STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted 5/16/22 through 5/24/22. The facility was found not in compliance with CFR 483.73. Emergencey Preparedness. Event ID O28411.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E 004		6/21/22

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

Electronically Signed | 06/17/2022

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E 004	Continued From page 1 * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide and maintain documentation of annual updates and review of the facility's Emergency Preparedness Plan. Findings included: A review of the facility's Emergency Preparedness (EP) Plan occurred on 5/19/22 at 11:30 AM with the Maintenance Director. During the review, it was discovered the plan had not been updated in the last 12 months and was last updated on 2/26/21. Emergency contact information was not updated. The resident risk assessment was not updated. The Maintenance Director indicated he was responsible for another facility within the company and this was his 2nd day working at this facility. He revealed his initial review of the EP plan at this facility was on 5/18/22. He confirmed there was no documentation of the annual training or required exercises for staff on the EP plan at this facility. On 5/19/22 at 1:00 PM an interview was	E 004	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to	

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E 004	Continued From page 2 conducted with the Nursing Home Administrator (NHA). The NHA explained she was new to the facility and was unaware the EP manual had not been updated in the last 12 months and there was no documentation of staff training or exercises for emergency preparedness. The NHA stated she expected the EP manual to be updated annually to include staff training and exercises as required.	E 004	provide quality of care to residents. E001 1. The facility has a comprehensive emergency preparedness program that has been reviewed and updated as of 6/21/22. 2. All residents residing in the facility have been identified as having the potential to be affected. 3. On 6/17/2022 the Regional Director of Operations educated the Nursing Home Administrator (NHA) on the Emergency Preparedness Plan including necessity of annual reviews and updates, The NHA or ERT will educate the staff on the Emergency Preparedness Program by 6/21/2022. Emergency Preparedness Manuals have been placed on each Nursing Unit. After 6/21/22 newly hired staff will be educated on the Emergency Preparedness Program by Nursing Home Administrator prior to start of their shift. 4. Beginning on 6/21/22 weekly for twelve weeks, the administrator or designee will interview five staff members across various shifts to validate their knowledge of the location of the Emergency Preparedness Manuals. Results of the audits will be presented by the Nursing Home Administrator (NHA) in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 3 A unannounced recertification and complaint investigation was conducted 5/16/22 through 5/24/22. Event ID O28411. The following complaint intakes were investigated. NC00189159, NC00188570, NC00188244, NC00187784, NC00187714, NC00187544, NC00187478, NC00186729, NC00186634, NC00186423, NC00186186, NC00186231, NC00186223, NC00186173, NC00186054, NC00185947, NC00185929, NC00185495, NC00185494, NC00185321, NC00185197, NC00184942. 47 of 91 complaint allegations were substantiated resulting in deficiencies. Immedidate Jeoporady was identified at: 483.10 at F580 - scope / severity - J 483.25 at F684 - scope / severity - J F684 constituted substandard quality of care Immediate Jeoporady began on 5/2/22 and was removed on 5/21/22 An extended survey was conducted. 6/20/22 - A new 2567 was issued to the facility to reflect the addition of F867 and change in scope / severity of F550 and F 558 to an H. F550 and F 558 constituted substandard quality of care	F 000		
F 550 SS=H	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F 550		6/21/22

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F 550	Continued From page 4	F 550		

self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:

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F 550	Continued From page 5 Based on observations, record review, staff and resident interview the facility failed to treat residents who required assistance with incontinence care in a dignified manner. Resident #77 expressed feelings of embarrassment because she did not have on a brief, was wet and had no linen on her bed. Resident #53 expressed feelings of embarrassment because the staff used 2 briefs and a towel to manage her incontinence because the facility did not have the correct size brief for her. This was evident for 2 of 8 residents reviewed for dignity. Finding included: 1. Resident #77 was admitted to the facility on 10/01/19 and diagnoses congestive heart failure and stage 4 kidney disease. Review of Resident #77's quarterly Minimum Date Set (MDS) dated 04/11/22 revealed her cognition was intact and she was able to communicate her needs to staff. Resident #77 was occasionally incontinent of bowel and bladder. Review of Resident #77's care plan dated 04/11/22 indicated Resident #77 needed extensive one-person assistance with bed mobility, dressing and personal hygiene. She was totally dependent on staff for toilet use. An observation of Resident #77 on 5/18/22 at 5:30 am revealed she was lying in bed and a strong urine odor was noted. The resident was lying on the right side of the bed, on her back with no bed covering on her body. She had a bath blanket folded in half lying under her torso and a folded sheet under her feet. The resident was not	F 550	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F550 1. Resident #77 is currently using briefs to manage incontinence and has linen on the bed. Resident #53 has the correct size brief for incontinence management. 2. Bariatric Residents who are incontinent have been identified as having the potential to be affected. On 6/9/22 observational rounds were conducted by the Unit Managers or Nursing Administration on bariatric residents who are incontinent to validate provision of care and application of correct size briefs for incontinence management and	

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F 550	Continued From page 6 wearing an adult brief. The bath blanket under her torso was saturated with urine dripping onto the floor. There was a puddle of urine on the floor. The resident stated a nursing assistant (NA) changed her top blanket but not the one under her. She stated she was a heavy sleeper and required a brief at night in case she was incontinent and could not make it to the bedside commode. She said the staff told her they were having trouble locating briefs in her size, a 4x, and they would return with one. She said this was at 11:30 p.m. No one returned with a brief and she fell asleep. When she woke up this morning she was drenched, and nobody had been in to change her all night. She said she would have liked to have been helped during the night instead of being left in a wet mess. The resident added she felt very embarrassed about not having a brief for her incontinence and left in such a mess and now someone had to clean the entire floor because she was not provided with the items she needed for her incontinent episodes during the night. An interview conducted on 5/18/22 at 5:52 am with NA#10 revealed she had not performed peri-care or put a clean sheet on Resident #77 ' s bed; she added she had cleaned the floor. NA #10 stated the resident told her she did not need to be changed because she could take herself to the bedside commode. An interview with Resident #77 on 5/18/22 at 5:54 am revealed NA #10 didn ' t clean up the floor and she hadn ' t told the NA on night shift she didn ' t need help. The resident stated NA #10 told her she was going to get linens and brief and never came back. A second observation of Resident #77 on 5/18/22	F 550	provision of bed linens. 3. Nursing Assistants will be educated by the Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON,) Unit Manager (UM) or Nursing Administration on incontinence management of bariatric to include applying the correct size brief and provision of bed linen. Education will be completed by 6/21/22. After 6/21/22 Nursing Assistants will be educated on incontinence management to include applying the correct size brief and provision of bed linen prior to the start of their next shift 4. Twice a week for twelve weeks, Unit Managers or Nursing Administration will observe five bariatric residents to validate incontinence management is being provided to include proper fitting briefs and bed linens. Results of the audits will be presented by the Director of Nursing (DON) in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 550	Continued From page 7	F 550		

at 11:00 am revealed she did not have a brief on. Resident #77 state the staff informed her that her size brief was not available. Resident #77 indicated this had been a going problem for a month. Resident #77 did not have any sheets under her during this observation. The resident indicated she was embarrassed about not having a brief on and not having a sheet underneath her.

An observation was conducted of the supply room on the 3rd floor on 05/19/22 at 11:25 am and there were no 3 x or 4 x briefs for residents on that hall.

An interview with the Administrator on 5/20/22 at 5:20 pm revealed she expected all residents needs to be met and the facility should have the correct size briefs available.

2. Resident #53 was admitted to the facility on 12/19/21 and diagnoses included acute on chronic respiratory failure.

Review of Resident #53's quarterly Minimum Date Set (MDS) dated 04/11/22 revealed her cognition was intact and was able to make her needs know to staff. Resident #53 was occasionally incontinent of bowel and bladder.

Review of Resident #53's care plan dated 04/11/22 indicated she needed extensive one-person assistance with bed mobility, dressing and personal hygiene and was totally dependent for toilet use.

Resident #53 was interviewed on 05/17/22 at 11:45am and indicated the facility was short on briefs for her size. She stated the staff had to put two smaller size briefs together for her buttocks

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F 550	Continued From page 8 and place a towel in front of her for incontinence care. Resident #53 indicated this was embarrassing to her. She added the facility never had enough briefs in her size and this had been going on since she came to the facility in December 2021. Resident #53 indicated that it was a "bad feeling" for staff to have to use two briefs." During an interview on 05/19/22 at 11:15 am with Nursing Assistant #11 (NA) she indicated she had only been working at the facility for a few months and it had been an ongoing issue with not having size 4x briefs for Resident #53. An observation was conducted of the supply room on the 3rd floor on 05/19/22 at 11:25 am and there were no size 3x or 4x briefs for residents on that hall. An interview with the Administrator on 5/20/22 at 5:20 pm revealed she expected all residents needs to be met and the facility should have the correct size briefs available.	F 550		
F 558 SS=H	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide the proper size briefs for 2 of 3 residents	F 558	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility	6/21/22

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F 558	Continued From page 9 reviewed for accommodation of needs (Resident #53 and Resident #77). This resulted in the residents expressing they felt bad and embarrassed. Finding included: 1. Resident #53 was admitted to the facility on 12/15/21 with diagnoses that included acute and chronic respiratory failure. Resident #53's quarterly Minimum Date Set (MDS) dated 03/24/22 indicated that Resident #53 was cognitively intact. Resident #53 needed extensive assistance with toilet use, dressing, transfer, and bed mobility. Resident #53 was occasionally incontinent of bowel and bladder. Resident #53's care plan dated 03/14/22 indicated that Resident #53 required extensive one-person assistance with bed mobility, dressing, toilet use and personal hygiene. A review of the central supply order forms for briefs indicated that from November 2021 to May 2022 the orders revealed only 4 boxes of 3 x to 4 x briefs ordered. Resident #53 was interviewed on 05/17/22 at 11:45 am and indicated the facility was short on briefs for her size. She stated the staff had to put two smaller size brief s together for her buttocks and place a towel in front of her for incontinence care. Resident #53 indicated this was embarrassing to her. Resident #53 indicated that she needed a size 4 x brief. She added the facility never had enough briefs in her size and this had been going on since she came to the facility in December 2021. Resident #53 indicated that it	F 558	reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F558 1. Residents #77 and #53 are currently using the correct size brief for incontinence management. 2. Bariatric Residents who are incontinent have been identified. On 6/9/22 observational rounds were conducted by the Unit Managers or Nursing Administration on incontinent residents to validate provision and application of correct size briefs for incontinence management. 3. Nursing Assistants will be educated by the Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON), Unit Manager or Nurse Manager on incontinence management to include	

