. Systemic changes On 1/27/2022, the QA Nurse Consultant began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: " The importance of staff call-outs, notification to Director of Nursing/Administrator, staffing assignments and evaluating staff ratios to meet resident needs, specifically incontinent care. " The Administrator and Director of Nursing will review daily staffing sheets at the morning stand up meeting to ensure staff is scheduled to meet the ADL and Assessment needs of the residents. The Director of Nursing will ensure that any Nurse or CNA who has not received	

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F 725	Continued From page 25 assist with answering lights or passing meal trays to help them out. An interview on 01/19/22 at 3:29 PM with NA #3 revealed staffing had been "bad since COVID-19." NA #3 stated she often had to stay over till 4:00 PM or 5:00 PM to get everything done that was expected on the 7:00 AM to 3:00 PM shift. NA #3 further stated she made incontinence rounds maybe 1 to 2 times in her shift but was not able to do every 2-hour incontinence checks and care. An interview on 01/20/22 at 10:14 AM with the Nurse Practitioner (NP) revealed "staffing had been a struggle." The NP stated the managers were often on carts giving medications and the NAs worked hard but just could not get everything done. She further stated some of the Residents had asked her to see them daily, so someone was looking at them and assessing them. The NP indicated everyone was aware of the staffing struggles and the administration was working to hire staff. An interview on 01/20/22 at 3:23 PM with the Director of Nursing (DON) revealed "none of the NAs could do everything expected of them on the 7:00 AM to 3:00 PM shift." The DON stated there was ancillary staff available to assist them with care, but they had to ask for assistance. She further stated they were expected to do incontinence rounds every 2 hours and check and change residents as needed. The DON indicated there were nurse managers and NAs with other duties who could assist if they just asked them for help. A phone interview on 01/24/22 at 1:31 PM with	F 725	this training will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Additionally, Facility has entered into contract with 1 staffing agency and initiated contracts with 3 other staffing agencies to ensure sufficient staff available to meet the needs of residents. Quality Assurance The Director of Nursing or the Administrator will monitor this issue using the Survey Quality Assurance Tool for Sufficient Staffing. The review will consist of at reviewing staffing ratios and assignments 5x a week for 4 weeks, then 3x weekly for 4 weeks, then weekly x 2 months or until resolved by the Quality of life/Quality Assurance Committee; a review of staffing schedules, staffing ratios, and assignments to include resident acuity, and reviewing for any grievance reports related to staffing. Interventions will be implemented as appropriate. In addition, the MDS schedule will be reviewed to ensure annual and quarterly assessments are	

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F 725	Continued From page 26 the Administrator revealed they currently had the following openings for Nurses and Nurse Aides: 7:00 AM to 7:00 PM - 3 LPNs 7:00 PM to 7:00 AM - 4 LPNs/RNs 7:00 AM to 3:00 PM - 3 NAs 3:00 PM to 11:00 PM - 3 NAs 11:00 PM to 7:00 PM - 3 NAs The Administrator stated they had implemented sign on bonuses for Nurses and Nurse Aides and had implemented referral bonuses as well to try to get better candidates for their positions. She further stated their biggest challenge remained call outs and they were currently working on a plan for scheduling on call staff to cover when someone calls out but stated the plan had not been implemented.	F 725	completed and submitted timely. Reports will be given to the monthly Quality of Life-QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 2/3/2022	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726		2/3/22

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F 726	Continued From page 27 assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to verify that Medication Aide (MA) #1 had the competency skills to administer medications. The MA was observed to omit 10 medications during a medication administration pass, administer a medication that had been discontinued and signed off for medications not given on 2 of 3 residents (Resident #7 and Resident #1) reviewed for medication administration. The findings include: This citation is cross referred to F-759. An interview was conducted with Medication Aide (MA) #1 on 01/21/22 at 10:40 AM. The MA explained that she was employed by the facility on an as needed basis for several months before she changed to full time status on 01/01/22. She continued to explain that she could not remember ever having a medication administration performance audit conducted on her.	F 726	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilitys allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F726- Competent Staff Corrective action for resident(s) affected by the alleged deficient practice For resident #1 On 1/19/20222, the Director of Nursing notified MD related medication error. and order given for Flonase 2 sprays daily as needed per resident request. For resident #7 On 1/19/2022 The Director of Nursing assessed resident and notified MD regarding medication errors and late medication administrations. The	

