STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced onsite recertification survey was conducted 5/23/2022 thru 5/26/2022. The facility was found in compliance with the requirment CFR 483.73 Emergency Preparedness.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted 5/23/2022 thru 5/26/2022. Event ID # YHE211.	F 000		
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 observations, staff and resident interviews and record review, the facility failed to assess and obtain Physician orders for the self-administration of a topical cream for 1 (Resident #99) of 2 residents reviewed for the self-administration . The findings included: 1. Resident #99 was admitted on 7/24/20 with a diagnosis of a Cerebral Vascular Accident (CVA). Review of Resident #99's active Physician orders included an order dated 5/11/21 for Aspercreme Original Cream 10 % (a topical cream used to treat joint pain) to be applied to his bilateral knees topically every 12 hours for knee pain. Review of Resident #99's care plan last revised	F 554	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F 554 The facility failed to assess and obtain physician orders for the self-administration of a topical cream for resident #99. 1. Corrective action for resident(s)	6/27/22

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

Electronically Signed | 06/18/2022

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F 554	Continued From page 1 on 2/7/22 did not include a care plan for the self-administration of his ordered topical cream. Resident #99's quarterly Minimum Data Set dated 5/8/22 indicated he was moderately cognitively intact. Review of Resident #99's electronic medical record did not include any evidence of an order for the self-administration of his Aspercreme and no evidence of a self-administration assessment. A medication administration observation and interview were completed on 5/25/22 at 8:30 AM with Nurse #2. She removed a tube of Aspercreme from the medication cart and put a generous amount of the cream into a plastic medication cup. Nurse #2 stated Resident #99 applied the cream himself. During the administration of Resident #99's medications, she set the medication cup with the Aspercreme on his bedside table and left the room. Resident #99 was interviewed on 5/25/22 at 8:31 AM following the medication administration observation and revealed Nurse #2 always left a cup of Aspercreme for him to apply himself but the other nurses did not. The Administrator stated on 5/25/22 at 2:41 PM, she was unable to find any documented evidence of an order or a self-administration for Resident #99. An interview was completed with Nurse #2 on 5/25/22 at 2:45 PM. She stated she was not aware that Aspercreme required a Physician order and a self-administration assessment had to be completed prior to leaving any prescribed	F 554	affected by the alleged deficient practice: For resident # 99 the medication was removed from the bedside on 5/25/2022 and secured on the medication cart. by the assistant director of nurses. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 6/17/2022 the Assistant Director of Nurses audited all resident rooms to assure that no medications were found at bedside that had not been assessed for resident self -administration. 2 other residents were identified with a medication found at bedside. On 6/17/2022 self-administration UDA's were completed on the 2 residents and orders obtained from the physician for self- administration/to be kept at bedside. Medications were secured on med cart until process for self-administration completed. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 6/16/2022 the Director of Nurses, Assistant Director of Nurses and Nurse Consultant began education of all Full Time, Part Time, PRN nurses, medication aides and agency nurses on facility policy related to medication safety that included resident assessment for self -administration of medication process and safely securing and storing medications. Education will be completed by 6/26/2022. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance	

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F 554	Continued From page 2 medication at the bedside. An interview was conducted on 5/26/22 at 1:00 PM with the Administrator and Director of Nursing (DON). The DON stated it was her expectation that Nurse #2 not leave topical medications at Resident #99's bedside but rather it be applied by the nurse as ordered every 12 hours.	F 554	process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nurses or designee to assess that the medication self- administration process is in compliance and that no other meds are at bedside if the resident is not appropriate for self-administration. Audits will be done weekly for 2 weeks, then monthly for 3 months or until resolved for compliance with facility policy on self- administration of medication process. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, acting Residential Care Coordinator, Activity Director and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.	

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F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		6/27/22

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F 636	Continued From page 4 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to submit an admission Minimum Data Set (MDS) within 14 days after admission. This was for 1 (Resident #201) of 21 MDS assessments reviewed for completion. The findings included; Resident #201 was admitted on 4/29/22. Resident #201 admission MDS assessment with the Assessment Reference Date (ARD) of 5/12/22 was still in progress on 5/25/22. An interview was completed on 5/26/22 at 12:10 PM with the MDS Nurse. She stated she realized it yesterday and locked the MDS assessment this morning. She stated she had gotten behind and	F 636	F636 Comprehensive Assessment and Timing The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to conduct comprehensive Minimum Data Set (MDS) assessment within 14 days of admission to the facility for resident #201. Corrective Action for Affected Resident: On date 05/25/22, the Minimum Data Set (MDS) Admission Assessment with Assessment Reference Date of 05/12/22 for resident (#201) was completed by the facility Minimum Data Set Nurse and was submitted and accepted into the state	

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F 636	Continued From page 5 there were other people assisting her with getting caught up and Resident #201's admission MDS assessment was not completed. She stated the assessment should have been completed by the 14th day after his admission. An interview was completed on 5/26/22 at 1:00 PM with the Administrator. She stated it was her expectation that all resident MDS assessment be completed and submitted within the regulated time constraints.	F 636	data base on 5/26/22 in Batch #471. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. The Regional Minimum Data Set (MDS) Consultant will complete a 100% audit of all residents admitted to facility from 05/16/22 – 06/16/22 in order to validate that the Admission Minimum Data Set assessments were completed by the due date. This audit will be completed no later than 06/24/22. All residents identified as having an Admission Minimum Data Set Assessment that is open and has not been completed yet will have these assessments completed no later than 06/24/22. Any resident identified as not having had an Admission assessment completed as required will have this assessment opened and completed no later than 06/24/22. This will be completed by the facility Minimum Data Set Nurse. Systemic Changes: On 06/20/22, the Regional Minimum Data Set (MDS) Consultant completed an in service training for the facility MDS Nurse on how to conduct a comprehensive assessment, identifying and analyzing conditions that can affect the function and quality of life of residents with consideration to their cognitive status. This education emphasized the required timeframes for completing admission	

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F 636	Continued From page 6	F 636	Minimum Data Set assessments as set by CMS and the importance of adherence to these timeframes. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The facility Director of Nursing or designated Nurse Manager will conduct audits of up to five (5) residents who were admitted during the past 30 days to ensure that Admission Minimum Data Set assessments were completed by the required due date. This will be completed using a quality assurance (QA) Admission Completion audit tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This audit will be done weekly for 4 weeks then monthly for 2 months or until sustained compliance met. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the resident was discharged from the hospice program for 1 of 2 residents reviewed for hospice (Resident #41). The findings included: Resident #41 was admitted to the facility on 11/19/20 with diagnoses that included vascular dementia and a stroke. A review of the medical record for Resident #41 revealed a physician's order dated 3/16/22 to discontinue Hospice services. A quarterly Minimum Data Set (MDS) assessment dated 3/16/22 indicated Resident #41 had severe cognitive impairment and was not coded for hospice services.	F 637	F637 Comprehensive Assessment after Significant Change For resident #41, a corrective action was initiated on 06/16/22. A Significant Change in Status Minimum Data Set Assessment with an Assessment Reference Date of 06/16/22 was opened on 06/16/22 and will be completed for Resident #41 by the facility Minimum Data Set Coordinator no later than the required due date (14 days after the Assessment Reference Date). Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Minimum Data Set Consultant will complete a 100% audit of all residents who have been admitted to or discharged from hospice care during the past 90 days to ensure that Significant Change	6/27/22

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F 637	Continued From page 8 On 5/26/22 at 12:09 PM, an interview was completed with the MDS Nurse who stated she wasn't aware a Significant Change in Status MDS assessment should have been completed within 14 days after Resident #41 was discharged from hospice services.	F 637	Minimum Data Set assessments have been completed. All current residents who have been admitted to or discharged from hospice services during the past 90 days and did not have a Significant Change Minimum Data Set completed will have a Significant Change assessment opened and completed by the facility Minimum Data Set Nurse. These assessments will be opened for completion no later than 06/24/22. Systemic Changes On 06/20/22, the Minimum Data Set Nurse Consultant in serviced the Minimum Data Set Coordinator on the requirement for and importance of completing a Significant Change Minimum Data Set assessment for all residents who are either admitted to or discharged from hospice services. Completion of a Significant Change MDS is also required if a resident changes hospice providers. The education emphasized the importance of completing the assessment as required in order to identify and address any changes in the resident's condition and care, which will then allow for optimal coordination of resident care. The Assessment Reference Date for the MDS may be set up to 14 days after the significant change in status has been identified. The significant change MDS must then be completed no later than 14 days after the Assessment Reference	

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F 637	Continued From page 9	F 637	Date. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will review 5 residents who have been either admitted to or discharged from hospice services OR who have changed hospice providers during the past 30 days to ensure that a Significant Change in Status Minimum Data Set assessment has been completed as required. This will be done using the quality assurance tool entitled "Significant Change in Status MDS Completion Audit Tool." This audit will be done on weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Therapy, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		6/27/22

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F 641	Continued From page 10 §483.20(g) Accuracy of Assessments. 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) assessment accurately in the areas of bowel and bladder (Residents #44 and #54), and medications (Resident #44). This was for 2 of 21 residents reviewed. The findings included: 1. Resident #54 was admitted on 8/2/21 with a diagnosis of Urinary Retention. Review of Resident #54's cumulative Physician orders included an order dated 4/5/22 for her suprapubic catheter. Resident #54's quarterly Minimum Data Set (MDS) dated 4/5/22 indicated she was cognitively intact, coded for a urinary catheter and coded for occasional urinary incontinence. An interview was completed on 5/26/22 at 12:10 PM with the MDS Nurse. She stated Resident #54's MDS dated 4/5/22 was coded inaccurately for occasional urinary incontinence and that it was an oversight. An interview was completed on 5/26/22 at 1:00 PM with the Administrator. She stated it was her expectation that all resident MDS assessments be coded accurately.	F 641	F641 Accuracy of Assessments For resident #44, a corrective action was obtained on 06/16/22. • The specific deficiencies for resident #44 for Minimum Data Set with Assessment Reference Date of 03/22/22 were corrected on 06/16/22 by modifying the Minimum Data Set assessment in order to correct miscoding of question H0400 (Bowel Continence) and N0410E (Anticoagulant). This correction was completed by the Regional Minimum Data Set Consultant. The corrected assessment was re-submitted and accepted by the state database on 06/16/22 in Batch #487. For resident #54, a corrective action was obtained on 06/16/22. • The specific deficiency for resident #54 for Minimum Data Set with Assessment Reference Date of 04/05/22 was corrected on 06/16/22 by modifying the Minimum Data Set assessment in order to correct miscoding of question H0300 (Bladder Continence) . This correction was completed by the Regional Minimum Data Set Consultant. The corrected assessment was re-submitted and accepted by the state database on 06/16/22 in Batch #486. Corrective action for residents with the	

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F 641	Continued From page 11 2a. Resident #44 was admitted on 12/13/2021 with a diagnosis of end stage renal disease. Review of Resident #44's cumulative Physician orders included an order dated 3/9/2022 for her colostomy care every shift. Resident #44's quarterly Minimum Data Set (MDS) dated 3/22/2022 indicated the resident had impaired vision and required extensive assistance with all activities of daily living. Resident #44 had a colostomy and was coded as always incontinent of bowel during the assessment period. An interview was completed on 5/26/2022 at 12:22 PM with the MDS Nurse. She stated Resident #44's MDS dated 3/22/2022 was coded inaccurately for always incontinent of bowel. She stated she should have coded it as not rated since the resident had a colostomy. She further stated it was an oversight. An interview was completed on 5/26/22 at 1:00 PM with the Administrator. She stated it was her expectation that all resident MDS assessments be coded accurately. 2b. Resident #44 was admitted on 12/13/2021 with a diagnosis of end stage renal disease. Review of Resident #44's Medication Administration Record (MAR) for March 2022 revealed the resident received heparin, 5000 units per milliliter subcutaneously twice daily for prophylaxis. Resident #44's quarterly Minimum Data Set (MDS) dated 3/22/2022 indicated the resident received antidepressants 5 out of 7 days, opioids	F 641	potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of the most recently completed Minimum Data Set assessment for all current residents who have a urinary catheter, colostomy, and/or are receiving anticoagulant medication will be conducted in order to determine if H0300, H0400 and N0410E were accurately coded. This audit will be completed by the Regional Minimum Data Set Consultant and will be completed no later than 06/24/22. All Minimum Data Set Assessments that are identified as having inaccurate coding of H0300, H0400 and/or N0410E will have modifications completed in order to make any necessary corrections. These corrections will be completed by the Regional Minimum Data Set Consultant and will be re-submitted to the state database no later than 06/24/22. Systemic Changes On 06/20/22, the Regional Minimum Data Set Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record and conducting a physical assessment of the resident prior to completion of the Minimum Data Set Assessment. This education emphasized the importance of	

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F 641	Continued From page 12 5 out of 7 days, and no anticoagulants during the assessment period. An interview was completed on 5/26/2022 at 12:22 PM with the MDS Nurse. She stated Resident #44's MDS dated 3/22/2022 was coded inaccurately for anticoagulants. The resident had received anticoagulants during the assessment period. She further stated it was an oversight. An interview was completed on 5/26/22 at 1:00 PM with the Administrator. She stated it was her expectation that all resident MDS assessments be coded accurately.	F 641	thorough assessment and review in order to be able to accurately code H0300 (bladder continence); H0400 (bowel continence); and N0410E (anticoagulant). This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the coding of MDS items H0300, H0400 and N0410E using the quality assurance audit tool entitled "Accurate Minimum Data Set Coding Audit Tool." This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		6/27/22