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F 558	Continued From page 10 was a "bad feeling for staff to have to use two briefs." During an interview on 05/19/22 at 11:15 am with Nursing Assistant #10 (NA) she indicated she had only been working at the facility for a few months and it had been an ongoing issue with not having 4 x briefs for Resident #53. An observation was conducted of the supply room on the 3rd floor on 05/19/22 at 11:25 am and there were no 3 x or 4 x briefs for residents on that hall. The Central Supply staff was not available for interview. An interview with the Administrator on 5/20/22 at 5:20 pm revealed she expected all residents needs to be met and the facility should have to correct size briefs available. 2. Resident #77 was admitted to the facility on 10/01/19 with diagnoses that included acute and chronic diastolic congestive heart failure, and chronic kidney disease stage 4. Resident #77's quarterly Minimum Date Set (MDS) dated 04/11/22 indicated that Resident #77 was cognitively intact. Resident #77 needed extensive one-person assistance with bed mobility, dressing and personal hygiene and was totally dependent on staff for toilet use. Resident #77 was occasionally incontinent of bowel and bladder. Resident #77's care plan dated 04/11/22 revealed she had a care plan for toilet use and was totally dependent on staff.	F 558	applying the correct size brief. Education will be completed by 6/21/22. After 6/21/22 Nursing Assistants will be educated on incontinence management to include applying the correct size brief prior to the start of their next shift. 4. Weekly for twelve weeks, Unit Managers or Nursing Administration will observe five bariatric residents to validate incontinence management is being provided to include proper fitting briefs. Results of the audits will be presented by the Director of Nursing DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 558	Continued From page 11 A review of the central supply order forms for briefs indicated that from November 2021 to May 2022 the orders revealed only 4 boxes of 3 x to 4 x briefs ordered. An observation of Resident #77 and an interview were conducted on 5/18/22 at 5:30 am and revealed she did not have a brief on and there was a puddle of urine under her bed. The resident indicated she was very embarrassed by that. She added the staff informed her that her size brief (4 x) was not available. Resident #77 indicated this had been going on for month. A second observation of Resident #77 on 05/19/22 at 11:00 am and revealed that Resident #77 did not have on a brief. During an interview on 05/19/22 at 11:15 am with Nursing Assistant (NA) #10 she indicated she had only been working at the facility for a few months and it had been an ongoing issue with not having 4 x briefs for Resident #77. An observation was conducted of the supply room on the 3rd floor on 05/19/22 at 11:25 am and there were no 3 x or 4 x briefs for residents on that hall. The Central Supply staff was not available for interview. An interview with the Administrator on 5/20/22 at 5:20 pm revealed she expected all residents needs to be met and the facility should have to correct size briefs available.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		6/17/22

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F 578	Continued From page 12 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578		

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F 578	Continued From page 13 Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately document advanced directives (code status) throughout the medical record for 1 of 1 hospice residents (Resident #83) reviewed for advanced directives. The findings included: 1. Resident #83 admitted to the facility on 10/6/21 and had a history of malignant neoplasm of prostate and bone. The active care plan last revised on 6/11/21 revealed Resident #83 and/or resident representative have chosen a code status of FULL CODE. A review of Resident #83 ' s physician order dated 11/8/21 revealed an order for Do Not Resuscitate (DNR). A review of the hospice plan of care (POC) dated 3/31/22 revealed start of care was 10/11/21 and certification period was 4/9/22-6/7/22 read in part Resident #83 had a DNR code status in place. On 5/19/22 at 1:09 pm an interview was conducted with MDS Nurse #1, and he verified Resident #83's had an order for DNR code status and Resident ' s full code status care plan was inaccurate and should have been care planned for a DNR code status. He stated, "It may just be an oversight."	F 578	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F578 1. Resident #83 care plan has been updated to reflect code status per physician order. 2. Residents with Advanced Directives have been identified as having the potential to be affected. By (6/17/22) the Minimum Data Set (MDS) Coordinators reviewed each resident Care Plan to	

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F 578	Continued From page 14 An interview was conducted on 5/20/22 at 5:30 pm with the Administrator and she stated she expected care plans to be updated to reflect the resident ' s status.	F 578	validate Care Plans are reflective of code status. 3. Social Workers were educated on 6/21/22 by the Director of Nursing (DON) on updating the plan of care to reflect the resident's Advanced Directives. 4. Weekly for twelve weeks the Social Workers will audit five residents, including new admissions Advanced Directives, to validate correct code status is reflective in the plan of care. Results of the audits will be presented by the Social Worker in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		6/17/22

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F 580	Continued From page 15 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, Medical Director (MD) and Nurse Practitioner (NP) interviews, the facility failed to: 1) immediately inform the physician when Resident #610 had an unwitnessed fall and could not get up as usual and notify the physician of x-ray results upon receipt from the radiology company. Resident	F 580	This constitutes a written allegation of compliance. Preparation and submission of this allegation of compliance does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusion set forth on	

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F 580	Continued From page 16 #610 was diagnosed with a fractured femur and a spinal injury. 2) notify the physician after a Resident #607, who received anticoagulant medication, fell for two of three residents reviewed for accidents (Residents #610 and #607). Immediate Jeopardy began on 5/2/2022 when the facility failed to inform the physician that Resident #610 had an unwitnessed fall and could not get up on his own, as usual. Immediate jeopardy was removed on 5/21/2022 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimum harm that is not Immediate Jeopardy) to implement corrections for Resident #607 and ensure the monitoring of the systems put into place and to complete facility employee training. The findings included: 1. Resident #610 was admitted to the facility on 3/2/2021 with diagnoses that included dementia, anxiety, seizures, and ischemic heart disease. A review of the annual Minimum Data Set (MDS) dated 2/28/2022 documented Resident #610 had severe cognitive impairment. A review of Resident #610's electronic medical record revealed no progress notes documented on the date of 5/2/2022. A signed statement made by NA #1, written on 5/4/2022 and read, on 5/2/2022 NA#1 was passing out 500 hall dinner trays, as I was taking	F 580	the statement of deficiencies. This allegation of compliance is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident. An incident report, was completed on 5/4/2022 5:00pm by the Director of Nursing, based on information obtained from facility staff regarding an event occurring on 5/2/22 where Resident #610, who was observed sitting on the floor beside his bed when staff entered his room to deliver the dinner tray. Resident #610 often preferred, to be seated on the floor, however he was unable to stand unassisted per his normal baseline. Two Nursing Assistants assisted with transferring resident #610 to be seated at the bedside for dinner. Both Nursing Assistants indicated Resident #610 did not appear to be in any distress and did not verbalize any complaints when he was assisted to side of bed. This occurrence was not reported to Nurse #1 as this was usual activity for Resident #610. Nurse #1 documented a late entry for Resident #610 on 5/4/2022 at 12:57PM, for the date of 5/3/2022, stating ”the baseline activity tolerance is up ad lib and ambulatory without assistance, resident has not been ambulating this shift, he is lying in bed, he did sit up and eat breakfast and lunch on the side of the bed but continued to lay back in the bed after eating.” On 5/3/2022 the Nurse Practitioner was in to assess the resident at the request of Nurse # 1 related to a new complaint of left leg pain	

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Resident #610 his tray, he was sitting in the floor. She sat the tray down and attempted to help him up but he was waving her off, so she asked another NA, NA #2, to assist her with helping pick him up to eat his food tray. After that, I saw Resident #610 walking on the hall before leaving my shift.

A signed statement made by Nurse #3, dated 5/5/2022 read: On May 2, 2022 Nurse #3 was the nurse taking care of Resident #610 from 7a.m. through 11 p.m. Resident #610 took his medication without any complications. He appeared to be at his baseline the entire shift. No issues or any changes in Resident #610 were reported to me throughout the entire shift from 7 a.m. - 11 p.m.

An attempt was made to interview the NA #1, NA #2 and Nurse #3 who worked on the evening of 5/2/2022, via telephone, unsuccessfully.

An interview was conducted on 5/19/2022 at 2:44 p.m. with Social Worker Assistant #1 via telephone with the Social Worker present. The interview revealed on 5/3/2022 Social Worker Assistant #1 was responsible for transporting Resident #610 to a podiatry visit in another area of the facility. She stated upon arrival in the room, between 10:30 a.m. and 11:00 a.m., she discovered Resident #610 sitting on the side of the bed with his pants not pulled up. She said she requested an NA, name unknown, to assist her to pull up the Resident's pants. She revealed the Resident refused to stand up with their assistance and wanted to only stand on his right leg and not his left leg. He kept his left leg bent and grimaced when they tried to stand him up. She said he appeared to be in a lot of pain. She added at this

and reduced mobility. The NP ordered bilateral x-rays of the hip, knee, and foot and Tylenol 5mg 3 x a day for pain x 7 days with Voltaren gel to bilateral knees.
On 5/3/2022 at 11:58pm the x-ray result conclusion: acute left femoral neck fracture questioned, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma, further recommended repeat x-ray or computerized tomography (CT) scan. On 5/4/2022 at 11:58 am Nurse #2 received the x-ray results from 5/3/222 notified the Nurse Practitioner of the results from 5/3/2022 and received an order to transfer the resident to the Emergency Department for evaluation, transfer was arranged via ambulance. On 5/4/2022 the guardian was notified of the x-rays results and the order received to transfer to the Emergency Department.
Resident #610 was admitted to the hospital on 5/4/2022 with the diagnosis of left femur fracture, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma.
On 5/19/2022 the Nurse managers reviewed residents who have fallen during the last 30 days to validate documentation of post fall nursing assessment including range of motion and pain assessment, MD and Responsible party notification was completed. Any opportunities identified during this audit will be corrected by the Nurse Managers by 5/20/22.

Specify the action the entity will take to alter the process or system failure to

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F 580	Continued From page 18 point, they laid the Resident down and proceeded to provide peri care because it was discovered he was wet and in need of care. When on his back, he pulled both legs up like he was in a fetal position, made a face like a grimace and like he was in pain. She said when the NA and herself pulled his pants down, it was discovered the Resident had a swollen left knee. She then said she went immediately and informed the hall nurse (Nurse #1). She said she was aware to report all new findings to a nurse because she was previously an NA and that was standard practice. Resident #610's progress notes revealed a nursing note dated 5/3/2022 at 2:52 p.m. (documented on 5/4/2022 at 12:57 p.m. as a late entry) written by Nurse #1 that read: baseline activity tolerance is up ad lib and ambulatory without assistance. Resident has not been ambulating this shift. He has been lying in bed. He did sit up and eat his breakfast and lunch on the side of the bed but continued to lay back down after eating. The Nurse Practitioner (NP) was in to assess him, ordered x-rays of the left hip, the left knee and the left foot, a pain-relieving gel for bilateral knees and Tylenol 500 milligrams (mg) 3 x a day for pain for 7 days. A call was placed to radiology company on 5/19/2022 at 10:55 a.m. and an interview was conducted with a staff member. He revealed the results of Resident #610 were faxed to the telephone number (336) 761-0703 on 5/3/2022 at 2300 and an email sent to the facility that read, ALERT, in all capital letters across the front. He added that a staff member from radiology company called the facility on 5/4/2022 at 11:52 a.m. and spoke to Nurse #2 to provide a report of the questioned fracture that required an additional	F 580	prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: The Staff Development Coordinator, Regional Director of Clinical Services, and unit managers educated Licensed Nurses regarding the requirement to complete and document a post fall nursing assessment to include range of motion and pain assessment prior to moving the resident. Education also included requirements for notification of the MD and Responsible Party following an incident. The Nurse Managers educated Nursing Assistants on the definition of a fall including a change of plane and to report falls to the Licensed Nurse immediately, prior to moving the resident. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. Education will be completed by 5/20/22 by the Nurse Managers. The Regional Director of Clinical Services educated the Nurse Management team and the Administrator regarding the clinical morning meeting process to include a review of residents with falls, to validate completion and documentation of post fall nursing assessment including Range of Motion and Pain assessment and notification of the MD and responsible party. This education was completed on 5/20/22 The Staff Development Coordinator, Regional Director of Clinical Services, and unit managers educated Licensed Nurses	

