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	345143	A. BUILDING _____ B. WING _____	C 03/17/2022

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SILER CITY CENTER	900 W DOLPHIN STREET SILER CITY, NC 27344

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E 000	Initial Comments An unannounced recertification survey was conducted 3/14/2022 through 3/17/2022. The facility compliance was in compliance with requirement CFR 483. See Event ID#I6C511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/14/2022 to 3/17/2022. The following intakes were investigated NC00185607, NC00186259, NC00186467, NC00186914, and NC00186916. 12 of the 22 complaint allegations were substantiated resulting in deficiencies. Event ID#I6C511	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		4/14/22

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

Electronically Signed | 04/08/2022

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with residents and staff, the facility failed to treat residents with dignity and respect when the facility staff utilized their cell phones for personal phone calls while assisting residents with the Activities of Daily (ADLs) care. This resulted in the residents feeling invisible and angry. This was for 3 (Resident #26, Resident #139 and Resident #96) of 7 residents reviewed for dignity. The findings included: 1. Resident #26 was admitted on 6/3/2019. Resident #26's quarterly Minimum Data Set dated 12/31/21 indicated he was cognitively intact and required extensive staff assistance with all of his	F 550	F550 □ Resident Rights/Exercise of Rights 1. Resident # 26, resident # 139, and resident #96 are currently receiving care with dignity and respect without staff using cell phones during care. 2. Social Services Director and Social Worker completed an interview with all current alert and oriented residents regarding resident rights being maintained during care 4/5/22. The interview included questions to determine if residents were being treated with dignity and respect during ADL care by staff not utilizing their cell phones while providing care. The audit revealed there were several	

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F 550	Continued From page 2 ADLs. An interview was conducted with Resident #26 on 3/17/22 at 2:22 PM. He stated it was not uncommon for the aides to talk on their personal phones during his care. He stated it made him feel invisible when they wore earbuds because he was unsure if the aides were talking to him or to the person on the phone. He stated he was the Resident Council President and this was discussed in a meeting months ago but there had been no improvement. Resident #26 stated it was mostly the agency aides doing it but some of the permanent staff were doing it too. He did not wish to provide any staff names. Review of a Resident Council grievance dated 11/28/21 indicated that the staff were gathering at the end of the 400 hall talking laughing and using their personal phones. Attached to the grievance was an in-service sign-in sheet dated 11/30/21 regarding professional behavior with 9 staff signatures. An interview was conducted on 3/17/22 at 11:25 AM with Nursing Assistant (NA) #4. She stated the staff was in-serviced about not using personal phones in the facility. She stated if staff needed to make or take a phone call, they had go outside or to their car. NA #4 continued that she did accept calls during resident care if they were important phone calls. An interview was conducted on 3/17/22 at 11:30 AM with NA #3. She stated she did answer her personal phone while performing personal care but she did not stay on her phone to chat.	F 550	residents on various units that have observed staff using their phones/earbuds in patient care areas. 3. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Practice Educator (NPE) provide education to all Licensed Nurses and Certified Nursing Assistants by 4/13/2022 (including weekend, agency, and PRN as needed staff) on resident rights. Residents should be treated with dignity and respect at all times by all staff. Cell phones, earbuds, or headphones should not be used by staff during patient care. Staff should not utilize their personal cell phones, earbuds, or headphones in patient care areas, including resident rooms and bathrooms. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. DON, ADON, NPE, and Nursing Supervisors will audit by performing walking rounds daily to monitor cell phone usage during care. Audits performed with observation of all five nursing units daily to include off shifts and weekends will be completed daily for 4 weeks, then 3 times weekly for 4 weeks, then weekly for 4 weeks. Social Service Director and Social Worker will interview five random alert and oriented residents three times per week for four weeks, then two times per week for four weeks, then weekly for four weeks. The Director of Nursing and Social Service Director will report the findings of the audits to the monthly Quality	

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F 550	Continued From page 3 An interview was conducted on 3/17/22 at 3:42 PM with the Administrator. He stated he was aware of the problem back in November 2021 and the aides were in-serviced about not talking on the personal phones during care out of respect. He stated he was not aware that it was an ongoing problem. 2. Resident #139 was admitted on 4/15/21. Resident #139's quarterly Minimum Data Set dated 2/23/22 indicated he was cognitively intact and required extensive staff assistance with all of his ADLs except for eating. An interview was conducted on 3/17/22 at 11:20 AM with Resident #139. He stated it was not uncommon for the aides to talk on their personal phones during care and it made him feel angry. He stated Nursing Assistant (NA) #4 frequently talked on her personal phone during care. Resident #139 stated it was brought to the attention of management months ago during a Resident Council meeting but was ongoing. Review of a Resident Council grievance dated 11/28/21 indicated that the staff were gathering at the end of the 400 hall talking laughing and using their personal phones. Attached to the grievance was an in-service sign-in sheet dated 11/30/21 regarding professional behavior with 9 staff signatures. An interview was conducted on 3/17/22 at 11:25 AM with NA #4. She stated the staff was in-serviced about not using personal phones in the facility. She stated if staff needed to make or take a phone call, they had go outside or to their	F 550	Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for ongoing compliance. 5. Compliance date: 4/14/2022.	

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F 550	Continued From page 4	F 550		

car. NA #4 continued that she did accept calls during resident care if they were important phone calls.
An interview was conducted on 3/17/22 at 11:30 AM with NA #3. She stated she did answer her personal phone while performing personal care but she did not stay on her phone to chat.

An interview was conducted on 3/17/22 at 3:42 PM with the Administrator. He stated he was aware of the problem back in November 2021 and the aides were in-serviced about not talking on the personal phones during care out of respect. He stated he was not aware that it was an ongoing problem.

3. Resident #96 was admitted on 9/14/21.

Resident #96's quarterly Minimum Data Set dated 2/2/22 indicated she was cognitively intact and required extensive staff assistance for all of her ADLs.

An interview was conducted on 3/17/22 at 8:57 AM with Resident #96. She stated staff used her room frequently to talk on their personal phones. She stated it was because the reception was better in her room. She stated there had been occasions where the agency aides were talking on their personal phones during her personal care and it made her feel angry. Resident #96 stated Nursing Assistant (NA) #3 did it frequently.

Review of a Resident Council grievance dated 11/28/21 indicated that the staff were gathering at the end of the 400 hall talking laughing and using their personal phones. Attached to the grievance was an in-service sign-in sheet dated 11/30/21 regarding professional behavior with 9 staff

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F 550	Continued From page 5 signatures An interview was conducted on 3/17/22 at 11:30 AM with NA #3. She stated she did answer her personal phone while performing personal care but she did not stay on her phone to chat. An interview was conducted on 3/17/22 at 11:25 AM with NA #4. She stated the staff was in-serviced about not using personal phones in the facility. She stated if staff needed to make or take a phone call, they had go outside or to their car. NA #4 continued that she did accept calls during resident care if they were important phone calls. An interview was conducted on 3/17/22 at 3:42 PM with the Administrator. He stated he was aware of the problem back in November 2021 and the aides were in-serviced about not talking on the personal phones during care out of respect. He stated he was not aware that it was an ongoing problem.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews the facility failed to assess whether self-administration of medications was clinically appropriate for 1 of 1 residents (Resident #60) who was observed to have medications bedside.	F 554	F554 □ Resident Self-Admin Meds-Clinically Appropriate 1. Nystatin Powder and Triamcinolone Cream were removed from bedside/room of resident #60 by Registered Nurse and Director of Nursing on 3/15/22. Resident	4/14/22

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F 554	Continued From page 6 The findings included: Resident #60 was admitted to the facility on 2/25/2020 with diagnoses that included chronic obstructive pulmonary disease (COPD) and a history of acute respiratory failure. Resident #60's Annual Minimum Data Set (MDS), dated 1/12/2022 indicated the resident was cognitively intact, had clear speech, understood others and could be understood by others. A review of medical records including physician's orders, assessments, and care plan revealed no order to have medications at bedside. There was no assessment or care plan for self-administration of medications. Resident #60 had a physician's order for the following medications: Triamcinolone Acetonide Cream 0.1 %, apply to active areas topically every day and night shift for skin lesions. Nystatin Powder 100000 Units per Gram, Apply to abdominal folds topically every day and night shift for rash. On 3/14/2022 at 1:59 PM the resident was observed to have one tube of Triamcinolone Acetonide Cream and two bottles of Nystatin powder bedside. An interview was conducted with Resident #60 at the time of the observation. He stated he administered the medications himself. On 3/15/2022 at 12:21 PM the resident was observed to have one tube of Triamcinolone Acetonide Cream and two bottles of Nystatin powder bedside.	F 554	#60 was evaluated for self-administering of medication on 3/15/22 by the Director of Nursing. 2. Audit completed on all current resident rooms in the facility by Nurse Supervisor 3/28/22 to monitor/observe for any medications being kept at bedside. The audit revealed there were 9 residents with medications at the bedside. Medications were removed from the resident room pending self-administering of medication evaluations to be completed. After reviewing the policy for self-administering medications and storing medications at bedside, none of these residents expressed desire to keep medications at bedside. All residents were agreeable to let the facility nurse store and administer medications as ordered. 3. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Practice Educator (NPE) provide education to all Licensed Nurses and Certified Nursing Assistants by 4/13/2022 (including weekend, agency, and PRN as needed staff) on the Policy and Procedure for self-administering medications and medication storage at bedside. Education included that residents must have a physician order to keep medication at bedside, a self-administering of medication evaluation indicating the resident is safe to administer and store medications, and a care plan must be in place indicating the resident is approved to self-administer medications. Certified Nursing Assistants (CNA) and Licensed	

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F 554	Continued From page 7 An interview was conducted with Nurse #3 on 3/15/2022 at 12:55 PM. He stated he was not aware of an assessment of Resident #60 for safe administration of medications. He further stated the medications should not have been left bedside. On 3/15/2022 at 3:44 PM an interview was conducted with the Director of Nursing (DON). She stated they do not have any residents that self-administer medications. She stated residents who do self-administer should have an assessment to ensure they are safe to self-administer, be care planned for self-administration, and have a physician's order to self-administer medications. When asked if Resident #60 had those criteria in place, she stated he did not and he should not have medications bedside.	F 554	Nurses should report to their supervisor immediately if medications are observed in any resident room. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. Director of Nursing, Assistant Director of Nursing, and Nurse Manager will audit 5 resident rooms three times per week for four weeks to monitor for medications in resident rooms; then 5 resident rooms two times weekly for four weeks, then 5 resident rooms weekly for four weeks. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for ongoing compliance. 5. Date of compliance 4/14/2022.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		4/14/22

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F 565	Continued From page 8 providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, Resident Council residents interviews, staff interviews and record review, the facility failed to resolve repeated grievances and failed to provide a written grievance response for 3 (November 2021, December 2021 and February 2022) of 3 months of resident council meeting minutes reviewed. The findings included Review of the facility policy titled "Grievances/Concern" last revised 11/1/21 read in part as follows: The facility will investigate, document and follow up on all concerns and grievances. The Center Executive Director (CED) will serve as the Grievance Officer with oversight of the grievance	F 565	F565 □ Resident/Family Group and Response 1. Written notification of Grievance resolution was provided to Resident Council regarding: better meals, repair of the television in the main dining room, renovation of the court yard door (adding an automatic opener), staff throwing soiled briefs on the floor, the courtyard being dirty, courtyard trash cans not being emptied often enough, and staff loudly talking at the end of the 400 hall and on their personal phones on 4/11/22. Education has been provided to dietary staff on meal preparation and always available breakfast menu on 4/4/22 and	

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F 565	Continued From page 9 process which include the issuing written grievance decisions to the resident for Civil Rights issues and upon request by the resident or responsible party (RP). Review of the Resident Council meeting minutes dated 11/28/21 read under the heading "What would make living here even better" with the documented response of better meals and repair of the television located in the main dining room. Attached to the meeting minutes was a grievance regarding Administration requesting follow up on the renovations to the door leading to the courtyard mentioned in the July 2021 Resident Council meeting. The response to the grievances read as follows: "Quotes being obtained." The grievance read that the resolution was shared with the Resident Council on 12/21/21. There was no mention that a written response was provided to the Resident Council President or committee members. There was also a grievance dated 11/28/21 regarding the staff gathering at the end of the 400 hall talking loudly, laughing and on their personal cell phones. There was no documented evidence that any follow up in person or written to the person in attendance of the meeting. Review of the Resident Council meeting minutes dated 12/27/21 read under the heading "Discussion of Old/Unfinished Business" read the television in the main dining room was still not fixed. There was attached to the minutes a grievance form from several residents regarding the staff not disposing dirty briefs in trash cans but leaving them on the floor in their rooms. Also attached was documentation of an in-service sign-in sheet dated 12/29/21 regarding the soiled briefs on the floors.	F 565	4/8/22; the television in the main dining room was replaced on 3/22/22; renovation of the dining room door to add an automatic opener is being evaluated for safety and a quote is being obtained; staff was educated on 3/28/22 about soiled briefs being discarded appropriately; the courtyard was cleaned on 3/8/22, and is on a weekly/as needed cleaning schedule; courtyard trash is on a weekly/as needed cleaning schedule as of 3/8/22; and, staff was educated about talking loudly at the end of 400 hall and being on the personal phones on 11/30/21. 2. Center Executive Director reviewed Resident Council minutes for 11/28/21, 12/27/21, and 2/27/22 and provided a written response to the Resident Council for the items listed above on 4/11/22. Center Executive Director reviewed Resident Council Minutes for the last 90 days and developed an action plan to correct all areas of Resident Concern. These plans will be brought to the Quality Assurance and Performance Improvement Committee for follow up and resolution. 3. Center Executive Director educated the Director of Social Services on 3/30/22 that all grievances, including grievances generated in Resident Council must be responded to in writing and a copy given to the person initiating the grievance showing the resolution. 4. Center Executive Director/designee will audit all grievances submitted for	

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F 565	Continued From page 10 There was no Resident Council meeting in January 2022 due to a COVID outbreak according to Social Worker (SW) #1. Review of the Resident Council meeting minutes dated 2/27/22 read under the heading "Discussion of Old/Unfinished Business" there no documentation regarding the meeting dated 12/27/21. There was documentation under the heading "What would make living here even better" with the response of better food, better cleaning and better laundry services. Attached to the meeting minutes was a grievance for Administration requesting the courtyard to be cleaned up, residents wanting to eat outdoors and another request for follow up about the courtyard door. There was no documentation that the Resident Council President or the committee members were informed of a response and no documentation regarding the date of a resolution. There was also attached a grievance regarding housekeeping which read that the trash cans in the courtyard were not being emptied often enough and the main dining room was frequently dirty. There was no documentation that the Resident Council President or the committee members were informed of a response and no documentation regarding the date of a resolution. Lastly, there was a grievance for Nursing regarding the staff still throwing soiled briefs on the floor instead of the trash can. There was no documentation that the Resident Council President or the committee members were informed of a response and no documentation regarding the date of a resolution. A Resident Council meeting was held on 3/16/22 at 10:00 AM. Residents present were the	F 565	resolution and that a written response with the resolution is given to the person generating the grievance, for four weeks, then randomly on an on-going basis. The Center Executive Director will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. Results of audits will be reviewed in the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for the on-going compliance. 5. Date of compliance 4/14/22.	

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F 565	Continued From page 11 Resident Council President, Vice President and 5 other residents who consistently attend the meeting. The members stated the food has been a problem for a long time and there had been no improvement. Also, the television in the main dining room was still not working, the courtyard door concerns were still unaddressed, the staff were still on their personal phones during care, staff continued to throw soiled briefs on the floor and the rooms and bathrooms were still not being cleaned properly. An interview was conducted on 3/17/22 at 9:58 AM with SW #1. She stated she conducted the Resident Council meetings, completed any concerns/grievance forms, maintained the grievance log, assigned the grievance to the correct department, ensured each grievance was addressed timely and provided the Resident Council any grievance responses during the next scheduled meeting. She stated after this, she gave the grievance with response to the Administrator for his signature. SW #1 stated she was not aware of the need for a written resolution and confirmed that the Administrator was the Grievance Officer. An interview was conducted on 3/17/22 at 3:42 PM with the Administrator. He verified that he was untimely the person responsible for the grievances. He stated SW #1 was responsible to ensure the grievance was addressed with a resolution. He stated he was not aware of the need to provide a written response to the person filing the grievance unless it was a Civil Rights violation.	F 565		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		4/14/22

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F 584	Continued From page 12	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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F 584	Continued From page 13 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to ensure resident rooms and a resident bed were in good repair (Rooms #305, #401, #404B and #309). In addition, the facility failed to ensure a resident's bathroom (Room 302), resident wheelchairs (Rooms #505A, #506A, #511B, #513A and #519B), and dining room (500 hall) were clean and sanitary. This was for 11 of 11 areas reviewed for environmental concerns. The findings included: 1. Resident #96 was admitted on 9/14/21. Resident #96's quarterly Minimum Data Set dated 2/2/22 indicated she was cognitively intact. An interview was conducted with Resident #96 on 3/15/22 at 11:00 AM. There was a foul odor in her room #302. Resident #96 stated the odor was coming from her bathroom. She stated neither her or her roommate used the toilet or a bed side commode. An observation of the bathroom in room 302 revealed a clump of dried brown substance approximately the size of a 50 cent piece on the floor at the entrance. There was also a bed side commode (BSC) in the bathroom. Observed around the sides of the BSC guard was splattered dried brown substance. The toilet was to the left of the BSC with the toilet seat down. On inspection, the toilet bowl wall was observed with so much dried brown substance that the white color of the toilet bowl wall was barely visible. In	F 584	F584 □ Safe/Clean/Comfortable/Homelike Environment 1. Resident room 305, 401, were repaired on 4/8/22. Room 309 ceiling tiles were replaced on 3/28/22. Room 309 wall was repaired on 4/12/22. Resident 404-2 footboard was replaced on 3/16/22. Resident□s bathroom in 302 was cleaned on 3/16/22. Resident wheelchairs for 505 -1, 506-1, 511-2 513-1 and 519-2 were cleaned on 4/1/22. The dining room for 500 Hall was cleaned on 3/15/22. 2. Center Executive Director, Maintenance Supervisor and Housekeeping Manager toured all resident rooms on 4/8/22 to look for damage requiring repair, wheelchairs that needed to be cleaned, and beds with footboards or headboards not in place, and common areas including dining rooms, lobby, hair salon, Activities Room, and shower rooms. The audit did not reveal any additional rooms with water damage. An audit was conducted by the district manager for Health Care Services Group of the bathrooms, wheelchairs, and the dining rooms on 3/17/22. 3. Environmental Services staff was educated by Housekeeping manager on 4/4/2022 on ensuring that all bathrooms, dining rooms, and wheelchairs are cleaned on timely schedule. Education	

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F 584	Continued From page 14 the center of the toilet bowl was a medium amount of stagnant brown liquid. An interview was conducted on 3/15/22 at 2:22 PM with the Housekeeping Manager (HKM). She stated she started her position at the facility approximately 2 weeks ago and there had been major staffing challenges. She stated she had only one housekeeper and herself to clean the facility today and that it was impossible to clean with the current staffing situation. The HKM stated she should have 4 housekeepers each day. She stated her District Supervisor (DS) was at the facility yesterday and assisted with some of the cleaning but she did not mention anything to her about ideas for the staffing situation. An observation was completed of room 302's bathroom with the HKM. When she saw the condition of the bathroom, she stepped back and covered her face with her hands. She stated "this is horrible." The HKM stated her staff did not remove bodily fluids or waste but rather the aides would be responsible for ensuring the stool was flushed and the HK staff were responsible for the cleaning and sanitation. She stated it was apparent that nobody had cleaned the bathroom in "awhile" since the stool on the floor, BSC and toilet basin wall was dried and caked. An observation was conducted of the bathroom in room 302 on 3/16/22 at 8:30 AM. The appearance was unchanged from 3/15/22 at 11:00 AM. The foul odor was still present as well. Another observation was conducted of the bathroom in room 302 on 3/16/22 at 8:40 AM with the Administrator. He stated the condition of the	F 584	included bathrooms, dining rooms, and wheelchair cleaning, 5 step cleaning method, 7 step cleaning method, deep clean method, and morning walk-through. Additional education from the Healthcare Services Group (HCSG) District Manager emphasizing bathrooms, dining rooms, and wheelchair cleaning, 5 step cleaning method, 7 step cleaning method, deep clean method, and morning walk-through will be conducted on 4/14/22 for all HCSG staff. Any department that observes soiled wheelchairs that are outside of the wheelchair schedule can be placed by staff on the service hall after its dated and labeled for housekeeping to clean and return. Maintenance Director was educated by the Center Executive Director on 4/8/22 regarding rounding of all resident areas a minimum of weekly, noting areas of damage/repair needed, and notifying Center Executive Director. All areas requiring repair will be added to the Center□s Work Order system for monitoring and completion by the Center Executive Director. Center Executive Director will independently review resident rooms. 4. Maintenance Supervisor will audit 10 resident rooms 3 times per week for 4 weeks looking for items needing repair or beds without footboards or headboards. The rooms being audited will vary each time. The Maintenance Supervisor/designee will then audit 5 resident rooms 3 times per week for 3 weeks looking for items needing repair or beds without footboards or headboards.	