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F 726	Continued From page 28 An interview was conducted with the Administrator on 01/21/22 at 1:20 PM. The Administrator explained that she was not sure when the last time the Pharmacist had audited MA #1 on a medication administration procedure but stated regardless, she expected the Medication Aide to administer the medications according to the appropriate medication administration procedure. During a follow up telephone interview with the Administrator on 01/24/22 at 1:36 PM the Administrator explained that the MA #1 was employed as a "prn", as needed employee from 04/20/20 through 12/20/21 and began full time employment on 01/01/22 and the facility had no record that the MA had a medication administration audit conducted during her employment.	F 726	Medication aide involved was verbally reeducated related medication administration policy by Director of Nursing and competency observed on 1/26/2022 by Marlon Boger, RN. Corrective action for residents with the potential to be affected by the deficient practice: All residents have potential to be affected. On 1/24/2022, QA Nurse Consultant audited all current resident charts from 1/19/2022 for missed medications as identified by blanks in MAR for Medication Aide noted with deficient practices. Any areas identified areas were corrected by 1/28/2022.On 1/24/2022, the Unit Managers/Support Nurses interviewed residents with BIMS of 13 or higher related to any concerns regarding medication administration. No concerns voiced regarding medication administration. Medication Aide completed skills competency x 2 with registered nurse and to receive ongoing training. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/27/2022 the Quality Assurance (QA) Nurse Consultant began educating all full time, part time, and prn nurses, medication aides, nurse aides and agency staff on the following topics: Competent Nursing Staff. Beginning on 1/26/2022, the Director of Nursing will initiate skill competencies for all medication aides. The Director of Nursing will ensure any nurse, medication aide, or nurse aide who has not completed training will not be allowed to work until training completed. In addition to this, any new hired nurse or medication aide will receive education on	

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F 726	Continued From page 29	F 726	Competent Nursing Staff related to Plan of Correction during orientation and any agency nurse/medication aide utilized by the facility will receive education on POC related Competent Nursing Staff prior to working their shift. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning 2/7/2022, The Director of Nurses or designee will monitor compliance utilizing the F726 Competent Staff QA monitoring tool. Monitoring will include med pass observation of 2 medication aides weekly x 4 weeks, then monthly x 4 months. Compliance will be monitored in the ongoing Quality Auditing program reviewed at the weekly Quality Assurance Meeting The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse mangers, Wound nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 2/3/2022	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		2/3/22

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F 759	Continued From page 30 Based on observations, record reviews, staff and Physician interviews, the facility failed to have a medication error rate of less than 5% as evidence of 11 medication errors out of 25 opportunities, resulting in a medication error rate of 44% for 2 of 3 residents (Resident #1 and Resident #7) observed during medication administration. The finding included: 1. Resident #7 was admitted to the facility on 08/10/21 with diagnoses that included fibromyalgia, hypertension, osteoarthritis, depression, anxiety and seizure disorder. A review of Resident #7's Physician's orders revealed orders for 1) Allegra Allergy Tablet 180 milligram (mg) give one tablet by mouth one time a day for Allergies, 2) Amlodipine Besylate 10 mg give one tablet by mouth one time a day for hypertension, 3) Aspirin Chewable Tablet 81 mg give one tablet by mouth one time a day for anticoagulation, 4) Celebrex Capsule 200 mg give one tablet by mouth one time a day for pain, 5) Duloxetine HCL Capsule 20 mg give 2 capsules by mouth one time a day for depression, 6) Magnesium Gluconate 500 mg give one tablet by mouth one time a day for supplement, 7) MiraLAX Powder give 17 gram (gm) (one capful) mix with 4-8 ounces of liquid by mouth one time a day for bowel regimen, 8) Baclofen 5 mg give one tablet by mouth twice a day for muscle spasms, 9) Buspirone HCL 5 mg give one tablet by mouth twice a day for anxiety and 10) Levetiracetam Solution 100 mg/ml (milliliters) give 2.5 ml by mouth every 12 hours for seizures, 11) Carafate 1 GM give one tablet by mouth once a day for gastrointestinal reflux disease GERD, 12) Prilosec Capsule 20 mg give one capsule by	F 759	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F759- Free of Medication Rate 5 % or More Corrective action for resident(s) affected by the alleged deficient practice: On 1/19/2022 the DON assessed resident # 7, those findings were no harm noted to resident #7. On 1/91/2021 the Resident # 7 received medications that were missed during the medication administration pass. Additionally, the MD was notified of medication error and saw resident on 1/19/2022 while in facility. On 1/24/22, the QA Nurse Consultant reeducated the medication aide and she was removed from her medication pass duties by the Director of Nursing pending medication aide competencies by registered nurse. Corrective action for residents with the potential to be affected by the deficient practice: All resident receiving medications have potential to be affected. On 1/24/2022 the Quality Assurance Consultant Director of Nursing began auditing 100% of resident medication administration records administered by	