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F 580	Continued From page 19 x-ray or CT scan. An interview was conducted with the NP on 5/18/2022 at 3:39 p.m. and she revealed she received a verbal report during rounds on 5/3/2022 from the Nurse that Resident #610 appeared to be in pain during the nurses care that day. She added that during her assessment the left knee appeared to have degenerative joint changes, through physical palpitation. She consulted with the MD and informed him of the changes she had observed. She stated the Resident was nonverbal but grimaced, so she provided an order for Tylenol 500 mg 3 x day, with a pain-relieving gel and x-rays to the left extremity. She stated the x-ray was not ordered as STAT because she was not aware there had been an unwitnessed fall and there was not reason to suspect a fracture. She added that the next day, on 5/4/2022, she was provided the results of the x-ray verbally during rounds and provided an order to transfer the Resident to an acute care hospital for further evaluation and treatment. An interview was conducted with the Medical Director (MD) on 5/18/2022 at 12:58 p.m. and he revealed his expectation for Resident #610 concerning the unwitnessed fall on 5/2/2022 at 5:00 p.m. was for a nurse to be notified at the time of the incident and an assessment conducted with MD notification to follow. He revealed the NP was notified verbally on 5/3/2022 by the day shift nurse during rounds and ordered diagnostic studies that included an x-ray. The MD added that he did not feel there was a concern with the delay in treatment because he needed to be scheduled, upon arrival at the hospital, for surgery.	F 580	regarding the follow up on X-Ray results and obtaining results from the Trident portal. Instructions for reference remain available at the Nurse's station. All licensed nurses have access to the Trident portal. License nurses follow up on the same shift if the X-Ray was obtained on their shift if no results they are to follow-up on the next shift. Abnormal results are to be called immediately to MD once received for further orders. Education complete date 5/20/2022 Effective 5/19/2022 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance Alleged Date of IJ Removal: 5/21/2022	

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An interview was conducted with the previous DON on 5/18/2022 at 1:31 p.m. and revealed she became aware Resident #610 had a fractured femur on 5/4/2022 when he was being transported to the hospital. She was informed by a unit manager from another unit via electronic communication. She added this was the first time she had been informed anything was going on with Resident #610.
She stated the assigned hall nurse, was Nurse #3 and the Nurse provided a statement that she had not been informed the Resident was discovered in the floor and had not conducted an assessment after the evening meal because it was the baseline for Resident #610 to go to bed after dinner. She added it was her expectation that the assigned hall nurse be informed of a fall immediately by any staff member that discovered a fall. This should be conducted prior to moving the resident to allow the nurse to conduct an assessment and then the physician should be notified and the standard practices after a fall should be implemented. She stated it was her expectation that night shift staff check for any updates on all outstanding lab work and x-ray results. She added that not following the facility process of sending all residents who fell to the emergency room for an exam, delayed Resident #610's diagnosis and treatment by 2 days. She added that the Administrator and the DON were not notified of this incident until the Resident was being transferred out of the facility and it was her expectation that the administrative team be updated on all unwitnessed falls, changes of condition and orders for diagnostic lab work that was a result of a change of condition.

Resident #610 was transferred from the facility to

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the emergency room on 5/4/2022 at 11:58 a.m.

A review of the emergency room Physician notes for the date of service, 5/4/2022 revealed Resident #610 was not in acute distress on examination but was not able to straighten his legs on examination. He was observed to keep his legs bent towards his torso. The Resident was found to have multiple traumatic injuries on imaging. These included a left femoral fracture, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma with a possible active extravasation (an uncommon cause of acute abdominal pain. It was an accumulation of blood in the sheath of the rectus abdominis, secondary to rupture of an epigastric vessel or muscle tear).

A review of the hospital discharge summary dated 5/11/2022 documented Resident #610 was admitted to the hospital on 5/4/2022. The trauma team managed the Resident by providing aggressive pain control. Orthopedic trauma was consulted for the left femur fracture and Resident #610 underwent a surgical procedure, on 5/7/2022. The Orthopedic spine team was consulted for the ligamentous injury at the C6-C7 level (cervical disc near the lower part of the neck near the top of the shoulder). The Resident was managed non operatively and fitted with a hard cervical collar.

The Administrator was notified of immediate jeopardy on 5/20/2022 at 12:50 p.m.

The facility provided a credible allegation of immediate jeopardy removal dated 5/20/2022.

An incident report, was completed on 5/4/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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5:00pm by the Director of Nursing, based on information obtained from facility staff regarding an event occurring on 5/2/22 where Resident #610, who was observed sitting on the floor beside his bed when staff entered his room to deliver the dinner tray. Resident #610 often preferred, to be seated on the floor, however he was unable to stand unassisted per his normal baseline. Two Nursing Assistants assisted with transferring resident #610 to be seated at the bedside for dinner. Both Nursing Assistants indicated Resident #610 did not appear to be in any distress and did not verbalize any complaints when he was assisted to side of bed. This occurrence was not reported to Nurse #1 as this was usual activity for Resident #610. Nurse #1 documented a late entry for Resident #610 on 5/4/2022 at 12:57PM, for the date of 5/3/2022, stating" the baseline activity tolerance is up ad lib and ambulatory without assistance, resident has not been ambulating this shift, he is lying in bed, he did sit up and eat breakfast and lunch on the side of the bed but continued to lay back in the bed after eating." On 5/3/2022 the Nurse Practitioner was in to assess the resident at the request of Nurse # 1 related to a new complaint of left leg pain and reduced mobility. The NP ordered bilateral x-rays of the hip, knee, and foot and Tylenol 5mg 3 x a day for pain x 7 days with Voltaren gel to bilateral knees. On 5/3/2022 at 11:58pm the x-ray result conclusion: acute left femoral neck fracture questioned, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma, further recommended repeat x-ray or computerized tomography (CT) scan. On 5/4/2022 at 11:58 am Nurse #2 received the x-ray results from 5/3/222 notified the Nurse Practitioner of the results from 5/3/2022 and received an order to transfer the resident to the

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Emergency Department for evaluation, transfer was arranged via ambulance. On 5/4/2022 the guardian was notified of the x-rays results and the order received to transfer to the Emergency Department.

Resident #610 was admitted to the hospital on 5/4/2022 with the diagnosis of left femur fracture, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma.

On 5/19/2022 the Nurse managers reviewed residents who have fallen during the last 30 days to validate that the MD had been notified any opportunities identified during this audit will be corrected by the Nurse Managers by 5/20/22.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The Staff Development Coordinator, Regional Director of Clinical Services, and Unit Managers educated Licensed Nurses regarding the requirement to complete and document a post fall nursing assessment to include requirements for notification of the Physician following an incident or change of condition and when receiving ordered lab and x-ray results. The Nurse Managers educated Nursing Assistants on the definition of a fall including a change of plane and to report falls and change in resident condition to the Licensed Nurse immediately. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. Education will be completed by 5/20/22 by the Nurse Managers.

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The Regional Director of Clinical Services educated the Nurse Management team and the Administrator regarding the clinical morning meeting process to include a review of residents with falls and change of condition, to validate completion and documentation of post fall nursing assessment and including notification of the MD and responsible party. This education was completed on 5/20/22.

The Staff Development Coordinator, Regional Director of Clinical Services, and unit managers educated Licensed Nurses regarding the follow up on X-Ray results and obtaining results from the Trident portal. Instructions for reference remain available at the Nurse's station. All licensed nurses have access to the Trident portal. License nurses follow up on the same shift if the X-Ray was obtained on their shift if no results they are to follow-up on the next shift. Abnormal results are to be called immediately to MD once received for further orders. Education complete date 5/20/2022.

Effective 5/19/2022 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 5/21/2022

Onsite validation was completed on 5/24/2022 through record review, staff, and resident interviews.

Staff were interviewed to validate in-service completion on post fall assessments and physician notification that included obtaining lab

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results. A review of the Staff Development Coordinators education logs was conducted and compared to the staff log. The facility immediate jeopardy removal was validated to be completed as of 5/21/2022.
2. Resident #607 was admitted to the facility on 8/24/2021. The resident's cumulative diagnoses included atrial fibrillation.

Resident #607's most recent Minimum Data Set (MDS) was a quarterly assessment dated 11/21/2021. The MDS revealed Resident #607 did not have intact cognitive skills for daily decision making. The MDS indicated Resident #607 received an anticoagulant medication on 7 out of 7 days during the look back period.

A review of Resident #607's Physician Orders included a medication order started on 1/23/2022 for Apixaban (an anticoagulant medication) 2.5 milligram tablet, given two times a day for atrial fibrillation.

A Nursing Progress Note written by Nurse #8 and dated 2/8/2022 at 8:30 P.M. read in part "Resident's lower extremities slid off left side of bed during incontinent care provided by assigned CNA. Large skin tears noted on bilateral lower extremities. Call placed to responsible party to make aware. Message left to call facility ASAP. MD will be notified. Writer cleansed wounds with normal sterile saline, applied Bacitracin, & wrapped both wounds with "Kerlix". Writer will contact "Wound Care Dir.", in AM. Denied pain. Will continue to monitor, closely."

An acute care Physician Note written by the Medical Director and dated 2/9/2022 read in part "Call was placed to her responsible party. A

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message was left to call the facility "ASAP." As per the note, MD will be notified (notification was not done to me until this morning). The writer cleaned the wound with normal saline. Bacitracin was applied. Also, the wounds were wrapped with Kerlix. "As per writer, they will contact the wound care doctor also in the morning." Wound care team assessed the patient on 02/09/2022 afternoon. They have noticed the patient does have skin tears to the right elbow, right knee, right inferior leg, and bilateral shins. Also noted bruising to the forehead which is light in color and bilateral hands and back of the left arm. The patient is chronically on blood thinners also. Treatment orders were initiated, and I was notified of the findings. I did examine the patient personally in the room after that finding with wound care team. The patient has been examined fully with the wound care team in the afternoon of 02/09/2022. At that time, decision was made to send the patient to the local emergency department for their evaluation and management and further definitive treatment. "

An interview was conducted with Nurse #8 on 5/18/2022 at 11:15 A.M. During the interview Nurse #8 revealed she was asked to go to Resident #607's room to assess her after a fall. During the interview Nurse #8 stated she left the Medical Director a message and he called back "right away".