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F 584	Continued From page 15 bathroom was "ridiculous." He stated they had identified the housekeeping problem about 3 weeks ago and the previous HKM was demoted. He stated the HKM started a plan of correction at that time. Review of the contracted housekeeping service provider's plan of correction dated 2/24/22 read as follows: The hallways and the floors in the resident rooms were not being maintained properly. Staffing was also identified as an issue. There was no mention of the cleanliness of the bathrooms in the plan of correction. An interview was conducted on 3/16/22 at 11:55 AM with Housekeeper (HK) #1. She stated she had worked at the facility for approximately 3 months and there was not enough HK staff to perform the daily cleaning. She stated there should be at least 4 HK staff daily to maintain the cleanliness of the residents rooms and bathrooms. HK #1 stated the HKM assisted with cleaning yesterday and now some of the other housekeeping managers were helping today. An interview was conducted on 3/16/22 at 1:16 PM with the housekeeping DS. She stated it came to her attention that the previous HKM was not actively recruiting staff so he was demoted. She stated the new HKM started on 2/1/22. The DS stated the appearance of the facility was not good at that time and the current condition of the facility's cleanliness was an improvement. She stated she started a plan of correction in February 2022 to support the need for the other managers to assist her because she needed documentation to support it. The DS stated the Administrator was aware of the problem and was participating in the plan to fix it	F 584	Center Executive Director will audit 10 resident rooms 3 times per week for 4 weeks verifying information for required repairs or beds without footboards/headboards, then Center Executive Director will audit 5 resident rooms, 3 times per week for 3 weeks verifying items needing repair or beds without footboards/headboards. Center Executive Director/designee will audit dining rooms 5 days a week for cleanliness for 4 weeks, then dining rooms 3 days/week for 3 weeks for cleanliness. Housekeeping Manager will audit all 500 Hall wheelchairs weekly for cleanliness for 3 weeks. The report of the audits will be taken to the monthly Quality Assurance and Performance Improvement meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. 5. Date of compliance 4/14/22.	

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An observation was conducted of room 302's bathroom on 3/17/22 at 10:30 AM. It had been cleaned and sanitized. There was no longer the foul odor.

An interview was conducted on 3/17/22 at 10:47 AM with Nursing Assistant (NA) #6 and NA #7. Both stated neither resident in room 302 used the bathroom because both residents were incontinent. NA #6 stated neither resident used a BSC either and unsure how or why it was in the bathroom. NA #6 stated it could be the staff using the bathroom in room 302.

An interview was conducted on 3/17/22 at 3:42 PM with the Administrator. He stated the toilet in room 302 was clogged and the maintenance person had to unclog it before it was cleaned and sanitized. He stated he expected that no resident's bathroom should appear as the one in room 302.

2. Resident #36 was admitted on 4/14/15.

Review of Resident #36's quarterly Minimum Data Set dated 1/3/22 indicated he resided in room 404B and his height was 66 inches or 5 feet 5 inches.

Resident #36 was observed in room 404B on 3/14/22 at 2:00 PM lying in bed on an air mattress with the mattress pump lying on the floor at the foot of the bed. The mattress was observed extending past the foot end of bed frame approximately 8 inches and the bed footboard was missing.

Room 404B was observed on 3/15/22 at 10:00

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AM. The appearance of his bed frame, air mattress pump and mattress were unchanged.

Room 404B was observed on 3/16/22 at 8:54 AM. The appearance of his bed frame, air mattress pump and mattress were unchanged.

Room 404B was observed on 3/16/22 at 11:02 AM. The appearance of his bed frame, air mattress pump and mattress were unchanged.

An interview was conducted on 3/16/22 at 1:16 PM with the Maintenance Supervisor (MS). He stated he had been the MS for the past 6 months. He stated he did not routinely inspect the resident bed's for function, disrepair or safety. He stated the staff complete a work order, but a lot of the time staff only tell him about needed repairs. He stated he had not received a work order regarding the bed in room 404B missing a footboard but stated it was easy to remove a footboard because it just slides over 2 bolts to be held in place. An observation was completed with the MS of the bed in room 404B. He stated he was unsure why the footboard was missing, and it was possible that the aides were removing the footboards. The footboard was not located anywhere in room. The MS also observed the mattress hanging off the bed frame with the air mattress pump on the floor. He confirmed that the mattress pump on the floor could cause someone to trip and the slipping of his mattress could result in an accident as well.

The MS stated on 3/16/22 at 1:55 PM that he replaced the footboard in room 404B, the air mattress pump was on his footboard and the mattress now fit snuggly in the bed frame.

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Room 404B was observed on 3/17/22 at 11:40 AM. The footboard was attached to the bed frame, the air mattress fit snuggly inside the bed frame and the air mattress pump was off the floor and attached to the footboard.

An interview was conducted on 3/17/22 at 9:00 AM with Nursing Assistant (NA) #7. She stated she had worked at the facility since June 2021 and the footboard in room 404B had not been attached to the bed for months. She stated the staff were not removing the footboards but rather the footboards would not stay on the bed and would fall off. She stated the MS was aware.

An interview was conducted on 3/17/22 at 9:09 AM with NA #15. She stated the footboard on the bed in room 404B would not stay on and the MS was aware.

An interview was conducted on 3/17/22 at 3:42 PM with the Administrator. He stated he was not aware that the footboard was missing from his bed in room 404B. He stated it was his expectation that resident beds were routinely inspected and if a problem with a bed was identified, it would address timely.

3) On 3/14/22 at 10:00 AM, an observation of room 305 revealed crumbling and missing areas of sheetrock to the wall between the bottom of the windowsill and the top of the heating/air conditioning unit.

Observations were conducted during a round with Maintenance on 3/16/22 at 11:39 AM. He observed the areas of sheetrock damage

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underneath the windowsill and stated he was unaware of the damage which did require attention and would be addressed.

The Administrator was interviewed on 3/17/22 at 4:45 PM, and stated it was important for the environment to be well repaired and homelike.

4) On 3/14/22 at 10:30 AM, an observation of room 401 revealed crumbling areas of sheetrock with visible water damage to the wall between the bottom of the windowsill and the top of the heating/air conditioning unit.

Observations were conducted during a round with Maintenance on 3/16/22 at 11:39 AM. He observed the areas of sheetrock damage underneath the windowsill and confirmed water damage was present. He stated he was unaware of the damage which did require attention and would be addressed.

The Administrator was interviewed on 3/17/22 at 4:45 PM, and stated it was important for the environment to be well repaired and homelike.

5) On 3/15/22 at 10:10 AM, an observation of room 309 revealed water damaged ceiling tiles in the left corner of the room and to the left of the top of the window. There was a slight bulge to the wall in the left corner of the room as well, but no dampness was felt to the wall.

During an interview with Maintenance on 3/15/22 at 3:04 PM, he stated 6 months ago a pipe burst around the area of room 309 which was fixed right away. He agreed there was water damage to the ceiling tiles in room 309, which should have

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been replaced shortly after the repair and could offer no reason as to why this did not occur. He further stated the buckling in the wall was due to wallpaper being painted over, which buckled when the water damage occurred. Maintenance stated he had been checking frequently on rainy days to ensure there was no further leaking.

On 3/16/22 at 5:00 PM, it was currently raining and had been since 1:00 PM with moderate to heavy rainfall. An observation occurred of room 309 and revealed no leaking from the damaged ceiling area and the wall was dry to the touch.

The Administrator was interviewed on 3/17/22 at 4:45 PM, and stated it was important for the environment to be well repaired and homelike.

6. On 3/14/22 at 10:39 AM, initial tour of the 500 hall (secured unit) was conducted. In the dining room, there were food particles and papers observed on the floor around and under the dining table. There was no housekeeper observed on the hall.

On 3/15/22 at 8:30 AM, the 500-hall dining room was again observed with food particles and papers on the floor. There was no housekeeper observed on the hall.

On 3/15/22 at 9:45 AM, a housekeeper was observed cleaning the dining room.

7. On 3/14/22 from 10:40 AM through 11:00 AM, the resident's wheelchairs were observed. The wheelchairs in rooms 505 A, 506 A, 511 B, 513 A and 519 B were observed with dust buildup and tan colored dried substance on the spokes. There were food particles and debris stuck on the

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side of the seat.

On 3/15/22 at 10:10 AM, another observation was made of the wheelchairs. The wheelchairs were observed on the same condition as above.

On 3/15/22 at 10:15 AM, the Director of Nursing (DON) was in the 500-hall dining room. She observed the food particles and papers on the floor. She also observed the resident's wheelchairs that were in the dining room to be dusty and dirty. She commented that the floor and the wheelchairs needed to be cleaned. The DON reported that the housekeepers were responsible for cleaning the wheelchairs.

On 3/15/22 at 10:16 AM, the Administrator was in the 500-hall dining room. He observed the dining room floor and the resident's wheelchairs in the dining room to be dirty. He stated that the facility was short of housekeepers, 1 housekeeper had called out today (3/15/22).

On 3/15/22 at 10:30 AM, the Housekeeping Manager was interviewed. She stated that she started as the housekeeping account manager at the facility 2 weeks ago. She reported that when she came to the facility, there was a shortage of housekeepers. She stated that she had identified problems in housekeeping and the company had sent account managers from the other facility to help. She indicated that she had 1 full time housekeeper and 3 floor technicians (techs) at this time. She also started using the floor techs as housekeepers, but 1 floor tech had called out today. She was also trying to hire more housekeepers. The Housekeeping Manager stated that she had plans to change the working time for the housekeepers to come in at 7 AM

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F 584	Continued From page 22 instead of 8 AM to ensure the floor in the dining room was clean before the residents eat their breakfast. She also stated that she already had a schedule plan for wheelchair cleaning but had not started yet due to staffing issues.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585		4/14/22

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facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions

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F 585	Continued From page 24 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a written grievance response summary for 4 of 4 residents reviewed for grievances (Residents #68, #77, #136 and #85). The findings included: 1) Resident #68 was originally admitted to the facility on 1/3/22. The admission Minimum Data Set (MDS) assessment dated 1/17/22 indicated she had moderately impaired cognition. Review of the facility grievance logs indicated 2 grievance forms were initiated on 1/6/22 by a family member for Resident #68 for the following:	F 585	F585 - Grievances 1. Residents #68, #77, #136 and #85 were advised verbally of the resolution to a grievance they initiated, but were not given written notice. Resident #136 claimed to the surveyor to have submitted several grievances, but record review of the grievance log back to the admission of resident #136 showed only one grievance submitted, which was resolved. Administrator gave written notice of the resolution of the grievances to resident # 68, #77, and #136 on 4/7/22. Administrator interviewed resident #136 about other grievances reportedly	

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F 585	Continued From page 25 - The first grievance form was regarding the call light not answered timely. The grievance form indicated a phone conversation was completed with the family member with an unknown date or time. The form indicated a written response was not provided to the family member and was signed and dated by the Administrator on 1/27/22. - The second grievance form was regarding a missing hand device used with meals. The grievance form indicated the device was found in her room but there was no indication of a verbal response to the family member regarding resolution of the grievance nor a written response provided. The grievance form was signed and dated by the Administrator on 2/16/22. On 3/17/22 at 9:58 AM, an interview occurred with Social Worker (SW) #1 who stated she maintained the facility grievance log and only made sure the staff responsible for investigating the concern completed the form completely. When a grievance form was returned it was then handed to the Administrator for final review. SW #1 stated she was not aware a written response was required for grievances, nor had she been told to provide written responses for grievance resolutions. The Administrator was interviewed on 3/17/22 at 3:48 PM and stated he was unaware a written grievance response was required. The Administrator stated it was his expectation for the facility to adhere to the regulatory guidelines regarding written grievance response summaries. 2) Resident #77 was originally admitted to the facility on 9/11/10. A quarterly MDS dated 1/19/22 indicated she had moderately impaired	F 585	submitted and he agreed that he had only submitted the one grievance and appreciated the follow up. Resident #136 signed the bottom of the written notice to acknowledge receipt. Administrator mailed a written copy of the resolution of the grievance to the Power of Attorney for resident #85 on 4/8/22, and mailed written copies to the family members of residents #68 and #77 who had initiated grievances for those residents. 2. Center Executive Director reviewed all Grievances for the last 30 days on 4/7/22, 4/11/22, and 4/12/22. The audit revealed that 15 Grievances had been received in the previous 30 days but the submitting party had not received written notification. Written notification was provided to all submitting parties between 4/7/22 and 4/12/22. 3. Center Executive Director educated the Director of Social Services on 3/30/22, and a policy was put in place for the Director of Social Services to ensure that all resident/family members received a written notification of the grievance resolution. 4. Center Executive Director will conduct an audit of all grievances submitted to ensure that a copy of the written resolution of the grievance is provided to the party initiating the grievance upon completion of the investigation. The Center Executive Director will report the findings of the audits to the monthly Quality Assurance and Performance	

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F 585	Continued From page 26 cognition. Review of the facility grievance logs indicated the following grievance forms had been initiated by a family member of Resident #77: - A grievance form was initiated on 11/3/21, regarding missing personal items and the cleanliness of her room. The grievance form indicated a staff member in housekeeping spoke with the family member on the phone, with an unknown date. The form indicated a written response was not provided and was signed and dated by the Administrator on 11/16/21. - A grievance form was initiated on 1/26/22 regarding cleanliness of Resident #77's bathroom. The grievance form indicated the housekeeping Account Manager conducted a face-to-face visit, but it was unclear as to whether this was with the family member or Resident #77. The form indicated a written response was not provided and was signed and dated by the Administrator on 2/16/22. On 3/17/22 at 9:58 AM, an interview occurred with Social Worker (SW) #1 who stated she maintained the facility grievance log and only made sure the staff responsible for investigating the concern completed the form completely. When a grievance form was returned, they were provided to the Administrator for final review. SW #1 stated she was not aware a written response was required for grievances, nor had she been told to provide written responses for grievance resolutions. The Administrator was interviewed on 3/17/22 at 3:48 PM and stated he was unaware a written grievance response was required. The Administrator stated it was his expectation for the	F 585	Improvement meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. 5. Date of compliance 4/14/22.	

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facility to adhere to the regulatory guidelines regarding written grievance response summaries.
3. Resident #136 was admitted 6/21/21 with a diagnosis of Diabetes.

Review of a grievance dated 11/22/21 by Resident #136 read he was not satisfied with the food.
His quarterly Minimum Data Set dated 2/16/22 indicated he was cognitively intact.
Resident #136's March 2022 Physician orders read that he was prescribed a regular diet.
An interview was conducted on 3/14/22 at 12:39 PM, Resident #136 stated the food was served cold, served the wrong items and the food was unpalatable. He stated he had completed grievances in the past but nothing ever improved so he just stopped filing food grievances.

An interview was conducted on 3/17/22 at 9:58 AM with Social Worker (SW) #1. She stated she maintained the grievance log, assigned the grievance to the correct department, ensured each grievance was addressed timely and provided any grievance responses to the person filing the grievance by phone or in person. She stated she then gave the grievance to the Administrator for his signature. SW #1 stated she was not aware of the need for a written resolution.
An interview was conducted on 3/17/22 at 3:42 PM with the Administrator. He verified that he was untimely the person responsible for the grievances. He stated SW #1 was responsible to ensure the grievance was addressed with a resolution. He stated he was not aware of the need to provide a written response to the person filing the grievance unless it was a Civil Rights violation.

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4. Resident # 85 was admitted to the facility on 1/31/22. Th admission Minimum Data Set (MDS) assessment dated 2/7/22 indicated that Resident #85 had memory and decision-making problems.

Resident #85's responsible party (RP) had filed a grievance on 2/12/22. The grievance/concern form indicated that the RP had visited Resident #85's room and observed the restroom was very dirty. The RP had notified the staff at the nurse's station. Later, at the end of the week, family members visited and found the restroom was still dirty.

The grievance/concern form dated 2/12/22 indicated that the grievance was investigated, and the concern was confirmed by the housekeeping account manager. The recommended corrective action was to in-service the staff and to hire more housekeeping staff. The form under written notification provided was left blank.

The Social Worker (SW) #1 was interviewed on 3/17/22 at 9:58 AM. The SW stated that she was responsible for maintaining the grievance log and ensure the staff responsible for investigating the concerns completed the form completely. When the grievance form was completed, the form was handed to the Administrator for final review. SW #1 indicated that she was not aware that a written response was required for grievances nor had been told to provide written responses for grievance resolution to the person filing the grievance.

The Administrator was interviewed on 3/17/22 at 3:48 PM. He stated that he was not aware a written response was required for grievances.