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F 759	Continued From page 31	F 759		

mouth twice a day for GERD, 13) Systane Balance Solution 0.6% eye drops, give 2 drops in each eye three times a day for dry eyes (scheduled to be administered at 8:00 AM), 14) Tylenol 325 mg give one tablet by mouth four times a day for pain, 15) Carbidopa/Levodopa 25-100 mg give 2 tablets by mouth five times a day for Parkinson disease (scheduled to be administered at 8:00 AM).

During a medication administration pass with Medication Aide (MA) #1 on 01/19/22 at 11:00 AM the MA administered medications: Carafate, Tylenol, Magnesium Gluconate, Systane eye drops and Carbidopa/Levodopa correctly to Resident #7. During the procedure the MA explained that she had computer problems that morning that she had to deal with which held her up about one and a half hours before she could finish her medication pass.

During medication reconciliation of Resident #7's Physician orders it was discovered that MA #1 did not administer the Resident's Allegra, Amlodipine, Aspirin, Celebrex, Duloxetine, MiraLAX, Baclofen, Buspar, Keppra and Prilosec during the 8:00 AM and 9:00 AM medication administration procedure but the MA signed the medication administration record as being given.

An interview was conducted with Medication Aide #1 on 01/19/22 at 3:15 PM. The MA explained that when she took over the medication cart (100 Hall-B Cart) that morning Nurse #1 told her she had already medicated a resident and she thought the Nurse was referring to Resident #7 since some of her medications were showing on the electric health record as red (which indicated the meds were late). The NA stated she thought

medication aides for medication errors. The results of the audit were additional blanks noted on MAR. MD was notified and corrections were made which included medication error reports.
Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/27/2022 the QA Nurse Consultant began educating all full time, part time, and prn nurses, medication aides, and agency staff on the following topics: Medication administration process to assure that medications are provided to residents per medical order and steps to take if a medication error occurs. Beginning 1/26/2022, medication aides began re-competency by the Director of Nursing / RN on the medication administration process and med pass observations. The Director of Nursing will ensure any nurse or medication aide will not be allowed to work until training completed. In addition to this, any new hired nurse or medication aide will receive education on Competent Nursing Staff related to Plan of Correction during orientation and any agency nurse/medication aide utilized by the facility will receive education on Competent Nursing Staff related to plan of correction prior to working their shift.

Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Beginning 2/7/2022, The Director of Nurses or designee will