An interview was conducted with the Medical Director (MD) on 5/18/2022 at 1:32 P.M. During the interview the MD revealed he was unaware Resident #607 had a fall on 2/8/2022 until he was contacted on 2/9/2022 by the Wound Care Director to assess a bruise on Resident #607's forehead. The MD stated had staff contacted him

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F 580	Continued From page 27 on 2/8/2022 and stated Resident #607 had a fall and was on an anticoagulant, he would have given orders to send Resident #607 to the emergency room for an evaluation. An interview was conducted with the Administrator on 5/19/2022 at 2:45 P.M. During the interview the Administrator stated when a resident had a fall at the facility, staff should have immediately contacted the medical director with resident medical information and information about the fall.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §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 review and staff interview the facility failed to code the minimum data set (MDS) accurately in the area of hospice for 1 of 1 resident sampled for hospice services. (Resident #83). The findings included: Resident #83 admitted to the facility on 10/6/21 and had a history of malignant neoplasm of prostate and bone. A review of the hospice plan of care (POC dated) 3/31/22 revealed start of care was 10/11/21 and certification period was 4/9/22-6/7/22. The Medical Director progress note dated 3/20/22 indicated Resident #83 was enrolled under	F 641	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility	6/17/22

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F 641	Continued From page 28 hospice care. Quarterly minimum data set (MDS) dated 4/13/22 revealed Resident #83 had moderate cognitive impairment and required extensive assistance with 1-person physical assist with bed mobility, toilet use extensive assistance with 2 persons assist with transfers and supervision with setup help with eating. On 5/19/22 at 1:09 pm an interview was conducted with MDS Nurse #1, and he stated the other MDS coordinator was on vacation, and she had coded the MDS dated 4/13/22. He indicated hospice should have been coded because Resident # 83 was on hospice. MDS Nurse #1 stated, "it must have been just an oversight." An interview was conducted on 5/20/22 at 5:30 pm with the Administrator and she stated she expected the MDS assessments to be coded accurately.	F 641	does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F641 1. Resident #83 quarterly MDS dated 4/13/22 was modified on 5/19/22 to reflect Hospice Services. 2. Residents with Hospice Services have been identified as having the potential to be affected. Residents receiving Hospice Services had their Minimum Data Set (MDS) reviewed by the MDS Coordinators on 6/15/22 to validate coding of Hospice Services per the Resident Assessment Instrument (RAI) Manual. 3. MDS Coordinators were educated on 6/15/22 by the Clinical Reimbursement Consultant on MDS coding of Hospice Services per the RAI Manual, if indicated. 4. Weekly for twelve weeks the MDS Coordinators will audit each resident on Hospice Services MDS to validate Hospice Services are coded per the RAI Manual. Results of the audits will be presented by the MDS Coordinator in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		6/17/22

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§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be

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F 655	Continued From page 30 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a baseline care plan within 48 hours of admission for 2 of 4 residents sampled for new admissions review. (Resident # 309 and Resident #659). 1. Resident #309 was admitted to the facility on 5/12/22 with diagnoses that included hemiplegia following cerebral infarction. Review of Resident #309's medical records on 5/18/22 revealed a baseline care plan had not been completed within 48 hours of the resident's admission. During an interview on 5/19/22 at 1:09 pm, MDS Nurse #1 communicated that the admitting nurse normally initiated the baseline care plan during admission. He could not locate the baseline care plan initiated within 48 hours of admission for Resident #309. During an interview on 5/20/22 at 5:30 pm with the Facility Administrator, she stated she expected the regulations to be followed and baseline care plans to be completed as required. 2. Resident #659 was admitted to the facility on 5/11/22 with diagnoses that included acute cerebrovascular insufficiency, aphasia, major depressive disorder, diabetes, hypertension, chronic kidney disease.	F 655	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F655 1. Residents #309 and #659 had their baseline care plans completed on 6/16/22. 2. Residents admitted in the last 30 days had their medical records reviewed by the Director of Nursing on 6/16/22 to validate completion of the baseline care plan. If	

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F 655	Continued From page 31 Review of Resident #659's medical records revealed no careplan on 5/17/22. During an interview on 5/18/22 at 10:04 am, the MDS Nurse #1 communicated that the admitting nurse normally initiated the baseline care plan during admission. He could not locate the baseline care plan initiated within 48 hours of admission for Resident #659. During an interview on 05/18/22 10:34 am with 400 floor Unit Manager, she stated Resident #659 did not have a careplan. The Unit Manager stated a baseline careplan should have been initiated upon admission for Resident #659. An interview was conducted on 05/18/22 12:46 pm with the Assistant Director of Nursing (ADON). She stated she expected nursing staff to have a careplan in order to provide care for Resident #659. She further stated the baseline care plan was supposed to be initiated and completed within 48 hours of a resident's admission. During an interview on 5/20/22 at 10:00 am with the Facility Administrator, she indicated a baseline care plan should have been completed within 48 hours of the resident's admission to effectively meet the needs of the resident.	F 655	the baseline care plan was not completed and there is not a comprehensive care plan in place, the Baseline Care Plan was completed at the time of the review. 3. The Unit Managers were educated by 6/21/22 by the Director of Nursing on completion of the Baseline Care plan within 48 hours of admission. 4. Weekly for twelve weeks the Unit Managers, Assistant Director of Nursing (ADON) or Director of Nursing (DON) will audit three new admissions a week to validate Baseline Care Plans are completed within 48 hours. Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 677 SS=G	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;	F 677		6/21/22

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F 677	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility failed to provide incontinence care (Resident #77, Resident #111), failed to provide clean and dry linens (Resident #77, Resident #111, Resident #610), failed to keep dependent residents' fingernails trimmed and clean (Resident #111), failed to shave a male resident (Resident #111) and failed to provide a shower (Resident #50) for 4 of 7 residents reviewed for activities of daily living (ADL) care. The findings included: 1. Resident #77 was admitted to the facility on 10/1/2019 with diagnoses that included congestive heart failure and hypertension. A review of Resident #77's quarterly Minimum Date Set dated 4/11/2022 revealed Resident #77 had intact cognition. The Resident was able to communicate her needs and had occasional incontinence of bowel and bladder. A review of Resident #77's care plan dated 4/11/2022 indicated that Resident #77 required extensive assistance of one staff member with bed mobility, dressing and personal hygiene. She was totally dependent on staff for toilet use. An observation of Resident #77 was conducted on 5/18/2022 at 5:28 a.m. and revealed a strong odor of urine. The Resident was lying on the right side of the bed, on her back, with no bed covering on her body. She had a bath blanket folded along the length of the blanket, under her torso and bottom. The blanket was dripping a wet substance onto the floor. There was not an incontinence pad. A puddle was observed under	F 677	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F677 1. Residents #77 and #111 are being provided incontinence management. Clean, dry linens are being provided to Residents #77, #111 and #610. Resident #111 is being provided nail care and is being shaved as needed. Resident #50 is being provided showers per her choice. 2. Residents who are dependent for ADL care have been identified as having the potential to be affected. On 6/9/22 observational rounds were conducted by	

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F 677	Continued From page 33 half of the bed, extending to the bedside table, the oxygen concentrator and to the wall. The Resident stated she was a heavy sleeper and required a brief at night in case she was incontinent and could not make it to the bedside commode. She said the staff, name unknown, told her they had trouble locating briefs in her size, a 4x, and they would return with one. She added this was at 11:30 p.m. on 4/17/2022 and no one returned. She said she fell asleep and woke up this morning drenched. She stated no one offered her assistance during the night until around 5:00 a.m. She said she would liked to have been offered assistance during the night instead of being left in the wet mess. She added that when the nursing assistant (NA) #9 came in to provide assistance she did not help her to clean up. The Resident then pointed to her peri care area, the private areas of a resident. She stated she felt very embarrassed when there was such a wet mess and someone had to clean the entire floor because she was not provided the items she needed for her episodes during the night. An interview was conducted on 5/18/2022 at 5:42 a.m. with Nurse #7, the hall nurse assigned to Resident #77. Nurse #7 stated she observed urine leaking from bed linens onto the floor with a puddle that was under the bed, under the bedside table and going towards the wall. She added the Resident had no top sheet or blanket. She revealed it was her expectation that when care was provided for a Resident, the Resident should have been provided clean sheets with a bariatric fitted sheet, peri care provided, and a blanket provided to the Resident. She revealed basic housekeeping needed to occur to the floor and the NA was responsible for this service since the	F 677	the Unit Managers or Nursing Administration on incontinent residents to validate provision of incontinence care, nail care, removing facial hair as needed, clean and dry linens and provision of showers per resident choice. 3. Certified Nursing Assistants were educated by 6/21/22 by the Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON) or Director of Nursing (DON), Unit Managers or Nursing Administration on provision of incontinence care, nail care, removing facial hair as needed, clean and dry linens and provision of showers per resident choice. After 6/21/22 Nursing Assistants will be educated on provision of incontinence care, nail care, removing facial hair as needed, and provision of showers per resident choice prior to the start of their next shift 4. Twice weekly for twelve weeks the Unit Managers, SDC, ADON, DON or Nursing Administration will audit two residents per unit a week to validate provision of incontinence care, nail care, removing facial hair as needed, clean and dry linens and provision of showers per resident choice. Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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housekeeping staff were not on duty yet. Nurse #7 stated she would immediately get a NA to help her provide assistance to the Resident.

An interview was conducted with NA#9 on 5/18/2022 at 5:50 a.m. and she stated she had been in around 5:00 a.m. to provide care to Resident #77. She stated peri care was not provided to Resident #77 and a clean sheet underneath the Resident was not provided. She stated she cleaned the floor and did not change the Resident because she said she could take herself to the bedside commode. The Resident spoke up and stated, "You did not clean the floor and I did not tell you that I did not need help this morning. You told me you were going to get linens." The NA then stated, well I am an agency NA and this was only my second day. I was going to clean the floor and get clean linens, but this was only my second night. No further comments were made, and she exited the room.

2. Resident #111 was admitted to the facility on 11/8/2021 with diagnoses that included Parkinson's disease, diabetes mellitus type 2, and muscle weakness.

A review of Resident #111's quarterly Minimum Data Set (MDS) dated 4/22/2022 revealed Resident #111 had moderate cognitive impairment. The Resident was able to communicate his needs to staff, was always incontinent of bowel and bladder and required extensive assistance of one staff member for bed mobility, personal hygiene and toileting.

A review of Resident #111's current care plan dated 4/22/2022 indicated a focused area that read:

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Resident #111 has an Activities of Daily living (ADL) self care performance deficit related to performance deficit. The interventions included the Resident requires assistance by staff for toileting, personal hygiene, and to turn and reposition.

An interview was conducted on 12:14 p.m. with Resident #111 and he stated he was wet and then held up the sheet and showed a saturated brief. The Resident was observed to have an orange substance on his face and beard. His nails were untrimmed with brown debris in the cuticle and under the nail. The Resident had scooted down the bed with his feet hanging off 6 inches and he stated, I want to get out of the wet diaper. His face was unshaven on the side with a goatee around the mouth. The unshaven area was 0.5 cm long. The sheet around the Resident had a large wet area with a strong urine odor. As the Resident moved around it was possible to observe the back of the brief and it was wet to the top of the brief. When asked if he could press the call light to call for assistance, he stated it was hard to press a call light with his tremors but he made the effort and successfully pressed the call light at 12:21 p.m.

On 5/17/2022 at 12:26 p.m. NA#11 entered Resident #111's room to respond to the call light and stated she would be back in a few moments with the necessary items to clean up the Resident.

On 5/17/2022 at 12:28 p.m. an observation of ADL care was conducted for Resident #111. NA #11 updated the Resident on what she was going to do. She pulled the privacy curtains, removed the soiled brief. The Resident was observed with

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a bowel movement and urine. She requested the Resident to roll to his side and an area of wet urine was around the lower area below his incontinence pad and on the incontinence pad. A large area covering the entire section under a draw sheet was wet with dried outer edges of yellow and brown discoloration. The NA stated she had checked on the Resident during rounds at 7:30 a.m. in the morning and he was dry at that time but she stated she did not check under the draw sheet or incontinence pad. She changed the sheets and provided a partial bed bath. She revealed she observed he needed to be shaved and his nails were dirty. She stated after lunch she would provide a shave and be sure his nails were trimmed. She stated it was the responsibilities of the hall nurse and the NA to trim fingernails.