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F 585	Continued From page 29 The Administrator indicated that it was his expectation for the facility to follow the regulation regarding written response for grievances.	F 585		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by:	F 604		4/14/22

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F 604	Continued From page 30 Based in observations, record reviews, and staff interviews, the facility failed to identify a trunk harness and a lap belt as a restraint for 1 of 1 (Resident #134) reviewed for physical restraints. The findings included: Resident #134 was admitted to the facility on 4/12/2021 with diagnoses that included cerebral palsy. The resident's quarterly Minimum Data Set (MDS) dated 2/16/2022 indicated the resident was severely cognitively impaired, rarely understood and rarely understood others. Resident #134 required extensive assistance for all activities of daily living and personal hygiene. The resident was coded as not having falls, pressure injuries, or restraints during the assessment period. Resident #134 had a physicians order to wear chest belt and lap belt at all times when in wheelchair. Resident #134's care plan, last updated 3/4/2022, did not contain a focus for restraints. On 3/14/22 at 2:38 PM Resident #134 was observe in the hall sitting in a wheelchair. She had on a H style trunk harness and a lap belt. Both were observed to be attached to the wheelchair. On 3/15/22 at 10:53 AM Resident #134 was observed in the hall seated in a wheelchair with the H style trunk harness and lap belt in use. Both were observed to be attached to the wheelchair. An interview was conducted on 3/15/2022 at 10:54 AM with Nurse Assistant (NA) #5. She	F 604	F604 □ Right to be Free from Physical Restraints 1. A restraint evaluation for resident # 134 was completed by the Director of Nursing 4/8/22. Physician orders for seat belts were updated 4/8/22 by the DON. Resident care plan was updated 4/8/22 by the DON to reflect the use of seatbelt. 2. The Nursing Supervisor completed an audit 4/5/22 of all current residents in the facility with specialty wheelchairs for presence of seat belt/position device attached to the wheelchair that could be considered a restrictive device. There were 3 residents using specialty wheelchairs with seat belts attached. Residents noted to have seat belt/position device attached to their specialty wheelchair will be evaluated by Physical Therapy for use of potential restraint. 3. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Practice Educator (NPE) provide education to all Licensed Nurses by 4/13/2022 (including weekend, agency, and PRN as needed staff) on the Policy and Procedure for restraint use. A restraint is defined as a device that cannot be easily removed by the resident on command and restricts the patient's freedom of movement. A restraint evaluation should be completed by the licensed nurse to determine if the device is in fact a restraint. When a restraint is necessary the resident needs a physician order including release instructions, a care plan should reflect the use of a	

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F 604	Continued From page 31 stated she was assigned to Resident #134 and she was familiar with the resident. She further stated the harness was for the resident's safety, to keep her from falling out of her wheelchair. NA #5 stated the resident was not able to release restraints on her own due to cognitive and physical disabilities. Nurse#4 was present at time of interview with NA#5 on 3/15/2022 10:54 AM. She also stated the resident's harness and lap belt were for the resident's safety. She further explained the staff lean the chair back to release the tension on the harness. Nurse #4 confirmed the resident was not able to release the harness or the lab belt on her own. When asked about physical restraint assessments, she stated the nurses do not complete the restraint assessments, she was not sure who did the restraint assessments. On 3/15/2022 at 11:42 AM an interview was conducted with the Director of Nursing (DON) regarding Resident #134's trunk harness and lap belt. She stated the harness and lap belt are for positioning and not considered a restraint, therefore they did not have a focus for restraints on the care plan and it is not coded on the MDS as a restraint. When asked if the resident could remove the harness or lap belt, she stated the resident could not remove either. She further stated therapy could explain the use of the harness and lap belt for the purpose of positioning. On 3/15/2022 at 11:44 AM an interview was conducted with physical and occupational therapist #1. He stated the resident came into the facility with a custom made " positioning device" that consisted of a harness that came across the	F 604	restraint, and the restraint should be coded on the Minimum Data Set (MDS). Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. The Nursing Supervisor will audit all current residents using specialty chairs including new admissions for attached devices that could be considered a restraint, audit will be completed weekly for three months. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for ongoing compliance. 5. Date of compliance 4/14/2022.	

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F 604	Continued From page 32 chest and a lap belt. The staff noticed she hyper-flexed her extensor muscles and was at risk for developing pressure injuries on her back. The therapy group contacted a company who specialized in this type of custom-made device. The company came to the facility, evaluated, measured, and custom made a harness and lap belt apparatus. The device needed to be kept taunt to maintain a body position that would not cause pressure injuries. He stated he did not consider the harness or the lap belt a restraint since they are used for positioning. When asked if the resident can remove the device, he stated she could not. On 3/15/22 at 12:35 PM a second interview was conducted with the DON. She stated there was no initial assessment nor were there quarterly assessments for the use of restraints for Resident #134.	F 604		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		4/14/22

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paragraph (c)(5) of this section.

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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F 623	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on record review and interview with the responsible party (RP), and or resident and staff, the facility failed to notify the RP in writing of the reason for the discharge to the hospital for 5 of 5 sampled residents reviewed for hospitalizations (Residents #20, #83, #136, #134, & #64). Findings included: 1. Resident #20 was admitted to the facility on 9/30/18. Review of the nurse's note dated 9/15/21 at 1:40 AM revealed that Resident #20 was discharged to the hospital after a fall and was readmitted back to the facility on 9/17/21. The quarterly Minimum Data Set (MDS) assessment dated 12/15/21 indicated that Resident #20 had severe cognitive impairment. Nurse #1 was interviewed on 3/16/22 at 8:30 AM. The Nurse stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. The Registered Nurse (RN) Supervisor #1 was interviewed on 3/16/22 at 10:05 AM. The RN Supervisor stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge. Resident #20's Responsible Party (RP) was not	F 623	F623 □ Notice Requirements before Transfer/Discharge 1. Written notice of discharge to the hospital was provided 4/8/22 by the Business Office Manager to the resident representative of residents #20,#83,#136, #134, and #64 2. The Business Office Manager and Director of Nursing completed an audit 3/29/22 of all residents discharged to the hospital within the last 30 days. Written notification of the resident's discharge to the hospital including date, location, and reason was provided to the resident representative or the residents who were discharged to the hospital by the BOM on 4/8/22 3. Education was provided to the Business Office Manager (BOM), Director of Nursing (DON), Assistant Director of Nursing(ADON), Nursing Supervisor and Social Service Director by Center Executive Director (CED) 4/8/22. Education included instructions on when a resident is discharged and admitted to the hospital a notification of transfer is either mailed to the resident representative or given to the resident if they are their own representative. The original copy is mailed to the responsible party or given to the responsible resident and a copy is maintained in the medical record. 4. The Business Office Manager (BOM) and Health Information Manager (HIM)	

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F 623	Continued From page 36 available for interview. The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. The DON stated that she didn't know the regulation to notify the RP in writing of the reason for hospitalization. She reported that the nurse notified the RP by calling her/him. 2. Resident #83 was admitted to the facility on 7/26/21. Review of the nurse's note dated 8/8/21 at 9:50 AM revealed that Resident #83 was discharged to the hospital due to positive occult blood and was readmitted back to the facility on 8/11/21. The quarterly Minimum Data Set (MDS) assessment dated 1/26/22 indicated that Resident #83 had severe cognitive impairment. Nurse #1 was interviewed on 3/16/22 at 8:30 AM. The Nurse stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. The Registered Nurse (RN) Supervisor #1 was interviewed on 3/16/22 at 10:05 AM. The RN Supervisor stated that when a resident was transferred/discharged to the hospital, the RP was called to notify her/him that the resident was discharged to the hospital. She added that she didn't know that the RP should be notified in writing of the reason for the discharge. Resident #83's Responsible Party (RP) was	F 623	will audit the medical record of all hospital admissions 5 days per week for 3 months during the clinical meeting to ensure all discharge notices are provided to the resident representatives or residents. A copy will also be placed in the resident□s medical record. The BOM will report the findings of the resident representative / resident notification audits and the HIM will report the findings of the copy of transfer notice in the medical record audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for ongoing compliance. 5. Date of compliance 4/14/2022.	

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F 623	Continued From page 37	F 623		

interviewed on 3/16/22 at 10:20 AM. She stated that she could not recall receiving a letter from the facility when the resident was admitted to the hospital.

The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. The DON stated that she didn't know the regulation to notify the RP in writing of the reason for hospitalization. She reported that the nurse notified the RP by calling her/him.

3. Resident #136 was admitted 6/21/21.

Resident #136 was listed as his own responsible party in the electronic medical record.

His quarterly Minimum Data Set dated 2/16/22 indicated he was cognitively intact.

Resident #136 was interviewed on 3/15/22 at 8:54 AM. He stated he was sent to the hospital on 2/25/22. He stated he never received anything in writing from the facility regarding his reason for the hospital transfer.

An interview was conducted on 3/15/22 12:21 PM with the Business Office Manager. She stated the facility did not provide a written reason for a hospital discharge to the residents or the responsible party (RP).

An interview was conducted on 3/15/22 at 12:35 PM with the DON. She acknowledged they do not provide a written reason for a hospital transfer to the resident or RP because the facility was not aware that a written reason was required.

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F 623	Continued From page 38	F 623		

4. Resident #134 was admitted to the facility on 4/12/2021 with diagnoses that included muscle weakness and abnormal posture.

The resident's quarterly Minimum Data Set (MDS) dated 2/16/2022 indicated the resident was severely cognitively impaired, rarely understood and rarely understood others.

The resident medical record revealed she was discharged to the hospital on 2/8/2022 and readmitted on 2/10/2022. A bed hold policy was completed but there was no written notice of discharge in the resident's medical record.

Attempts to contact the RP were not successful.

An interview was conducted with the Business Office Manager on 3/15/2022 at 12:21 PM. She stated when a resident is transferred to the hospital, they send a bed hold policy but not a written notice of discharge.

On 3/15/2022 at 12:35 PM and interview was conducted with the DON. She stated the resident was discharge to the hospital after her feeding tube was displaced. The DON acknowledged no written notice of discharge was sent to Resident #134's RP. She stated they called the RP and they completed the bed hold but they did not complete a written notice of discharge. She was not aware a written notice was required.

5) Resident #64 was originally admitted to the facility on 11/12/21. The admission Minimum Data Set (MDS) assessment dated 1/4/22 indicated he

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F 623	Continued From page 39 had severely impaired cognition. Resident #64's medical record revealed he was transferred to the hospital and readmitted to the facility on 11/14/21 to 11/18/21, 11/24/21 to 12/2/21, 12/8/21 to 12/13/21 and 12/22/21 to 12/29/21. There was no documentation that a written reason for hospital transfer was provided to the responsible party (RP). On 3/15/22 at 11:42 AM, the Director of Nursing (DON) was interviewed and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information if present, physician orders, medication and treatment administration records and the Bed Hold policy were sent when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and reason for transfer. The DON stated she was unaware of a written notification of transfer being sent to the RP. The Business Office Manager was interviewed on 3/15/22 at 12:21 PM and stated a Bed Hold policy was sent with the resident when they were transferred to the hospital, but she was unaware of anything being sent to the RP regarding the reason for hospital transfer. The DON was interviewed again on 3/17/22 at 2:00 PM. She stated she was unaware of the regulation regarding the need for written reason for hospital transfer to be sent to the resident and/or RP and confirmed this was not occurring.	F 623		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		4/14/22

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F 641	Continued From page 40 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of Activities of Daily Living (ADL) (Resident #64), pressure ulcer (Resident #64), active diagnosis (Resident #136), discharge disposition (Resident #143), and medications (Residents #131 and #38). This was for 5 of 34 residents reviewed. The findings included: 1.) Resident #64 was originally admitted to the facility on 11/12/21 with diagnoses that included presence of a feeding tube. a.) A review of the active physician orders revealed an order dated 12/29/21 for Nothing by mouth (NPO) status. The admission MDS assessment dated 1/4/22, indicated Resident #64 had severe cognitive impairment and was nonverbal. He was coded as being independent with setup help only for eating. The swallowing/nutrition status section of the assessment indicated Resident #64 had a feeding tube present and received all nutrition and fluids via the tube. A review of the medical record for Resident #64 from 11/12/21 to 3/15/22 revealed all nutrition and fluids were provided by nursing staff via a feeding tube. On 3/16/22 at 8:54 AM, an observation of	F 641	F641 □ Accuracy of Assessments 1. Modifications were made to the Minimum Data Set (MDS) for Residents that were miscoded. Modifications were made to the MDS of resident #64 by the MDS Nurse on 4/1/22. Modifications were made to the MDS of resident #136 by the MDS Nurse 4/1/22. Modifications were made to the MDS of resident #143 by the MDS Nurse on 3/30/22. Modifications were made to the MDS of resident #131 by the MDS Nurse 3/17/22. Modifications were made to the MDS of resident #38 by the MDS Nurse on 4/1/22. Two modifications for resident #64 included changing the meal assistance in ADL section G to total dependence with physical assistance of 1 staff member and modification of section M residents' pressure wound was changed from one MASD wound to one unstageable wound. Modification to resident # 136 included adding diagnosis of Psychosis to section I. Modification to resident # 143 included changing residents discharge status to discharged home in section A. Modification to resident # 131 included changing resident from not receiving antipsychotic to receiving antipsychotic during assessment period in section N. A modification to resident #38 included adding that resident had a GDR attempt of antipsychotic medication to section N. 2. MDS Nurse completed an audit of	

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F 641	Continued From page 41 Resident #64's feeding tube site care was completed with the Assistant Director of Nursing (ADON). She stated Resident #64 received all fluids, nutrition, and medication by the feeding tube. An interview was conducted with the MDS Nurse on 3/17/22 at 3:03 PM. She reviewed the 1/4/22 MDS assessment and verified the eating portion of the MDS was marked as independent with setup help only. She explained the ADL portion of the assessment was coded based on the ADL charting completed by the Nurse Aide for eating and should have been coded as total dependence and 1-person physical assistance as Resident #64 received all nutrition and fluids via a feeding tube and was not able to participate with the activity. b.) A review of a form titled "Skin Integrity Report" was reviewed from 11/12/21 until 1/4/22 and revealed the following pressure ulcers: - 12/2/21 unstageable pressure ulcer to the sacrum. - 12/8/21 Resident #64 was in the hospital. - 12/13/21 unstageable pressure ulcer to the sacrum. - 12/21/21 unstageable pressure ulcer to the sacrum. - 12/22/21 Resident #64 was in the hospital. - 1/4/22 unstageable pressure ulcer to the sacrum. A review of the physician orders revealed an order dated 12/29/21 until 1/12/22 to cleanse the sacral wound with wound cleanser, apply Santyl (a medication that removes dead tissue from wounds so they can start to heal) to the wound	F 641	Minimum Data Set (most current MDS) for those residents with feeding tubes to ensure accurate coding for assistance and support needed with meal assistance on 4/4/22. MDS Nurse completed an audit of most current MDS for those residents with pressure wounds to ensure accurate coding on 4/4/22. MDS Nurse completed an audit of most current MDS for those residents that have discharged within the last 30 days to ensure accurate coding on 3/30/22. MDS Nurse completed an audit of most current MDS for those residents with a diagnosis of Psychosis to ensure coding was correct on 4/5/22. MDS Nurse completed an audit of the most recent MDS for those residents receiving Antipsychotic medication to ensure coding was correct on 4/7/22. MDS Nurse completed an audit of the most recent MDS for those residents receiving Antipsychotic medications with Gradual Dose Reductions to ensure coding was correct on 4/7/22. Deviations were corrected with a modification assessment. 3. Regional Clinical Reimbursement Coordinator provided re-education to MDS Nurse on 4/7/22. 4. Director of Nursing (DON), Assistant Director of Nurses (ADON), MDS Nurse, and Nursing Supervisor will audit sections A, G, I, M, and N prior to transmission of MDS assessment. Audit will be completed five times a week for three months. The center's MDS Nurse will present the results of the audit for accuracy for Sections A, G, I, M, and N of the MDS that	

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F 641	Continued From page 42 and cover with a foam dressing every day and as needed. A physician progress note dated 1/3/22 indicated Resident #64 had a sacral ulcer. The admission MDS assessment dated 1/4/22, indicated Resident #64 had severe cognitive impairment and was nonverbal. He was coded with Moisture Associated Skin Damage (MASD) and no pressure ulcers. On 3/16/22 at 8:54 AM, an interview occurred with the Assistant Director of Nursing (ADON) who measured pressure ulcers weekly for the facility. She explained when Resident #64 was originally admitted to the facility he had areas of redness to his sacrum and buttocks but when he returned to the facility after a hospitalization on 12/29/21 there was a large pressure area present to the sacral area. The area was not able to be staged at that time due to 100% slough (dead tissue that indicates tissue injury of stage 3 or higher, pressure ulcers) but was classified as an unstageable pressure ulcer. Stated there was never a time when the area would have been classified as MASD. An interview was conducted with the MDS Nurse on 3/17/22 at 3:03 PM. She reviewed the 1/4/22 MDS assessment and stated she coded MASD based on nursing notes she had read when completing the MDS assessment. She further stated she didn't always get the Skin Integrity Report in time to complete the MDS and did not inquire either. After reviewing the Skin Integrity Report, she stated Resident #64 should have been coded as having one unstageable pressure ulcer.	F 641	was completed prior to submission monthly to the Quality Assurance and Performance Improvement monthly. The QAPI Committee is responsible for ongoing compliance. 5. Date of compliance 4/14/2022.	

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On 3/17/22 at 4:23 PM, the Director of Nursing was interviewed and stated it was her expectation for the MDS assessment to be coded accurately.

2. Resident #136 was admitted on 6/21/21 and readmitted on 3/4/22 with cumulative diagnoses of Diabetes, Depression and Congestive Heart Failure.

Resident #16's quarterly Minimum Data Set (MDS) dated 2/16/22 indicated he was cognitively intact, exhibited no behaviors and coded as receiving an antipsychotic. Review of the Diagnosis section of the MDS did not include a diagnosis to support the use of an antipsychotic. Reviews of Resident #136's written medical record included evidence of a diagnosis of Psychosis.
An interview was conducted on 3/17/22 at 3:00 PM with the MDS Nurse. She stated she only coded Resident #136 for depression and did not coded the MDS for his Psychosis diagnosis. She stated it was an oversight.

An interview was conducted on 3/17/22 at 4:20 PM with the Director of Nursing (DON). She stated Resident #136's quarterly MDS dated 2/16/22 should have been coded for his diagnosis of Psychosis.

3. Resident #143 was admitted on 1/10/22 with a fractured humerus.
Review of his 5-day/Discharge Minimum Data Set dated 1/14/22 read Resident #143 was coded for a hospital discharge.
Review of Resident #143's electronic medical record read he left the facility Against Medical Advice (AMA) on 1/14/22.

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An interview was conducted on 3/17/22 at 3:00 PM with the MDS Nurse. She stated she coded Resident #143's discharge disposition incorrectly and should have coded him as discharging home.

An interview was conducted on 3/17/22 at 4:20 PM with the Director of Nursing (DON). She stated Resident #143's MDS dated 2/16/22 should have been coded for a discharge to home.

3. Resident #131 was admitted to the facility on 3/5/2018 with diagnoses that included schizophrenia and dementia.

The resident had a physician's order for Fluphenazine (first generation antipsychotic) 1 milligram (mg) by mouth daily at bedtime with a start date of 12/28/2021.

Resident #131's Medication Administration Records from January 2022 and February 2022 revealed the resident got Fluphenazine daily per physician's order.

The resident's annual Minimum Data Set (MDS) dated 2/15/2021 indicated the resident received antipsychotics 7 out of 7 days, antidepressants 7 out of 7 days, and antianxiety medications 7 out of 7 days during the assessment period. Under Antipsychotic review, the MDS indicated the resident had not received antipsychotic medications during the assessment period.

On 3/17/2022 at 9:10 AM an interview was conducted with the MDS. She reviewed the annual MDS dated 2/15/2022 and stated the resident did receive antipsychotics during the assessment period. She further stated she coded the MDS incorrectly.