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F 656	Continued From page 13 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 local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 14 (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 and staff interviews, the facility failed to develop a comprehensive care plan for the use of an as needed psychotropic medication (Resident #61) and the use of oxygen (Resident #96). This was for 2 of 21 residents reviewed. The findings included: 1. Resident #61 was admitted to the facility on 12/20/21 with diagnoses that included anxiety disorder and seizure disorder. Resident #61's active physician orders revealed an order dated 12/20/21 for Lorazepam (an antianxiety medication) 0.5 milligrams (mg) 1 tablet by mouth every hour as needed for anxiety. A review of the March 2022 Medication Administration Record (MAR) revealed Resident #61 received Lorazepam seven times. A quarterly Minimum Data Set (MDS) assessment dated 4/4/22 indicated Resident #61 was cognitively intact and received 3 out of 7 days of an antianxiety medication. Resident #61's active care plan, last reviewed 4/15/22, made no reference to the use of antianxiety medications or the associated risks. A review of the April 2022 MAR revealed Resident #61 received Lorazepam 11 times.	F 656	F 656 Develop/Implement Comprehensive Care Plan Corrective Actions for Resident #61. A corrective action was taken in order to correct the care plan for Resident #61 on 05/26/22. This corrective action was completed by the facility Minimum Data Set Nurse. Corrective Actions for Resident #96. A corrective action was taken in order to correct the care plan for Resident #96 on 05/26/22. This corrective action was completed by the facility Minimum Data Set Nurse. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100% audit of all current residents who are currently receiving antianxiety medication and/or are receiving oxygen therapy was conducted in order to ensure that their care plans accurately reflect these services. This audit will be completed by the Regional Minimum Data Set Consultant and will be completed no later than 06/24/22. Any resident whose care plan is identified as not accurately reflecting antianxiety medication use and/or oxygen therapy will be revised by the Regional Minimum Data	

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F 656	Continued From page 15 On 5/26/22 at 12:09 PM, an interview occurred with the MDS Nurse who indicated it was an oversight not to have developed a comprehensive care plan for the use of an as needed psychotropic medication used for anxiety. During an interview with the Administrator and Director of Nursing on 5/26/22 at 1:10 PM they indicated it was their expectation for Resident #61's care plan to be comprehensive and felt it was an oversight not to have included the use of psychotropic medications for anxiety. 2. Resident #96 was originally admitted to the facility on 10/25/19. Her diagnoses included congestive heart failure (CHF) and hypertensive heart disease with heart failure. A physician order dated 6/28/21 revealed oxygen at 2 liters via nasal cannula as needed for saturations below 90%. Physician progress notes from 12/28/21 until 4/26/22 indicated Resident #96 had oxygen in place via nasal cannula when she was assessed each time. A quarterly Minimum Data Set (MDS) assessment dated 5/9/22 indicated Resident #96 had severely impaired decision-making skill and required extensive to total assistance with all Activities of Daily Living. She was not coded for oxygen use. A review of Resident #96's active care plan, last reviewed 5/20/22, revealed no care plan in place for the as needed order for oxygen.	F 656	Set Consultant and will be completed no later than 06/24/22. Systemic Changes On 06/20/22 the Regional Minimum Data Set Nurse Consultant provided in-service education to the facility Minimum Data Set Nurse on Comprehensive Care Plans. This education included the importance of ensuring that each resident's care plan addressed actual problems, risk factors, resident strengths and preferences. The education emphasized that the care plan must communicate the resident's current condition, needs, and preferences to the staff. Therefore, the care plan must have ongoing revisions and updates as the resident's condition changes. The education also included the importance of ensuring that resident care plans must be updated and accurately reflect the resident's current nutritional status. The educational material included the fact that the care plan is a tool used to communicate resident's condition, needs, preferences, strengths, special needs to the interdisciplinary team and primarily frontline staff, and that in order to provide the highest quality of care possible and to ensure residents' needs are met, the care plans must be person-centered and an accurate and current reflection of resident. Emphasis was placed on ensuring that the care plan accurately reflects the use of any psychotropic medication including antianxiety agents as well use of oxygen therapy. This information has been integrated into the standard orientation training for new	

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F 656	Continued From page 16 Nursing progress notes from 1/1/22 until 5/24/22 indicated Resident #96 used oxygen at 2 liters via nasal cannula. On 5/23/22 at 10:40 AM, Resident #96 was observed lying in bed with oxygen in place via nasal cannula. An interview with Medication Aide (MA) #1 occurred on 5/25/22 at 1:55 PM, who stated she had always known Resident #96 to use oxygen continuously. On 5/26/22 at 12:09 PM, an interview was held with the MDS Nurse who reviewed Resident #96's medical record and care plan. She explained she had always observed Resident #96 with oxygen in place and felt it was an oversight not to have developed a care plan for oxygen use. During an interview with the Director of Nursing, on 5/26/22 at 1:10 PM, she stated it was her expectation for care plans to be an accurate reflection of the resident. She further stated she would have expected a care plan and interventions to be in place to address Resident #96's use of as needed oxygen.	F 656	Minimum Data Set Nurses. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will conduct audits to ensure that current residents have care plans that accurately reflect if they are receiving antianxiety medication and/or oxygen therapy. The Quality Assurance tool entitled "Comprehensive Care Plans QA Tool" will be completed weekly for 4 weeks then monthly for 2 months or until sustained compliance has been achieved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. The title of the person responsible for implementing the plan of correction. The Administrator and/or Director of Nursing is responsible for implementation and completion of the acceptable plan of correction.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		6/27/22

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F 657	Continued From page 17 §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 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 staff interviews and record review the facility failed to revise the comprehensive care plan for contracture management (Resident #60), the development of a pressure ulcer (Resident #3) and for feeding assistance (Resident #74). This was for 3 of 21 residents reviewed for care plan revision. The findings included: 1. Resident #60 was admitted 3/22/22 with a non-traumatic intercranial hemorrhage with left side hemiplegia.	F 657	F657 Care Plan Timing and Revision Corrective Action for Affected Residents Corrective Action for Resident #60: The care plan for resident #60 was revised in order to add that the resident is receiving restorative nursing services for PROM to upper extremities and left hand splinting. This was completed by the Minimum Data Set Nurse Consultant on 06/16/22. Corrective Action for Resident #3: The care plan for resident #3 was revised by	

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F 657	Continued From page 18 His admission Minimum Data Set (MDS) dated 4/4/22 indicated he had severe cognitive impairment, coded for total assistance with all of his activities of daily living (ADLs) and coded for impairment to his bilateral upper and lower extremities. Review of a Restorative or Maintenance referral form dated 5/2/22 indicated Resident #60 was to receive passive range of motion (PROM) to his left upper extremities and to wear a wrist-hand orthosis splint to his left hand 3 times per weeks for 3-4 hours for prevention of a left hand contracture. Review of Resident #60's comprehensive care plan 4/22/22 did not include a care plan for contracture management or restorative nursing. An interview was completed on 5/26/22 at 12:10 PM with the MDS Nurse. She stated Resident #60's comprehensive care plan should have been revised to included Resident #60's contracture management for PROM and splinting. An interview was completed on 5/26/22 at 1:00 PM with the Administrator. She stated it was her expectation that Resident #60's revised care plan include the area of contracture management. 2. Resident #3 was on 4/1/8/20 with dementia and osteoarthritis. Review of a nursing noted dated 11/25/21 at 11:06 AM read Resident #3 developed an open area to her left lateral leg under her knee immobilizer.	F 657	the Minimum Data Set Nurse Consultant on 06/16/22 in order to add focus, goal and related interventions for pressure ulcer to left lateral leg. Corrective Action for Resident #74: The care plan for resident #74 was revised by the Minimum Data Set Nurse 05/26/22 in order to add that the resident requires staff assistance with eating meals. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be impacted by the alleged deficient practice. • A100% audit will be conducted on all current residents who are currently receiving restorative nursing services in order to determine if these services are accurately reflect on the care plan. • A 100% audit will be conducted on all current residents who currently have pressure ulcer(s) in order to determine if the care plan reflects pressure ulcer(s). • A 100% audit will be conducted on all current residents who require staff assistance with meals in order to determine if this is accurately reflected on the care plan. This audit will be completed by the facility Minimum Data Set Nurse and will be completed no later than 06/24/22. Any resident whose care plan is identified as not accurately reflecting any of the above audited items will be revised in order to ensure that the care plan is accurate and current reflection of resident's condition and needs. All corrections will be completed by the	

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F 657	Continued From page 19 Review of a nursing note dated 12/10/21 read Resident #3's left knee immobilizer was discontinued and new orders were received for the treatment of her left lower lateral pressure ulcer. Review of Resident #3's comprehensive care plan last revised on 2/28/22 did not include a care area with interventions for her stage 4 pressure ulcer. Resident #3's quarterly Minimum Data Set (MDS) dated 5/1/22 indicated she had severe cognitive impairment and was coded for one stage 4 pressure ulcer. An interview was completed on 5/26/22 at 12:10 PM with the MDS Nurse. She stated Resident #3's comprehensive care plan should have been revised to included Resident #3's pressure ulcer with the onset date of 11/25/21. An interview was completed on 5/26/22 at 1:00 PM with the Administrator. She stated it was her expectation that Resident #3's revised care plan include the pressure ulcer development to her left lower extremity with interventions. 3. Resident #74 was admitted 1/15/2021 with diagnoses that included dementia. Resident #74's quarterly Minimum Data Set (MDS) dated 5/4/2022 indicated the resident has severely impaired cognition, required extensive assistance with activities of daily living and	F 657	facility Minimum Data Set Nurse and will be completed no later than 06/24/22. Systemic Changes On 06/20/22, the Minimum Data Set Nurse Consultant in-serviced the facility Minimum Data Set Nurse on the importance of maintaining up to date care plans that are reflective of the resident's current status and needs. Emphasis was placed on ensuring that care plans are individualized for each resident's specific needs. This includes ensuring that the care plan accurately reflects the presence of pressure ulcers, resident's need for staff assistance with feeding/meals and special services that they may be receiving including restorative nursing services. Frontline staff who provide direct care to residents rely on the care plan in order to provide safe and effective care. Therefore, it is critical that in addition to the routine quarterly assessment and care plan reviews and updates that are completed, that care plans also be updated and revised as a resident's condition changes. Care plan updates and revisions is an on-going process. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will	

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F 657	Continued From page 20 required supervision and set up only for eating. Review of Resident #74's comprehensive care plan revised 1/26/2022 included a focus for nutritional problem related to weight loss. The resident's interventions stated the resident could feed herself after tray set up. Review of Resident #74's medical record revealed a progress note dated 3/30/2022 written by the former Director of Nursing (DON). The progress note read; Resident has lost weight. Resident will eat if assisted with meals. New intervention is to have resident assisted with meals. New task put in for resident to be assisted with each meal. The resident's medical record also included a progress note dated 3/30/2022 by the Dietary Manager (DM) that read; put in recommendation to have her assisted with feedings and will continue to monitor her weight. On 5/26/2022 at 11:38 AM a phone interview was conducted with the former DON. She stated the intervention was discussed in the morning interdisciplinary meeting and she did document the resident required assistance with feeding in the resident's progress notes. She made the Minimum Data Set (MDS) nurse aware the resident required assistance with meals and the MDS nurse should have revised the resident's care plan. The former DON stated she did not add assistance with meals to the resident's care task, that would have been the responsibility of the MDS nurse. On 5/26/2022 at 12:25 PM an interview was conducted with the MDS nurse. She stated she	F 657	audit up to 5 current residents in order to validate whether or not the care plan accurately reflects whether the resident currently is currently receiving restorative nursing services, has a pressure ulcer or requires staff assistance with feeding/meals. This will be done on weekly basis x 4 weeks then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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F 657	Continued From page 21 did not recall the interdisciplinary meeting in March or being asked to add feeding assistance with each meal to Resident #74's care plan interventions. An interview was completed on 5/26/22 at 1:00 PM with the Administrator. She stated it was her expectation that care plan be revised to reflect the resident's needs.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews, the facility failed to identify the correct route of medication administration for 1 of 3 residents (Resident #44) reviewed for medication administration. The findings included: Resident #44 was admitted on 12/13/2021 with a diagnosis of end stage renal disease. Resident #44's quarterly Minimum Data Set (MDS) dated 3/22/2022 indicated the resident had moderately impaired vision, required extensive assistance with all activities of daily living, had a percutaneous endoscopic gastric tube (PEG or feeding tube), and received antidepressants and opioids during the assessment period.	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 The facility failed to identify the correct route of medication administration for resident #44. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 06/17/2022 the Director of Nurses	6/27/22

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F 658	Continued From page 22 Resident #44's comprehensive care plan, last updated 3/2/2022, contained a focus for nutritional problem related to weight loss, feeding tube, and dialysis. Resident #44's Medication Administration Record (MAR) for May 2022 revealed he received some medications via oral route while others were ordered to be administered via feeding tube. Resident #44's medical record revealed active physician orders for the following medications to be given through the PEG tube; Aspirin 81milligrams (mg) daily via PEG tube Fish oil 1000mg capsule once daily via PEG tube Fluoxetine 40mg table daily via PEG tube Melatonin 3mg, 2 tablets nightly via PEG tube Nephrovite 1mg tablet via PEG tube daily Probiotic capsule daily via PEG tube. Metoprolol 25mg, half tablet via PEG 2 times daily Midodrine 10mg via PEG tube every 8 hours On 5/24/2022 at 2:00 PM an interview was conducted with Nurse #4. She stated she gave all of Resident #44's medication via oral route. She stated when he first came back from the hospital the orders were written via PEG tube and they were never changed. Nurse #4 stated Resident #44 did not have any difficulty swallowing medications, the PEG was placed for supplemental feedings due to weight loss. She gave all his medication via oral route. Nurse #4 stated it was the nurse's responsibility to change the route of administration if it was incorrect. She had not noticed the route was ordered to be given via PEG and she should have had the order clarified.	F 658	audited the medication routes for resident #44 to assure they were appropriate and clarified with the physician that all medications maybe taken orally. As of 06/17/2022 all medication orders were in compliance. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 6/17/2022 the Director of Nurses and nursing team audited residents with feeding tubes to assure all medication orders were ordered to be administered via the correct route of administration. Results: 4 of 4 residents with feeding tubes were in compliance. As of 6/17/2022 all residents were in compliance. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 6/15/2022 the Director of Nurses, Nurse Consultant and Assistant Director of Nurses began in-service education to all full time, part time, and as needed nurses and agency nurses Topics included: • Monitoring of the route of administration for residents with feeding tubes to assure the medication route is correct. • Facility policy on clarification of medication orders to include route of administration to include those residents with feeding tubes. • The 6 rights of med pass. This information has been integrated into the standard orientation training and in the	