3. Resident #610 was admitted to the facility on 3/2/2021 with diagnoses that included dementia, anxiety, seizures and ischemic heart disease.

The annual Minimum Data Set (MDS) dated 2/28/2022 documented Resident #610 had severe cognitive impairment and was rarely or never understood. Resident #610 required assistance of one staff with bed mobility, and personal hygiene and total assistance of one staff for toileting.

A review of the current care plan initiated 3/8/2021 had a focused area identified for daily living self care performance deficit related to dementia with interventions that included, the Resident requires assistance by staff with personal hygiene, The Resident requires assistance by staff for toileting, and anticipate and meet the Resident's needs.

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An observation was conducted on 5/18/2022 at 6:00 a.m. of Resident #610 lying in bed. The top sheet had a dried yellow stain and was covering half of the Resident. The bottom sheet had an area of dark yellow dried urine visible coming out from under the draw blanket. The draw blanket had dark areas that were wet and dried in other areas. On the right side of the Resident, a betadine wrapper was observed waded up, and a straw wrapper stuck to the Resident's side, on his skin, visible from the door way. The bedside table was not near the bed. The Resident's gown was stuck to his skin and moist.

An interview was conducted on 5/18/2022 at 6:02 a.m. with Nurse #6 and he revealed Resident #610 had received personal hygiene care during the morning rounds by the nursing assistant staff. He stated the reason the sheets were soiled was because the staff were waiting for clean linens to arrive to the floor. He lifted the Resident's gown and demonstrated a dry brief but stated he was unaware the Resident was lying on a wet draw sheet. When asked about the trash stuck to the Resident's skin he stated he was unsure how the trash got into the bed with the Resident because he could not walk to get the trash. He stated the betadine wrapper must have been left in the bed by accident by the nurse. He stated he would have staff change the sheets as soon as possible and get the Resident a clean gown and wash his skin off.

4. Resident #50 was admitted to the facility on 5/17/2021 with diagnoses that included chronic heart failure, atrial fibrillation, and schizoaffective disorder.

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A review of the comprehensive Minimum Data Set (MDS) dated 3/20/2022 revealed Resident #50 was cognitively intact and could communicate her needs to staff. On the interview for daily and activity preferences, the question, how important was it to the Resident to choose between a tub bath, shower, bed bath, or sponge bath, the Resident answered very important. The Resident required total dependence on one staff member for bathing.

The current care plan dated 5/15/2021 identified a focused area that read, Resident #50 has an ADL self care performance deficit related to impaired balance and limited mobility with interventions that included, the Resident required assistance by staff with bathing and showering as necessary and check nail length and trim and clean on bath day as necessary.

On 5/17/2022 a review of the electronic medical record for the bath history task list revealed documentation that the Resident received a shower on 4/20/2022 at 2:59 and on 5/9/2022 at 1:59 p.m. The Resident was documented to have had a full bed bath on 4/22/2022 at 11:51 a.m., 4/25/2022 at 1:12 p.m. and 5/6/2022 at 2:29 p.m.

An interview was conducted on 5/17/2022 at 12:53 p.m. with NA #10 when questioned about shower documentation, she revealed at this time, she was not able to complete showers as scheduled but would complete a bed bath on all of her people. She stated this was due to the staffing ratio on the unit. She revealed with the lay out of the unit, with the halls not able to be visualized from one hall to the next, and with dementia residents wandering into the day room, with three NAs on the total assignment, one

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would need to watch the day room area, one would be on one of the split hall and one on the other hall. She stated if they leave the hall to go to the shower room, it does not feel safe. She stated this had been expressed to the previous and current administrator. She added she could only complete about two assigned showers a day out of 5 or 6 assigned showers.

An interview was conducted on 5/17/2021 at 4:30 p.m. with Resident #50 and she revealed she loved to take a shower. She stated she was able to wash herself and give herself a shower if staff would set everything up. She stated the shower room was kept locked so she had to wait until staff were willing. She revealed she will walk up to the nursing station and request a shower and was usually provided some excuse why the staff cannot give her a shower. She added she usually just washed herself up at the sink and that staff do not assist her with this. She added that she had been to the shower room once in the past month that she could remember and when shown the documentation on the ADL task report she stated, that it was probably about right and then said, "isn't that sad." She stated not getting her showers makes her feel lousy and dirty. She went on to say taking a shower makes a person feel better and she was afraid she was now going to die dirty. She added that she had told the staff she preferred a shower over a bed bath or a sink bath and was not offered a shower and was not offered assistance.

An observation was observed on 5/17/2022 at 4:33 p.m. of Resident #50 with hair uncombed and greasy.

An interview was conducted with NA #12 on

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F 677	Continued From page 40 5/18/2022 at 9:13 a.m. and she demonstrated where the shower schedule was for the 500 hall. She stated she was an agency staff member and the shower schedule was demonstrated to her on the first day of orientation to the facility. She added she was aware of how and where to locate what residents receive a shower based on the location of this book and what was written inside. A review of the shower schedule book, on the 500 hall, revealed the A beds for the even rooms were scheduled on Monday, Wednesday and Friday for first shift and the B beds wound be on second shift of the same days. The odd rooms would be on Tuesday, Thursday and Saturday with the A beds on first shift and the B beds on second shift. Based on this, Resident #50 was in an even room in an A bed so she was assigned Monday, Wednesday and Friday for first shift.	F 677		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner (NP), Medical Director (MD), and radiology company interviews, the facility failed to assess Resident #610 after he was found on the floor and was unable to get up without assistance, as	F 684	This constitutes a written allegation of compliance. Preparation and submission of this allegation of compliance does not constitute an admission or agreement by the provider of	6/17/22

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he normally was able to do. Two nurse aides picked him up from the floor and put him in bed. The nurse was not informed. The next day, Resident #610 was prepared for a transfer by Social Worker Assistant #1 when Resident #610 was found in pain and had a swollen knee. An assessment was initiated, the Nurse Practitioner assessed, ordered x-rays and pain relievers. X-ray results were faxed to the facility late that night but were not seen until close to noon the following day. Resident #610 was diagnosed with a femur fracture, a spinal injury and a rectus sheath hematoma. A rectus sheath hematoma is an accumulation of blood in the sheath of the abdominus muscle. This deficient practice affected one of three residents reviewed for accidents.

Immediate Jeopardy began on 5/2/2022 when two staff picked up Resident #610 off the floor without reporting it to the nurse. Immediate jeopardy was removed on 5/21/2022 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimum harm that is not immediate jeopardy) to ensure the monitoring of the systems put into place and to complete facility employee training.

The findings included:

Resident #610 was admitted to the facility on 3/2/2021 with diagnoses that included dementia, anxiety, seizures, and ischemic heart disease.

The annual Minimum Data Set (MDS) dated 2/28/2022 documented Resident #610 had severe cognitive impairment, was rarely or never

the truth of the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. This allegation of compliance is prepared and submitted solely because of requirement under state and federal law, and to demonstrate the good faith attempts by the provider to continue to improve the quality of life of each resident.
An incident report, was completed on 5/4/2022 5:00pm by the Director of Nursing, based on information obtained from facility staff regarding an event occurring on 5/2/22 where Resident #610, who was observed sitting on the floor beside his bed when staff entered his room to deliver the dinner tray. Resident #610 often preferred, to be seated on the floor, however he was unable to stand unassisted per his normal baseline. Two Nursing Assistants assisted with transferring resident #610 to be seated at the bedside for dinner. Both Nursing Assistants indicated Resident #610 did not appear to be in any distress and did not verbalize any complaints when he was assisted to side of bed. This occurrence was not reported to Nurse #1 as this was usual activity for Resident #610. Nurse #1 documented a late entry for Resident #610 on 5/4/2022 at 12:57PM, for the date of 5/3/2022, stating "the baseline activity tolerance is up ad lib and ambulatory without assistance, resident has not been ambulating this shift, he is lying in bed, he did sit up and eat breakfast and lunch on the side of the bed but continued to lay back in the bed after eating." On 5/3/2022 the Nurse Practitioner was in to assess

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F 684	Continued From page 42 understood, and had disorganized thinking continuously present that did not fluctuate during the lookback period. The Resident required minimal assistance of one staff with bed mobility and supervised assistance of one staff with transfers, walking in the corridor and locomotion on the unit. He was assessed to be not steady when walking but able to stabilize without staff assistance. No range of motion impairments were identified. Resident #610 had not had a fall since the prior assessment. The current care plan, initiated 3/8/2021, revealed focused areas that included: Resident #610 had a risk of potential for injury from other residents with dementia, wandering and behaviors. Resident #610 was a wanderer related to diagnoses of dementia, episodes of wandering to other residents' rooms. Resident #610 was at risk for falls related to confusion, incontinence, and psychoactive drug use. The Resident specific interventions included: 1) Anticipate and meet the Resident's needs. 2) Report to the Medical Director changes in Resident's behavior. 3) Assess for fall risk. 4) Monitor, document, and report as needed any changes and declines in function. Resident #610's electronic medical record revealed no progress notes documented on the date of 5/2/2022.	F 684	the resident at the request of Nurse # 1 related to a new complaint of left leg pain and reduced mobility. The NP ordered bilateral x-rays of the hip, knee, and foot and Tylenol 5mg 3 x a day for pain x 7 days with Voltaren gel to bilateral knees. On 5/3/2022 at 11:58pm the x-ray result conclusion: acute left femoral neck fracture questioned, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma, further recommended repeat x-ray or computerized tomography (CT) scan. On 5/4/2022 at 11:58 am Nurse #2 received the x-ray results from 5/3/222 notified the Nurse Practitioner of the results from 5/3/2022 and received an order to transfer the resident to the Emergency Department for evaluation, transfer was arranged via ambulance. On 5/4/2022 the guardian was notified of the x-rays results and the order received to transfer to the Emergency Department. Resident #610 was admitted to the hospital on 5/4/2022 with the diagnosis of left femur fracture, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma. On 5/19/2022 the Nurse managers reviewed residents who have fallen during the last 30 days to validate documentation of post fall nursing assessment including range of motion and pain assessment, MD and Responsible party notification was completed. Any opportunities identified during this audit will be corrected by the Nurse Managers by 5/20/22.	