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F 641	Continued From page 45	F 641		

On 3/17/2022 at 4:23 PM an interview was conducted with the Director of Nursing (DON). She stated she expected the MDS to be coded correctly.

4. Resident #38 was admitted to the facility on 2/23/18 with multiple diagnoses including schizoaffective disorder, bipolar type.

Resident #38 had a physician's order dated 2/23/18 for Risperdal (an antipsychotic drug) 1 milligrams (mgs) in the morning and 3 mgs at bedtime for schizoaffective disorder. On 5/24/20, there was an order to decrease the Risperdal to 1 mgs twice a day.

Resident #38's annual Minimum Data Set (MDS) assessment dated 1/4/22 revealed that Resident #38 had received an antipsychotic medication for 7 days during the assessment period. The assessment further indicated that the resident had received the antipsychotic medication on a routine basis and a gradual dose reduction (GDR) for the antipsychotic medication had not been attempted.

The MDS Nurse was interviewed on 3/17/22 at 3:01 PM. The MDS Nurse reviewed the annual MDS assessment dated 1/4/22 and she verified that it was an oversight on her part. She confirmed that a GDR for the Risperdal had been attempted for Resident #38 and it should have been coded on the MDS, but it was not.

The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. The DON stated that she expected the MDS assessment to be coded

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F 641	Continued From page 46 accurately.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		4/14/22

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SILER CITY CENTER	900 W DOLPHIN STREET SILER CITY, NC 27344

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F 656	Continued From page 47 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to develop an individualized and comprehensive care plan for Activities of Daily Living (ADL) assistance (Residents #64 and #94), contractures (Resident #64), pressure ulcers (Residents #73 and #94) and physical restraints (Resident #134). This was for 4 of 29 residents reviewed. The findings included: 1.) Resident #64 was originally admitted to the facility on 11/12/21 with diagnoses that included hemiplegia (paralysis) to the dominant side, presence of a feeding tube and a tracheostomy. Resident #64 had multiple hospitalizations from 11/14/21 until 12/29/21. His most recent readmission to the facility was 12/29/21. The admission Minimum Data Set (MDS) assessment dated 1/4/22, indicated Resident #64 had severe cognitive impairment and was nonverbal. He required total assistance of 2 staff members for dressing, bathing, and toileting. Limited range of motion was present to all extremities. a.) Review of the active care plan dated 1/5/22, revealed Resident #64's care plan for ADL care had not addressed the amount of ADL assistance he required. The care plan was not individualized	F 656	F656 □ Develop/Implement Comprehensive Care Plans 1. Assistance and support needed with ADLs added to the care plan of resident #64 on 4/7/22 by Licensed Nurse. A care plan was added to resident # 64 to prevent new/further decline of contractures on 4/7/22 by Licensed Nurse. The care plan for resident #94 was updated on 4/7/22 by Licensed Nurse to reflect the amount of assistance and support needed with ADLs and the risk for impaired skin integrity and pressure ulcers. Resident #73 discharged home. The care plan for resident #94 was updated to add focus on respiratory care including continuous oxygen at 2 liters per minute via nasal cannula on 4/1/22 by Licensed Nurse. 2. Director of Nursing (DON), Assistant Director of Nursing (ADON), Minimum Data Set Nurse (MDS Nurse), and Nursing Supervisors completed an audit of all resident ADL care plans to ensure assistance and support needed is documented on 4/8/22. The audit revealed there were residents throughout the facility without individualized ADL care plans. Care plans were updated to include assistance and support needed	

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F 656	Continued From page 48 to meet the needs of Resident #64. Review of the nursing progress notes from 11/12/21 to 3/15/22 indicated Resident #64 required total assistance from staff to complete ADL's. On 3/17/22 at 3:03 PM, an interview occurred with the MDS Nurse, who reviewed Resident #64's MDS assessment dated 1/4/22 and the active care plan. She confirmed the ADL assistance care plan was not comprehensive and individualized to the meet the needs of Resident #64, as he was totally dependent on staff for all ADL's and required 2-person assistance with dressing, bathing, and toileting tasks. She was unable to explain why the care plan was not individualized to Resident #64's amount of assistance required for ADL's. The Director of Nursing was interviewed on 3/17/22 at 4:23 PM and stated it was her expectation for the care plan to be person centered and should have included the assistance required with ADL's. b.) Resident #64's active care plan dated 1/5/22, was reviewed and there was no care plan developed to prevent further decline of the contractures to all extremities. An observation occurred on 3/14/22 at 10:20 AM of Resident #64, who was lying in bed. Contractures were noted to his bilateral hands and his bilateral legs were observed in a frog leg stance. On 3/17/22 at 3:03 PM, an interview occurred	F 656	with ADLs. Director of Nursing (DON), Assistant Director of Nursing (ADON), MDS Nurse, and Nursing Supervisors completed an audit of all residents with contractures to ensure the care plan reflects prevention, treatments, and risks on 4/8/22. The audit revealed there were residents throughout the facility without a care plan for contracture risk, prevention, and management. Care plans were updated to reflect the residents' individual needs. Director of Nursing (DON), Assistant Director of Nursing (ADON), Clinical Reimbursement Coordinator (CRC), and Nursing Supervisors completed an audit of all residents to ensure residents with risk of impaired skin integrity and residents with active skin impairments have care plans that are reflective and current on 4/7/22. The audit revealed there were residents throughout the facility without a care plan for at risk of impaired skin integrity or active skin impairments. Care plans were updated to reflect the residents' individual needs. Director of Nursing (DON), Assistant Director of Nursing (ADON), Clinical Reimbursement Coordinator (CRC), and Nursing Supervisors completed an audit of all residents receiving oxygen to ensure the care plan reflects the resident is receiving respiratory care on 4/1/22. The audit revealed there were residents throughout the facility without a care plan for oxygen use. Care plans were added to reflect the residents' need and use of oxygen. 3. Director of Nursing (DON), Assistant	

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F 656	Continued From page 49 with the MDS Nurse, who reviewed Resident #64's MDS assessment dated 1/4/22 and the active care plan. She confirmed a care plan was not present for contractures to Resident #64's extremities but should have been developed, stating it was an oversight. The Director of Nursing was interviewed on 3/17/22 at 4:23 PM and stated it was her expectation for the care plan to be person centered and should have included Resident #64's contractures. 2a.) Resident #94 was originally admitted to the facility on 9/30/21 with diagnoses that included lack of coordination, adult failure to thrive, and unsteadiness on feet. Resident #94 had a hospitalization from 10/10/21 until 10/25/21. The admission Minimum Data Set (MDS) assessment dated 11/1/21 indicated Resident #94 had moderately impaired cognition. He was coded for extensive assistance with dressing, toileting, personal hygiene and was dependent on staff for bathing. The Activities of Daily Living (ADL) care area assessment (CAA) summary dated 11/5/21 indicated Resident #94 required extensive to total assistance with his ADL care and would be care planned. Review of the active care plan revealed Resident #94's ADL care plan was initiated on 11/22/21 but did not address the amount of ADL assistance he required. The care plan was not individualized to meet the needs of Resident #94.	F 656	Director of Nursing (ADON) provided education to Minimum Data Set (MDS) Nurse and Nursing Supervisors on developing and implementing a comprehensive care plan by 4/13/22. Education included developing and implementing an individualized person centered care plan for all residents. Care plans were updated to reflect the care being provided to residents. 4. The Interdisciplinary Team led by MDS Nurse to include DON, ADON, MDS Nurse, Nursing Supervisor, Social Services, Activities, and Dietary will audit 5 random resident care plans weekly for three months. The MDS Nurse will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for ongoing compliance. 5. Date of compliance 4/14/2022.	

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On 3/17/22 at 3:03 PM, an interview occurred with the MDS Nurse. She reviewed Resident #94's MDS assessment dated 11/1/21 and active care plan. The MDS nurse confirmed the ADL assistance care plan was not comprehensive and individualized to meet the needs of Resident #94. She verified he required assistance from staff for all ADL's, but was unable to explain why the care plan was not individualized for Resident #94.

The Director of Nursing was interviewed on 3/17/22 at 4:23 PM and stated it was her expectation for the care plan to be person centered and should have included the assistance required with ADL's.

2b.) Resident #94 was originally admitted to the facility on 9/30/21 with diagnoses that included lack of coordination, adult failure to thrive and diabetes type 2. Resident #94 had a hospitalization from 10/10/21 until 10/25/21.

The admission Minimum Data Set (MDS) assessment dated 11/1/21 indicated Resident #94 had moderately impaired cognition and required extensive assistance from staff for bed mobility and toileting. He was incontinent of bowel and bladder and was at risk for pressure ulcers. The assessment further indicated he had no pressure ulcers or other skin conditions.

The pressure ulcer Care Area Assessment (CAA) summary dated 11/5/21 indicated Resident #94 was at risk for skin breakdown related to incontinence of bowel and bladder, limited mobility and friction and would be care planned. A quarterly MDS assessment dated 2/1/22 indicated Resident #94 had severe cognitive

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impairment and required extensive assistance for bed mobility and was dependent on staff for toileting and bathing. He was incontinent of bowel and bladder and was at risk for pressure ulcers. The assessment indicated no pressure ulcers or other skin conditions were present.

Review of the active care plan, last reviewed on 2/15/22, revealed Resident #94 was not care planned for the risk of pressure ulcers.

On 3/17/22 at 3:03 PM, an interview occurred with the MDS Nurse. She reviewed Resident #94's MDS assessments dated 11/1/21 and 2/1/22 as well as the active care plan. The MDS nurse confirmed there was no care plan in place for the risk of pressure ulcers and felt like it was an oversight.

The Director of Nursing was interviewed on 3/17/22 at 4:23 PM and stated it was her expectation for the care plan to be person centered and should have included the risk of pressure ulcers.

3.) Resident #73 was originally admitted to the facility on 1/19/22 with diagnoses that included pressure ulcer of the sacral region and chronic osteomyelitis.

The care plan for Resident #73 was reviewed. A focus area for pressure ulcers was initiated on 1/19/22, that read, "Resident is at risk for skin breakdown and has actual skin breakdown related to shear/friction". There was no care plan developed for the actual pressure ulcer to the sacral region.

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The admission Minimum Data Set (MDS) assessment dated 1/26/22 indicated Resident #73 was cognitively intact and had one stage 4 pressure ulcer present on admission. No other skin impairments were noted.

On 3/17/22 at 3:03 PM, an interview occurred with the MDS Nurse. She reviewed Resident #73's MDS assessment dated 1/26/22 as well as the active care plan. The MDS nurse confirmed there was no care plan in place for the stage 4 pressure ulcer that was present when Resident #73 was admitted to the facility. She stated the care plan that read actual skin breakdown related to shear/friction, should have read related to stage 4 pressure ulcer to the sacrum.

The Director of Nursing was interviewed on 3/17/22 at 4:23 PM and stated it was her expectation for the care plan to be person centered and should have included Resident #73's sacral pressure ulcer.

4. Resident #93 was admitted to the facility 1/31/2022 with diagnoses that included chronic obstructive pulmonary disease (COPD).

Resident #93 admission Minimum Data Set (MDS) dated 2/7/2022 indicated the resident was oxygen.

The resident's comprehensive care plan, last updated on 2/21/2022 did not have a focus for respiratory care and did not indicate the resident was on continuous oxygen.

A review of Resident #93's medical record revealed orders for the following
Oxygen at 2 Liters per minute via nasal cannula, continuously.

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F 656	Continued From page 53 Pulse ox every shift to keep oxygen saturations greater than or equal to 90%. On 3/14/2022 at 3:29 PM Resident #93 was observed lying in bed with nasal cannula in place. The oxygen concentrator was set on 2 Liters per minute. On 3/15/22 12:45 PM Resident #93 was observed lying in bed with a nasal cannula in place and the oxygen concentrator was set on 2 Liters per minute. On 3/16/2022 at 10:11 AM an interview was conducted with the MDS nurse. She stated oxygen was not on the resident's care plan and it should have been. She stated it was an oversight and she would correct it.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		4/14/22

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F 657	Continued From page 54 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to review and revise the care plan in the area of nutrition (Resident #83) for 1 of 29 residents reviewed. The findings included: Resident #83 was admitted to the facility on 7/26/21 with multiple diagnoses including dementia and small bowel obstruction. Resident #83's weight on admission (7/26/21) was 195 pounds (lbs.), 10/6/21 - 185 lbs., 12/15/21 - 180 lbs., 1/11/22 - 170 lbs., 2/24/22 - 168 lbs. and on 3/10/22 - 165 lbs. Resident #83's care plan for nutrition dated 7/29/21 was reviewed. The care plan problem was Resident #83 was at nutritional risk due to diagnoses of heart disease and hypercholesterolemia. The goal was "Resident #83 will maintain a stabilized weight with no significant changes through next review". The approaches included honor food preferences within meal plan, weigh as ordered and to notify the RD of any significant loss or gain, provide regular/liberalized diet as ordered and house	F 657	F657 □ Care Plan Timing and Revision 1. Resident #83 was assessed by the Registered Dietician on 3/16/22 and an updated progress note was written and intervention put into place at that time and added to the care plan. 2. All residents with weight loss have potential to be effected. The Director of Nursing ran a report for all current residents with weight loss in the last 90 days to ensure that they have appropriate Registered Dietician follow up with documentation, interventions in place and appropriate care plan to address resident□s individual needs. 3. Education provided to the Registered Dietician by the Regional Dietician on ensuring that weight loss is monitored with appropriate documentation and interventions in place was completed on 3/29/22. Education was initially done on 3/16/22 focusing on Resident #83. Education with the Registered Dietician was completed by the Regional Dietician on 3/29/22. The focus of the education	

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F 657	Continued From page 55 supplement as ordered. There were no changes to the care plan after Resident #83 had a significant weight loss. The quarterly Minimum Data Set (MDS) assessment dated 1/26/22 indicated that Resident #83 had severe cognitive impairment, and he needed supervision with set up help only with eating. The assessment further indicated that the resident's weight was 170 pounds (lbs.), and he had a weight loss, not on physician prescribed weight-loss regimen. The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. She stated that the weights were discussed during the clinical meeting and the RD was in attendance. The DON further stated that the resident's weights were entered electronically, and the RD had access to the residents' weights. She indicated that the RD was responsible for addressing weight loss and for adding interventions when a resident had experienced a weight loss. The RD was interviewed on 3/17/22 at 3:35 PM. The RD stated that she was responsible for coding the MDS assessment section K (nutritional status) and for developing and revising the care plan for nutrition. She reported that she assessed resident's nutritional status quarterly and the last time she saw Resident #83 was on 1/24/22. She verified that she was aware that Resident #83 had a significant weight loss, but she missed to add new interventions and to revise the care plan.	F 657	was: review of resident issue and interventions; review of weight loss documentation; review of adding supplements/interventions as appropriate; review of interventions/recommendations; and, review of updating care plans. 4. Registered Dietician to run weight variance report weekly to document on weight changes that are noted from prior week weights obtained and make recommendations as appropriate, with care plan updates as indicated. The Regional Dietician will audit for compliance with this documentation and follow up weekly for 4 weeks, then two times per week for 4 weeks, then monthly for 2 months. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance 4/14/22.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		4/14/22

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F 677	Continued From page 56 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, staff interviews and record review, the facility failed to provide nail care, assistance with shaving and showers for 4 (Resident #36, Resident #94, Resident #20 and Resident #64) of 5 residents dependent on the staff for assistance with activities of daily living (ADLs). The findings included: 1. Resident #36 was admitted on 4/14/15 with a diagnosis of Parkinson's Disease. Resident #36's quarterly Minimum Data Set dated 1/3/22 indicated he was cognitively intact, no behaviors and required total staff assistance with all of ADLs to include personal hygiene. Resident #36 was care planned on 9/20/19 that read he required assistance and was dependent for his ADL care due to cognitive loss/dementia. There were no documented interventions related to his nail care. He was also care planned last revised on 4/3/21 for impaired communication due to his advanced Parkinson's Disease. There was no care plan for any refusals or behaviors. Resident #36 was observed on 3/14/22 at 2:00 PM lying in bed. His right hand was contracted and his fingernails on his left hand extended past the fingertips approximately ½ of an inch. The fingernails on his right contracted hand were observed to be folded into his right palm. It appeared that the fingernails on his right contracted hand also extended past his fingertips approximately ½ of an inch. The cleanliness of	F 677	F677 □ ADL Care Provided for Dependent Residents 1. Nail care including trimming was provided for resident #36 on 3/17/22. Nail care including trimming and shower was provided to resident #94 on 3/18/22. Resident #20 received a shower and was shaved on 3/17/22. Nail care including trimming was provided to resident #64 on 3/17/22. 2. The Nursing Supervisor completed an audit to assess all current residents' fingernails for cleanliness and need for trimming on 3/25/22. The audit revealed there were residents throughout the facility on various units in need of nail care/trimming. Nail care including trimming was provided to residents with need. The Nursing Supervisor completed an audit of all current residents for facial hair and the need to shave on 4/1/22. The audit revealed there were residents throughout the facility on various units that needed to be shaved. Shaving or facial hair trimming was provided to residents with need. The Nursing Supervisor completed an audit of all current residents' most recent scheduled shower date for completion or documentation of refusal 4/8/22. The audit revealed there were residents throughout the facility on various units without documentation of receiving a shower. Showers were	

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the fingernails was difficult to determine due to his right-hand contracture.

An observation on 3/15/22 at 10:00 AM with Resident #36's fingernails unchanged.

An observation on 3/16/22 on 8:54 AM at with Resident #36's fingernails unchanged.

An interview was conducted on 3/16/22 at 10:10 AM, Nurse Assistant (NA) #8. She stated she didn't perform nail care but would let the nurse know if she saw a need.

An interview was conducted on 3/16/22 at 10:12 AM with NA #6. She stated she completed nail care when she saw it was needed. If the resident was a diabetic the nurse would cut their fingernails. She stated Resident #36 was complaint with his care.

An observation on 3/16/22 on at 11:02 AM with Resident #36's fingernails unchanged.

An interview was conducted on 3/16/22 at 11:35 AM with NA #4 and NA #9. They explained nail care should be completed daily with personal care ensuring the nails were clean underneath and short. If a resident was a diabetic, they would let the nurse know. Both aides stated Resident #36 was complaint with his ADLs.

An observation on 3/16/22 on at 1:16 PM with Resident #36's fingernails unchanged.

An interview was conducted on 3/16/22 at 3:15 PM with the Assistant Director of Nursing (ADON). She stated the aides provided nail care during personal care when needed and if the

offered to residents according to their assigned shower schedule.

3. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Practice Educator (NPE) provided education to all Licensed Nurses and Certified Nursing Assistants provide education to all Licensed Nurses and Certified Nursing Assistants by 4/13/2022 (including weekend, agency, and PRN as needed staff) on providing activity of daily living services necessary to maintain proper grooming and personal hygiene. Education included providing routine nail care with nail trimming as needed, providing assistance with maintaining facial hair, and providing routine showers as scheduled. If a resident declines activity of daily living services the refusal will be documented in the medical record. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift.