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F 658	Continued From page 23 On 5/25/2022 at 10:49 AM an interview was conducted with Nurse #6. She stated she was an agency/contract nurse and did not work in the facility full time. She confirmed she administered Resident #44's medications. Nurse #6 stated she crushed Resident #44's medication for administration via PEG tube. However, when she entered the room, the resident informed her he did not take his medication via PEG and he had been taking them orally for several months. Nurse #6 stated she did not know; she was following the orders on the MAR. Nurse #6 stated she made the unit manager aware the orders needed clarification. An interview was conducted with Resident #44. He stated all his medication were being administered orally. He further stated he had no difficulty with swallowing and had been taking his medication via oral route for several months. An interview was conducted with the Administrator and the Director of Nursing (DON) on 5/26/2022 at 1:00 PM. The Administrator stated it was her expectation that all medication be given via route ordered. Attempts to interview the facility's medical director were not successful.	F 658	required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing and/or designee will utilize the QA tool for F 658 to monitor compliance with clarification of the route of administration of medications and that medications are being administered via the clarified route. The Director of Nurses and/or designee will monitor 3 residents with ordered feeding tubes weekly x 2 and then monthly for 3 months for compliance. This will include direct observation of 3 residents on various day and evening shifts and days of the week to include weekends if applicable). This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing,	

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F 658	Continued From page 24	F 658	Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director.	
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 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 record reviews, observations, resident and staff interviews, the facility failed to trim and clean dependent residents' fingernails (Residents #41, #78, #96 and #44) for 4 of 4 residents reviewed for Activities of Daily Living (ADL). The findings included: 1. Resident #41 was admitted to the facility on 11/19/20 with a stroke affecting the right dominant side and vascular dementia. A quarterly Minimum Data Set (MDS) assessment dated 3/16/22 indicated Resident #41 had severe cognitive impairment and had no behaviors or refusal of care. He required extensive assistance with personal hygiene and bathing tasks and was coded with limited range of motion affecting one upper extremity and both lower extremities. A review of Resident #41's active care plan, last reviewed 4/7/22, included the following focus areas: - Potential for impairment to skin integrity. The	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F677 The facility failed to provide nail care. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #+41, on 06/17/2022 nail care was provided and documented by the hall nurse. For resident #78, on 06/17/2022 nail care was provided and documented by the hall nurse. For resident # 96, on 06/17/2022 nail care was provided and documented by the hall nurse.	6/27/22

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F 677	Continued From page 25 interventions included to keep fingernails short. - ADL self-care performance deficit, with an intervention to check nail length, trim and clean as necessary. A review of Resident #41's nursing progress notes from 1/1/22 to 5/24/22 revealed no refusals of nail care documented. On 5/23/22 at 10:25 AM, Resident #41 was observed while lying in bed watching TV. He was noted to have long fingernails on both hands with a dark substance under them. Resident #41 was observed on 5/24/22 at 11:05 AM while lying in bed watching TV. His nails on both hands remained unchanged from previous observations. On 5/24/22 at 3:30 PM, an interview was completed with NA #4, who was familiar with Resident #41, and assigned to care for him that day. She explained nail care would be completed when needed but had not rendered nail care to Resident #41 "in a while". An observation of Resident #41's nails occurred with NA #4 who verified they were long with a dark substance under them and stated, "well they do need clipping. I'll have to find some clippers." On 5/25/22 at 8:51 AM, an observation was made of Resident #41's hands, which revealed fingernails remained long with a dark substance under them. Resident shook his head "no" when asked if anyone had offered to complete his nail care. Another observation was made of Resident #41 on 5/25/22 at 1:55 PM. He was lying in bed with	F 677	For resident # 44, on 06/17/2022 nail care was provided and documented by the hall nurse. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. Beginning on 6/16/2022, the nursing team began auditing all current residents for the need of nail care. This audit will be completed by 06/26/2022 and nail care will be provided to those residents identified in need of nail care. The Minimum Data Set Nurse/Nursing Team will then task the requested shower schedule to Point Click Care tasks to fire to the certified nursing assistant's for documentation. This will be completed by 06/ 17/2022 The nursing team obtained orders for diabetic nail care by a nurse for each diabetic resident as of 6/16/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 6/15/2022, the Director of Nurses, Assistant Director of Nurses and Nurse Consultant began education of all full time, part time, and PRN Nurses and CNA's and Med Aides on the following: • Nail care should be performed daily with baths/showers and documented by the CNA in tasks in the electronic health record. • Refusal documentation for CNA's/Nurses.	

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F 677	Continued From page 26 his eyes closed and hands resting on top of the covers. His fingernails on both hands were long with a dark substance under them. On 5/26/22 at 9:40 AM, an interview occurred with NA #2 who was assigned to care for Resident #41 on 5/26/22. She stated "a group" came around to provide nail care to the residents, but she would clean nails if they were dirty. She denied providing recent nail care to Resident #41. An interview was held with NA #6 on 5/25/22 at 11:00 AM and stated she provided nail care when there was a need, unless the resident was a diabetic, then she would let the nurse know. She was unable to state if she had provided nail care to Resident #41. On 5/25/22 at 2:25 PM, an interview was completed with NA #5 and NA #8, who stated nails were to be cleaned and trimmed on shower days or when there was a need. Diabetic fingernails were cared for by the nurse. They were unaware of Resident #41 refusing nail care in the past but had not cared for him in a while. The Administrator and Director of Nursing (DON) were interviewed on 5/26/22 at 1:10 PM and stated they would expect nail care to be rendered during personal care or shower assistance. The DON further added if a NA was unable to complete the task she would expect the nurse to be notified of the need. The Administrator and DON were unable to explain why nail care had not occurred for Resident #41 as there was no documentation to show this had or had not been completed or attempted. 2. Resident #78 was admitted to the facility on	F 677	• Diabetic nail care schedule and documentation by nurses. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. Auditing will include various shifts and days of the week to include weekends. The Director of Nursing will monitor nail care compliance. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care.	

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F 677	Continued From page 27 1/19/2 with diagnoses that included osteoarthritis and seizure disorder. A quarterly Minimum Data Set (MDS) assessment dated 4/27/22 indicated Resident #78 had moderately impaired cognition and had no behaviors or refusal of care. He required extensive assistance with personal hygiene and bathing tasks. A review of Resident #78's active care plan, last reviewed 5/20/22, included a focus area for ADL self-care performance deficit. One of the interventions was to provide assistance with grooming and personal hygiene. A review of Resident #78's nursing progress notes from 1/19/22 to 5/24/22 revealed no refusals of nail care documented. On 5/23/22 at 10:15 AM, an interview occurred with Resident #78 while he was sitting in a wheelchair in his room. He was noted to have long fingernails with a dark substance under them. Resident #78 stated he didn't like his nails that long and had been "a while" since they were cut. He added he would bite them, but it would have left them jagged. Resident #78 was observed on 5/24/22 at 11:07 AM while lying in bed watching TV. His nails on both hands remained unchanged from previous observations. On 5/24/22 at 3:30 PM, an interview was completed with NA #4, who was familiar with Resident #78, and assigned to care for him that day. She explained nail care would be completed when needed but she had not rendered nail care	F 677	The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/27/2022	

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to Resident #78 "in a while. An observation of Resident #78's nails occurred with NA #4 who verified they were long with a dark substance under them and stated she would care for them.

On 5/25/22 at 8:54 AM, an observation was made of Resident #78's hands, which revealed fingernails remained long with a dark substance under them. Resident stated no one had offered to provide nail care to him this week.

Another observation was made of Resident #78 on 5/26/22 at 11:00 AM. He was sitting in the wheelchair looking out his window. His fingernails remained long with a dark substance under them.

On 5/26/22 at 9:40 AM, an interview occurred with NA #2 who was assigned to care for Resident #78 on 5/26/22. She stated "a group" came around to provide nail care to the residents, but she would clean nails if they were dirty. She denied providing recent nail care to Resident #78.

An interview was held with NA #6 on 5/25/22 at 11:00 AM and stated she provided nail care when there was a need, unless the resident was a diabetic, then she would let the nurse know. She was unable to state if she had provided nail care to Resident #78.

On 5/25/22 at 2:25 PM, an interview was completed with NA #5 and NA #8, who stated nails were to be cleaned and trimmed on shower days or when there was a need. Diabetic fingernails were cared for by the nurse. They were unaware of Resident #78 refusing nail care in the past but had not cared for him in a while.

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The Administrator and Director of Nursing (DON) were interviewed on 5/26/22 at 1:10 PM and stated they would expect nail care to be rendered during personal care or shower assistance. The DON further added if a NA was unable to complete the task she would expect the nurse to be notified of the need. The Administrator and DON were unable to explain why nail care had not occurred for Resident #78 as there was no documentation to show this had or had not been completed or attempted.

3. Resident #96 was originally admitted to the facility on 10/25/19 with diagnoses that included cerebral palsy, muscle spasms and osteoporosis.

A quarterly Minimum Data Set (MDS) assessment dated 5/9/22 indicated Resident #96 had severely impaired decision-making skills and had no behaviors or refusal of care. She required extensive to total assistance with all ADL and had limited range of motion to all her extremities.

A review of Resident #96's active care plan, last reviewed 5/20/22, included a focus area for potential for impairment to skin integrity with an intervention to keep fingernails short.

A review of Resident #96's nursing progress notes from 1/19/22 to 5/24/22 revealed no refusals of nail care documented. The nursing progress notes also indicated Resident #96 could nod her head to yes/no questions.

On 5/23/22 at 10:40 AM, Resident #96 was observed lying in bed listening to music. She was noted to have contractures to her hands with her fingernails to the right hand long and touching the palm of her hand. Fingernails on her left hand

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were short in length. There was no skin break down observed.

Resident #96 was observed on 5/24/22 at 11:15 AM while lying in bed listening to the radio. Her fingernails to the right hand remained unchanged from previous observations.

An interview occurred with Nurse Aide (NA) #7 on 5/24/22 at 3:05 PM. She indicated she was not aware of the facility's policy on nail care and was not sure when nail care would be performed.

On 5/24/22 at 3:30 PM, an interview was completed with NA #4, who was familiar with Resident #96, and assigned to care for her that day. She explained nail care would be completed when needed but she had not rendered nail care to Resident #96 "in a while". An observation of Resident #96's nails to the right hand occurred with NA #4 who confirmed they needed attention.

On 5/25/22 at 9:00 AM, an observation was made of Resident #96's hands, which revealed fingernails to her right hand remained long and touching her palm. Resident #96 shook her head "no" when asked if anyone offered to provide nail care this week.

Another observation was made of Resident #96 on 5/26/22 at 9:34 AM who was lying in bed listening to the radio. Her fingernails to the right hand remained long and she indicated with a nod of her head that no one had offered to trim them.

On 5/26/22 at 9:40 AM, an interview occurred with NA #2 who was assigned to care for Resident #96 on 5/26/22. She stated "a group" came around to provide nail care to the residents,

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but she would clean nails if they were dirty. She denied providing recent nail care to Resident #96.

An interview was held with NA #6 on 5/25/22 at 11:00 AM and stated she provided nail care when there was a need, unless the resident was a diabetic, then she would let the nurse know. She was unable to state if she had provided nail care to Resident #96.

On 5/25/22 at 2:25 PM, an interview was completed with NA #5 and NA #8, who stated nails were to be cleaned and trimmed on shower days or when there was a need. Diabetic fingernails were cared for by the nurse. They were unaware of Resident #96 refusing nail care in the past but had not cared for her in a while.

The Administrator and Director of Nursing (DON) were interviewed on 5/26/22 at 1:10 PM and stated they would expect nail care to be rendered during personal care or shower assistance. The DON further added if a NA was unable to complete the task she would expect the nurse to be notified of the need. The Administrator and DON were unable to explain why nail care had not occurred for Resident #96 as there was no documentation to show this had or had not been completed or attempted.

4. Resident #44 was admitted on 12/13/2021 with a diagnosis of end stage renal disease.

Resident #44's quarterly Minimum Data Set (MDS) dated 3/22/2022 indicated the resident had moderately impaired vision and required extensive assistance with all activities of daily living.

Resident #44's comprehensive care plan had a

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focus for risk of inability to perform activities of daily living and at risk of self-care deficits related to blindness and end stage renal disease.

On 5/23/2022 at 10:50 AM Resident #44 was observed sitting in his wheelchair. His fingernails were long with a black substance under the nails on both hands. Resident #44 stated his family trim his nails when they come to visit. He further stated he had asked the nurse assistants (NA) about trimming his fingernails and they stated they would trim his nails when they had time. He could not identify the NAs he had asked to assist with fingernail care. The resident stated he was aware his nails were long but due to his vision loss, he was not able to see that they were dirty.

On 5/24/2022 at 11:13 AM Resident #44 was observed sitting in his wheelchair. His fingernails were long and had a black substance under the nails on both hands.

An interview was conducted with NA #7 on 5/24/2022 at 3:05 PM. She stated she was assigned to Resident #44 and was familiar with him. NA #7 observed Resident #44's fingernails and stated the nails were long and dirty. She stated the resident did need nail care. She further stated she was an agency nurse and did not know the facility's policy for nail care. She knew the resident was a diabetic and some facility's do not allow NAs to provide nail care to diabetic residents.