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F 684	Continued From page 43 A signed statement made by NA #1, written on 5/4/2022 and read, on 5/2/2022 NA#1 was passing out 500 hall dinner trays, as I was taking Resident #610 his tray, he was sitting in the floor. She sat the tray down and attempted to help him up but he was waving her off, so she asked another NA, NA #2, to assist her with helping pick him up to eat his food tray. After that, I saw Resident #610 walking on the hall before leaving my shift. A signed statement made by Nurse #3, dated 5/5/2022 read: On May 2, 2022 Nurse #3 was the nurse taking care of Resident #610 from 7a.m. through 11 p.m. Resident #610 took all of his medication without any complications. He appeared to be at his baseline the entire shift. No issues or any changes in Resident #610 were reported to me throughout the entire shift from 7 a.m. - 11 p.m. An attempt was made to interview the NA #1, NA #2 and Nurse #3 who worked on the evening of 5/2/2022, via telephone, unsuccessfully. An interview was conducted on 5/19/2022 at 2:44 p.m. with Social Worker Assistant #1 via telephone with the Social Worker present. The interview revealed on 5/3/2022, Social Worker Assistant #1 was responsible for transporting Resident #610 to a podiatry visit in another area of the facility. She stated upon arrival in the room, between 10:30 a.m. and 11:00 a.m., she discovered Resident #610 sitting on the side of the bed with his pants not pulled up. She said she requested an NA, name unknown, to assist her to pull up the Resident's pants. She revealed the Resident refused to stand up with their assistance and wanted to only stand on his right leg and not his left leg. He kept his left leg bent and grimaced	F 684	Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: The Staff Development Coordinator, Regional Director of Clinical Services, and unit managers educated Licensed Nurses regarding the requirement to complete and document a post fall nursing assessment to include range of motion and pain assessment prior to moving the resident. Education also included requirements for notification of the MD and Responsible Party following an incident. The Nurse Managers educated Nursing Assistants on the definition of a fall including a change of plane and to report falls to the Licensed Nurse immediately, prior to moving the resident. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. Education will be completed by 5/20/22 by the Nurse Managers. The Regional Director of Clinical Services educated the Nurse Management team and the Administrator regarding the clinical morning meeting process to include a review of residents with falls, to validate completion and documentation of post fall nursing assessment including Range of Motion and Pain assessment and notification of the MD and responsible party. This education was completed on 5/20/22 The Staff Development Coordinator,	

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THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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 684	Continued From page 44 when they tried to stand him up. She said he appeared to be in a lot of pain. She added at this point, they laid the Resident down and proceeded to provide peri care because it was discovered he was wet and in need of care. When on his back, he pulled both legs up like he was in a fetal position, made a face like a grimace and like he was in pain. She said when the NA and herself pulled his pants down, it was discovered the Resident had a swollen left knee. She then said she went immediately and informed the hall nurse (Nurse #1). She said she was aware to report all new findings to a nurse because she was previously an NA and that was standard practice. Resident #610's progress notes revealed a nursing note dated 5/3/2022 at 2:52 PM (documented on 5/4/2022 at 12:57 p.m. as a late entry) written by Nurse #1 that read: baseline activity tolerance was up ad lib and ambulatory without assistance. Resident has not been ambulating this shift. He has been lying in bed. He did sit up and eat his breakfast and lunch on the side of the bed but continued to lay back down after eating. The Nurse Practitioner (NP) was in to assess him, ordered x-rays of the left hip, the left knee and the left foot, a pain-relieving gel for bilateral knees and Tylenol 500 milligrams (mg) 3 x a day for pain for 7 days. Resident 610's Medication Administration Record for the month of May 2022 revealed an order dated 5/3/2022 for Tylenol 500 mg by mouth to be given three times a day for pain for 7 days. The medication was documented as administered on 5/3/2022 2:00 p.m. and 9:00 p.m. and on 5/4/2022 at 9:00 a.m. A review of the pain assessment using a scale of 0 to 10, with 0 being no pain and 10 being the worst pain ever,	F 684	Regional Director of Clinical Services, and unit managers educated Licensed Nurses regarding the follow up on X-Ray results and obtaining results from the Trident portal. Instructions for reference remain available at the Nurse's station. All licensed nurses have access to the Trident portal. License nurses follow up on the same shift if the X-Ray was obtained on their shift if no results they are to follow-up on the next shift. Abnormal results are to be called immediately to MD once received for further orders. Education complete date 5/20/2022 Effective 5/19/2022 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance Alleged Date of IJ Removal: 5/21/2022	

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revealed a documented pain level on 5/3/2022 of 4 out of 10.

The NP notes dated 5/3/2022 documented, Resident #610 was seen on 5/3/2022 at the request of Nurse #1 due to signs of pain in the left leg and not ambulating. The Resident's baseline was usually ambulating and today he was not walking around per usual and appears to be in pain per Nurse #1. Resident has dementia and therefore was unable to communicate his needs or cannot describe his pain. Pain was first noticed by Nurse #1 5/3/2022 in the a.m. The assessment revealed left leg pain with movement and bilateral knees with degenerative joint disease changes. Orders for x-rays to the left knee, hip and foot, Tylenol 500 mg 3 x day with a pain-relieving gel to bilateral knees.

The x-ray lab result dated 5/3/2022 at 10:58 p.m. revealed a result of a fracture of the left femoral neck with impaction. The conclusion read: Acute left femoral neck fracture questioned, recommended repeat x-ray or computerized tomography (CT) scan. The result had a large ALERT typed across the result.

A call was placed to Radiology company on 5/19/2022 at 10:55 a.m. and an interview was conducted with a staff member. He revealed the results of Resident #610 were faxed to the telephone number (336) 761-0703 on 5/3/2022 at 11:00 PM and an email sent to the facility that read, ALERT, in all capital letters across the front. He added that a staff member from the radiology company called the facility on 5/4/2022 at 11:52 a.m. and spoke to Nurse #2 to provide a report of the questioned fracture that required an additional x-ray or CT scan.

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Resident #610's nursing progress notes revealed a note on 5/4/2022 at 11:58 a.m. written by Nurse #2 and read: Received x-ray results from 5/3/2022. Notified the NP of results and new order noted to send to the emergency room for evaluation. 911 was called for transport of the Resident. A call was placed to Resident's guardian and notified of x-ray results and order to transfer. Emergency medical services on site for transport.

The NP progress notes for the date of service 5/4/2022 read, seen today at request of staff due to an abnormal left hip x-ray. X-ray revealed a left femoral neck fracture questioned and Resident will need an acute care evaluation in the emergency department. Resident was lying in bed, had been started on Tylenol 500 mg by mouth 3 x day. The Resident grimaces when the left lower extremity was flexed towards the body and repositioned.

An interview was conducted with the NP on 5/18/2022 at 3:39 p.m. and she revealed she received a verbal report during rounds on 5/3/2022 from the hall nurse, Nurse #1, on the 500 hall that Resident #610 appeared to be in pain during the nurses care that day. She added that during her assessment the left knee appeared to have degenerative joint changes, through physical palpitation. She consulted with the MD and informed him of the changes she had observed. She stated the Resident was nonverbal but grimaced, so she provided an order for Tylenol 500 mg 3 x day, with a pain-relieving gel and x-rays to the left extremity. She stated the x-ray was not ordered as STAT because she was not aware there had been an unwitnessed fall and

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there was not reason to suspect a fracture. She added that the next day, on 5/4/2022, she was provided the results of the x-ray verbally during rounds and provided an order to transfer the Resident to an acute care hospital for further evaluation and treatment.

An interview was conducted with the Medical Director (MD) on 5/18/2022 at 12:58 p.m. and he revealed his expectation for Resident #610 concerning the unwitnessed fall on 5/2/2022 at 5:00 PM was for a nurse to be notified at the time of the incident and an assessment conducted with MD notification to follow. He revealed the NP was notified verbally on 5/3/2022 by the day shift nurse during rounds and ordered diagnostic studies that included an x-ray. The MD added that he did not feel there was a concern with the delay in treatment because he needed to be scheduled, upon arrival at the hospital, for surgery. The MD revealed he requested the DON investigate what happened.

The facility incident report completed on 5/4/2022, for the date of 5/2/2022 at 5:00 PM, by the Director of Nursing (DON #1) documented per nursing assistant staff, Resident was observed sitting on the floor beside his bed when his dinner tray was brought in the room on 5/2/2022. Sitting on the floor was not an uncommon observation for resident but Resident did not get up out of the floor unassisted per his baseline as he normally would. Nursing assistant indicated another nursing assistant came in the room and assisted with transferring Resident to bedside to eat his dinner. Nursing assistants indicated Resident did not appear to be in any distress when he was assisted to the side of the bed, but this was not reported to the nurse.

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An interview was conducted with the DON #1 on 5/18/2022 at 1:31 p.m. and revealed she became aware Resident #610 had a fractured femur on 5/4/2022 when he was being transported to the hospital. She was informed by a unit manager from another unit via electronic communication. She added this was the first time she had been informed anything was going on with Resident #610. She stated she came into the facility immediately, investigated and was able to determine an unwitnessed fall occurred on 5/2/2022 that involved two nursing assistants, nursing assistant (NA) #1 and NA #2, two agency staff members. She stated the investigation revealed NA#1 discovered the Resident sitting in the floor beside his bed and went to get NA#2 to assist her to help Resident #610 up to the side of the bed for his evening meal tray. She provided directions of where her file of the statements from NA #1 was located. She stated the assigned hall nurse, was Nurse #3 and the Nurse provided a statement that she had not been informed the Resident was discovered in the floor and had not conducted an assessment after the evening meal because it was the baseline for Resident #610 to go to bed after dinner. She added it was her expectation that the assigned hall nurse be informed of a fall immediately by any staff member that discovered a fall. This should be conducted prior to moving the resident to allow the nurse to conduct an assessment and then the physician should be notified and the standard practices after a fall should be implemented. She stated it was her expectation that night shift staff check for any updates on all outstanding lab work and x-ray results. She added that not following the facility process of sending all residents who fell to the emergency room for an exam, delayed

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Resident #610's diagnosis and treatment by 2 days. She added that the Administrator and the DON were not notified of this incident until the Resident was being transferred out of the facility and it was her expectation that the administrative team be updated on all unwitnessed falls, changes of condition and orders for diagnostic lab work that was a result of a change of condition.

Resident #610 was transferred from the facility to the emergency room on 5/4/2022 at 11:58 a.m.

The emergency room Physician notes for the date of service, 5/4/2022 revealed Resident #610 was not in acute distress on examination but was not able to straighten his legs on examination. He was observed to keep his legs bent towards his torso. The Resident was found to have multiple traumatic injuries on imaging. These included a left femoral fracture, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma with a possible active extravasation (an uncommon cause of acute abdominal pain. It was an accumulation of blood in the sheath of the rectus abdominis, secondary to rupture of an epigastric vessel or muscle tear).

A review of the hospital discharge summary dated 5/11/2022 documented Resident #610 was admitted to the hospital on 5/4/2022. The trauma team managed the Resident by providing aggressive pain control. Orthopedic trauma was consulted for the left femur fracture and Resident #610 underwent a surgical procedure, on 5/7/2022. The Orthopedic spine team was consulted for the ligamentous injury at the C6-C7 (cervical disc near the lower part of the neck near the top of the shoulder) level which was managed non-operatively and fitted with a hard, cervical

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collar.

The Administrator was notified of immediate jeopardy on 5/19/2022 at 4:10 p.m.

The facility provided a credible allegation of immediate jeopardy removal dated 5/21/2022.

An incident report, was completed on 5/4/2022 5:00pm by the Director of Nursing, based on information obtained from facility staff regarding an event occurring on 5/2/22 where Resident #610, who was observed sitting on the floor beside his bed when staff entered his room to deliver the dinner tray. Resident #610 often preferred, to be seated on the floor, however he was unable to stand unassisted per his normal baseline. Two Nursing Assistants assisted with transferring resident #610 to be seated at the bedside for dinner. Both Nursing Assistants indicated Resident #610 did not appear to be in any distress and did not verbalize any complaints when he was assisted to side of bed. This occurrence was not reported to Nurse #1 as this was usual activity for Resident #610. Nurse #1 documented a late entry for Resident #610 on 5/4/2022 at 12:57PM, for the date of 5/3/2022, stating" the baseline activity tolerance is up ad lib and ambulatory without assistance, resident has not been ambulating this shift, he is lying in bed, he did sit up and eat breakfast and lunch on the side of the bed but continued to lay back in the bed after eating." On 5/3/2022 the Nurse Practitioner was in to assess the resident at the request of Nurse # 1 related to a new complaint of left leg pain and reduced mobility. The NP ordered bilateral x-rays of the hip, knee, and foot and Tylenol 5mg 3 x a day for pain x 7 days with Voltaren gel to bilateral knees. On 5/3/2022 at

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11:58pm the x-ray result conclusion: acute left femoral neck fracture questioned, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma, further recommended repeat x-ray or computerized tomography (CT) scan. On 5/4/2022 at 11:58 am Nurse #2 received the x-ray results from 5/3/222 notified the Nurse Practitioner of the results from 5/3/2022 and received an order to transfer the resident to the Emergency Department for evaluation, transfer was arranged via ambulance. On 5/4/2022 the guardian was notified of the x-rays results and the order received to transfer to the Emergency Department.