4. The Activity Director will complete a random audit of nail care for five residents□ per day five times a week for two weeks, then three times a week for two weeks, then weekly for 2 months. The Activity Director will complete a random audit of facial hair for five residents□ per day five times a week for two weeks, then three times a week for two weeks, then weekly for 2 months. The Nursing Supervisor will complete a random audit of scheduled showers to include day and evening shifts for five residents□ per day

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F 677	Continued From page 58 resident was a diabetic the nurses would cut their fingernails. She stated she was unaware Resident #36 needed nail care. An observation on 3/17/22 on at 11:40 AM revealed Resident #36's fingernails had been trimmed. An interview was conducted on 3/17/22 at 4:20 PM with the Director of Nursing (DON). She stated it was her expectation for nail care to be provided during personal care tasks and if the aides were unable to complete the task, she would expect the nurse to be notified. 2) Resident #64 was originally admitted to the facility on 11/12/21 with diagnoses that included nontraumatic intracerebral hemorrhage (bleeding into the brain tissue) , hemiplegia (paralysis) affecting dominant side and aphasia (difficulty in communication). Resident #64 had multiple hospitalizations from 11/14/21 until 12/29/21. His most recent readmission to the facility was 12/29/21. The admission Minimum Data Set (MDS) assessment dated 1/4/22 indicated Resident #64 had severe cognitive impairment and required extensive to total assistance with personal hygiene and bathing. Resident #64's active care plan, last reviewed on 1/5/22, included a focus area for requiring assistance/is dependent for Activities of Daily Living (ADL) care related to stroke. The	F 677	five times a week for four weeks, then three times a week for four weeks, then weekly for four weeks. The Activity Director will report the findings of the nail care and facial hair audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for ongoing compliance. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance. The QAPI committee is responsible for ongoing compliance. 5. Date of compliance 4/14/2022.	

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interventions did not address the assistance needed for ADL care.

A review of the nursing progress notes from 11/12/21 to 3/15/22 revealed Resident #64 was totally dependent on staff for all ADL's and refusals specific to nail care were not documented.

An observation was made of Resident #64 on 3/14/22 at 10:20 AM, while he was lying in bed with his hands laying on top of the covers. His hands had mild contractures present and long fingernails to both hands which had created a small indention to his palms.

On 3/15/22 at 10:22 AM, Resident #64 was observed lying in bed with long nails to both hands which were contracted into fists.

On 3/16/22 at 10:10 AM, Nurse Aide (NA) #8 was interviewed and stated she didn't perform nail care but would let the nurse know if she saw a need.

NA #6 was interviewed on 3/16/22 at 10:12 AM and stated she completed nail care when she saw it was needed. If the resident was a diabetic the nurse would cut their fingernails. She was familiar with Resident #64 and stated she wasn't aware his nails were long.

An interview was conducted with NAs #4 and #9 on 3/16/22 at 11:35 AM, who explained nail care should be completed daily with personal care ensuring the nails were clean underneath and short. If a resident was a diabetic they would let the nurse know. Neither NA could confirm nor deny providing recent nail care to Resident #64.

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An interview occurred with the Assistant Director of Nursing on 3/16/22 at 3:15 PM. She explained the NAs provided nail care during personal care when needed and if the resident was a diabetic the nurses would cut their fingernails. She stated she was unaware Resident #64 required nail care.

The Director of Nursing was interviewed on 3/17/22 at 4:23 PM and stated it was her expectation for nail care to be provided during personal care tasks and if the NA was unable to complete the task she would expect the nurse to be notified.

3a) Resident #94 was originally admitted to the facility on 9/30/21 with diagnoses that included diabetes type 2 and adult failure to thrive.

A quarterly Minimum Data Set (MDS) assessment dated 2/1/22 indicated Resident #94 had severe cognitive impairment, required extensive assistance for personal hygiene and was dependent on staff for bathing. There was no rejection of care coded.

Resident #94's active care plan, last reviewed on 2/15/22, included a focus area for being at risk for decreased ability to perform Activities of Daily Living (ADLs) related to limited mobility. The interventions did not address the assistance needed for ADL care.

A review of the nursing progress notes from 9/30/21 to 3/15/22 revealed Resident #94 required extensive to total assistance for all ADL's and there were no refusals specific to nail care

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were documented.

An observation was made of Resident #94 on 3/14/22 at 12:48 PM, while he was lying in bed with hands laying on top of the covers. He was noted to have a dark substance under the nails to both hands.

On 3/15/22 at 9:00 AM, Resident #64 was observed lying in bed with his eyes closed. The dark substance under his fingernails to both hands remained.

On 3/16/22 at 10:10 AM, Nurse Aide (NA) #8 was interviewed and stated she didn't perform nail care but would let the nurse know if she saw a need.

NA #6 was interviewed on 3/16/22 at 10:12 AM, and stated she completed nail care when she saw it was needed. If the resident was a diabetic the nurse would cut their fingernails, but she could clean underneath them.

Resident #94 was observed on 3/16/22 at 11:00 AM lying in bed watching TV. The dark substance remained under the fingernails to both hands.

An interview was conducted with NAs #4 and #9 on 3/16/22 at 11:35 AM, who explained nail care should be completed daily with personal care ensuring the nails were clean underneath and short. If a resident was a diabetic they would let the nurse know so the nails could be trimmed. Neither NA could confirm nor deny providing recent nail care to Resident #94.

An interview occurred with the Assistant Director of Nursing on 3/16/22 at 3:15 PM. She explained

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the nurse aides (NAs) provided nail care during personal care when needed and if the resident was a diabetic the nurses would cut their fingernails. She stated she was unaware Resident #94 required nail care.

The Director of Nursing was interviewed on 3/17/22 at 4:23 PM and stated it was her expectation for nail care to be provided during personal care tasks and if the NA was unable to complete the task she would expect the nurse to be notified.

3b) Resident #94 was originally admitted to the facility on 9/30/21 with diagnoses that included diabetes type 2, lack of coordination, and adult failure to thrive.

A review of the nursing progress notes from 9/30/21 to 3/15/22 revealed Resident #94 required extensive to total assistance for all Activities of Daily Living (ADLs) and no refusals specific to bathing were documented.

A review of the medical records indicated Resident #94 was to receive a shower every Tuesday and Friday on the 3:00 PM to 11:00 PM (2nd) shift.

A review of Resident #94's shower/bathing records for January 2022 indicated he received 2 showers on 1/21/22 and 1/28/22. The personal care records did not indicated any refusals.

A quarterly Minimum Data Set (MDS) assessment dated 2/1/22 indicated Resident #94 had severe cognitive impairment, displayed no rejection of care and was dependent on staff for

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bathing.

Resident #94's active care plan, last reviewed on 2/15/22, included a focus area for being at risk for decreased ability to perform ADLs related to limited mobility. The interventions did not address the assistance needed for ADL care.

A review of Resident #94's shower/bathing records from 2/1/22 to 3/15/22, revealed he had received 2 showers on 2/4/22 and 2/8/22. The personal care record indicated Resident #94 refused a scheduled shower on 2/18/22 and 3/4/22.

An interview occurred with Nurse Aide (NA) #10 who stated she was familiar with Resident #94 and often cared for him on the 7:00 AM to 3:00 PM (1st) shift. NA #10 explained Resident #94 did not refuse assistance with personal care in the mornings and that she didn't provide him with a shower as that was scheduled on the 2nd shift.

A phone interview was conducted with NA #11 who worked on the 2nd shift and was often assigned to care for Resident #94. She stated she tried to give Resident #94 his scheduled showers, but he was often resistant to get out of bed and would normally just provide him with a bed bath. She could not confirm or deny attempting to provide the scheduled showers on the Tuesday and Fridays that were not documented as refused or given in the personal care record.

NA #12 was assigned to care for Resident #94 as well on the 2nd shift and was called on 3/17/22 at 1:03 PM. There was no answer or ability to leave a message.

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A phone call was placed to NA #13 on 3/17/22 at 1:05 PM. She worked the 2nd shift and was scheduled to care for Resident #94 often. A message was left for a return call that was not received during the time of the survey.

The Director of Nursing was interviewed on 3/17/22 at 4:23 PM and stated it was her expectation for all residents to receive showers as requested and scheduled. If a resident refused, the NA should alert the nurse so a progress note could be written, and an alternate means of bathing provided.

4. Resident # 20 was admitted to the facility on 9/30/18 with multiple diagnoses including vascular dementia. The quarterly Minimum Data Set (MDS) assessment dated 12/15/21 indicated that Resident #20 had severe cognitive impairment and he needed extensive assistance with personal hygiene.

Resident #20's care plan dated 12/15/21 indicated that he required assistance with activities of daily living (ADL) care related to limited mobility. The goal was resident's ADL care will be anticipated and met. The approaches included monitor for decline in ADL function and refer to rehabilitation (rehab) therapy if decline in ADL was noted.

Resident #20 was observed on 3/14/22 at 10:42 AM. He was lying on his bed and was unshaven. The amount of facial hair seemed to be approximately 3 -4 days growth.

Another observation was made on 3/15/22 at 10:45 AM. Resident #20 was in bed and was still unshaven. At 12:30 PM, Nurse Aide (NA) # 1

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F 677	Continued From page 65 was observed to provide bed bath to the resident. The NA was not observed to shave the resident. Another observation was made on 3/16/22 at 2:10 PM. Resident #20 was up in wheelchair on the hallway. Review of the shower documentation for Monday (3/14/22) revealed there was no documentation that a shower was provided to the resident. NA #1, assigned to Resident #20, was interviewed on 3/16/22 at 2:11 PM and she stated that residents were shaved during their shower days. The NA further stated that Resident #20 was scheduled to receive a shower on Mondays and Thursdays on 3-11 shift. NA #1 observed Resident #20's face and confirmed that he needed to be shaved. NA #1 was observed to assist the resident with shaving. NA #2, assigned to Resident #20 on 3-11 shift, was interviewed on 3/16/22 at 4:13 PM. She stated that she was assigned to the resident on Monday (3/14/22) but she could not remember what happened on Monday. The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. The DON stated that residents should be shaved during shower days but if the resident needed to be shaved, she expected the nursing staff to assist residents with shaving and not to wait for their shower days.	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	F 688		4/14/22

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F 688	Continued From page 66 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, staff interviews and record review, the facility failed apply a right-hand orthotic carrot or a rolled wash cloth as ordered. This was for 1 (Resident #36) of 3 residents reviewed for range of motion. The findings included: Resident #36 was admitted on 4/14/15 with a diagnoses of Parkinson's Disease and Cerebral Vascular Accident. Review of Resident #36's cumulative Physician orders included an order dated 9/29/21 for the use of and orthotic carrot/rolled wash cloth in his right hand daily and to remove it at bedtime. An orthotic carrot enables painless positioning the fingers away from the palm to protect the skin from excessive moisture, pressure, and the risk of nail puncture injuries. Review of Resident #36's undated electronic	F 688	F688 □ Increase/Prevent Decrease in ROM/Mobility 1. Resident #36 currently receiving hand orthotics as ordered/care planned. 2. Director of Nursing (DON), Assistant Director of Nursing (ADON), Minimum Data Set Nurse (MDS) and Nursing Supervisor(s) completed an audit of current residents with physician orders for orthotic devices on 4/8/22. The audit revealed residents with orthotic devices were being used as ordered. A care plan audit of all current residents with orthotic device orders was completed on 4/8/22 to ensure that interventions were in place accordingly. The audit revealed that residents with orthotic devices were care planned for use of devices. 3. Director of Nursing (DON), Assistant	

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F 688	Continued From page 67 Bedside Kardex read an orthotic carrot/rolled wash cloth in his right hand daily and remove it at bedtime. A electronic Kardex is a brief overview of each resident that provides information about how to and what to do when caring for a resident. Resident #36's quarterly Minimum Data Set dated 1/3/22 indicated he was cognitively intact, no behaviors and required total staff assistance with all of his activities of daily living (ADLs) and limited range of motion to both upper extremities. Resident #36's care plan last revised on 7/8/21 for a risk of skin breakdown due to contractures. Interventions included a orthotic carrot/rolled wash cloth in his right hand daily. Review of Resident #36's daily electronic Nursing Assistant (NA) documentation for March 2022 indicated no evidence that his orthotic carrot or rolled wash cloth was applied on 3/8/22 and 3/11/22. NA #9 documented she applied his orthotic on 3/14/22 at 11:43 AM. There was no documentation that Resident #36 orthotic carrot or rolled wash cloth was applied on 3/15/22 but there was documentation on 3/16/22 at 6:51 AM but there was no staff initials. An observation was conducted on 3/14/22 at 2:00 PM of Resident #36 lying in bed. His right hand was contracted and his fingers were folded into his right palm. There was no observed orthotic carrot or rolled wash cloth in his right hand. Also, there was no observed orthotic carrot lying anywhere in his room. Observations conducted on 3/15/22 at 10:00 AM, 12:50 PM and 4:16 PM of Resident #36 lying in	F 688	Director of Nursing (ADON), and Nurse Practice Educator (NPE) will provide education to all licensed nurses and certified nursing assistants by 4/13/22 (including agency, weekend and as needed staff) on applying orthotic devices per physicians order and care plan. Education also included instructions for certified nursing assistants to refer to the residents' Kardex for orthotic devices orders. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. Nursing Supervisors will complete a random audit of current residents including new admissions with orders for orthotic devices to ensure the order is being followed and the care plan is reflective of the order. Audit will be completed on five residents daily for two weeks, then three times a week times two weeks, then one time a week times two months. The Director of Nursing will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. 5. Date of compliance 4/14/2022.	

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bed. There was no observed orthotic carrot or rolled wash cloth in his right hand.

Observations conducted on 3/16/22 at 8:54 AM, 11:02 AM and 1:16 PM of Resident #36 lying in bed. There was no observed orthotic carrot or rolled wash cloth in his right hand.

An interview was conducted on 3/16/22 at 11:00 AM with NA #6. She stated she was not aware that Resident #36 should wear a orthotic carrot or a rolled wash cloth to his right hand. She stated if he was to wear one, it would be on his electronic Kardex.

An interview was conducted on 3/16/22 at 11:40 AM with NA #9. She stated she worked with Resident #36 on 3/14/22 and she applied a rolled wash cloth to his right hand contracture. She stated if it wasn't in his hand at 2:00 PM, someone must have removed it or it fell out of his hand.

An interview was conducted on 3/17/22 at 9:09 AM with NA #3. She stated she was not aware that Resident #36 should wear a orthotic carrot or a rolled wash cloth to his right hand. NA #3 stated apparently there was not an order for it because she did not think it was on his daily electronic Kardex task documentation.

An observation was conducted on 3/17/22 at 11:40 AM of Resident #36. There was no observed orthotic carrot or rolled wash cloth in his right hand.

An interview was conducted on 3/17/22 at 4:20 PM with the Director of Nursing (DON). She

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F 688	Continued From page 69 stated Resident #36 was ordered to have a orthotic carrot or a rolled wash cloth in his right hand every day. The DON stated it was likely due to staffing turnover and the use of agency aides that it was not being applied consistently.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to prevent a resident from falling out of bed during a bed bath when one staff provided assistance for a resident who was dependent on two staff for bathing (Resident #64). The facility also failed to thoroughly investigate and analyze falls to determine causative factors and implement appropriate interventions to reduce the risk for further falls (Residents #64 and #67). This was for 2 of 9 residents reviewed for accidents. The findings included: 1) Resident #64 was originally admitted to the facility on 11/12/21 with diagnoses that included nontraumatic intracerebral hemorrhage (bleeding into the brain tissue) , quadriplegia (paralysis of all extremities), aphasia (difficulty in communication), and presence of a feeding tube	F 689	F689 □ Free of Accident Hazards/Supervision Devices 1. The care plan was updated to reflect the assistance needed with activities of daily living. This information was also transferred to the Kardex (nursing assistant care guide) for nursing assistant access for resident #64 on 4/7/22. Updates included staff assistance needed with ADL care for bathing, dressing, toileting, personal hygiene, bed mobility and transfers. Care plan for resident #64 was reviewed for appropriate interventions to reduce risk for falls on 4/7/22. Interventions that were not appropriate to resident centered care were removed from the care plan on 4/7/22. Care plan for resident #67 was updated to include providing education to the resident and her family to call staff and allow staff to	4/14/22

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and tracheostomy. Resident #64 had multiple hospitalizations from 11/14/21 until 12/29/21. His most recent readmission to the facility was 12/29/21.

The admission Minimum Data Set (MDS) assessment dated 1/4/22 indicated Resident #64 rarely made himself-understood, rarely understood others and had severely impaired decision-making skills. Resident #64 had no behaviors or rejection of care. He was coded as extensive assistance of 2 people for bed mobility and was dependent on 2 people for bathing, dressing and toileting. Resident #64 was coded with limited mobility to both sides of his upper and lower extremities.

The plan of care for Resident #64 included the following:
- A focus area for requiring assistance/is dependent for Activities of Daily Living (ADL) care related to stroke. This care area was initiated on 12/29/21 and last reviewed on 1/5/22. The interventions did not address the assistance needed for ADL care, to include bathing, or the need for 2-person assistance ADL tasks, initially or after the review on 1/5/22.
- A focus area for risk for falls due to impaired mobility. This care area was initiated on 12/29/21. The interventions read: to provide verbal cues for safety and sequencing when needed, place call light within reach while in bed or close proximity to the bed and maintain a clutter free environment with consistent furniture arrangement. On 2/28/22 an intervention was added that read; "2 person assist with ADL care as needed".

a) An Event Summary Report dated 2/28/22 indicated Resident #64 had a witnessed fall in his

assist with needs instead of family attempting on 4/7/22. Fall investigation report for fall that occurred on 1/29/22 was updated to include family attempting to assist resident with transfers as part of the root cause resulting in the fall.

2. Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator, and Nursing Supervisor conducted an audit on 4/8/22 of all falls and fall incident reports for the last 30 days to ensure a thorough fall investigation was completed including the root cause to assist in determining appropriate interventions to reduce the risk of falls. Fall investigation audit revealed there were investigations without an accurate root cause documented. The root causes of the falls were updated to be more reflective of the individual fall. Care plan audit revealed there were residents without appropriate interventions in place to reduce falls. Those care plans were updated by adding appropriate interventions and removing inappropriate interventions.

3. Director of Nursing, Assistant Director of Nursing, and Nurse Practice Educator provided Education to all Licensed Nurses by 4/13/22 (including agency, weekend and PRN as needed staff) on documenting all factors involved at the time of a fall. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. Director of Nursing to provide education to MDS Nurse and Nursing Supervisor on

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F 689	Continued From page 71 room during a bed bath on 2/28/22 at 11:15 AM. The narrative of the incident indicated a nurse aide (NA) was giving Resident #64 a bath and had him turned to his left side when he started to slide off the bed. The NA was unable to stop the fall with her hands as they were covered in soapy water and couldn't hold onto him. Resident #64 was noted with minor injuries described as a small scratch below his left eyebrow and facial redness under the left eyebrow, cheek, and forehead area. A Nurse Practitioner note dated 2/28/22 indicated Resident #64 was observed on the floor during her rounds and nursing staff had reported Resident #64 slid from the bed during morning care. He was assessed with only a small bruise noted to his left upper eyelid. The tracheostomy and feeding tube were in place. Resident #64's Bedside Kardex Report (NA Care Guide) dated 3/16/22 was reviewed and revealed it had been updated on 2/28/22 to read; "a 2 person assist with ADL care as needed" for dressing, grooming, and bathing. No other assistance needs were noted for ADLs such as toileting, personal hygiene, or transfers on the report. On 3/16/22 at 2:10 PM, an interview occurred with Nurse #5 who completed the falls incident report on 2/28/22 and was familiar with Resident #64. She explained NA #14 requested assistance because Resident #64 had fallen out of bed while she was providing a bed bath to him. The NA explained to her that she had rolled Resident #64 towards her, and he kept rolling over, falling to the floor. Nurse #5 stated the NA was unable to stop the fall as her hands were soapy and wet.	F 689	completing adequate fall investigations to determine potential root cause and ensuring effective interventions are used to prevent further falls by 4/13/22. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. The Interdisciplinary Team led by Director of Nursing to include ADON, MDS Nurse, Nursing Supervisor, Social Services, Activities, and Dietary will audit all resident falls including incident reports to ensure the potential root cause of the fall is identified and an effective intervention is put in place to prevent further falls. Audit will be completed five days per week for three months. The Director of Nursing will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. 5. Date of compliance 4/14/2022.	