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F 759	Continued From page 32 Nurse #1 had already given Resident #7 some of her medications, so she gave the rest of her medications that had not been given. The MA continued to explain that she gave Resident #7 the medications that showed up in red on the electronic health record. When the MA was asked how she knew to sign off for the other medications that she thought the Nurse had given (because the medications would have been in red as well), the MA did not answer the question. 2. Resident #1 was admitted to the facility on 10/24/20 with diagnosis that included chronic obstructive pulmonary disease (COPD). The quarterly Minimum Data Set assessment dated 01/04/22 indicated Resident #1 was cognitively intact. On 01/19/22 at 11:35 AM during an interview with Resident #1 Medication Aide (MA) #1 brought the Resident's Wixela Inhub Aerosol Powder Breath 250-50 micrograms (MCG)/Dose used for COPD and administered one puff by mouth and Flonase Suspension 50 MCG/ACT nasal spray used for allergies and administered one spray in each nostril. The Resident explained that the MA brought the medications in earlier with her morning medications, but she was eating, and she asked the MA to bring the medications back after she had finished her breakfast. On medication reconciliation of Resident #1's Physician orders it was discovered that the Flonase nasal spray was discontinued on 01/12/22. An interview was conducted with MA #1 on 01/19/22 at 3:15 PM. The MA was asked to	F 759	monitor Compliance with the regulatory requirements utilizing F 759 Med Pass QA monitoring tool. Monitoring will include observing medication pass following the 6 rights of medication administration for 1 medication aide and 1 nurse 2 x a week for 4 weeks, then monthly x 3 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 2/3/2022	

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F 759	Continued From page 33 review Resident #1's medication administration record for the Flonase nasal spray. In reading the medication order for the Flonase nasal spray the MA acknowledged the medication was discontinued on 01/12/22. The MA explained that she thought the Resident was still getting the nasal spray and gave her the medication. When the MA was asked how she made that medication error the MA stated the nurse who was on the medication cart when the medication was discontinued should have removed the medication from the cart so that the medication error could not have been made. A telephone interview was conducted with the Physician on 01/21/22 at 11:20 AM. The Physician explained that she could not imagine why the medications were not given but that her expectation was for the medications to be given as ordered by the Physician. The Physician continued to explain that missing one dose of Resident #7's medications would not affect her especially since she did not have any adverse side effects that she had been made aware of by the facility. The Director of Nursing was not available for an interview. An interview was conducted with the Administrator on 01/21/22 at 1:20 PM. The Administrator explained that there should have been better communication between the MA and the Nurse, and it was her expectation that the Medication Aide follow the electronic health record when administering the medications.	F 759		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		2/3/22

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F 867	Continued From page 34 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility ' s Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place on 12/24/21. This was for four (4) deficiencies in the areas of Safe, Clean and Homelike Environment, Activities of Daily Living for Dependent Residents, Range of Motion and Sufficient Nursing Staff which were all originally cited on the 11/19/21 recertification survey. These areas were cited again on the current complaint investigation survey with an exit date of 01/24/22. The continued failure of the facility during the two federal surveys showed a pattern of the facility ' s inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This citation is cross referred to: 1. F584: Based on observations, and staff interviews, the facility failed to maintain clean hallways on 1 of 4 hallways (200 hall) and failed to dust overhead lights in 3 of 3 resident rooms (504,507, and 514). During the recertification survey completed on 11/19/21 the facility was cited for failing to	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-tag 866 QAPI the facility □s QAA committee failed to maintain implemented procedures to monitor interventions in four areas resulting in repeat citations. Corrective action for resident(s) affected by the alleged deficient practice: F-tag 584 Safe Clean and home like environment: For resident # room 504, 507, 514 and 200 hallways. On 1/19/2022, Housekeeping cleaned rooms and walls identified with deficient practice. F tag: 677 Activities of Daily living for dependent residents: For resident# 1 incontinent care provided by CNA on 1/19/2022 F-tag 688 Increase/Prevent Decrease Range of Motion: On 1/20/2022, the	