An interview was conducted with NA #6 on 5/25/2022 at 11:01 AM. She stated she worked in all areas of the facility and was familiar with Resident#44. She stated nail care is done as needed and NAs were allowed to perform nail

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F 677	Continued From page 33 care on fingernails but not toenails for diabetic residents.	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, staff and Wound Physician interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight (Residents #17, #96, #3 and #30) for 4 of 8 residents reviewed for pressure ulcers. The findings included: 1. Resident #17 was originally admitted to the facility on 2/1/22 with diagnoses that included a stroke with paralysis, weakness to the dominant (right) side and diabetes type 2. The admission Minimum Data Set (MDS) assessment dated 2/18/22 indicated Resident #17 and modified independence for daily decision	F 686	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F686 The facility failed to ensure the alternating pressure reducing mattress was set according to the resident's weight.	6/27/22

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F 686	Continued From page 34 making. He was coded with moisture associated skin damage (MASD) and had a pressure reducing device to the bed. Resident #17's active physician orders included an order dated 3/16/22 for a low air loss mattress to the bed. Check inflation of 75 to 150 per manufacturer guideline. A review of Resident #17's medical record revealed from 4/9/22 until 5/12/22 a foam dressing was applied to his sacrum due to redness every other day. Resident #17's weight on 5/13/22 was 153.4 pounds (lbs.). A review of Resident #17's active care plan, last reviewed 5/20/22, included a focus area for risk for pressure ulcer development due to bowel and bladder incontinence and decreased ability to assist with repositioning. One of the interventions included a pressure reducing mattress to the bed. The May 2022 Treatment Administration Record (TAR) revealed nursing staff had been checking the inflation of the low air loss mattress to Resident #17's bed for the correct weight setting. On 5/23/22 at 10:35 AM, an observation was made of Resident #17. He was sitting up in a wheelchair at bedside. The alternating pressure reducing mattress machine was set at 75 lbs. per weight setting. The machine had settings of 75 lbs., 150 lbs., 175 lbs., 225 lbs., 300 lbs., 375 lbs., 450 lbs., and 500 lbs. and indicated to set according to the resident's weight per pounds. Resident #17 was observed lying in bed watching	F 686	1. Corrective action for resident(s) affected by the alleged deficient practice: On 06/16/2022 the nursing team verified the resident's weight and adjusted the alternating pressure reducing air mattress setting accordingly to assure each were set correctly for resident # 17,# 96, # 3 and # 30. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 06/16/2022 the nursing team audited all residents with ordered alternating pressure reducing air mattresses to assure that the mattress was at the correct setting based on the resident's weight. Results: All residents with alternating pressure reducing air mattresses were in compliance. As of 06 /26/2022 all residents with ordered alternating pressure reducing air mattresses were in compliance. On 06/20/2022 the Director of Nurses educated the wound nurse on the expectation that alternating pressure reducing mattresses will be set following the manufacturer recommends and the resident's weight. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 6/15/2022 the Director of Nurses, Nurse Consultant and Assistant Director of Nurses began in-service education to all full time, part time, and as needed nurses and agency nurses. Topics included:	

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TV on 5/24/22 at 11:10 AM. The alternating pressure reducing mattress machine was set at 75 lbs.

An observation occurred of Resident #17 on 5/25/22 at 9:15 AM while he was lying in bed. The alternating pressure reducing mattress machine was set at 75 lbs.

An interview occurred with Medication Aide (MA) #1 on 5/25/22 at 2:00 PM. She stated she checked the functionality of the pressure reducing mattress' making sure the connections were good, the light was on, and the mattress was inflated, but was unaware of a weight setting on the machine.

On 5/25/22 at 2:35 PM, an observation was made with the Treatment Nurse of Resident #17's alternating pressure reducing mattress machine, confirming it was set at 75 lbs. The Treatment Nurse stated she checked the functionality of the air mattress' daily during her rounds to make sure the connections were secured, and the mattress was inflated. She indicated she checked the weight settings as well and was unable to explain why Resident #17's mattress was set 75 lbs. unless it had been bumped by staff.

The Wound Physician consultant was interviewed on 5/25/22 at 3:10 PM and stated he expected the alternating pressure reducing mattress machines to be checked daily and set according to the resident's weight as stated on the machine. He added large gaps between the resident's weight and the weight on the machine would not be a useful intervention.

On 5/26/22 at 1:10 PM, an interview was held

- Alternating pressure reducing mattresses and assuring they are set to the appropriate setting and are in functioning condition.
- Reporting of concerns with a mattress to the Wound Nurse or Director of Nurses.
- How to apply these principles to their daily practice.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022.

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

The Director of Nursing, and/or designee will utilize the QA tool for Alternating Pressure Ulcer Mattresses to monitor compliance that the appropriate setting is in place for each mattress. The Director of Nurses, and/or designee will monitor three residents with alternating pressure ulcer mattresses weekly for 2 weeks, then monthly for 3 months for accuracy of the mattress setting. This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been

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F 686	Continued From page 36 with the Administrator and Director of Nursing, who stated they expected the alternating pressure reducing mattress machine to be set according to the resident's weight as stated on the machine. 2. Resident #96 was originally admitted to the facility on 10/25/19 with diagnoses that included cerebral palsy and osteoporosis. Resident #96's active physician orders included an order dated 10/27/21 for a low air loss mattress to the bed. Check proper inflation range of 75 to 150 per manufacturer weight guidelines. A quarterly Minimum Data Set (MDS) assessment dated 5/9/22 indicated Resident #96 had severely impaired cognition and had a pressure reducing device to the bed. Resident #96's weight on 5/13/22 was 86.8 pounds (lbs.). A review of Resident #96's active care plan, last reviewed 5/20/22, included a focus area for risk for pressure ulcer development due to history of stage 4 pressure ulcer to the coccyx area and related to bowel and bladder incontinence and decreased ability to assist with repositioning. One of the interventions included a low air loss mattress on the bed. Ensure the mattress is inflated and functioning properly. The May 2022 Treatment Administration Record (TAR) revealed nursing staff had been checking the inflation of the low air loss mattress to Resident #96's bed for the correct weight setting. On 5/23/22 at 10:40 AM, an observation was	F 686	determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director.	

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made of Resident #96, while she was lying in bed listening to the radio. The alternating pressure reducing mattress machine was set at 200 lbs. per weight setting. The machine had settings of 75 lbs., 150 lbs., 175 lbs., 225 lbs., 300 lbs., 375 lbs., 450 lbs., and 500 lbs. and indicated to set according to the resident's weight per pounds.

Resident #96 was observed lying in bed listening to the radio on 5/24/22 at 11:15 AM. The alternating pressure reducing mattress machine was set at 200 lbs.

An observation occurred of Resident #96 on 5/25/22 at 9:00 AM while she was lying in bed. The alternating pressure reducing mattress machine was set at 200 lbs.

An interview occurred with Medication Aide (MA) #1 on 5/25/22 at 2:00 PM. She stated she checked the functionality of the pressure reducing mattress' making sure the connections were good, the light was on, and the mattress was inflated, but was unaware of a weight setting on the machine.

On 5/25/22 at 2:35 PM, an observation was made with the Treatment Nurse of Resident #96's alternating pressure reducing mattress machine, confirming it was set at 200 lbs. The Treatment Nurse stated she checked the functionality of the air mattress' daily during her rounds to make sure the connections were secured, and the mattress was inflated. She indicated she checked the weight settings as well and was unable to explain why Resident #96's mattress was set 200 lbs. unless it had been bumped by staff.

The Wound Physician consultant was interviewed

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on 5/25/22 at 3:10 PM and stated he expected the alternating pressure reducing mattress machines to be checked daily and set according to the resident's weight as stated on the machine. He added large gaps between the resident's weight and the weight on the machine would not be a useful intervention.

On 5/26/22 at 1:10 PM, an interview was held with the Administrator and Director of Nursing, who stated they expected the alternating pressure reducing mattress machine to be set according to the resident's weight as stated on the machine.

3. Resident #30 was admitted on 10/19/20 with a stage 4 pressure ulcer.

Resident #30's revised care plan dated 5/25/21 read she had a pressure ulcer to her sacrum present on admission 10/21/20. Interventions included ensuring her air mattress was inflated and functioning properly.

The quarterly Minimum Data Set (MDS) assessment dated 3/15/22 indicated Resident #30 was cognitively intact, coded for a stage 4 pressure ulcer, a pressure reducing device to the bed and for a weight of 248 pounds (lbs).

Resident #30's active physician orders included an order dated 4/6/22 for a low air loss mattress to the bed. Check inflation of 225-300 per manufacturer guidelines every shift.

A review of Resident #30's April and May 2022 electronic Treatment Administration Record (TAR) revealed nursing staff had documented evidence that they had been checking the inflation of the low air loss mattress to Resident #30's bed for

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the correct weight setting on all three shifts.

Resident #30's last record weight in her electronic medical record dated 5/13/2022 was 271.4 lbs.

An observation was completed on 5/23/22 at 3:40 PM. Resident #30's alternating pressure reducing mattress machine weight setting was between 175-225 lbs.

An observation was completed on 5/24/22 at 11:30 AM. Resident #30's alternating pressure reducing mattress machine weight setting was between 175-225 lbs.

An interview was completed with Medication Aide (MA) #1 on 5/25/22 at 2:00 PM. She stated she checked the functionality of the pressure reducing mattress' making sure the connections were good, the light was on, and the mattress was inflated, but was unaware of a weight setting on the machine.

An interview was completed with Nurse #2 on 5/25/22 at 2:45 PM. She stated Treatment Nurse (TN) #1 ensured the alternating pressure reducing mattress machine weight setting were correct on first shift and the floor nurses were responsible to check on all other shifts. She stated she documented her observations on the TAR.

An observation was completed on 5/25/22 at 4:30 PM. Resident #30's alternating pressure reducing mattress machine weight setting was between 175-225 lbs.

On 5/25/22 at 4:40 PM, an observation was made

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with TN #1 of Resident #30's alternating pressure reducing mattress machine, confirming it was set between 175-225 lbs. TN #1 stated she checked the functionality of the air mattress daily during her rounds to make sure the connections were secured, and the mattress was inflated. She indicated she checked the weight settings as well and was unable to explain why Resident #30's mattress was set between 175-225 lbs unless it had been bumped by staff. She stated she documented her observations on the TAR for first shift.

The Wound Physician consultant was interviewed on 5/25/22 at 3:10 PM and stated he expected the alternating pressure reducing mattress machines to be checked daily and set according to the resident's weight as stated on the machine. He added large gaps between the resident's weight and the weight on the machine would not be a useful intervention.

An interview was completed with the Administrator and the Director of Nursing (DON on 5/26/22 at 1:00 PM. The DON stated she expected the alternating pressure reducing mattress machine to be set according to the resident's weight as stated on the machine.

4. Resident #3 was admitted on 4/1/8/20 with Dementia and Osteoarthritis.

Resident #3's quarterly Minimum Data Set dated 5/1/22 indicated she had severe cognitive impairment, coded for one stage 4 pressure ulcer, coded for a pressure reducing device to the bed and her weight was 127 pounds (lbs).

Resident #3 comprehensive care plan last

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revised 2/28/22 did not include a care plan for her stage 4 pressure ulcer.

Resident #3's active physician orders included an order dated 10/27/21 for a low air loss mattress to the bed. Check inflation of 75-150 per manufacturer guidelines every shift.

Resident #3's last record weight in her electronic medical record was dated 5/11/22 was 127.2 lbs.

A review of Resident #3's April and May 2022 electronic Treatment Administration Record (TAR) revealed nursing staff had documented evidence that they had been checking the inflation of the low air loss mattress to Resident #3's bed for the correct weight setting on all three shifts.

An observation was completed on 5/23/22 at 11:00 AM. Resident #3's alternating pressure reducing mattress machine weight setting was between 150-175 lbs.

An observation was completed on 5/24/22 at 12:05 PM. Resident #3's alternating pressure reducing mattress machine weight setting was between 150-175 lbs.

An observation was completed on 5/25/22 at 9:40 AM. Resident #3's alternating pressure reducing mattress machine weight setting was between 150-175 lbs.

An interview was completed with Medication Aide (MA) #1 on 5/25/22 at 2:00 PM. She stated she checked the functionality of the pressure reducing mattress' making sure the connections were

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good, the light was on, and the mattress was inflated, but was unaware of a weight setting on the machine.

An interview was completed with Nurse #2 on 5/25/22 at 2:45 PM. She stated TN #1 ensures the alternating pressure reducing mattress machine weight setting were correct on first shift and on the other shifts the floor nurses were responsible to check. She stated she documented her observations on the TAR.

On 5/25/22 at 4:40 PM, an observation was made with Treatment Nurse (TN) #1 of Resident #3's alternating pressure reducing mattress machine, confirming it was set between 150-175 lbs. TN #1 stated she checked the functionality of the air mattress' daily during her rounds to make sure the connections were secured, and the mattress was inflated. She indicated she checked the weight settings as well and was unable to explain why Resident #3's mattress was set between 150-175 lbs unless it had been bumped by staff. She stated she documented her observations on the TAR for first shift.

The Wound Physician consultant was interviewed on 5/25/22 at 3:10 PM and stated he expected the alternating pressure reducing mattress machines to be checked daily and set according to the resident's weight as stated on the machine. He added large gaps between the resident's weight and the weight on the machine would not be a useful intervention.