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Nurse #5 stated NA #14 was the only staff member present at the time of the fall and that Resident #64 required 2 staff members with his ADL care prior to and after the fall on 2/28/22. Nurse #5 stated Resident #64 only sustained a small abrasion to the left outer eye and was assessed by the facility Nurse Practitioner immediately, as she was in the facility making rounds.

An interview was conducted with NA #14 on 3/16/22 at 2:20 PM, who stated she had worked at the facility for close to two years and was familiar with Resident #64. NA #14 was asked to describe the events that occurred on 2/28/22 when Resident #64 fell out of bed during his bed bath. NA #14 stated she had turned him on his left side facing her. She had one hand on his body and the other hand was in the soapy water basin getting the washcloth ready when he began to continue rolling forward ending up on the floor. NA #14 stated she couldn't prevent the fall with her hands as they were soapy and wet, so she tried to guide him to the floor using her legs and retrieved Nurse #5 immediately. NA #14 indicated she assisted Resident #64 with his morning care and bed bath without assistance from another staff member on 2/28/22, had always provided care to Resident #64 by herself and was unaware he required 2 people to be present. When she was asked she would know someone needed 2-person assistance with personal care and bathing she stated, "by asking the nurse". NA #14 denied knowing what the NA Care Guide was used for or where to find it.

On 3/16/22 at 2:30 PM, the Director of Nursing (DON) was interviewed and stated she was aware that Resident #64 fell from the bed during

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a bed bath with only 1 staff member present, when there should have been 2 staff members present. She was aware the nursing supervisor provided education to the nursing and NA staff on 3/2/22 regarding Resident #64 required 2 person assist with ADLs as needed. The DON explained the NA Care Guide was generated by the care plan and because the care plan didn't specify 2-person assistance with ADL's it would not have shown up on the NA Care Guide, however she felt the staff knew to provide 2-person assistance with Resident #64's ADL care as he was unable to provide assistance due to his medical conditions.

An interview occurred with NAs #6 and #7 who were familiar with Resident #64. They both stated had required 2-person assistance with all ADLs prior to and after the fall that occurred on 2/28/22 as he had no control with his body movements.

b) An Event Summary Report dated 2/28/22 indicated Resident #64 had a witnessed fall in his room during a bed bath on 2/28/22 at 11:15 AM. The narrative of the incident indicated a nurse aide (NA) was giving Resident #64 a bed bath and had him turned to his left side when he started to slide off the bed. The NA was unable to stop the fall with her hands as they were covered in soapy water. Resident #64 was noted with minor injuries described as a small scratch below his left eyebrow and facial redness under the left eyebrow, cheek, and forehead area. The fall investigation area of the incident report included the following:
- Preventive measures in place: verbal cues for safety and sequencing when needed.

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- Interventions added immediately after the fall and care plan updated: resident assisted back to bed.
- Activity during incident: NA was doing ADL care.
- Was fall related to ambulation status: yes-non-ambulatory.
- Potential contributing factors were stroke and quadriplegia status.

The Summary of Investigation portion of the report stated the root cause/conclusion was physical deficits and the corrective action was for 2 person assist with ADL care as needed. The report did not indicate if an Interdisciplinary Departmental Team (IDT) meeting was held, or the date investigation of the incident was completed.

Nurse #5 was interviewed on 3/16/22 at 2:10 PM. She was the nurse that completed the Event Summary Report for Resident #64 on 2/28/22. She recalled the resident rolled out of bed during a bed bath with only one NA present. When she assessed him he was found to have a small scratch to the left eyebrow area and redness to the left side of his face. The nurse placed Resident #64 on routine neurochecks, and vital signs with no other injuries were noted. Nurse #5 stated she completed the computerized Event Summary Report to the best of her ability and placed the root cause as physical deficits and corrective action was to have 2 people present during ADL's.

On 3/17/22 at 10:40 AM, an interview was conducted with the Director of Nursing (DON). She stated falls were discussed every morning in an IDT meeting that included herself, the therapy department, social work, nurse managers, activities, and the Registered Dietician via Zoom.

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The Event Summary Reports were reviewed and discussed, however, there was no formal documentation of the meeting, only what was present on the Event Summary Reports. The DON further added, when a fall occurred the assigned nurse completed as much as they could of the computerized Event Summary Report to include the root cause and any interventions that were put into place. After the falls meeting the nursing supervisors were responsible for adding to the investigation area what was discussed in the meeting, and to update the root cause, interventions, and care plan accordingly.

Nursing Supervisor #1 was interviewed on 3/17/22 at 1:58 PM, and confirmed she was part of the daily IDT meeting where falls were discussed. They discussed what happened and what type of interventions might be needed. Nursing Supervisor #1 stated there was no documentation regarding the IDT meeting and most of the time the nursing staff had already filled out the Summary of Investigation portion of the Event Summary Report. She verified after the IDT meeting the nursing supervisors were to update the root cause and interventions as needed as well as update the care plan. Nursing Supervisor #1 was unable to state whether this did or did not occur for Resident #64's 2/28/22 fall.

2) Resident #67 was admitted to the facility on 1/10/22 with diagnoses that included muscle weakness, pain in the lower leg and polyneuropathy (damage to nerves in different parts of the body).

The admission Minimum Data Set (MDS)

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assessment dated 1/17/22 indicated Resident #67 had moderately impaired cognition. She had no behaviors or rejection of care and required supervision of 1 person for bed mobility and transfers. A wheelchair was used for mobility.

Resident #67's active care plan included a focus area for being at risk for falls due to impaired mobility and history of multiple falls, that was initiated on 1/10/22. The interventions included:
- Call light within reach when in bed or in close proximity to the bed.
- Clutter free environment.
- When in bed or bedside chair, place personal items within reach.
- Encourage resident to call for assistance with toileting. This was added on 1/28/22.

An Event Summary Report dated 1/29/22, revealed Resident #67 had a fall at 11:45 AM on 1/29/22. The circumstances of the event indicated staff observed Resident #67 on the floor with her head near the dresser and bed. She was laying on her left side with complaints of right hip pain. Her son was present in the room as well. The physician was notified and provided an order to send Resident #67 to the Emergency Room (ER) for evaluation of right hip pain. The Summary of Investigation portion of the report indicated the root cause/conclusion was mental/physical deficits and the corrective action was physician evaluation. The report did not indicate if an Interdisciplinary Departmental Team (IDT) meeting was held, or the date the investigation of the incident was completed.

On 3/17/22 at 10:40 AM, an interview was conducted with the Director of Nursing (DON) who stated falls were discussed every morning in

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an IDT meeting that included herself, therapy department, social work, nurse managers, activities, and the Registered Dietician via Zoom. The Event Summary Reports were reviewed and discussed, however, there was no formal documentation of the meeting only what was present on the electronic Event Summary Reports. The DON further stated, when a fall occurred the assigned nurse completed as much as they could of the Event Summary Report to include the root cause and any interventions that were put into place. After the falls meeting the nursing supervisors were responsible for adding to the investigation area what was discussed in the meeting, and to update the root cause, interventions, and care plan accordingly.

An interview was conducted with Nurse #5 on 3/17/22 at 11:10 AM. She was the nurse that completed the Event Summary Report for Resident #67 on 1/29/22. She recalled being called to the room and finding Resident #67 lying beside the bed in front of the bedside commode with her son standing over her. Nurse #5 stated Resident #67 told her she was being assisted by her son to the bedside commode and her legs gave out causing her to fall. He was unable to assist her back up due to new onset of pain in her right hip. She was sent to the ER for evaluation and returned to the facility a short time later with no injuries. Nurse #5 explained nursing staff completed the computerized Event Summary Report and filled out the form to include the root cause and intervention section. When filling these two parts out the nursing staff are to put what they felt was the contributing factors at the time of the fall.

Nursing Supervisor #1 was interviewed on

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F 689	Continued From page 78 3/17/22 at 1:58 PM, and confirmed she was part of the daily IDT meeting where falls were discussed. They discussed what happened and what type of interventions might be needed. Nursing Supervisor #1 stated there was no documentation regarding the IDT meeting and most of the time the nursing staff had already filled out the Summary of Investigation portion of the report. She verified after the IDT meeting the nursing supervisors were to update the root cause and interventions as well as update the care plan. Nursing Supervisor #1 was unable to state whether this did or did not occur for Resident #67's fall on 1/29/22.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		4/14/22

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F 692	Continued From page 79 This REQUIREMENT is not met as evidenced by: Based on record review, observation, Registered Dietician (RD), family and staff interview, the facility failed to implement new interventions when a resident was identified to have a significant weight loss for 1 of 5 sampled residents reviewed for nutrition (Resident #83). Findings included: Resident #83 was admitted to the facility on 7/26/21 with multiple diagnoses including dementia and small bowel obstruction. Resident #83's weight on admission (7/26/21) was 195 pounds (lbs.) and on 1/11/21, he weighed 170 lbs., a 12.82 % weight loss in 6 months. Resident #83's weight on 12/15/21 was 180 lbs. and on 1/11/21, the resident weighed 170 lbs., a weight loss of 5.56 % in 1 month. Resident #83 had a physician's order for house supplement daily on 9/3/21 and was increased to twice a day on 11/4/21. Review of Resident #83's weights revealed that he continued to lose weight. His weight on 2/21/22 was 168 lbs. and on 3/10/22, his weight was 165 lbs. Resident #83's care plan for nutrition dated 7/29/21 was reviewed. The care plan problem was "Resident #83 was at nutritional risk due to diagnoses of heart disease and hypercholesterolemia". The goal was "Resident #83 will maintain a stabilized weight with no	F 692	F692 □ Nutrition/Hydration Status Maintenance 1. Resident #83 was assessed by the Registered Dietician on 3/16/22 and an updated progress note was written and intervention put into place at that time and added to the care plan. 2. All residents with weight loss have potential to be effected. The Director of Nursing ran a report for all current residents with weight loss in the last 90 days to ensure that they have appropriate Registered Dietician (RD) follow up with documentation, interventions in place and appropriate care plans to address resident□s individual needs. The RD will pull the weight variance report from Point Click Care (PCC) weekly to review any weight loss noted and will put interventions in place as needed. The RD will also update the white board for weight loss to be reviewed in the weekly Clinically At Risk meeting. 3. Education provided to the Registered Dietician by the Regional Dietician on ensuring that weight loss is monitored with appropriate documentation and interventions was initially completed on 3/16/22 focusing on Resident #83. Education with the Registered Dietician was completed by the Regional Dietician on 3/29/22. Employee was educated prior to the date certain of 4/14/22, and was not required to come off of the schedule. The focus of the education was: review of	

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F 692	Continued From page 80 significant changes through next review". The approaches included honor food preferences within meal plan, weigh as ordered and to notify the RD of any significant loss or gain, provide regular/liberalized diet as ordered and house supplement as ordered. There were no changes to the care plan after Resident #83 had a significant weight loss. The quarterly Minimum Data Set (MDS) assessment dated 1/26/22 indicated that Resident #83 had severe cognitive impairment, and he needed supervision with set up help only with eating. The assessment further indicated that the resident's weight was 170 pounds (lbs.), and he had a weight loss, not on physician prescribed weight-loss regimen. The RD notes were reviewed. The note dated 10/29/21 indicated that Resident #83's weight was 185 lbs. He was on a regular/liberalized diet, consuming 25-75% of meals with averaged of 54%. Per family, he likes sweets, house shake was ordered for additional caloric support. The note dated 1/24/22 revealed Resident #83's weight was 170 lbs. He has a significant weight loss of 13 % in 6 months. His meal intakes and weights remained stable in 3 months. His house shake was increased recently. No new recommendation at this time. Resident #83 was observed on 3/16/22 at 12:25 PM. His lunch tray contained a fish sandwich. He did not eat his sandwich and stated that he didn't like fish. His dietary card did not list his food likes and dislikes. Nurse Aide (NA) #1 was interviewed on 3/16/22 at 12:46 PM. She stated that Resident #83 was a	F 692	resident issue and interventions; review of weight loss documentation; review of adding supplements/interventions as appropriate; review of interventions/recommendations; and, review of updating care plans. 4. Registered Dietician to run weight variance report weekly to document on weight changes that are noted from prior week weights obtained and make recommendations as appropriate, with care plan updates as indicated. The Regional Dietician will audit for compliance with this documentation and follow up weekly for 4 weeks, then 2 times a week for 4 weeks, then monthly for 2 months. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of Compliance 4/14/2022.	

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picky eater, and he would seldom eat the food served. The NA reported that the resident's family had brought food for him, and they were kept in the freezer. At 12:50 PM, the NA was observed to heat a hamburger sandwich and offered it to the resident.

Resident #83's family member was interviewed on 3/16/22 at 10:20 AM. The family member indicated that she/he was concerned of resident's weight loss. The resident was a picky eater and she/he brought food to the facility for him to eat in case he refused the food served by the facility. The family member was concerned that the staff was not offering the food she brought for the resident. When she came to visit, the foods (she brought) were still in the freezer. The family was told by the staff that they did not have a microwave in the unit to heat the resident's frozen food. The family further stated that the resident disliked fish and the staff was informed of this.

The Nurse Practitioners were not available for interview.

The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. She stated that the weights were discussed during the clinical meeting and the RD was in attendance. The DON further stated that the resident's weights were entered electronically, and the RD had access to the resident's weights. She indicated that the RD was responsible for addressing weight loss and for adding interventions when a resident had experienced a weight loss.

The RD was interviewed on 3/17/22 at 3:35 PM. The RD stated that she was responsible for coding the MDS assessment section K (nutritional

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F 692	Continued From page 82 status) and for developing and revising the care plan for nutrition. She reported that she assessed resident's nutritional status quarterly and the last time she saw Resident #83 was on 1/24/22. She verified that she was aware that Resident #83 had a significant weight loss, but she missed to add new interventions. She explained that the resident was already on house supplement, and she had recommended yesterday (3/16/22) to increase it from twice a day to 3 times a day and to weigh the resident weekly. The RD further stated that she added the resident's food preferences on the dietary card.	F 692		
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.	F 693		4/14/22

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F 693	Continued From page 83 This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer water flushes via a feeding tube at the physician ordered flow rate for 1 of 2 residents reviewed with tube feedings (Resident #64). The findings included: Resident #64 was originally admitted to the facility on 11/12/21 with diagnoses that included nontraumatic intracerebral hemorrhage (bleeding into the brain tissue) , aphasia (difficulty in communication), and presence of a feeding tube. Resident #64 had multiple hospitalizations from 11/14/21 until 12/29/21. His most recent readmission to the facility was 12/29/21. The admission Minimum Data Set (MDS) assessment dated 1/4/22 indicated Resident #64 rarely made himself understood, rarely understood others and had severely impaired decision-making skills. He was coded as receiving 51% of more of his total calories through a tube feeding and an average fluid intake of 501 cubic centimeters (cc) per day or more by tube feeding. Resident #64's active care plan, last reviewed 1/5/22, revealed a focus area for an enteral feeding tube to meet nutritional needs. The interventions included to provide water as ordered. A review of Resident #64's active physician orders included an order dated 1/28/22 to flush the feeding tube with 150 milliliters (ml) of water every 4 hours.	F 693	F693 □ Tube Feeding Mgmt/Restore Eating Skills 1. Water flush pump setting for resident # 64 was reset to the prescribed rate of 150 ml every 4 hours by the Nursing Supervisor on 3/16/22. Rate is currently running at the correct prescribed rate. 2. Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an audit of all current residents receiving Enteral Nutrition to ensure feeding and water flush rates were set and running at the correct prescribed rate on 4/1/22. The audit revealed that all residents were receiving the correct prescribed water flush at the prescribed rate. 3. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Practice Educator (NPE) provided Education to all Licensed Nurses by 4/13/22 (including agency, weekend and as needed staff) on correct operation of feeding pumps and administering water flushes at physician ordered flow rate. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. The Nursing Supervisor will complete an audit of all residents receiving Enteral Nutrition to ensure physician ordered water flush flow rates are set at the correct ordered rate. Audit will be completed daily for four weeks, then three	

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F 693	Continued From page 84 A nutritional note dated 2/12/22 indicated Resident #64 received 100% nutrition and hydration via a feeding tube. The feeding tube was to be flushed with 150 ml of water every 4 hours. An observation of Resident #64 on 3/14/22 t 10:20 AM, revealed his feeding tube was connected to a continuous bottle of formula with a standby bag of water running at 145 ml every 4 hours on the pump. Resident #64's lips were not dry or cracked in appearance. On 3/15/22 at 10:22 AM, an observation of Resident #64 occurred. He was connected to a continuous bottle of tube feed formula with a standby bag of water running at 145 ml every 4 hours on the pump. On 3/16/22 at 8:54 AM, Resident #64 was observed. He was connected to a continuous bottle of tube feed formula with a standby bag of water running at 145 ml every 4 hours on the pump. An observation was made with Nursing Supervisor #1 on 3/16/22 at 10:01 AM, of Resident #64's water flush setting on the tube feed pump. She acknowledged the rate was at 145 ml every 4 hours and would need to check the orders for the correct rate setting. Nursing Supervisor #1 was interviewed on 3/16/22 at 10:35 AM. She had reviewed Resident #64's current physician orders and verified the water flush order was for 150 ml every 4 hours. She was unable to state why the rate was different than the physician's order. During the	F 693	times a week for four weeks, then weekly for four weeks. The Director of Nursing (DON) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. 5. Date of compliance 4/14/2022.	