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F 867	Continued From page 35 maintain clean walls on 4 of 4 hallways, clean privacy curtains in 2 of 18 rooms, clean bathroom in 1 of 3 resident rooms, functioning paper towel dispenser in 2 of 3 resident bathrooms, and dusting of the over the bed lights in 3 of 3 resident rooms all reviewed for environment. 2. F677: Based on observations, record reviews, and staff, and Resident interviews, the facility failed to provide incontinence care for 1 of 3 residents (Resident #1) who was dependent on facility staff for activities of daily living. During the recertification survey completed on 11/19/21 the facility was cited for failing to provide incontinence care during meal service for 1 of 6 residents and failed to provide routine incontinence care for 2 of 6 residents all reviewed for activities of daily living. 3. F688: Based on observations, record reviews, and resident and staff interviews, the facility failed to apply a hand splint for contracture management as ordered by the physician for 1 of 3 residents reviewed for range of motion. During the recertification survey completed on 11/19/21 the facility was cited for failing to apply an arm splint as ordered to a resident following a stroke for 1 of 2 residents reviewed for range of motion. 4. F725: Based on observations, record reviews, resident, Nurse Practitioner and staff interview, the facility failed to provide sufficient staff to provide incontinence care for 1 of 3 residents (Resident #1) reviewed for activities of daily living (ADL). During the recertification survey completed on	F 867	occupational therapist replaced split closure strap and applied left hand splint to resident #6 left hand. F -tag 725 sufficient nursing staffing: For resident # 1: on 1/19/2022 incontinent care provided by CNA Corrective action for residents with the potential to be affected by the deficient practice□ All residents have potential to be affected by the failure to maintain procedures and monitor interventions that committee put in place. F-tag584 Safe Clean and home like environment: All residents have the potential to be affected. All hallways and rooms were inspected on 1/24/2022, the Interdisciplinary Team completed round on all halls to identify any areas in need of deep cleaning to include dusting sweeping mopping, and decluttering. On 1/24/2022, the hallways and rooms on 100 hall, 200 hall, 300 hall, 400 hall, 500 hall, and 600 halls were cleaned by housekeeping staff to include sweeping, mopping, dusting overbed lights and windowsills, and cleaning walls and base boards on hallways. The blinds, bedside table and over bed table were cleaned. Bathrooms cleaned. Deep cleaning schedule initiated for all rooms and maintenance task list initiated for repairs and painting to ensure a safe, clean, comfortable and homelike environment. F tag 677 Activities of Daily living for dependent residents: All residents who	

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F 867	Continued From page 36 11/19/21 the facility was cited for failing to provide sufficient staff to ensure 2 of 6 residents were allowed a choice regarding showers; failed to provide incontinence care for 2 of 6 residents reviewed for activities of daily living; failed to complete an admission Minimum Data Set (MDS) assessment for 3 of 5 residents; and failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Dates (ARD) for 3 of 5 residents reviewed for quarterly MDS completion. A phone interview on 01/24/22 at 1:31 PM with the Administrator revealed the facility had hired new staff in housekeeping as well as a new housekeeping supervisor and they were new and getting their flow regarding keeping the building clean. The Administrator explained incontinence care should have been provided to the resident and said there were other staff available to assist if the Nurse Aides (NAs) just asked for assistance. She stated the staff should have applied the splint especially since the resident wanted the splint on and there was a picture of the splint and how to apply it on her closet door. The Administrator further stated staffing had been a challenge since she had been at the facility and they had implemented bonuses, relaxed their disciplinary policy, given their staff a pay increase and implemented referral bonuses. The results of the annual recertification survey and audits from the survey were reviewed and had been presented at their monthly QA meeting in December. The Administrator stated staffing had been a challenge since she had been at the facility, and they had made changes but stated they would continue to recruit the best candidates and would be doing more extensive education with the staff. The Administrator indicated their	F 867	need assistance with toileting have the potential to be affected by this alleged deficient practice. On 1/27/2022 and 1/28/2022, Nurse Managers audited all current incontinent residents for toileting and incontinent care needs. Any resident identified with toileting or incontinent needs were promptly toileted or care provided by the assigned CNA. F-tag 688 Increase/Prevent Decrease Range of Motion: Residents who utilize a splint for contractures have the potential to be affected. On 1/27/2022, the QA Nurse Consultant audited all current residents with order for splints to ensure they were wearing splints and if any splints were noted to be misplaced a therapy referral was completed. Once it was determined who needed a splint, brace, palm guard, or hand roll replaced a therapy referral was completed. This process was completed by 1/28/2022. F -tag 725 Sufficient nursing staffing: On 1/24/2022, a 100% review of staffing ratios and assignments were completed by the Director of Nursing, Administrator, and Nurse Management team. The review Administrator initiated contracts with staffing agency to supplement current permanent staff. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/27/2022 the Corporate Regional Director of Operations and Quality Assurance Nurse Consultant began in-service education to the Administrator,	