An interview was completed with the Administrator and the Director of Nursing (DON on 5/26/22 at 1:00 PM. The DON stated she expected the alternating pressure reducing

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F 686	Continued From page 43 mattress machine to be set according to the resident's weight as stated on the machine.	F 686		
F 689 SS=G	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 observations, resident, staff and Medical Director (MD) interviews, the facility failed to provide wound care in a safe manner that resulted in a resident fall with injury. Resident #54 fell during wound care and sustained a distal femur fracture. In addition, the facility failed to complete an investigation for Resident #54's fall. The facility also failed to lift a non-ambulatory resident with a mechanical sling lift according to the manufacturer instructions resulting in a distal femur fracture (Resident #3). This was for 2 of 3 residents reviewed for accidents. The findings included: 1. Resident #54 was admitted on 8/2/21 with Congestive Heart Failure and a history of a left knee arthroplasty (knee replacement). She was readmitted on 3/31/22 with a closed distal femur fracture to her left leg after a fall. Resident #54's quarterly Minimum Data Set dated 2/9/22 indicated she was cognitively intact, non-ambulatory and required the assistance of 2	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F689 The facility failed to provide wound care in a safe manner that resulted in a fall with injury for resident #54 and failed to complete an investigation for a fall and to lift a non ambulatory resident with a mechanical lift according to manufacturer instructions for resident #3. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #54 had an ordered x-ray on 3/21/22 following a fall on 3/20/21 with	6/27/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44 persons with transfers. Resident #54's incident report dated 3/20/22 at 6:30 PM completed by Nurse #5 read Treatment Nurse (TN) #2 was providing care to the resident when she had to assist her to the floor. There were no initial complaints of pain but later stated her left knee was painful. The MD was notified and ordered an x-ray on 3/21/22. The follow up note dated 3/21/22 read the incident was discussed during the clinical meeting. Resident #54 was receiving wound care and lowered to the floor by TN #2. New intervention was to educate TN #2 to perform wound care while the resident was in the bed. A nursing note dated 3/20/22 at 7:03 PM completed by Nurse #5 read TN #2 was providing wound care to Resident #54 and assisted her to the floor. There were no noted abnormalities and the note did not have any documentation regarding pain. The MD was notified and ordered an x-ray to her left knee on the following morning (Monday 3/21/22). Resident #54's fall care plan last revised 3/21/22 read she sustained an actual fall with the new intervention of educating TN #2 to provide wound care with resident in the bed. The x-ray results dated 3/21/22 indicated a possible distal femur fracture of the left knee. A nursing note dated 3/21/22 at 4:30 PM read the MD was notified and an orthopedic consult was recommended. She was scheduled to see the orthopedist on 3/25/22.	F 689	indication of a possible distal femur fracture of left knee. The resident was referred to an orthopedist for follow up. On 3/24 she was seen in the hospital and a diagnosis of a periprosthetic distal femur fracture was found on x-ray. The resident was to the hospital for follow up. Resident #3 was sent to the orthopedist on 11/09/2021 for follow up care related to complaints of left knee pain related to an apparent injury during use of a mechanical lift for transfers by two staff that occurred on 10/26/21 and the resident was ordered to be placed in a knee immobilizer with a diagnosis of closed fracture distal end of left femur. The x-ray that was ordered post incident and obtained on 10/26/2021 resulted that there was no evidence of a fracture but there was soft tissue swelling to the medial aspect of the left knee. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents and those requiring use of a mechanical lift for transfers are at risk for the alleged deficient practice. On 6/17/2022 the Director of Nursing, Nursing Team and Minimum Data Set Nurse audited change in condition reports identified through the Daily Clinical Meeting for indicators of falls and any current residents with identified falls in the past week (6-10 to 6/16/2022), to ensure that the incident report process was in place and all interventions identified by the Interdisciplinary team were in place on the care plan/kardex.	

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F 689	Continued From page 45 A nursing note dated 3/24/22 at 12:07 AM Resident #54 was sent out to the vascular clinic on 3/24/22 for a left lower extremities arteriogram. Resident #54 was admitted to the hospital at this time. Resident #54's hospital history and physical dated 3/24/22 read she presented to the hospital for an elective aortogram to her left lower extremity when her left knee was noted swollen and painful. Imaging revealed a periprosthetic distal femur fracture. She was admitted to the hospital and orthopedic surgery was consulted. Resident #54's hospital discharge summary dated 3/31/22 read a nonoperative strategy was pursued for her fracture and she was fitted with a knee immobilizer with follow up at orthopedic surgery. She was discharged back to the facility with orders to be non-weight bearing to her left lower extremity and a knee immobilizer. Review of Resident #54's active Physician orders included an order dated 3/31/21 for her to be transferred using a mechanical sling lift and non-weight bearing to her left lower extremity while wearing a leg brace for movement. Resident #54 was interviewed on 5/23/22 at 1:48 PM. Resident #54 stated she was non-ambulatory prior to the fall and was being transferred using the sit-to-stand lift. She stated TN #2 was changing the dressing to her sacral wound while she leaned over the side of the bed when her knees gave out. Resident #54 stated TN #2 did not use the sit-to-stand lift but rather lifted her by the shoulder to the standing position. Resident #54 stated TN #2 was the only nurse who completed her sacral wound care that way	F 689	Results:7 of 7 residents were in compliance with the incident report/investigation process. As of 6/26/2022 all care plans will be in compliance for moderate and high risk fall risk care plans and interventions. On 06/16-17/2022 the nursing leadership team and therapy manager reviewed all residents care plans/kardex for appropriate transfer status. As of 06/17 /2022 all care plans/kardex reflect the appropriate transfer status and level of assistance for transfers for fall between 6/10-6/6/2022 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 06/16/2022 the Nurse Consultant began education with the Director of Nurses and Assistant Director of Nurses and Minimum Data Set Nurse on the incident report/post fall process to include accessing the kardex/care plan for transfer status and the post fall/incident report process. On 06/16/22 the Director of Nurses and Assistant Director of Nurses began education of all full time, part time, as needed nurses, certified nursing assistants, medication aides and agency on the following topics: • Definition of a fall • Incident Report Process • Post Fall Process • Notifications post fall • How/when to access kardex to view care required to include transfer/ambulation status and use of a mechanical lift	

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on the weekends. She stated had a history of a left knee replacement in the past and her knee was swollen and slightly painful prior to being admitted to the hospital on 3/24/22. Resident #54 stated TN #2 got assistance then she and an aides assisted her back to bed using the mechanical sling lift.

An interview was completed on 5/25/22 at 2:35 PM with NA #5. She stated she was assigned Resident #54 on Sunday 3/20/22 at the time of her fall. NA #5 stated she went into the room and she had already been placed in bed. She stated Resident #54 complained of pain at the time of her fall to her left knee and an x-ray was ordered. She stated Resident #54 was unable to stand independently so she was transferred using the sit-to-stand lift prior to the fall. NA #5 stated TN #2 did not ask for assistance with using the sit-to-stand lift to assist Resident #54 to bed for her wound care but rather was attempting to complete her wound care while Resident #54 was holding herself upright while leaning against her bed. She stated since the fall, Resident #54 had to be transferred using a mechanical sling lift. NA #5 stated Resident #54's electronic Kardex indicated she was a sit-to-stand for transfers at the time of the fall and TN #2 did not ask her for any assistance to transfer Resident #54 to her bed for wound care.

An interview was completed on 5/25/22 at 2:49 PM with NA #1. She stated TN #2 stepped out of Resident #54's doorway and stated she needed help quickly. NA #1 stated when she entered the room Resident #54 was on both knees beside her bed. She stated TN #2 stated Resident #54 did not fall but was assisted to the floor. NA #1 stated TN #2 did not transfer Resident #54 to bed for

• Resident safety when providing wound care- wound care should be provided while the resident is in bed.
• Safe resident transfer with a mechanical lift and use of 2 persons for all mechanical lift transfers.
This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nursing or designee will monitor compliance utilizing the F689 Quality Assurance Tools weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor to ensure the post fall/incident process is in compliance and by direct observation that the mechanical lift transfer process is being safely performed. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of

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her wound care but rather stood her up from her wheelchair and had Resident #54 lean up against her bed while she completed wound care to her sacrum. NA #1 stated prior to her fall, she was a sit-to-stand lift and now was a mechanical sling lift transfer. NA #1 stated Resident #54's electronic Kardex indicated she was a sit-to-stand for transfers at the time of the fall and TN #2 did not ask her for any assistance to transfer Resident #54 to her bed for wound care.

An interview was completed on 5/25/22 at 3:46 PM with Unit Manager (UM) #1. She stated TN #2 was doing Resident #54's wound care to her sacrum while having Resident #54 stand up and brace herself against the bed with her hands when her knees gave out and TN #2 assisted her to the floor. UM #1 stated Resident #54 was known to be unable to support her own weight or stand independently and staff transferred Resident #54 using the sit-to-stand lift.

An interview was completed on 5/25/22 at 11:35 AM with the MD. He stated he was not aware of the circumstances involving Resident #54's fall but he ordered an x-ray for the following morning since she was not complaining of pain and the nurse said there was no obvious injuries. The MD stated Resident #54's fall could have been prevented if TN #2 had used the sit-to-stand lift to put her to bed and completed her wound care.

Attempts to interview the Nurse #5 assigned Resident #54 on 3/20/22 were unsuccessful.

A telephone interview was completed on 5/26/22 at 11:34 AM with the former DON. She stated TN #2 informed her that Resident #54 did not have a fall but was assisted to the floor onto her knees.

Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.

Date of Compliance: 06/27/2022

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The former DON stated Resident #54 was supposed to be transferred using the sit-to-stand lift at that time but she was not aware that TN #2 was not utilizing the lift at the time of the fall. She stated she did not complete an investigation because it was not considered a fall according to TN #2.

A telephone interview was completed on 5/26/22 at 11:43 AM with TN #2. She stated she stood Resident #54 up from her wheelchair by lifting her under her arm and leaned her against the side of her bed. TN #2 stated she always completed Resident #54's sacral dressing changes that way on the weekends. TN #2 stated Resident #54 preferred to have her sacral wound care completed while standing because if the sit-to-stand lift was used to transfer her back to bed for her wound care, the staff would not get her back up. TN #2 stated she did not use the sit-to-stand to transfer Resident #54 back to bed or did she ask for another staff member to transfer her back to bed to complete her wound care. TN #2 stated Resident #54's legs gave out and she assisted her to floor onto her knees but what happened was not a fall. She stated she informed the former DON and she didn't ask her anything about the circumstances since she did not consider it a fall.

An interview was conducted on 5/26/22 at 1:00 PM with the Administrator and DON. The DON stated anytime a resident was assisted to the floor, it was considered a fall and the circumstances involving an assisted fall should be thoroughly investigated to ensure the staff did not do something wrong resulting in a fall.

2. Review of the manufacture instructions for use

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of the mechanical sling lift dated 3/2020 read as follows on page #25: when lowering the spreader bar, ensure that the resident's legs and feet were well clear of moving mast to avoid injuries.

Resident #3 was admitted on 4/1/8/20 with Dementia and Osteoarthritis.

Resident #3's quarterly Minimum Data Set dated 7/22/21 indicated severe cognitive impairment, non-ambulatory and total staff assistance of 2 with transfers.

Resident #3's revised care planned for a risk of falls dated 8/5/21 read she was a mechanical sling transfer with the assistance of 2 staff.

Review of an undated electronic Kardex indicated Resident #3 was a full mechanical sling lift for all transfers.

Reviews of Resident #3's nursing notes included a note dated 10/26/21 at 2:03 PM that read 2 staff were using the mechanical sling lift to transfer her when she complained of left knee pain. There was no redness or swelling noted. She was given Tylenol and the Medical Director (MD) ordered a knee x-ray.

Resident #3's left knee x-ray results dated 10/26/21 read there was no evidence of a fracture but soft tissue swelling the medical aspect of her left knee.

Review of a nursing note dated 11/5/21 at 12:18 PM read Resident #3 complained of increased pain to her left knee. The MD ordered an orthopedic consult to check on her left knee replacement hardware.

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Review of the orthopedic consult note dated 11/9/21 read Resident #3's leg was caught when being transferred from the wheelchair and had been painful since. Additional x-rays revealed a left periprosthetic distal femur fracture. She was to return to the orthopedic in 4 weeks.

Review of a nursing note dated 11/9/21 at 6:07 PM read Resident #3 returned from the orthopedic consult and was noted to have a left femur fracture treated with a knee immobilizer.

Review of an undated Investigation Guide completed by the former Director of Nursing (DON) read Resident #3 was sitting in her wheelchair at 2:30 PM on 10/26/21. The aides used the mechanical sling lift to transfer Resident #3 back to bed. She complained of knee pain after being laid down. The MD was notified and an x-ray was ordered. Review of the conclusions with root cause analysis read the incident occurred due to osteoarthritis, hypothyroidism and a total left knee replacement. She was referred to orthopedics. Attached to the Investigation Guide were staff written statements all written on 11/10/21.

Review of the written statement dated 11/10/21 was completed by agency Nursing Assistant (NA) #9 read she and agency NA #10 were putting Resident #3 back to bed using the mechanical sling lift and while doing so, her legs were on each side of the lift mast (hydraulic motor and battery pack part of a lift attached to the sling bar). The statement read Resident #3 was pulled back and her legs moved to get the lift mast from between her legs when she complained of pain.

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Review of a written stated dated 11/10/21 completed by agency NA #10 read NA #9 asked her to assist her with transferring Resident #3 back to bed using the mechanical sling lift. She indicated NA #9 hooked sling to the lift bar and began to lift her up while her legs were on each side of the lift mast. NA #9 pulled Resident #3 back so the mast would not be between her legs and then placed her on the bed. She complained of pain once in bed.

Review of the written statement dated 11/10/21 completed by Nurse #1 read Resident #3 asked to be put to bed after lunch and NA #9 and NA #10 used the mechanical sling lift to transfer her to the bed when she yelled out in pain. There was no redness or swelling and the MD was notified with orders for an x-rays and her as needed Tylenol.

An observation was completed on 5/23/22 at 11:52 AM of Resident #3. She was lying in bed and easily aroused. She recalled an incident when a girl was putting her to bed using the lift when she heard a snap. She said her left knee was immediately painful. Resident #3 stated there was only one staff member transferring her and she didn't think NA #9 knew what she was doing.