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F 693	Continued From page 85 interview, Nursing Supervisor #1 re-set the tube feed pump for water flushes at 150 ml every 4 hours. The Director of Nursing was interviewed on 3/17/22 at 4:23 PM and stated she expected water flushes to be at the prescribed rate.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to administer oxygen at the prescribed rate (Residents #64 and #139 and failed to display a cautionary sign indicating the use of oxygen for oxygen dependent residents (Resident #64, #139, #60 and #93). This was for 4 of 6 residents reviewed for respiratory care. The findings included: 1) Resident #64 as originally admitted to the facility on 11/12/21 with diagnoses that included nontraumatic intracerebral hemorrhage (bleeding into the brain tissue), acute and chronic respiratory failure, and presence of a tracheostomy. Resident #64 had multiple hospitalizations from 11/14/21 until 12/29/21. His	F 695	F695 □ Respiratory/Tracheostomy Care and Suctioning 1. Oxygen rate for resident # 64 was adjusted on 3/16/22 by the Nursing Supervisor to the prescribed rate of 5 liters by trach mask. Resident #139 oxygen rate was adjusted to the prescribed rate of 2 liters via nasal cannula by the Nursing Supervisor on 3/16/22. Oxygen in use sign was added to the door frame for resident # 64 and # 139 on 3/16/22 and resident # 60 and # 93 on 3/17/22 by the Nursing Supervisor. 2. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an audit of all residents with orders for oxygen to check for correct flow	4/14/22

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F 695	Continued From page 86 most recent readmission to the facility was 12/29/21. a.) A review of the active physician orders included an order dated 12/29/21 for the oxygen concentrator to be set to 5 liters via tracheostomy mask continuously. The admission Minimum Data Set (MDS) assessment dated 1/4/22 indicated Resident #64 rarely made himself understood, rarely understood others and had severely impaired decision-making skills. He was coded with oxygen use. Resident #64's active care plan, last reviewed 1/5/22, revealed the following focus areas: - Requires continuous oxygen as ordered. The interventions included to administer oxygen as ordered. - Exhibits or is at risk for respiratory complications related to a tracheostomy. The interventions included to provide oxygen as ordered. On 3/14/22 at 10:20 AM, Resident #64 was observed lying in bed with oxygen flowing via the tracheostomy mask. The oxygen regulator on the concentrator was set at 4.5 liters flow when viewed horizontally at eye level. Resident #64 was observed while lying in bed on 3/15/22 at 10:22 AM. The oxygen regulator on the concentrator was set at 4.5 liters flow by tracheostomy mask when viewed horizontally, eye level. An observation occurred of Resident #64 on 3/16/22 at 8:54 AM, which revealed the oxygen regulator on the concentrator was set at 4.5 liters	F 695	rate in use on 3/31/22. The audit revealed that all residents with orders to receive oxygen were receiving oxygen correctly at the physician ordered flow rate. DON and ADON completed an audit of all residents with orders for oxygen to ensure the oxygen in use sign was visible on the door or door frame on 3/31/22. The audit revealed all rooms with oxygen in use had a cautionary sign on the door or door frame. 3. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Practice Educator (NPE) provided Education to all Licensed Nurses by 4/13/22 (including agency, weekend and PRN as needed staff) on ensuring residents are receiving oxygen at the physician prescribed rate and oxygen dependent residents should have a cautionary sign displayed on the door indicating the use of oxygen. Nurses should observe the oxygen concentrator horizontally at eye level to ensure accurate flow rate. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. The Nursing Supervisor will audit current residents using oxygen to ensure oxygen flow is accurate and set at the prescribed rate daily. Audit to be completed on five residents using oxygen five times per week for four weeks, then five residents three times per week for four weeks, then five residents weekly for four weeks. The Central Supply Director	

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F 695	Continued From page 87 flow by tracheostomy mask when viewed horizontally at eye level. An observation was made with Nursing Supervisor #1 of Resident #64's oxygen concentrator on 3/16/22 at 10:01 AM, who stated the oxygen regulator on the concentrator was set at 4.5 liters when viewed horizontally at eye level and looked to be set on 5 liters when standing over the concentrator. Nursing Supervisor #1 adjusted the flow to administer 5 liters of oxygen. During an interview with the Director of Nursing on 3/17/22 at 4:23 PM, she indicated it was her expectation for oxygen to be delivered at the ordered rate. b.) A review of the active physician orders included an order dated 12/29/21 for oxygen at 5 liters via a tracheostomy mask continuously. The admission Minimum Data Set (MDS) assessment dated 1/4/22 indicated Resident #64 rarely made himself understood, rarely understood others and had severely impaired decision-making skills. He was coded with oxygen use. Resident #64's active care plan, last reviewed 1/5/22, revealed the following focus areas: - Requires continuous oxygen as ordered. The interventions included to administer oxygen as ordered. - Exhibits or is at risk for respiratory complications related to a tracheostomy. The interventions included to provide oxygen as ordered. On 3/14/22 at 10:20 AM, Resident #64 was observed lying in bed with oxygen flowing via the	F 695	will audit current residents using oxygen to ensure they have a cautionary sign displayed on the door of their room indicating oxygen is in use. Audit will be completed on five residents five times per week for four weeks, then three times per week for four weeks, then weekly for four weeks. The Director of Nursing (DON) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. 5. Date of compliance 4/14/2022.	

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tracheostomy mask. There was no oxygen in use signage anywhere on the door or door frame.

Resident #64 was observed while lying in bed on 3/15/22 at 10:22 AM, with oxygen flowing via a tracheostomy mask. There was no oxygen in use signage anywhere on the door or door frame.

An observation was conducted on 3/16/22 at 8:54 AM. There was a red, magnetic oxygen in use sign on Resident #64's door frame.

Nursing Supervisor #1 was interviewed on 3/16/22 at 10:01 AM, and stated when a resident was ordered oxygen, a red, magnetic oxygen in use sign was normally placed on the door frame. She was unable to state why this had not occurred for Resident #64 but had been corrected this morning.

2. Resident #139 was originally admitted to the facility on 7/5/19 with the most recent readmission date of 4/15/21. His diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and dependence of supplemental oxygen.

a.) A review of the active physician orders for Resident #139, included an order dated 6/20/21 for oxygen at 2 liters via nasal cannula continuously.

A quarterly Minimum Data Set (MDS) assessment dated 2/23/22 indicated Resident #139 was cognitively intact and used oxygen.

Resident #139's active care plan, last reviewed 3/9/22, included a focus area for COPD- clinical

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management. Oxygen at 2 liters via nasal cannula continuously. The interventions included to administer oxygen as ordered/indicated.

On 3/14/22 at 10:10 AM, Resident #139 was observed lying in bed with his eyes closed. Oxygen was flowing via nasal cannula. The oxygen regulator on the concentrator was set at 3 liters flow when viewed horizontally at eye level.

Resident #139 was observed sitting up in bed on 3/15/22 at 10:30 AM and confirmed he was dependent on oxygen. The oxygen regulator on the concentrator was set at 3 liters flow when viewed horizontally, eye level.

On 3/16/22 at 8:46 AM, Resident #139 was observed sitting up in bed watching TV. The oxygen regulator on the concentrator was set at 3 liters flow when viewed horizontally at eye level.

An observation was made with Nursing Supervisor #1 of Resident #139's oxygen concentrator on 3/16/22 at 10:05 AM, who stated the oxygen regulator on the concentrator was set at 3 liters when viewed horizontally at eye level. Nursing Supervisor #1 adjusted the flow to administer 2 liters of oxygen.

During an interview with the Director of Nursing on 3/17/22 at 4:23 PM, she indicated it was her expectation for oxygen to be delivered at the ordered rate.

b.) A review of the active physician orders for Resident #139, included an order dated 6/20/21 for oxygen at 2 liters via nasal cannula continuously.

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A quarterly Minimum Data Set (MDS) assessment dated 2/23/22 indicated Resident #139 was cognitively intact and used oxygen.

Resident #139's active care plan, last reviewed 3/9/22, included a focus area for COPD- clinical management. Oxygen at 2 liters via nasal cannula continuously. The interventions included to administer oxygen as ordered/indicated.

On 3/14/22 at 10:10 AM, Resident #139 was observed lying in bed with his eyes closed and oxygen flowing via nasal cannula. There was no oxygen in use signage anywhere on the door or door frame.

Resident #139 was observed sitting up in bed on 3/15/22 at 10:30 AM, wearing his oxygen and confirmed he was dependent on oxygen. There was no oxygen in use signage anywhere on the door or door frame.

On 3/16/22 at 8:46 AM, Resident #139 was observed sitting up in bed watching TV, with oxygen flowing via nasal cannula. There was no oxygen in use signage anywhere on the door or door frame.

An observation was made with Nursing Supervisor #1 of Resident #139's oxygen concentrator on 3/16/22 at 10:05 AM, and stated when a resident was ordered oxygen, a red magnetic oxygen in use sign was normally placed on the door frame. She was unable to state why this had not occurred for Resident #139 but would correct it immediately.
3. Resident #60 was admitted to the facility on 2/25/2020 with diagnoses that included chronic

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obstructive pulmonary disease (COPD) and a history of acute respiratory failure.

Resident #60's Annual Minimum Data Set (MDS), dated 1/12/2022 indicated the resident received oxygen while a resident.

Resident #60's medical record revealed a physician's order for the following;
Oxygen concentrator set to 4 liters/minute with a start date of 10/9/2021
Oxygen at 4 Liters/minute via nasal cannula continuously with a start date of 10/9/2021.

On 3/14/2022 at 2:07 PM Resident #60 was observed in his bed with oxygen via nasal cannula at 4 Liters per minute. There was no oxygen in use sign posted on the door or at the entrance to his room.

On 3/15/2022 at 12:21 PM Resident #60 was observed in his bed with oxygen via nasal cannula at 4 Liters per minute. There was no oxygen in use sign posted on the door or at the entrance to his room.

On 3/15/2022 at 12:55 PM an interview was conducted with Nurse #4, assigned to Resident #60. When asked if the resident was on oxygen therapy, he stated Resident #60 was on oxygen continuously. When asked if the resident had a sign on the door indicating oxygen was in use, he stated he should, but he did not. When asked who was responsible for placing signage on the doors, Nurse #4 stated nursing staff is responsible for placing signage on or around the door of residents who were on oxygen.

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F 695	Continued From page 92 4. Resident #93 was admitted to the facility 1/31/2022 with diagnoses that included chronic obstructive pulmonary disease (COPD). Resident #93 admission Minimum Data Set (MDS) dated 2/7/2022 indicated the resident was oxygen. A review of Resident #93's medical record revealed orders for the following Oxygen at 2 Liters per minute via nasal cannula, continuously. Pulse ox every shift to keep oxygen saturations greater than or equal to 90%. On 3/14/2022 at 3:29 PM Resident #93 was observed lying in bed with nasal cannula in place. The oxygen concentrator was set on 2 Liters per minute. On 3/15/22 12:45 PM Resident #93 was observed lying in bed with a nasal cannula in place and the oxygen concentrator was set on 2 Liters per minute. On 3/15/2022 at 12:55 PM an interview was conducted with Nurse #4, assigned to Resident #93. When asked if the resident was on oxygen therapy, he stated Resident #93 was on oxygen continuously. When asked if the resident had a sign on the door indicating oxygen was in use, he stated he should, but he did not. When asked who was responsible for placing signage on the doors, Nurse #4 stated nursing staff is responsible for placing signage on or around the door of residents who were on oxygen.	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		4/14/22

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F 759	Continued From page 93 §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: Based on record review, observation and staff interview, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors of 25 opportunities resulting in a medication error rate of 8% for 2 of 5 residents observed during the medication pass (Residents # 95 & #47). Findings included: 1. Resident #95 was admitted to the facility on 7/1/15 with multiple diagnoses including glaucoma. Resident #95 had physician's orders dated 7/1/15 for Combigan (used to treat glaucoma) - instill 1 drop in both eyes twice a day, wait 3 -5 minutes between drops and on 6/10/16 for Trusopt (used to treat glaucoma) - 1 drop to left eye twice a day. Resident #95 was observed on 3/16/22 at 9:10 AM during the medication pass. Nurse #2 was observed to instill 1 drop of Combigan to the resident's left and right eye and followed by 1 drop of Trusopt to the resident's left eye. Nurse #2 did not wait at least 3 minutes between eye drops. Nurse #2 was interviewed on 3/16/22 at 9:14 AM. When asked how long she had to wait between eye drops, she replied "I don't know".	F 759	F759 □ Free of Medication Error Rts 5 Prcnt or More 1. Medication Incident Report was completed for resident #95 including notifying the Medical Director on 3/16/22 by licensed nurse. Resident #95 had no negative side effects related to medication error. Medication Incident Report was completed for resident #47 on including notifying the Medical Director on 3/16/22 by licensed nurse. Resident #47 had no negative side effects related to medication error. 2. On 3/17/22 the Nurse Practice Educator provided one on one education on medication administration and the five rights of medication administration with the licensed nurse responsible for the medication error involving resident # 95 and #47. The licensed nurses□ education also included direct observation of administration of eye drops and insulin and a medication administration competency was completed. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Practice Educator (NPE) completed an audit of all current residents with a physician order for more than one type of eye drop and all current residents with orders to administer	

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F 759	Continued From page 94 The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. She stated that she expected nurses to wait 3-5 minutes between eye drops. The DON reported that Nurse #2 was an agency nurse, and she was a new nurse with one or two years of nursing experience. 2. Resident # 47 was admitted to the facility on 5/8/08 with multiple diagnoses including diabetes mellitus (DM). Resident #47 had a physician's order dated 5/18/21 for Regular insulin (used to treat DM) 4 units subcutaneous (SQ) with meals for DM. Resident #47 was observed during the medication pass on 3/16/22 at 11:40 AM. Nurse #2 was observed to check the resident's finger stick blood sugar and the result was 96. Nurse #2 was observed to prepare and to administer 4 units of Regular insulin to the resident's right lower quadrant. Resident #47 did not have her lunch tray yet. Resident #47 was observed to have her lunch tray served on 3/16/22 at 12:40 PM. Nurse #2 was interviewed on 3/16/22 at 12:45 PM. She reported that she always administered Resident #47's insulin before meals. When she checked the order to give it with meals, she replied, "I missed that order". The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. The DON stated that she expected nurses to follow physician's orders. The DON reported that Nurse #2 was an agency	F 759	insulin with meals. One on one nurse observations were completed by the DON, ADON, and NPE during medication administration for the residents identified. Observations included ensuring the physician's order was followed using the five rights of medication administration including, the right patient, the right drug, the right dose, the right route, and the right time. The audit revealed that residents receiving more than one eye drop received the medication correctly by following order as prescribed by the physician. The audit revealed that residents with order for insulin to be given with meals received the insulin dose correctly by following order as prescribed by physician. 3. Director of Nursing, Assistant Director of Nursing and Nurse Practice Educator provided medication administration education to all licensed nurses by 4/13/22 (including agency, weekend and PRN as needed staff). Education included the five rights of medication administration; the right patient, the right drug, the right dose, the right route, and the right time, one on one direct observation during medication administration, and completion of medication administration competency. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. Director of Nursing, Assistant Director of Nursing, and Nurse Practice Educator	

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F 759	Continued From page 95 nurse, and she was a new nurse with one or two years of nursing experience.	F 759	will observe licensed nurses during eye drop and insulin administration to ensure physician orders are followed. Audit will include observation with five nurses per week for four weeks, then three nurses per week for four weeks, then one nurse per week for four weeks. The Nurse Practice Educator will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. 5. Date of compliance 4/14/2022.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to prevent a significant medication error for 1 of 1 sampled resident reviewed for facility reported incident (Resident #49). Resident #49 had taken an opioid medication 2 tablets without a doctor's order. Findings included: Resident #49 was admitted to the facility on 10/6/21 with multiple diagnoses including tobacco and alcohol abuse and schizophrenia. Review of the incident report dated 12/31/21 revealed that the facility had investigated a medication error incident on Resident #49. The	F 760	F760 □ Residents are Free of Significant Med Errors 1. Medication Incident Report was completed for resident #49 including notifying the Medical Director on 12/31/21 Licensed Nurse. The resident had no negative side effects related to the medication error. 2. The licensed nurse involved in medication error was provided with one on one education on procedures of medication administration including the five rights of medication administration by Assistant Director of Nursing on 12/31/21. The licensed nurse was observed during	4/14/22

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F 760	Continued From page 96 investigation revealed that Nurse #3 had left a medication cup containing 2 tablets of oxycodone (opioid pain reliever)/acetaminophen (non-opioid pain reliever) 5/325 milligrams (mgs) and 1 tablet of gabapentin (used to treat seizures and nerve pain) on top of the bedside table in front of Resident #49. The medications (oxycodone and gabapentin) were ordered and prepared for Resident #49's roommate. When the Nurse turned his back to assist Resident #49's roommate, Resident #49 took the medications. The report indicated that the physician was notified of the medication error and the resident was monitored for possible adverse reactions. The root cause of the error was "medications were not handled correctly and should not have been placed on wrong resident's bedside table". The corrective action was Nurse #3 was provided education on medication administration. The quarterly Minimum Data Set (MDS) assessment dated 1/12/22 indicated that Resident #49 had moderate cognitive impairment. Nurse #3 was interviewed on 3/16/22 at 4:30 PM. The Nurse stated that Resident #49 was confused and had memory problems. He reported that on 12/31/21 at round 8 AM, he prepared Resident #49 roommate's medications (Oxycodone/acetaminophen 5/325 mgs - 2 tablets and Gabapentin 300 mgs - 1 tablet). He went into Resident #49's room and his roommate requested to be pulled up in bed. He placed the medication cup with the medications on top of the bedside table in front of Resident #49 and assisted his roommate. When he turned his back, Resident #49 had taken the medications. Nurse #3 confirmed that it was his fault for	F 760	medication administration and completed medication administration competency on 4/1/22. No incidents observed. On 4/6/22 the Director of Nursing completed an audit of all medication error reports for the past six months to determine if significant medication errors were identified involving opioid medications or medications being left at bedside. The audit revealed no medication errors were identified involving opioid medications or medications left at bedside. 3. Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator and Registered Nurse Supervisor provided medication administration education to all licensed nurses by 4/13/22 (including agency, weekend and PRN as needed staff). Education included the five rights of medication administration; the right patient, the right drug, the right dose, the right route, and the right time, one on one direct observation during medication administration, and completion of medication administration competency. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator and Registered Nurse Supervisor will observe licensed nurses medication administration to ensure physician orders are followed and nurses are following the five rights during medication administration. Audit will include observation with five nurses	

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F 760	Continued From page 97 leaving the medications in front of a resident who was confused. Nurse #3 reported that the physician was notified of the medication error and the resident was monitored for possible adverse reactions. The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. The DON verified the medication error incident on Resident #49. She stated that the medication error incident dated 12/31/21 was investigated and the Nurse was in-serviced on medication administration and the importance of not leaving medications within reach of roommate. Resident #49 was monitored and there were no adverse reactions noted.	F 760	per week for four weeks, then three nurses per week for four weeks, then one nurse per week for four weeks. The Nurse Practice Educator will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. 5. Date of compliance 4/14/2022.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		4/14/22

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F 761	Continued From page 98 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to discard expired medications and to date multiple dose medications in 1 of 2 medication carts (400 hall medication cart) and 1 of 1 medication room observed. Findings included: 1. On 3/17/22 at 11:30 AM, the medication cart on 400 hall was observed with Nurse #2. The following expired and undated medications were observed in the cart: 1 bottle of Sodium Chloride 1 gram (gm) tablet - expiration date 1/2022 2 bottles of Aspirin 325 milligrams (mgs) tablet - expiration date 11/2021 1 Albuterol Sulfate 90 microgram (mcg) inhalation - expiration date 10/2021 1 Ventolin HFA 90 mcg. Inhalation - expiration date 10/2021 1 bottle of Iron liquid 220 mgs /5 milliliter (ml) - expiration date 2/2022 1 vial of Humalog insulin (used) - undated (the manufacturer's storage instruction indicated once opened, Humalog should be stored at room temperature and used within 28 days) 2. On 3/17/22 at 12:01 PM, the medication room was observed. There was 1 expired medication	F 761	F761 □ Label/Store Drugs and Biologicals 1. Expired or unlabeled medications that were identified during observations were discarded immediately on 3/17/22 by the nurse and nurse supervisor. 2. The Nursing Supervisor completed an audit for expired and open undated medications on 3/31/22. The audit included all five medication carts and the medication storage rooms. Expired and undated medications were discarded immediately by the Nursing Supervisor. No discrepancies were noted during the medication room audit. 3. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Practice Educator will provide education to all licensed nurses by 4/13/22 (including agency, weekend and PRN as needed staff) on proper medication storage requirements. Education included policy and procedure for labeling, dating, storing and discarding drugs appropriately. Any staff member not receiving this education by 4/13/22 will receive the education prior to working their next scheduled shift. 4. The Nursing Supervisor will audit all	