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F 867	Continued From page 37 administrative team would be meeting to discuss the concerns and look at ways to resolve them in the best interests of the residents. She further indicated the overall staffing situation had contributed to their inability to sustain compliance through their QAPI program.	F 867	Director of Nursing Service, Business office manager, human resources manager, Activity y director, MDS Coordinator, Environmental services director, Maintenance director, Nurse manger and treatment nurse on the Quality Assurance and performance improvement policy Additional training on maintaining procedures and monitoring interventions to preventing failure of QA process related to QAPI. F-tag 584 Safe Clean and home like environment: An in-service was provided for housekeeping and maintenance staff on 1/27/2022 by the Environmental Services Director on the expectation for a clean, safe, comfortable and homelike environment. The deep cleaning schedule has been revised to ensure one room per hall (100 hall, 200 hall, 300 hall, 400 hall, 500 hall and 600 hall) per week (6 rooms per week) and walls and high dusting is being done. Additionally, skills check off for housekeeping staff added. Beginning 2/1/2022, Environmental Services Director began completing skills check offs for all housekeeping staff. As of 2/3/2022, all current housekeeping staff has been educated and completed skills check offs. F tag 677 Activities of Daily living for dependent residents: On 1/27/2022 the Director of Nursing began in-servicing all current full time, part time and PRN Nurses and CNA's. This in-service included the following topics: " ADL Care for Dependent Resident " Performing Incontinent/Perineal Care	

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F 867	Continued From page 38	F 867	per Plan of Care " UTI Prevention All training is to be completed by 2/3/2022. If training is not completed, The Director of Nursing will ensure that any Nurse or CNA who has not received this training will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. F-tag 688 Range of Motion: On 1/27/2022, the QA Nurse Consultant began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: ¿ The importance for applying splints, palm guards, hand rolls as ordered by the MD. ¿ What to do and who to notify if resident refuses to wear splint What to do when the device cannot be located. Nurse Managers will monitor residents requiring splints and compliance of use related plan of care daily and report in Clinical Meeting for review to include notifying MD of noncompliance and complete therapy referral and updating plan of care. Additionally, monitoring will increase to ensure compliance. The Director of Nursing will ensure that any Nurse or CNA who has not received this training by 2/3/2022 will not be	

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F 867	Continued From page 39	F 867	allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. F -tag 725 Sufficient nursing staffing: On 1/27/2022, the QA Nurse Consultant began an in-service education to all full time, part time, and as needed nurses and CNA□s. Topics included: " The importance of staff call-outs, notification to Director of Nursing/Administrator, staffing assignments and evaluating staff ratios to meet resident needs, specifically incontinent care. " The Administrator and Director of Nursing will review daily staffing sheets at the morning stand up meeting to ensure staff is scheduled to meet the ADL and Assessment needs of the residents. The Director of Nursing will ensure that any Nurse or CNA who has not received this training by 2/3/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified	

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F 867	Continued From page 40	F 867	above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA□s who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. Additionally, Facility has entered into contract with 1 staffing agency and initiated contracts with 3 other staffing agencies to ensure sufficient staff available to meet the needs of residents. This information has been integrated in to the standard orientation training and in the required in-service refresher courses for the Administrator, Director of Nursing and other department heads as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 2/11/2022. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 2/7/2022 The Regional Director of Operations, Quality Assurance nurse, Administrator and Director of Nurses will monitor facility QA Compliance with an ongoing auditing program with Plan of Correction Compliance Audits to assure that the	

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ROYAL PARK REHAB & HEALTH CTR OF MATTHEWS	2700 ROYAL COMMONS LANE MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 41	F 867	corrective actions implemented remain in place The audit will be reviewed at the weekly Quality Assurance Meeting weekly x4 then monthly x 3 or until deemed as no longer necessary as determined by the Regional Director of Operations and Quality Assurance Nurse Consultant. The weekly QA Meeting is attended by the Regional Director of Operations, Quality Assurance Nurse Consultant, Administrator, Director of Nursing, MDS Coordinator, and Nurse Managers, Wound nurse, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 2/3/2022	