An interview was completed on 5/25/22 at 11:35 AM with the MD. He stated he was not aware of the circumstances involving Resident #3's left knee injury but he ordered an x-ray and an orthopedic consult. The MD stated there was no evidence of a fall involving Resident #3 on 10/26/21.

An interview was completed on 5/25/22 at 3:46 AM with Unit Manager (UM) #1. She stated

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Resident #3 was being transferred by 2 agency aides that no longer worked at the facility. She began to complain of pain and was sent for an orthopedic evaluation.

Attempts to interview the Nurse #1 assigned Resident #54 on 3/20/22 were unsuccessful.

A telephone interview was completed on 5/26/22 at 9:06 AM with Nurse #3. She recalled writing the nursing note dated 11/5/21. She stated the aides were changing her on when she complained of left knee pain and she never complained. She stated she notified the MD and received orders for the orthopedic consult. Nurse #3 stated she was aware that Resident #3 had orthopedic hardware in her left knee and heard that something happened to her leg during a lift transfer. She said it wasn't long after that they were in-serviced on the proper use of the mechanical sling lift.

An observation was completed of the facility's mechanical sling lift was completed on 5/26/22 at 10:20 AM with NA #1. She stated there always had to be 2 staff member present while using the lift. She demonstrated how a lift pad was attached to the sling bar and lifted using the hydraulic pump on the lift mast. NA #1 stated anytime performing a mechanical sling lift, the resident must be facing the person operating the lift. NA #1 stated the reason the resident must face the person operating the lift was to ensure the resident was tolerating the transfer safely and also to prevent any injuries related to striking the lift mast.

A telephone interview was completed on 5/26/22 at 11:23 AM with NA #10. She stated she was

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F 689	Continued From page 53 only the spotter during the lift transfer. When questioned about her written statement, she stated she did not recall if Resident #3's legs were on either side of the mast before she was lifted. NA #10 stated she was not trained on the proper use of the facility's mechanical sling lift until after the incident involving Resident #3. Multiple telephone messages were left for NA #9 to return call to discuss the circumstances involving Resident #3's injury were unsuccessful. A telephone interview was completed on 5/26/22 at 11:34 AM with the former DON. She recalled completing the investigation involving Resident #3 and it was determined that the aides hit her left knee on the side of the lift mast. She stated all the staff were in-served on the correct use of the mechanical sling lift but there was no ongoing monitoring or resident observations for the correct way to use the lift. An interview was conducted on 5/26/22 at 1:00 PM with the Administrator and DON. The Administrator provided evidence of training on the mechanical sling lift for NA #9 and NA #10 dated 11/11/21 after the incident. The Administrator stated she expected all the nursing staff use the mechanical sling lift properly to prevent resident injuries.	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	F 692		6/27/22

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F 692	Continued From page 54 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. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with Registered Dietician (RD), family, and staff, the facility failed to implement new intervention for a resident identified with weight loss for 1 of 7 residents reviewed for nutrition (Resident #74). The findings included: Resident #74 was admitted 1/15/2021 with diagnoses that included dementia. Resident #74's quarterly Minimum Data Set (MDS) dated 5/4/2022 indicated the resident has severely impaired cognition, required extensive assistance with activities of daily living and required supervision and set up only for eating. Review of Resident #74's comprehensive care plan revised 1/26/2022 included a focus for nutritional problem related to weight loss. The	F 692	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F692 1. For clinical services, a corrective action was obtained on 5/23/2022. Based on staff interviews, observations, and record review the facility failed to implement interventions to maintain nutrition and hydration status for 1 of 7 reviewed residents. For Resident #74	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 55 resident's interventions stated the resident could feed herself after tray set up. Review of Resident #74's medical record revealed a progress note dated 3/30/2022 written by the former Director of Nursing (DON). The progress note read; Resident has lost weight. Resident will eat if assisted with meals. New intervention is to have resident assisted with meals. New task put in for resident to be assisted with each meal. The resident's medical record also included a progress note dated 3/30/2022 by the Dietary Manager (DM) that read; put in recommendation to have her assisted with feedings and will continue to monitor her weight. A dietary review was conducted by the Registered Dietician (RD) on 3/31/2022. The RD documented Resident #74's meal intake varied between 26-100%. The RD documented feeding assistance was ordered with meals. On 5/23/2022 at 9:10 AM Resident #74 was observed in bed with meal tray. The resident was not receiving assistance with her meal. On 5/23/2022 at 12:55 PM Resident #74 was observed sitting in her wheelchair being assisted with her lunch meal by a family member. The family member stated the facility staff provided assistance with meals when she was not there. The family member further stated she had some concerns assistance was not being provided with meals. On 5/26/2022 at 9:26 AM Resident #74 was observed sitting in her wheelchair with a meal tray set up in front of her. The resident was not	F 692	assistance at meals was not provided per orders and resident experienced significant weight loss. Resident #74 passed away 6/2/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 6/15/2022 in-service was initiated with nursing, nursing assistants, and department heads. On 6/20/2022 all resident orders were reviewed to create a comprehensive list of residents that require assistance at meals and made available to staff via communication book. MAR/Care tasks were reviewed and updated on 6/20/2022 to reflect current meal assistance needs. Meal tickets were also altered to highlight meal assistant requirements. 3. Systemic changes Beginning on 6/15/2022 In-service education was provided to all full time, part time, and as needed – Certified Nursing Assistants, Medication Aides and nurses to include agency by the Director of Nurses/Assistant Director of Nurses/Nurse Consultant. Topics included: • ADL's Eating Presentation • Tray Delivery and Set-up for Nursing/CNA Training • Nursing and Nursing Assistant Meal	

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F 692	Continued From page 56 receiving assistance with her meal. An interview was conducted with Nurse Assistant (NA) #7 on 5/26/2022 at 10:30 AM. She stated she was assigned to Resident #74. She stated the resident did not get assistance with every meal. The resident's care tasks indicated she was independent with meals but if she noticed the resident was not eating, she would try to assist her. On 5/26/2022 at 9:38 AM a phone interview was conducted with the RD. She stated Resident #74's weight loss was discussed in a multidisciplinary meeting in March. She further stated the former DON was present at the meeting and stated she would put in an intervention for the resident to receive assistance with each meal. On 5/26/2022 at 11:38 AM a phone interview was conducted with the former DON. She stated the intervention was discussed in the morning interdisciplinary meeting and she did document the resident required assistance with feeding in the resident's progress notes. She made the Minimum Data Set (MDS) nurse aware the resident required assistance with meals and the MDS nurse should have revised the resident's care plan. The former DON stated she did not add assistance with meals to the resident's care task, that would have been the responsibility of the MDS nurse. On 5/26/2022 at 12:25 PM an interview was conducted with the MDS nurse. She stated she did not recall the interdisciplinary meeting in March or being asked to add feeding assistance with each meal to Resident #74's care plan	F 692	Procedures • Nutrition and Hydration Policies. Any nursing staff who does not receive scheduled inservice training will not be allowed to work until the training has been completed by June 26, 2022. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Education for staff will be completed by 6/26/2022. 4. Quality Assurance monitoring procedure. The Director of Nursing or designee will monitor meal service 5 times weekly x 4 weeks, then weekly x 2 months, and then monthly x 3 months using the Quality Assurance Audit tool. Monitoring will include ensuring staff are using the proper channels to review which residents require assistance at meals, providing assistance with meals, and updating multiple channels to provide accurate information regarding assistance at meals. The Clinical Team will ensure significant weight changes are addressed properly and timely to maintain nutrition and hydration status. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the	

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F 692	Continued From page 57 interventions or care tasks.	F 692	Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 695 SS=D	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, Medical Director and staff interviews, the facility failed to clarify an physician's order for oxygen and administer oxygen as ordered for 1 of 1 resident reviewed for respiratory care (Resident #96). The findings included: Resident #96 was originally admitted to the facility on 10/25/19 with diagnoses that included congestive heart failure (CHF) and hypertensive heart disease with heart failure. Review of the active physician orders revealed an order dated 6/28/21 for oxygen at 2 liters via nasal cannula as needed for oxygen saturations below 90% and an order dated 10/15/21 if oxygen saturations are greater than 92% may discontinue use of oxygen. A physician progress note dated 4/26/22 indicated	F 695	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F695 The facility failed to clarify a physic order for oxygen and administer oxygen as ordered. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #96, the oxygen orders were confirmed with the physician by the nursing team on 06/16/2022 and state	6/27/22

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F 695	Continued From page 58 Resident #96 smiles and nods her head when asked a question but was non-verbal. Oxygen was on via nasal cannula and was to continue using at 2 liters as ordered. A quarterly Minimum Data Set (MDS) assessment dated 5/9/22 indicated Resident #96 has severely impaired decision-making skills and received extensive to total assistance from staff for her Activities of Daily Living (ADLs). She was not coded for oxygen use. A review of the Resident #96's nursing progress notes from 1/1/22 to 5/25/22 indicated she was on 2 liters of oxygen via nasal cannula. A review of the May 2022 Medication Administration Record (MAR) revealed an entry for if oxygen saturations greater than 92% may discontinue use of oxygen at 9:00 AM. The form had a daily check mark and staff initials. In addition, the MAR had an entry for oxygen at 2L as needed for oxygen saturations below 90% and was blank for number of liters of oxygen administered and nursing initials. On 5/23/22 at 10:40 AM, an observation was made of Resident #96 while she was lying in bed listening to the radio. The oxygen regulator on the concentrator was set at 1.5 liters flow when viewed horizontally at eye level. Resident #96 was observed on 5/24/22 at 11:15 AM, while lying in bed listening to music. The oxygen regulator on the concentrator was set at 1.5 liters flow when viewed horizontally, eye level. An observation occurred on 5/25/22 at 9:00 AM of Resident #96, which revealed the oxygen	F 695	that oxygen is to be provided at 2 liters per minute continuously via nasal cannula. On observation by the Assistant Director of Nurse on 06/16/2022 and the O2 flow rate was confirmed to be set at 2 lpm and the oxygen delivery in place as ordered. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 6/16/2022, the nursing team began audited all current residents receiving oxygen. Oxygen flow rate was observed for compliance and orders for oxygen confirmed with the physician to assure there were no conflicting oxygen orders in place. As of 6/16/ 2022. 100% compliance in place. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 06/14/2022, the Director of Nurse/Assistant Director of Nurses and Nurse Consultant began education to all full time, part time, and PRN Nurses and agency nurses on the following: • Resident's liter flow of oxygen must be set at the amount ordered by the MD and the order confirmed by the nurse. • The liter amount should be verified at eye level. • If the resident is adjusting the oxygen liters, then their respiratory status should be assessed or if refusing to utilize the oxygen notify the MD/RP of your findings. • Oxygen orders should be clarified to	

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F 695	Continued From page 59 regulator on the concentrator was set at 1.5 liters flow by nasal cannula when viewed horizontally at eye level. On 5/25/22 at 1:55 PM, an interview occurred with Medication Aide (MA) #1 who was familiar with Resident #96 and provided her care. She stated she had been employed at the facility for the past two years and had always known Resident #96 to use oxygen continuously. After reviewing the May 2022 MAR, the MA indicated she checked and initialed the entry that read "if oxygen saturations greater than 92% may discontinue use of oxygen" at 9:00 AM meaning the resident was using oxygen. Stated the oxygen saturations were checked with the oxygen on. On 5/25/22 at 2:45 PM, an observation of Resident #96 was completed with Nurse #2, who confirmed the oxygen regulator on the concentrator was set at 1.5 liters when viewed horizontally at eye level and looked to be set on 2 liters when standing over the concentrator. Nurse #2 adjusted the flow to administer 2 liters of oxygen as ordered. In addition, Nurse #2 reviewed Resident #96's May 2022 MAR and stated oxygen saturations were checked with oxygen on and that resident utilized oxygen continuously. Nurse #2 stated a clarification order should have been obtained as the orders are very confusing in relation to the oxygen use. Nurse #2 stated the nurse or MA working with Resident #96 would be responsible for ensuring the oxygen was at the right setting. An interview was conducted with the Medical Director on 5/25/22 at 11:37 AM. He reviewed Resident #96's active physician orders and verified the oxygen orders from 6/28/21 and	F 695	assure there are no conflicting orders in place. • Documentation of notification and education should be completed in the progress notes for the resident along with the resident's condition. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F695 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Monitoring will occur on each shift and include weekends. The Director of Nursing will monitor compliance with oxygen liter flow according to MD orders. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate.	