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F 761	Continued From page 99 observed. 1 bottle of Hibiclens - expiration date 10/2021 Nurse #2 was interviewed on 3/17/22 at 12:03 PM. The Nurse stated that the night shift nurses were responsible for checking the medication carts and the medication room for expired and undated medications. The Registered Nurse (RN) Supervisor #1 was interviewed on 3/17/22 at 12:06 PM. The RN Supervisor observed the expired and undated medications and confirmed that the medications identified were expired and the used insulin was undated. She commented that obviously the night shift nurses who were responsible for checking the medication carts and the medication room were not doing their job. The Director of Nursing (DON) was interviewed on 3/17/22 at 2:10 PM. The DON stated that the night shift nurses were responsible for checking the medication carts and the medication room for expired and undated medications.	F 761	five medication carts and the medication storage room three times per week for four weeks, then weekly for two months, and then randomly thereafter to ensure that expired medications are disposed of and medications are dated/labeled appropriately. The Director of Nursing will report the findings of the audits to the monthly QAPI Meeting to ensure compliance. The QAPI committee is responsible for the ongoing compliance. 5. Date of compliance 4/14/2022.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803		4/14/22

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F 803	Continued From page 100 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, staff, and Registered Dietician (RD) interviews, the facility failed to follow the facility menus for 2 of 3 meals observed (Residents # 68, 73, and #291). This had the potential to affect other residents in the facility. The findings included: 1. A review of the facility's breakfast menu for 3/14/22 revealed residents were to receive assorted fruit juice, grits, a banana, country biscuit, orange garnish, 2% milk and assorted beverage. a. Resident #68 was originally admitted to the facility on 1/3/22 and resided on the 300 hall. Her admission Minimum Data Set (MDS) assessment dated 1/17/22 indicated she had mild cognitive impairment. Nursing notes revealed she was oriented and able to answer questions appropriately.	F 803	F803 □ Menus Meet Resident Nds/Prep in Adv/Followed 1. Menus are currently being served as posted for all residents. 2. Updated breakfast menu showing the choices available every day to the residents was posted on 4/5/22 at the main Dining room by the Dietary Manager. Dietary Manager provided a copy to the Activities Director to deliver to all resident rooms on 4/5/22. A copy of the updated breakfast menu was mailed by the Activity Director to all Responsible Parties for residents unable to make their own selection on 4/8/22. A copy of the updated breakfast menu was given to the Admissions Director for inclusion in each newly admitted resident□s welcome packet by the Center Executive Director on 4/7/22. The Admissions Director will review the information for newly admitted	

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F 803	Continued From page 101 On 3/14/22 at 8:00 AM, an observation was made of Resident #68's breakfast tray. She had scrambled eggs, 1 piece of toast, grits and 1 piece of sausage. There was no milk. On 3/14/22 at 10:30 AM, an interview occurred with Resident #68, who stated the breakfast meal was always the same with no variety or fresh fruit. In addition, she stated it was very rare to have the same food items that was printed on her meal ticket at breakfast. b. Resident #73 was admitted to the facility on 1/19/22 and resided on the 300 hall. Her admission MDS assessment dated 1/26/22 indicated she was cognitively intact. An observation was made of Resident #73's breakfast tray on 3/14/22 at 8:03 AM. She had scrambled eggs, 1 piece of toast, grits, a banana and 1 piece of sausage. There was no milk. On 3/14/22 at 10:40 AM, an interview occurred with Resident #73, who stated the breakfast meal ticket never matched what was served on the plate, which was the same items day after day. c. Resident #291 was admitted to the facility on 2/28/22 and resided on the 300 hall. Her admission MDS assessment dated 3/7/22 revealed she was cognitively intact. On 3/14/22 at 8:06 AM, an observation was made of Resident #291's breakfast tray. She had scrambled eggs, 1 piece of toast, grits, a banana and 1 piece of sausage. There was no milk. On 3/14/22 at 11:15 AM, an interview was	F 803	residents during their sign in process. 3. Dietary staff was trained/educated reviewing the fundamental concepts and the importance of following tray tickets and honoring resident choices by the Healthcare Services Group (HCSG) District Manager/Dietary Manager on 4/4/22 and 4/8/22. 4. Resident satisfaction audits will be completed weekly for continuous checks for resident satisfaction. A minimum of 7 residents per week will be completed, for 4 weeks. Following this 3 resident audits will be done weekly for continuous checks for resident satisfaction on an ongoing basis. Any resident preference updates will be entered into Meal Tracker by the Dietary Manager on the date received. Audit results will be presented to the Administrator and District Manager for review. Audit results and findings will be included within the Quality Assurance Performance Improvement committee monthly meetings to evaluate the effectiveness of the plan. 5. Date of Compliance 4/14/2022.	

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F 803	Continued From page 102	F 803		

conducted with Resident #291, who stated the breakfast meal was always the same food choices with very little fresh fruits provided, other than a banana from time to time like this morning.

2. A review of the facility's breakfast menu for 3/15/22 indicated the residents were to be served assorted fruit juice, oatmeal, apple pancakes, breakfast grilled ham slice, 2% milk and assorted beverage.

An observation of the 300 hall breakfast trays was made on 3/15/22 at 7:55 AM. The breakfast plates contained scrambled eggs, a packaged Danish, 1 piece of bacon and a bowl of oatmeal.

a. On 3/15/22 at 8:05 AM, Resident #291 stated she had received the same breakfast food today as every day since admission and it was lukewarm when she received it. Resident #291 stated the eggs were like plastic with no flavor, had received only 1 piece of bacon and the food on her plate didn't match what was listed on the meal ticket.

b. Resident #73 was interviewed on 3/15/22 at 8:10 AM and stated when she received her breakfast meal it was the same tasteless eggs that she received every day since admission. The food was lukewarm when received and had no flavor except for the packaged Danish roll and 1 piece of bacon that she got this morning.

The Dietary Manager (DM) was interviewed on 3/16/22 at 10:41 AM and reported at times the item on the menu was not available, so she had to substitute it with something else. She explained since the COVID-19 pandemic, it has been difficult to get items from her vendor and at

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F 803	Continued From page 103 time substitutes will be sent instead of what was ordered. After reviewing the 2 breakfast meals observed on 3/14/22 and 3/15/22, the DM agreed the meals provided at breakfast were repetitive and stated it was due to the vendor's food supplies. The DM stated she did not have any frozen apple pancakes to serve with this morning's breakfast, but she did have the country ham and wasn't sure why it was not served. An interview was conducted with the Registered Dietician on 3/17/22 at 11:45 AM and was not aware the facility' breakfast menu was not being followed. She added it was expected for substitutions to happen but not frequently, however she was not aware of the substitutions being made.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents and staff, the facility failed to provide food that was palatable and served at an appetizing temperature for 4 of 4 residents reviewed for food palatability (Residents #68, #73, #291 and #136). This had the potential to affect other residents in the facility.	F 804	F804 □ Nutritive Value/Appear, Palatable/Prefer Temp 1. Residents are currently being served their meals at an acceptable temperature. 2. Center ordered additional dome lids and insulated bases on 4/4/22, with an	4/14/22

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F 804	Continued From page 104 The findings included: The breakfast meal was observed on 3/14/22 at 7:55 AM for the 100 hall and 200 hall. The enclosed tray delivery carts were carts present on the hallways and nursing staff were observed retrieving resident trays and closing the door in between. The breakfast tray contained a plate with no warming base and was covered with a lid that did not fit securely over the plate. a. Resident #68 was originally admitted to the facility on 1/3/22. Her admission Minimum Data Set (MDS) assessment dated 1/17/22 indicated she had mild cognitive impairment. Nursing notes revealed she was oriented and able to answer questions appropriately. On 3/14/22 at 10:30 AM, an interview occurred with Resident #68 who resided on the 300 hall. She stated the food was either cold or lukewarm, especially in the mornings, and was very bland with no flavoring. b. Resident #73 was admitted to the facility on 1/19/22. Her admission MDS assessment dated 1/26/22 indicated she was cognitively intact. On 3/14/22 at 10:40 AM, an interview occurred with Resident #73, who resided on the 300 hall. She stated the food was often served cold or lukewarm and had no seasoning. She added the vegetables had a very strange taste to them. c. Resident #291 was admitted to the facility on 2/28/22. Her admission MDS assessment dated 3/7/22 revealed she was cognitively intact.	F 804	expected delivery of 4/11/22. Dietary Manager audited recipes to ensure meals are prepared and served according to documented recipe books. Center is doing random test tray audits evaluating the temperature, the presentation, the palatability and that the menu was followed 7 times weekly at various meals. Documentation on test tray audits is to be submitted to the Healthcare Services Group (HCSG) District Manager and the Center Executive Director. Resident Council concerns or Resident grievances will be followed-up by the Dietary Manager and submitted to the HCSG District Manager and intervention and outcome will be given to the Center Executive Director. 3. Dietary staff was trained on 4/4/22 and 4/8/22 by HCSG District Manager/Dietary Manager reviewing the fundamental concepts and the importance of following the standard recipes to prepare meals the correct way. 4. Random test tray audits evaluating the temperature, the presentation, the palatability and that the menu was followed will be conducted by the Dietary Manager/designee a minimum of 7 times weekly at various meals for 1 month, then be completed by the Dietary Manager/designee a minimum of 5 times weekly at various meals for the next month. In the third month random test tray audits evaluating the temperature, the presentation, the palatability and that the menu was followed will be completed by	

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	345143	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 804	Continued From page 105 On 3/14/22 at 11:15 AM, an interview was conducted with Resident #291 who resided on the 300 hall. She stated the breakfast meal was usually served cold or lukewarm and was always the same food choices. In addition, the food that was provided had no seasoning and the vegetables often tasted like metal. Resident #291 stated she had asked about fresh fruit and vegetables but had not received anything other than a banana from time to time. d. Resident #136 was originally admitted to the facility on 6/21/21. A quarterly MDS assessment dated 2/16/22 indicated he was cognitively intact. On 3/14/22 at 12:39 PM, an interview occurred with Resident #136 who resided on the 400 hall. He stated the meals were often cold or lukewarm and was served 2 or more starches with meals even though he was a diabetic. An observation of the 300 hall breakfast trays was made on 3/15/22 at 7:55 AM. Nursing staff were passing out trays and closing the doors to the enclosed tray delivery cart in between trays. The breakfast plate was not sitting on a warming base and the lid that covered the food did not fit securely over the plate. On 3/15/22 at 8:05 AM, Resident #291 stated she had received the same breakfast food today as every day since admission and it was lukewarm when she received it. Resident #291 stated the eggs were like plastic with no flavor and she had received only 1 piece of bacon. Resident #73 was interviewed on 3/15/22 at 8:10 AM and stated when she received her breakfast meal it was the same tasteless eggs that she	F 804	the Dietary Manager/designee a minimum of 3 times weekly at various meals. Dietary Manager will audit recipe books three times a week for three weeks and then weekly for two months after that. Resident satisfaction audits will be done for a minimum of 7 residents per week for 4 weeks, and then 3 Resident satisfaction audits will be done weekly for continuous checks for resident satisfaction on an ongoing basis. Audit results will be presented to the Administrator and District Manager for review. Audit results and findings will be included within the Quality Assurance Performance Improvement committee monthly meetings to evaluate the effectiveness of the plan. 5. Date of compliance 4/14/2022.	

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F 804	Continued From page 106	F 804		

received every day since admission. The food was lukewarm when received and had no flavor except for the packaged Danish roll and 1 piece of bacon.

The Dietary Manager (DM) was interviewed on 3/15/22 at 11:35 AM and stated she had been employed as the DM at the facility for close to 5 years. She stated over the past few years she had received a few complaints regarding cold food but felt it was due to the nursing staff passing out trays. She explained the facility had never had base warmers for the plates to sit in, but it might help for continued warmth of food being delivered to the residents.

An interview was conducted with the DM on 3/16/22 at 10:41 AM, who explained fresh fruit and vegetables would be served if specified on the meal ticket as a request by a resident or if the recipe called for it. The DM added in the past she would send out fresh fruit and it would often come back uneaten or spoil in the refrigerator, so that was why she just followed the menu and sent out if specifically requested by a resident. The DM explained that salt and pepper packs were sent on the trays for residents to season their own food because in the past she had received complaints about the food being too salty or too much pepper. She had informed her cooks "to be light handed " with the seasoning. Spices, salt, and pepper were only used in the food if called for in the recipe.

The Administrator was interviewed on 3/17/22 at 4:45 PM and stated he was aware there had been expressed concerns regarding cold food and the taste of the food and should not be an ongoing problem.

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F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label, and date opened food items in 1 of 2 nourishment refrigerators reviewed for food storage (500 hall). The findings included: In an observation of the 500-hall nourishment refrigerator conducted with Nurse #1 on 3/16/22 at 3:30 PM, the following were observed: - One 16-ounce bottle of sauce that was opened but had no date to indicate when it was originally opened. - One 10-ounce container of coffee creamer that was opened but had not date to indicate when it was originally opened.	F 812	F812 □ Food Procurement, Store/Prepare/Serve-Sanitary 1. The opened bottle of sauce that was not dated was removed from the refrigerator on 3/16/22. The 10 ounce container of coffee creamer that was opened but was not dated was removed on 3/16/22. The sandwich that was undated was removed from the refrigerator on 3/16/22. 2. Dietary Manager is responsible for checking the nourishment rooms. Former Dietary Manager is no longer employed at the Center. New Dietary Manager inspected all nourishment rooms on	4/14/22

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F 812	Continued From page 108 - One half of a ham sandwich in a clear plastic bag that was unsealed and not dated to indicate when the sandwich was made. During the observation , an interview was conducted with Nurse #1 and stated all items should be dated when opened and received from a family member for a resident. Nurse #1 confirmed the items found in the 500-hall nourishment refrigerator did not have a date on them and were disposed. The Dietary Manager (DM) was interviewed on 3/17/22 at 11:10 AM, and stated dietary staff were responsible for removing opened items that were not labeled and dated or sealed.	F 812	4/4/22 to verify that they did not have any undated food and all were in compliance. 3. New Dietary Manager was trained by Healthcare Services Group (HCSG) District Manager on marking and dating food properly, along with proper storage on 4/4/22. Dietary staff was trained by the HCSG District Manager/Dietary Manager on marking and dating food properly, along with proper storage, on 4/4/22 and 4/8/22. Center nursing staff was trained on marking and dating food properly, along with proper storage by the Director of Nursing/designee on 4/8/22. Staff not receiving education on 4/8/22 will not be permitted to work until education is completed. 4. Dietary Manager will check the nourishment rooms 2x per day for 4 weeks, then daily from then on and complete an audit tool each time checked. Audit results will be presented to the Center Executive Director and District Manager for Health Care Services Group for review. Audit results and findings will be reviewed within the Quality Assurance Performance Improvement committee to evaluate the effectiveness of the correction and adjust if necessary. 5. Date of compliance 4/14/2022.	
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that	F 835		4/14/22

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F 835	Continued From page 109 enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility administration failed to provide effective oversight to ensure residents were treated with dignity and respect during care (Residents #26, #139 and #96). The facility administration also failed to provide effective oversight to ensure resident rooms (Rooms #305, #401, #404B and #309), bathroom (Room #302), wheelchairs (Rooms #505A, #506A, #511B, #513A and #519B) and dining room (500 hall) were in good repair, clean and sanitary. This deficient practice affected 3 of 7 residents, 10 of 10 resident rooms and 1 of 1 dining room. The findings included: 1) This citation is cross referred to F550-E Based on record review and interviews with residents and staff, the facility failed to treat residents with dignity and respect when the facility staff utilized their cell phones for personal phone calls while assisting residents with the Activities of Daily (ADLs) care. This resulted in the residents feeling invisible and angry. This was for 3 (Resident #26, Resident #139 and Resident #96) of 7 residents reviewed for dignity. 2) This citation is cross referred to F584-E: Based on record reviews, observations, resident and staff interviews, the facility failed to ensure resident rooms and a resident bed were in good repair (Rooms #305, #401, #404B and #309). In	F 835	F835 □ Administration 1. Resident room 305, 401, and 309 were repaired on 4/6/22. Resident 404-2 footboard was replaced on 3/16/22. Resident□s bathroom in 302 was cleaned on 3/16/22. Resident wheelchairs for 505 -1, 506-1, 511-2 513-1 and 519-2 were cleaned on 4/1/22. The dining room for 500 Hall was cleaned on 3/15/22. Resident # 26, resident # 139, and resident #96 are currently receiving care with dignity and respect without staff using cell phones during care. 2. Center Executive Director, Maintenance Supervisor and Housekeeping Manager toured all resident rooms on 4/8/22 to look for damage requiring repair, wheelchairs that needed to be cleaned, and beds with footboards or headboards not in place, and common areas including dining rooms, lobby, hair salon, Activities Room, and shower rooms. An audit was conducted by the district manager for Health Care Services Group of the bathrooms, wheelchairs, and the dining rooms on 3/17/22. Social Services Director and Social Worker completed an interview with all current alert and oriented residents regarding resident rights being maintained during care on 4/5/22. The interview included questions to determine	

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F 835	Continued From page 110 addition, the facility failed to ensure a resident's bathroom (Room 302), resident wheelchairs (Rooms #505A, #506A, #511B, #513A and #519B), and dining room (500 hall) were clean and sanitary. This was for 11 of 11 areas reviewed for environmental concerns. An interview was conducted with the Administrator on 3/17/22 at 3:42 PM. He stated there had been a problem a few months ago about the staff talking on their cell phones at the end of the 400 hall but he was not aware that the staff were using their personal cell phones during care. The Administrator also stated he was aware there were ongoing issues with the contracted environmental provider. He stated the contracted environmental provider and the facility were actively working together to improve the concerns.	F 835	if residents were being treated with dignity and respect during ADL care by staff not utilizing their cell phones while providing care. 3. Education provided to the Center Executive Director by the Regional Vice President of Operations and the Regional Nurse regarding the regulatory requirements of F 550 and F 584 and the responsibility of Administration to ensure oversite of these areas on 4/5/22. 4. The Center Executive Director is responsible for ensuring that residents are treated with Dignity and Respect and have a clean and homelike environment. The Regional Vice President of Operations and the Regional Nurse will visit the center monthly to monitor compliance in these areas, their findings will be shared with the Center Executive Director with appropriate follow up actions as necessary to ensure compliance. These visit findings will be brought before the Quality Assurance and Performance Improvement Committee monthly by the Center Executive Director with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance 4/14/22.	