Resident #610 was admitted to the hospital on 5/4/2022 with the diagnosis of left femur fracture, a possible ligamentous injury with the cervical spine and a rectus sheath hematoma.

On 5/19/2022 the Nurse managers reviewed residents who have fallen during the last 30 days to validate documentation of post fall nursing assessment including range of motion and pain assessment, MD and Responsible party notification was completed. Any opportunities identified during this audit will be corrected by the Nurse Managers by 5/20/22.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The Staff Development Coordinator, Regional Director of Clinical Services, and unit managers educated Licensed Nurses regarding the requirement to complete and document a post fall nursing assessment to include range of motion

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and pain assessment prior to moving the resident. Education also included requirements for notification of the MD and Responsible Party following an incident. The Nurse Managers educated Nursing Assistants on the definition of a fall including a change of plane and to report falls to the Licensed Nurse immediately, prior to moving the resident. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff will receive education prior to the start of their shift. Education will be completed by 5/20/22 by the Nurse Managers.

The Regional Director of Clinical Services educated the Nurse Management team and the Administrator regarding the clinical morning meeting process to include a review of residents with falls, to validate completion and documentation of post fall nursing assessment including Range of Motion and Pain assessment and notification of the MD and responsible party. This education was completed on 5/20/22.

The Staff Development Coordinator, Regional Director of Clinical Services, and unit managers educated Licensed Nurses regarding the follow up on X-Ray results and obtaining results from the Trident portal. Instructions for reference remain available at the Nurse's station. All licensed nurses have access to the Trident portal. License nurses follow up on the same shift if the X-Ray was obtained on their shift if no results they are to follow-up on the next shift. Abnormal results are to be called immediately to MD once received for further orders. Education complete date 5/20/2022
Effective 5/19/2022 the Administrator will be responsible to ensure implementation of this

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F 684	Continued From page 53 immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 5/21/2022 Onsite validation was completed on 5/24/2022 through record review, and staff interviews. Staff were interviewed to validate in-service completion on post fall assessments and physician notification that included obtaining lab results. A review of the Staff Development Coordinators education logs was conducted and compared to the staff log. The facility immediate jeopardy removal was validated to be completed as of 5/21/2022.	F 684		
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 record review and staff interview, the facility failed to provide safe care to a dependent resident which resulted in the resident falling out of bed and substaining injuries. One staff repositioned Resident #607, who received anticoagulant medication, too close to the edge of the bed and Resident #607 slid off the bed. The resident was sent to the hospital and diagnosed with a left proximal humerus fracture, a fractured eye socket, and a mild scalp contusion. This	F 689	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility	6/21/22

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F 689	Continued From page 54 deficient practice affected 1 of 3 residents reviewed for accidents (Resident #607). Findings included: Resident #607 was admitted to the facility on 8/24/2021. The resident's cumulative diagnoses included atrial fibrillation, respiratory failure, presence of a pacemaker, generalized muscle weakness, and lack of coordination. The plan of care for Resident #607 included a focus area for potential risk for falls related to gait/balance problems and incontinence with an initiation and last revision date of 8/30/2021. Interventions included anticipate and meet the resident's needs, educate the resident/family/caregiver about safety reminders and what to do if a fall occurs. The care plan stated Resident #607 had a at risk for abnormal bleeding or hemorrhage due to anticoagulant use related to Apixaban use for atrial fibrillation with an initiation and last revision date of 8/30/2021. Interventions included monitor for signs of bleeding, call medical director for signs and symptoms of noted bleeding. Resident #607's most recent Minimum Data Set (MDS) was a quarterly assessment dated 11/21/2021. The MDS revealed Resident #607 did not have intact cognitive skills for daily decision making. The MDS indicated Resident #607 was assessed as extensive assistance from two staff members with bed mobility and transfers. Resident #607 required total assistance from one staff member with toileting and personal hygiene. The MDS further showed Resident #607 was always incontinent of bladder and bowel.	F 689	reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F689 1. On 2/8/22 Resident #607 was provided post fall assessment; care was rendered by a Licensed Nurse and Medical Doctor was notified. On 2/9/22 Resident #607 Medical Doctor was consulted, and Resident #607 was transferred to the Emergency Department for further evaluation. 2. Residents who are dependent for turning and repositioning in the bed have been identified as having the potential to be affected. On 6/9/22 observational rounds were conducted by the Unit Managers or Nursing Administration on residents who are dependent for turning and repositioning in the bed to validate the residents are not positioned too close to the edge of the bed. 3. Certified Nursing Assistants were educated on by 6/21/22 by the Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON) or Director of Nursing (DON), Unit Managers	

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F 689	Continued From page 55 A review of Resident #607's Physician Orders included a medication order started on 1/23/2022 for Apixaban (an anticoagulant medication) 2.5 milligram tablet, given two times a day for atrial fibrillation. A post fall review report dated 2/8/2022 completed by Nurse #8 indicated Resident #607 had a witnessed fall on 2/8/2022 at 8:30 P.M. The fall resulted in an injury of large unmeasurable skin tears noted on bilateral lower extremities. The report indicated Resident #607 was in her room in bed prior to the fall and Resident #607 was receiving incontinence care at the time of the fall. A Nursing Progress Note dated 2/8/2022 at 8:30 P.M. completed by Nurse #8 read in part "Resident's lower extremities slid off left side of bed during incontinent care provided by assigned NA. NA stated she made an attempt to avoid it, but resident continued to slide off bed. She landed in sitting position. Large skin tears noted on bilateral lower extremities. . . Writer cleansed wounds with normal sterile saline, applied Bacitracin (an ointment antibiotic used to prevent wound infections), & wrapped both wounds with "Kerlix"(rolled gauze used wrap around body part to cover open wounds). Writer will contact "Wound Care Dir.", in AM. Denied pain. Will continue to monitor, closely." A telephone interview was attempted with Nurse Aide (NA) #13 on 5/18/2022 at 12:24 P.M. The NA was unable to be reached. NA#13 was assigned Resident #607 at the time of the fall on 2/8/2022. An interview was conducted with NA #14 on	F 689	or Nursing Administration on turning and positioning residents who are dependent for bed mobility. After 6/21/22, newly hired and agency staff Certified Nursing Assistants will be educated on turning and positioning residents who are dependent for bed mobility prior to the start of their next shift by the Staff Development Coordinator. 4. Weekly for twelve weeks to include weekends the Unit Managers, SDC, ADON, DON or Nursing Administration will audit three residents per unit a week to validate residents who are dependent for bed mobility are not positioned too close to the edge of the bed. Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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5/20/2022 at 7:26 P.M. During the interview, NA #14 stated she completed rounds on 2/8/22 with NA #13 prior to the end of shift at 11 P.M. NA #14 stated she entered Resident #607's room with NA #13 and found Resident #607 lying in bed on her back. NA #14 stated when Resident #607 was checked, she was clean of incontinence; however, Resident #607 was found with bowel movement on her fitted bed sheet, and the sheet needed to be changed. NA #14 stated she left the room to get a clean fitted sheet and told NA #13 she would be right back. NA #14 stated when she returned to Resident #607's room with the fitted sheet, Resident #607 up on her side. NA #14 stated NA #13 repositioned Resident #607 too far onto her side and Resident #607 fell off the side of the bed away from the door and onto the floor. NA #14 stated when she walked to the side of the bed Resident #607 fell from, the resident was found lying beside the bed with blood on her legs. NA #14 stated she was unsure if Resident #607 hit her head when she fell. NA #14 stated she went to get the nurse, while NA #13 stayed with Resident #607. NA #14 revealed Resident #607's bed had been raised to the high position because there were two staff member present in the room to change the fitted sheet and NA #14 stated the other NA should have waited for her to return to the room before repositioning Resident #607. During the interview NA #14 further stated there was not a fall mat beside the bed and she did not recall the bed having a side rail. NA #14 stated Resident #607 slept through the night and did not voice any concerns of pain.

An interview was conducted with Nurse #8 on 5/18/2022 at 11:15 A.M. During the interview, Nurse #8 stated she was not assigned Resident #607 on 2/8/22, but an NA came to her hallway

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and told her Resident #607 had fallen from her bed. Nurse #8 stated she went to Resident #607's room and found Resident #607 sitting on the floor beside the bed. Nurse #8 indicated the NA told her Resident #607 started to slip when incontinence care was provided, and the NA was unable to stop Resident #607 from falling. Nurse #8 further revealed the NA stated Resident #607 had not hit her head when she fell from the bed and when Nurse #8 assessed Resident #607, she found skin tears on bilateral lower extremities. NA #8 revealed she did not see any bruising on her forehead. Nurse #8 stated she completed a fall report and contacted the MD. During the interview Nurse #8 revealed the NA should have waited for a second staff member before repositioning or turning Resident #607.

A Nursing Progress Note dated 2/9/2022 at 1:13 P.M. completed by the Wound Director read, in part, "Nursing Writer notified that resident had a fall with injuries. Into assess resident who had noted skin tears to right elbow, right knee, right inferior leg, and bilateral shins. Also noted with bruising to forehead, bilateral hands and back of Left arm. Treatment orders initiated and applied."

An interview was conducted with the Wound Director on 5/18/2022 at 11:50 A.M. During the interview, the Wound Director stated on 2/9/2022 she was asked to assess Resident #607's skin tears from a fall the previous evening. During the interview the Wound Director revealed there was blood on the sheets from "huge shearing skin tears" on Resident #607's shins, with no active bleeding. The Wound Director further stated Resident #607 had a bruise on her left arm, a skin tear on her right elbow, and a bruise on her forehead. The Wound director revealed Resident

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#607 stated she had fallen, and her head was hurting. The Wound Director stated due to Resident #607 having a fall and not knowing exactly what happened with the fall, she contacted the Medical Director who was in the building to assess Resident #607.

A Physician Progress Note dated 2/9/2022 completed by the Medical Director (MD) read, in part, "Wound care team assessed the patient on 02/09/2022 afternoon. They have noticed the patient does have skin tears to the right elbow, right knee, right inferior leg, and bilateral shins. Also noted bruising to the forehead which is light in color and bilateral hands and back of the left arm. The patient is chronically on blood thinners also. Treatment orders were initiated, and I was notified of the findings. I did examine the patient personally in the room after that finding with wound care team. At that time, decision was made to send the patient to the local emergency department for their evaluation and management and further definitive treatment. The patient did not endorse any pain or discomfort to me. At baseline, she was alert and oriented to herself. . . She did not endorse to me any headache."