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F 695	Continued From page 60 10/15/21 were confusing. The Medical Director acknowledged Resident #96 used oxygen continuously at 2 liters via nasal cannula and was unaware of the as needed order. The Medical Director stated he would provide a clarification order for resident to receive oxygen at 2 liters via nasal cannula as he intended it to be originally. During an interview with the Administrator and Director of Nursing on 5/26/22 at 1:10 PM, they indicated it was their expectation for oxygen to be delivered at the ordered rate, checked daily by the assigned nurse or MA and obtain clarification orders when there was a question.	F 695	Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff, Medical Director (MD) interviews, the facility failed to obtain and implement Physician orders for the care and monitoring residents on hemodialysis (Resident #30 and Resident 44). This was for 2 of 2 resident reviewed for dialysis. The findings included: 1. Resident #30 was admitted on 10/19/20 with End Stage Renal Disease. Review of Resident #30's April and May 2022 Physician orders only included an order dated	F 698	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F698	6/27/22

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F 698	Continued From page 61 3/11/22 for dialysis every Monday, Wednesday and Friday. Resident #30's quarterly Minimum Data Set (MDS) assessment dated 3/15/22 indicated she was cognitively intact and coded as receiving dialysis. Resident #30's comprehensive care plan included a care area dated 5/25/21 that read she was scheduled for hemodialysis 3 times weekly. Interventions included checking for at least 24 hours of any bleeding episodes, no blood pressure readings of lab work to the graft arm, keep the dressing on the dialysis access site as ordered, monitor for a thrill (vibrations felt when touching the fistula) and a bruit (a loud swishing sound when listening to the fistula using a stethoscope) and obtaining her vital signs as ordered. Review of Resident #30's April and May 2022 medication administration records (MARs) and treatment administration records (TARs) did not include any documentation related to dialysis or her dialysis access site. Review of Resident #30's nursing notes from 4/1/22 to 5/18/22 did not include any documentation of monitoring post dialysis treatments, vital signs or evidence of monitoring her graft site for a thrill or bruit. Review of Resident #30's electronic medical record for vital sign following a dialysis treatment did not include any vital signs documentation on	F 698	The facility failed to obtain and implement physician orders for the care and monitoring residents on hemodialysis for resident #30 and resident #44. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident # 44 orders for care and monitoring of the dialysis site were obtained and implemented on 5/24/2022 and for resident #30 on 5/25/2022. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents receiving dialysis have the potential to be affected by this alleged deficient practice. On 06/16/2022, the Director of Nursing and nursing team began auditing 100% of dialysis residents to ensure the dialysis batch orders were firing to the eMAR. Those orders included each shift assessment of permcath or shunt site, post dialysis weights, every shift monitoring for bleeding, post dialysis shunt dressing removal, permcath dressing on, and dialysis frequency. This was completed on 06/16/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 06/14/2022, the Director of Nurse/Assistant Director of Nurses and Nurse Consultant began education of all full time, part time, PRN Nurses and agency nurses on the following: Dialysis Order Process This in-service included the following	

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F 698	Continued From page 62 4/8/22, 4/11/22, 4/13/22, 4/15/22, 4/18/22, 4/20/22,4/25/22, 4/29/22, 5/2/22, 5/16/22, 5/20/22 or 5/23/22. An interview was completed on 5/24/22 at 11:30 AM with Resident #30. She stated she had a graft in her left upper arm and was going 5/26/22 to have her graft assessed and opened up to improve the blood flow. Resident #30 stated when she first started dialysis, the facility was giving her a folder to take with her for communication between the facility and the dialysis clinic. She stated that stopped a long time ago because the facility nor the dialysis clinic were documenting anything. She stated the facility staff did not routinely check her graft for a thrill or bruit, assess her vital signs after a dialysis treatment, check her graft for bleeding and did not remove her pressure dressing from her graft. Resident #30 stated she removed her own dressing. An interview was completed on 5/24/22 at 4:18 PM with the Administrator. She stated the facility was not completing or sending a dialysis communication form with Resident #30 to dialysis. She stated she was not certain why the practice stopped. She stated the staff were monitoring her vital signs and her graft site but she was unable to find any documentation to support it. An interview was completed on 5/25/22 at 11:35 AM with the MD. He stated he was not aware that the facility was not monitoring Resident #30 after her dialysis treatments and not assessing her access for a thrill and bruit. He stated he	F 698	topics: • How and when to enter dialysis batch orders • Dialysis communication form to and from dialysis • Dialysis protocol The Director of Nursing will ensure that any nurse who has not received this training by 06/26/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F698 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. The Director of Nursing will monitor compliance with Dialysis care and monitoring order process for all dialysis residents. Reports will be presented to the weekly Quality Assurance committee	

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F 698	Continued From page 63 expected the facility to provide necessary monitoring and care for any dialysis resident. An interview was completed with Medication Aide (MA) #1 on 5/25/22 at 2:00 PM. She stated she was not aware of any ongoing monitoring or assessment of Resident #30 and her dialysis site. She stated she recalled there should not be blood pressure or lab work done on her access arm. An interview was completed on 5/25/22 at 2:40 PM with Nursing Assistant (NA) #5. She stated the only thing she did after Resident #30's dialysis treatments was give her food and lay her down in bed. NA #5 stated she did not obtain any vital signs post dialysis because Resident #30 had a folder that she took with her and the dialysis staff obtained her vital after her treatments. NA #5 stated she was not aware that Resident #30's post dialysis site pressure dressing should be monitored for signs of bleeding. She stated she was only aware that no blood pressure or lab work should be done in her left arm because of her graft. An interview was completed with Nurse #2 on 5/25/22 at 2:45 PM. She stated she obtained a post dialysis weight, pulse, temperature, oxygen saturation and occasionally Resident #30's blood pressure. Nurse #2 stated she was not aware that Resident #30's dialysis site pressure dressing should be monitored for bleeding and not removed until the following day. She also stated she was not aware of the need to assess Resident #30's graft site daily for a thrill and bruit because there were no orders to do any of the things.	F 698	by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/27/2022	

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F 698	Continued From page 64	F 698		

An interview and observation was completed on 5/25/22 at 3:00 PM of Resident #30. She stated she had just returned from her dialysis treatment. Her left arm graft site did not have a pressure dressing in place. She stated she removed it when she got back to the facility. Resident #30 stated nobody had told her that she needed to leave her dialysis site pressure dressing in place until the following day. She stated the facility staff did not obtain her vital signs or check her dressing after each dialysis treatment.

An interview was completed on 5/25/22 at 3:46 PM with Unit Manager (UM) #1. She stated Resident #30 left for her dialysis treatments on third shift at approximately 5:45 AM. She stated the nurse was responsible for sending Resident #30's dialysis communication folder with her but apparently it was not happening and hadn't for a while. UM #1 stated she was not aware of the need to obtain Resident #30's vital signs, check her graft dressing for bleeding or the need to leave the dressing in place until the following day after Resident #30's dialysis treatment. She stated the reason she was not aware was because there were no Physician orders to do so. UM #1 the only thing she was aware of was the need to assess her graft for a thrill and bruit and no blood pressures or lab work to her left arm.

An interview was conducted on 5/26/22 at 1:00 PM with the Administrator and Director of Nursing (DON). The Administrator and DON stated they expected the nurses to obtain Physician orders, implement those orders and be knowledgeable

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F 698	Continued From page 65 regarding the care of a dialysis resident.	F 698		

2. Resident #44 was admitted on 12/13/2021 with a diagnosis of end stage renal disease.

Resident #44's comprehensive care plan included a care area dated 12/14/2021 with a focus for hemodialysis 3 times weekly. Interventions included checking for at least 24 hours of any bleeding episodes, no blood pressure readings of lab work to the graft arm, keep the dressing on the dialysis access site as ordered, monitor for a thrill (vibrations felt when touching the fistula) and a bruit (a loud swishing sound when placing stethoscope over fistula site) and obtaining her vital signs as ordered.

Resident #44's quarterly Minimum Data Set (MDS) dated 3/22/2022 indicated the resident had moderately impaired vision and required extensive assistance with all activities of daily living and received dialysis.

Review of Resident #44's April and May 2022 Physician orders only included an order dated 3/2/2022 for dialysis every Monday, Wednesday and Friday.

Review of Resident #44's April and May 2022 medication administration records (MARs) and treatment administration records (TARs) did not include any documentation related to monitoring resident after dialysis or monitoring the dialysis

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F 698	Continued From page 66	F 698		

access site.

Review of Resident #44's nursing notes from April 2022 through 5/18/22 did not include any documentation of monitoring post dialysis treatments, monitoring post dialysis vital signs or evidence of monitoring her graft site for a thrill or bruit.

An interview was completed with Resident #44 on 5/24/2022 at 11:12 AM. Resident #44 stated he had just returned from dialysis. He stated sometimes the nurses would check on him after he returned from dialysis but most of the time the Nurse Assistants (NA) check on him when he returned to the facility. He further stated the facility staff did not routinely check his vital signs or his graft site after a dialysis treatment.

On 5/24/2022 at 2:00 PM an interview was conducted with Nurse #4. She stated she was assigned to Resident #44 and he received dialysis on Tuesdays, Thursdays, and Saturdays. She further stated she did check on the resident when he returned from dialysis, but she did not complete a set of vital signs. Nurse #4 stated in the past, dialysis residents took a form with them to dialysis. The form indicated if the resident had any changes in medications or had any recent change in health status. She did not know why the facility was not using the forms any longer.

An interview was completed on 5/24/22 at 4:18 PM with the Administrator. She stated the facility was not completing or sending a dialysis communication forms with Resident #44 to dialysis. She stated she was not certain why the practice stopped. She stated the staff were monitoring vital signs and the graft site but she

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F 698	Continued From page 67 was unable to find any documentation to support it. An interview was completed on 5/25/22 at 11:35 AM with the MD. He stated he was not aware that the facility was not monitoring Resident #44 after his dialysis treatments and not assessing the dialysis access site. He stated he expected the facility to provide necessary monitoring and care for dialysis residents. An interview was conducted on 5/26/22 at 1:00 PM with the Administrator and Director of Nursing (DON). The Administrator and DON stated they expected the nurses to obtain Physician orders, implement those orders and be knowledgeable regarding the care of a dialysis resident.	F 698		
F 726 SS=G	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		6/27/22

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F 726	Continued From page 68 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to provide documented evidence 2 of 2 agency nursing assistants (NA's) (NA #9 and NA #10) were trained on the safe use of the facility's mechanical sling lift resulting in a distal femur fracture (Resident #3). This was for 2 of 3 residents reviewed for accidents. The findings included: The findings included: Resident #3 was admitted on 4/1/8/20 with dementia and osteoarthritis. Resident #3's quarterly Minimum Data Set dated 7/22/21 indicated severe cognitive impairment, non-ambulatory and total staff assistance of 2 with transfers. Resident #3's revised care planned for a risk of falls dated 8/5/21 read she was a mechanical sling transfer with the assistance of 2 staff. Review of the manufacture instructions for use of the mechanical sling lift dated 3/2020 read as follows on page #25: when lowering the spreader bar, ensure that the resident's legs and feet were	F 726	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F726 The facility failed to provide documented evidence of safe use of a mechanical lift for 2 agency nursing assistants. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #3 was sent to the orthopedist on 11 / 09/2022 for follow up care related to complaints of left knee pain related to an apparent injury during use of a mechanical lift for transfers by two staff that occurred on 10/26/21. The x-ray that was ordered post incident and obtained	

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F 726	Continued From page 69 well clear of moving mast to avoid injuries. Reviews of Resident #3's nursing notes included a note dated 10/26/21 at 2:03 PM that read 2 staff were using the mechanical sling lift to transfer her when she complained of left knee pain. There was no redness or swelling noted. She was given Tylenol and the Medical Director (MD) ordered a knee x-ray. Resident #3's left knee x-ray results dated 10/26/21 read there was no evidence of a fracture but soft tissue swelling the medical aspect of her left knee. Review of a nursing note dated 11/5/21 at 12:18 PM read Resident #3 complained of increased pain to her left knee. The MD ordered an orthopedic consult to check on her left knee replacement hardware. Review of the orthopedic consult note dated 11/9/21 read Resident #3's leg was caught when being transferred from the wheelchair and had been painful since. Additional x-rays revealed a left periprosthetic distal femur fracture. Review of an undated Investigation Guide completed by the former Director of Nursing (DON) read Resident #3 was sitting in her wheelchair at 2:30 PM on 10/26/21. The aides used the mechanical sling lift to transfer Resident #3 back to bed. She complained of knee pain after being laid down. The MD was notified and an x-ray was ordered. Review of the conclusions with root cause analysis read the incident occurred due to osteoarthritis, hypothyroidism and a total left knee replacement. She was	F 726	on 10/26/2021 resulted that there was no evidence of a fracture but there was soft tissue swelling to the medial aspect of the left knee. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents requiring use of a mechanical lift for transfers have the potential to be affected by this alleged deficient practice. On 6/17/2022, the Director of Nurses and Assistant Director of Nurses began competency evaluation of all Certified Nursing Assistants, Medication Aides and agency nursing aides on use of the mechanical lift. As of 6/26/2022 all of the above are in compliance. Competency evaluation will continue for 100% of newly hired certified nursing assistants to include staff or agency nursing assistants, along with medication aides by the Assistant Director of Nurses or Director of Nurses. Competency re-evaluation will occur following mechanical lift related incidents or injuries based on the investigation/identified root cause of the incident. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 06/168/2022, the Director of Nurse/Assistant Director of Nurses and Nurse Consultant began education of all full time, part time, PRN Nurses and agency nurses, certified nursing	

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F 726	Continued From page 70	F 726		

referred to orthopedics. Attached to the Investigation Guide were staff written statements all written on 11/10/21.

Review of the written statement dated 11/10/21 was completed by agency Nursing Assistant (NA) #9 read she and agency NA #10 were putting Resident #3 back to bed using the mechanical sling lift and while doing so, her legs were on each side of the lift mast (hydraulic motor and battery pack part of a lift attached to the sling bar). The statement read Resident #3 was pulled back and her legs moved to get the lift mast from between her legs when she complained of pain.

Review of a written stated dated 11/10/21 completed by agency NA #10 read NA #9 asked her to assist her with transferring Resident #3 back to bed using the mechanical sling lift. She indicated NA #9 hooked sling to the lift bar and began to lift her up while her legs were on each side of the lift mast. NA #9 pulled Resident #3 back so the mast would not be between her legs and then placed her on the bed. She complained of pain once in bed.

An interview was completed on 5/25/22 at 3:46 AM with Unit Manager (UM) #1. She stated Resident #3 was being transferred by 2 agency aides that no longer worked at the facility. UM #1 stated she did not recall if the agency staff received training on the use of the facility's mechanical sling lifts upon hire.

A telephone interview was completed on 5/26/22 at 11:23 AM with NA #10. She stated she was only the spotter during the lift transfer. When questioned about her written statement, she stated she did not recall if Resident #3's legs

assistants and med aides on the following:
This in-service included the following topics:
• Transfer safety and mechanical lifts
On 6/15/2022 the Nurse consultant began education with the Administrator, Director of Nurses. Assistant Director of Nurses and Nursing team on
• The investigation process post incident, Root Cause Analysis and needed follow up/competency evaluation/staff education based on the root cause of the investigation.
• The orientation process and competency evaluation for mechanical lifts for Certified Nursing assistants, Medication Aides and Agency nursing assistants.
The Director of Nursing will ensure that any nurse who has not received this training by 06/26/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. Any nursing staff who does not receive scheduled in-service training or competency evaluation will not be allowed to work until the training has been completed by June 26, 2022.

4. Monitoring Procedure to ensure that

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F 726	Continued From page 71 were on either side of the mast before she was lifted. NA #10 stated she was not trained on the proper use of the facility's mechanical sling lift until after the incident involving Resident #3. Multiple telephone messages were left for NA #9 to return call to discuss the circumstances involving Resident #3's injury were unsuccessful. A telephone interview was completed on 5/26/22 at 11:34 AM with the former DON. She stated she completed an investigation and it was determined that the aides hit her left knee on the side of the lift mast. She stated all the staff were in-served 11/11/21 on the correct use of the mechanical sling lift and she did not recall if the agency NA #9 and NA #10 received training on the use of the facility's mechanical sling lifts prior to the injury on 10/26/21. An interview was conducted on 5/26/22 at 1:00 PM with the Administrator and DON. The Administrator provided evidence of training on the mechanical sling lift for NA #9 and NA #10 dated 11/11/21 after the incident. The Administrator stated she expected all the nursing staff to be trained and knowledgeable on the use of mechanical sling lift to prevent resident injuries.	F 726	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F726 Quality Assurance Tool for staff competency and the F689 audit tool to assure safe transfers via mechanical lift by observing mechanical lift transfers on various shifts to include weekends weekly x 2 then monthly x 3 or until resolved. The Director of Nursing will monitor compliance with competency evaluation for the use of mechanical lifts for all certified nursing assistants and medication aides (staff/agency) as part of facility orientation and following a mechanical lift related incident that results in resident injury or if need indicated as part of the identified root cause and investigation. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 06/27/2022	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		6/27/22

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F 756	Continued From page 72 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756		

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F 756	Continued From page 73 Based on record reviews and interviews with staff, Pharmacy Consultant and Medical Director, the facility failed to act upon recommendations made by the Pharmacy Consultant for 1 of 6 residents whose medications were reviewed (Resident #61). The findings included: Resident #61 was admitted to the facility on 12/20/21 with diagnoses that included malignant neoplasm of the brain and anxiety disorder. A review of the active physician orders revealed the following: " An order dated 12/20/21 for Lorazepam (Ativan- an antianxiety medication) 0.5 milligrams (mg) 1 tab by mouth every hour as needed for anxiety, nausea, or shortness of breath. " An order dated 12/20/21 for Haloperidol (Haldol- an antipsychotic medication) 2 mg, give 2 tablets by mouth every 2 hours as needed for agitation until symptoms are under control. " An order dated 12/20/21 for Haloperidol 2 mg, give 2 tablets every 4 hours as needed for agitation. A Pharmacy Medication Regimen Review progress note dated 3/11/22 indicated recommendations were found with a report sent to the Administrator and Director of Nursing (DON). The facility was unable to locate a copy of the recommendation report. A quarterly Minimum Data Set (MDS) assessment dated 4/4/22 indicated Resident #61 was cognitively intact with no behaviors noted. He was coded with receiving 3 days of an antianxiety medication during the assessment	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F756 The facility failed to act upon recommendations made by the Pharmacy Consultant for resident #61. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident# 61, on 06/16/2022 the physician order was updated to include a 14 day stop date and appropriate clinical indications for use of the antipsychotic medications. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. As of 06/16/2022 the Director of Nurses and nursing team began auditing of all pharmacy consultant recommendations for the last 30 days to assure that recommendations made by the pharmacy consultant have been reviewed by the physician and have been implemented as ordered. This will be completed by 06/26/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient	

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F 756	Continued From page 74 period as well as hospice care. Pharmacy Medication Regimen Review progress notes dated 4/11/22 and 5/10/22, indicated recommendations were found with a report sent to the Administrator and DON. The facility was unable to locate a copy of these recommendation reports. An interview occurred with the Medical Director on 5/25/22 at 11:37 AM, who stated the former DON would provide him with pharmacy recommendations but stated he may "have seen a dozen out of 50 plus recommendations that came through each month" and was unable to recall if he had viewed the recommendations dated 3/11/22, 4/11/22 or 5/10/22 for Resident #61. A phone interview was completed with the Consulting Pharmacist on 5/26/22 at 8:55 AM who explained the former DON did not respond to pharmacy recommendations consistently to include the ones that required physician responses. The Consulting Pharmacist stated she sent the same recommendations regarding time limited need for the PRN psychotropic medications each month as she had seen no change from month to month. A duplicate recommendation would continue to be made until a response was identified. The pharmacist explained recommendations were sent to the DON via email and the DON would provide to the physician for follow-up if the recommendation required a physician response and signature. On 5/26/22 at 11:34 AM, a phone interview was held with the former DON. She confirmed receiving the pharmacy reports and	F 756	practice: Beginning on 06/16/2022 the Nurse Consultant educated the Director of Nurses and nursing team on the following topics: • Drug regimen reviews should include an audit of the monthly pharmacy consultant recommendations to assure that they have been addressed by the physician and orders received as a result of recommendations have been implemented timely. • Drug regimen reviews are uploaded to the individual resident documents once all steps in the process have been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F756 Quality Assurance Tool for compliance with the Drug Regimen Review Process weekly x 2 weeks then monthly x 3 month or until resolved. The Director of Nursing will monitor for follow through of physician	

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F 756	Continued From page 75 recommendations each month from the Consulting Pharmacist but stated she "didn't always have time to do them since" she "had 5 other things to do". The Former DON added she left employment with the facility in April 2022.	F 756	review and that all orders received are initiated. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		6/27/22

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F 758	Continued From page 76 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Pharmacy Consultant, Medical Director, and staff, the facility failed to ensure an as needed (PRN) psychotropic medications were time limited in duration (Resident #61) and failed to have an adequate clinical indication for the use of an antipsychotic medication (Resident #61). This was for 1 of 6 residents whose medications were reviewed. The findings included: Resident #61 was admitted to the facility on	F 758	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F758 The facility failed to ensure an as	

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	345370	A. BUILDING _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 77 12/20/21 with diagnoses that included malignant neoplasm of the brain and anxiety disorder. A review of the active physician orders revealed the following: - An order dated 12/20/21 for Lorazepam (Ativan-an antianxiety medication) 0.5 milligrams (mg) 1 tab by mouth every hour as needed for anxiety, nausea, or shortness of breath. - An order dated 12/20/21 for Haloperidol (Haldol-an antipsychotic medication) 2 mg, give 2 tablets by mouth every 2 hours as needed for agitation until symptoms are under control. - An order dated 12/20/21 for Haloperidol 2 mg, give 2 tablets every 4 hours as needed for agitation. The March 2022 Medication Administration Record (MAR) indicated Resident #61 had received the as needed dosage of Lorazepam seven times and the as needed dosages of Haloperidol eight times. A quarterly Minimum Data Set (MDS) assessment dated 4/4/22 indicated Resident #61 was cognitively intact. He was coded with receiving 3 days of an antianxiety medication during the assessment period as well as hospice care. Antipsychotic medications were not received during the assessment period. The April 2022 and May 2022 MARs revealed Resident #61 had received the as needed dosage of the Lorazepam 14 times in April and seven times in May. Resident #61 had received the as needed dosages of the Haloperidol nine times in April and four times in May. A review of Resident #61's medical record	F 758	needed (PRN) psychotropic medications were time limited in duration and failed to have an adequate clinical indication for the use of the antipsychotic medication for resident # 61. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident # 61, Haldol was discontinued on 6/17/2022. For the Lorazepam the clinical indication is Anxiety Disorder. As of 6/17/2022 orders were received from the physician that included a 14 day stop date with reevaluation for Lorazepam and includes appropriate clinical indications for use. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 06/15/2022 the pharmacy consultant will begin review of all current residents on antipsychotic medications for appropriate clinical indication and time limited duration for PRN antipsychotic medication orders. Any concerns noted will be reviewed with the MD for changes to assure clinical indications are appropriate and PRN psychotropic medications are time limited in duration. This process will be completed by 06/26/2022. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 06/16/2022 the nurse consultant will educate the Director of Nursing, MDS Nurse, and Administrator on the acceptable indications for Antipsychotic medications. Beginning on 6/16/2022, the Director of	

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F 758	Continued From page 78 revealed there was no documented medical justification for the use of PRN Haloperidol. An interview occurred with the Medical Director (MD) on 5/25/22 at 11:37 AM, who stated he was aware of the regulation that required all as needed (PRN) psychotropic medications to be time limited in duration. He indicated he thought hospice residents were exempt from the regulation. In addition, the MD stated he was familiar with Resident #61 who was admitted to the facility with Hospice services in place. He reviewed Resident #61's medical record and indicated agitation was the reason for the use of Haloperidol as well as Lorazepam. The MD was unaware of any psychiatric diagnoses prior to his admission to the facility. On 5/25/22 at 2:45 PM, an interview was conducted with Nurse #2 who was familiar with Resident #61 and was aware he had PRN orders for both Lorazepam and Haloperidol. She reported that when Resident #61 became agitated she utilized either the Haloperidol or Lorazepam since they both relieved his agitation and anxiety. She characterized his agitation as asking for family more frequently, tremors becoming more intense and tearfulness. Nurse #2 stated Resident #61 did not display any aggressive behaviors towards staff or others. She would utilize other interventions such as talking, turning on music or calling his family before medication was utilized. On 5/25/22 at 3:47 PM, an interview was held with Unit Manager #1 who was aware there was a time limited duration for psychotropic medications but thought residents enrolled on hospice care were exempt and allowed to have indefinite PRN	F 758	Nurses, Assistant Director of Nurses and Nurse Consultant began education of all full time, part time, and PRN Nurses and agency nurses on the following: • Clinical indications for antipsychotic medications • Stop date with evaluation by the physician for prn antipsychotic medications to include residents on Hospice services This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F758 Quality Assurance Tool for compliance with the antipsychotic medication process weekly x 2 weeks then monthly x 3 months. The Director of Nursing will monitor for acceptable clinical indication/diagnosis for anti-psychotics and time limited duration for PRN antipsychotic medications. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is	

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F 758	Continued From page 79 psychotropic medications. A phone interview was conducted with the consulting Pharmacist on 5/26/22 at 8:55 AM. She was able to review her monthly DRR's for Resident #61 and stated she had not requested for the physician to provide a qualifying diagnosis for the PRN Haloperidol, as she expected it to be used minimally and on a short-term basis. The consulting Pharmacist stated she had been repetitively asking for the PRN Haloperidol and Lorazepam to have a stop date. The Director of Nursing was interviewed on 5/26/22 at 1:10 PM and indicated she had been employed at the facility for four days. She was aware all PRN psychotropic medications required time limited duration even if enrolled on hospice care, to allow for reassessment of the need for the medication or if any alterations might be needed. The DON also indicated that agitation was not an appropriate clinical indication for the use of PRN Haloperidol.	F 758	initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting until deemed no longer necessary for compliance unnecessary medications and psychotropic medications. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as	F 947		6/27/22

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F 947	Continued From page 80 determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide Nursing Assistants (NAs) with annual dementia training for 4 of 5 sampled Nurse Aides reviewed for required in-service training (NAs #1, #2, #3, and #12). The findings included: NA #1's date of hire was 7/26/10. Review of in-service records revealed she was not provided annual dementia training. NA #2's date of hire was 10/21/13. Review of in-service records revealed she was not provided annual dementia training. NA #3's date of hire was 6/17/20. Review of in-service records revealed she was not provided annual dementia training. NA #12's date of hire was 10/23/08. Review of in-service records revealed she was not provided annual dementia training. On 5/26/22 at 10:08 AM, the Administrator stated she reviewed the in-service records for NA's #1, #2, #3 and #12 and could not find documentation that they were provided dementia training annually. She stated the Staff Development	F 947	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F947 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to provide nursing assistant annual dementia training. 1. Corrective action for resident(s) affected by the alleged deficient practice: Nursing Assistants #1, 2, 3 and 12 will complete Dementia Training ("Care of the Cognitively Impaired Resident") in Health Care Academy online training by 06/26/2022. 2. Corrective action for residents with the potential to be affected by the alleged	

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F 947	Continued From page 81 Coordinator was no longer employed at the facility for the last few months. The Administrator further stated she had identified a problem with in-service education for the staff, but would expect all NAs to be up to date with dementia training.	F 947	deficient practice. Beginning on 06/16/2022 the Director of Nurses/Assistant Director of Nurses began auditing all nursing assistants and med aides to identify completion of annual Dementia training. This audit was completed as of 6/16/2022. 3 certified staff nursing assistants /med aides had not completed annual Dementia Education and all agency nursing assistants were in compliance. Any Certified Nursing Assistant or Med Aide identified without completed Dementia training will complete the course “Care of the Cognitively Impaired Resident” in Health Care Academy online training by 06/26/2022 and any agency nursing assistants will be provided Dementia education by 6/26/2022. The Director of Nurses will begin monitoring as of 6/26/2022 for ongoing compliance on a quarterly basis for both staff and agency certified nursing assistants. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The administrator will fire Dementia Training via Health Care Academy on line training to all full time, part time and as needed nursing assistants that did not have the annual education documented. All identified nursing assistants will complete the Dementia training by 06/26/2022 at which time all identified nursing assistants and med aides must be in-serviced prior to working. All agency certified nursing assistants will be provided Dementia education by	

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F 947	Continued From page 82	F 947	6/26/2022 prior to working. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by June 26, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses/Assistant Director of Nurses will monitor compliance utilizing the Dementia Training Quality Assurance Tool weekly x 2 weeks then monthly x 3 months. The Director of Nursing/Assistant Director of Nurses will monitor all nursing assistants and med aides for compliance with the completion of annual Dementia training. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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