An interview was conducted with MD on 5/18/2022 at 1:32 P.M. The MD stated he received a phone call from the Wound Director, who asked him to assess Resident #607. The MD stated when he arrived in Resident #607's room, he noticed bruising on her arm and her forehead. The MD revealed Resident #607 did not voice any concerns of pain, was alert, and answered his questions. During the interview the MD stated he was told by staff, Resident #607 slipped out of her bed while staff provided her with personal care. The MD further stated he felt there needed

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to be two staff members because there were no bars on her bed to prevent her from rolling out. During the interview the MD stated after his assessment and due to bruising on Resident #607's forehead, he felt she needed to be sent to the emergency department for further evaluation.

A Nursing Progress Note dated 2/9/2022 at 2:51 P.M. completed by Nurse #9 read, in part, "Resident visited by MD. Assessed injuries to forehead and bilateral lower extremities and bilateral upper extremities. Received new order to transfer resident to ED (emergency department) to evaluate and treat. . . Resident is in bed resting quietly."

Hospital records dated 2/8/2022 at 1:36 P.M. revealed history provided by Resident and EMS personnel, indicated Resident #607 present to the ED with a fall that occurred in unknown circumstances where the point of impact was the head. A physician exam was completed and showed a hematoma (a collection of blood outside the blood vessel) to frontal scalp, skin tears to the right upper extremity and bilateral lower extremities. The hospital records stated history was retrieved from Nurse #8 who stated Resident #607 was found with a hematoma to the forehead this morning, unclear cause with presumed fall from bed last night.

Hospital records indicated Trauma Surgery consulted to evaluate Resident #607 on 2/9/2022 at 1:07 P.M. The imaging results were as follows: computed tomography (CT) Spine showed a buidlup of fluid throughout the upper spine which may reflect ligamentous injury (an injury caused by an extreme motion) or sequelae of degenerative changes. CT of face revealed no

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F 689	Continued From page 60 evidence of acute facial fracture, a remote left orbital floor fracture (the bones of the eye socket floor buckled following a blaunt point of impact), and a mild right frontal scalp contusion (bruise). An orthopedic consult not dated 2/9/2022 at 2:32 P.M. revealed Orthopedics were consulted for a left fracture of the upper arm bone at the shoulder joint. Resident #607 had anticipated non-operative management with pain controlled in the ER. Resident #607 was placed in a sling for closed management of the fracture. An interview was conducted on 5/18/2022 at 3:39 P.M. with the Director of Nursing (DON) #2. During the interview, the DON stated she was unsure when she was notified Resident #607 had a fall. The DON stated she recalled as was standard procedure, Resident #607 was sent to the emergency department for further evaluation post fall due to being on blood thinners to ensure no acute issues had developed due to the fall. The DON stated staff should ensure resident safety was maintained when care was provided. An interview was conducted with the Administrator #2 on 5/20/2022 at 12:05 P.M. During the interview Administrator #2 revealed Resident #607 had a bad fall when she resided at the facility that resulted in a bruise on her forehead and the resident being sent to the emergency department for evaluation. Administrator #2 stated she was unaware of the specifics that lead to the fall.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		6/17/22

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F 692	Continued From page 61 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Registered Dietician (RD) interviews the facility failed to obtain weekly weights ordered by the physician for a resident with weight loss for 1 of 6 residents (Resident #23) reviewed for nutrition. The findings included: Resident #23 was admitted to the facility on 2/24/2022 with diagnoses that included a fracture of the facial bones, a lefort fracture, a fracture of the fifth cervical vertebra, cognitive communication deficit, anxiety, dysphagia, restlessness, and agitation. A review of the admission Minimum Data Set (MDS) dated 2/25/2022 revealed Resident #23	F 692	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical	

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F 692	Continued From page 62 had severe cognitive impairment and required total assistance from one staff member with eating. She had a height of 64 inches and a weight of 84 pounds (lb.) entered on the assessment. A review of the physician orders revealed an order dated 2/23/2022 for weekly weights x 4 weeks. A review of the electronic medical record for Resident #23 revealed the following weights: 2/23/2022 89.0 lbs. 2/24/2022 84.0 lbs. 4/6/2022 64.2 lbs. 4/26/2022 73.4 lbs. 5/6/2022 75.0 lbs. 5/19/2022 68.2 lbs. A review of the RD progress note for 3/14/2022 revealed the Resident was on a pureed diet with a thin liquid consuming 26-100% of her meals. She was wearing a cervical collar. She documented the readmission weight indicated significant weight loss and unsure of the accuracy, so she requested the Resident be re-weighed and that weekly weights be ordered for monitoring. The Residents labs were reviewed. A supplement was ordered that of 237 milliliters of a fortified nutritional supplement three times a day due to being underweight and weight loss. Staff to document the percentage of intake of the supplement to monitor acceptance. A review of the RD progress note for 4/1/2022 revealed there was no new weight documented in the Resident's chart since the last RD assessment and with an underweight body mass	F 692	examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F692 1. On 5/19/22 and 5/24/22 Resident #23 had weekly weights obtained. On 5/29/22 Resident #23 was discharged from the facility and has not returned. 2. Residents with physician orders for weekly weights have been identified has having the potential to be affected. As of 6/9/22 weekly weights are being obtained for the identified residents. 3. On or before 6/21/22 Unit Managers were educated by the Director of Nursing (DON) to ensure weekly weights are obtained per MD order. 4. Weekly for twelve weeks the Assistant Director of Nursing (ADON) or DON or Nursing Administration Designee will audit residents with physician's orders for weekly weights to validate weights were obtained per physician's order. Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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index of 14.0, weekly weights were ordered to monitor. The Resident remains on a pureed diet with thin liquids consuming only a fair amount by mouth of her meals.

A review of the RD progress note for 5/13/2022 read, ongoing RD referral due to Resident presents with an underweight body mass index of 12.5%. Weekly weights ordered to monitor. A referral has been placed to a gastroenterologist for a placement of a feeding tube per the responsible party request as of 5/11/2022. The Resident was on a pureed diet with thin liquids consuming 26 - 75% by mouth with most meals. One meal refusal was reported in the past 14 days. She had a poor appetite reported but received encouragement from staff. She continued to receive a fortified nutritional supplement three times a day. A new recommendation was made to add a frozen nutritional treat twice a day at lunch and dinner and document intake to monitor acceptance.

An interview was conducted with the RD on 5/20/2022 at 3:06 p.m. and she revealed she identified a need for the correction of obtaining weights at the facility because the admission, readmission and weekly weights were not being obtained. She stated she had expressed this on a report to the administrative team, that included the previous Director of Nursing and the Administrator, that there was an issue with the staff not following weighing residents as ordered.

An interview was conducted with the Director of Nursing (DON) #1 on 5/20/2022 at 3:40 p.m. and she revealed the RD had expressed a concern with not receiving weights on admission or as recommended for weekly and monthly weights.

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F 692	Continued From page 64 She stated that it was the responsibility of the assigned staff to ensure the weights were obtained and submitted to the administrative team on the date ordered by the Physician.	F 692		
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 review, observations and staff and resident interviews the facility failed to follow Physician's orders for administering supplemental oxygen therapy for 1 of 1 resident (Resident #44). The findings included: Resident #44 was admitted to the facility on 03/04/22 with a diagnosis of respiratory failure. A review of the Physicians order dated 03/04/22 revealed Resident #44 to have oxygen therapy at 3 liters per minute every 24 hours. A review of Resident #44 minimum data set (MDS) assessment dated 03/17/22 indicated Resident #44 was cognitively intact and utilized oxygen therapy. A review of Resident #44 care plan dated	F 695	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or	6/17/22

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F 695	Continued From page 65 03/24/22 revealed a focus of heart failure with a goal to minimize complications. Interventions were put into place to assisted Resident #44 with meeting the goal such as applied oxygen therapy as ordered by the Physician. Review of the Medication Administration Record (MAR) for May 2022 revealed there was no entry for the administration of oxygen for Resident #44. Observations conducted on 05/16/22 at 2:32pm revealed Resident #44 was lying in bed with a nasal cannula in her nose attached to a concentrator which was at 5 liters per minute. Resident #44 was alert and oriented and did not appear to be in distress. Observations conducted on 05/17/22 at 1:42pm revealed Resident #44 was lying in bed with a nasal cannula in her nose attached to a concentrator which was at 5 liters per minute. Resident #44 was alert and oriented and did not appear to be in distress. Observations conducted on 05/18/22 at 12:15pm revealed Resident #44 was lying in bed with a nasal cannula in her nose attached to a concentrator which was at 5 liters per minute. Resident #44 was alert and oriented and did not appear to be in distress. An interview conducted with Resident #44 on 05/18/22 at 12:15pm stated she does not touch her oxygen concentrator or adjust the settings. Resident #44 further stated that Nursing does check the concentrator, but this does not occur daily. Interview conducted with a Nurse #4 on 05/18/22	F 695	criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F695 1. Resident #44 is currently receiving oxygen per physician order. 2. Residents with physician orders for oxygen have been identified has having the potential to be affected. On 6/9/22 the Respiratory Therapist made observational rounds on residents with physician orders for oxygen to validate oxygen was being delivered per physician order. 3. On or before 6/21/22 Licensed Nurses were educated by the Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON) or Director of Nursing (DON), Unit Managers or Nursing Administration Designee to ensure residents with physician's orders for oxygen receive the oxygen per physician's order. 4. Weekly for twelve weeks the ADON, DON or Nursing Administration Designee will audit three residents with physician's orders for oxygen to validate oxygen is being provided per physician's order. Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 695	Continued From page 66 at 12:30pm stated he was assigned to care for Resident #44 on 05/18/22. Nurse #4 stated that Resident #44 oxygen order did not show in the medication administration record and therefore would not alert him to check the rate. Interview conducted with the interim Director of Nursing on 05/19/22 at 9:30am stated she expected Nurses to follow Physicians orders.	F 695		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and the staff interviews the facility failed to have a Registered Nurse scheduled for 8 hours a day, 7 days a week for 1 (04/16/22) of 30 days reviewed. Findings included: A review of the Nursing schedule dated 04/01/22 through 04/30/22 revealed no scheduled Registered Nurse on 04/16/22	F 727	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility	6/17/22

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THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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F 727	Continued From page 67 An interview conducted with the Scheduler on 05/18/22 at 11:00am stated there should have been a Registered Nurse scheduled on 04/16/22. The Scheduler stated she worked with staff agencies to ensure coverage and that she likely overlooked the schedule for 04/16/22. An interview conducted with the interim Director of Nursing on 05/18/22 at 11:30am stated she expected the facility to have a Registered Nurse employed for 8 hours a day, 7 days a week. An interview conducted with the Administrator on 05/19/22 at 1:00pm stated she expected the Scheduler to staff a Registered Nurse for 8 hours per day, 7 days a week.	F 727	reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F727 1. The facility has a minimum of eight Registered Nurse hours per day. 2. Residents residing in the facility have the potential to be affected. 3. On or before 6/21/22 the Scheduler was educated by the Director of Nursing (DON) to ensure a Registered Nurse is scheduled eight consecutive hours daily. 4. Weekly for twelve weeks the Nursing Home Administrator (NHA), Assistant Director of Nursing (ADON) or Director of Nursing (DON) or Nursing Administration Designee will audit the nursing schedule and actual hours worked to validate eight consecutive hours of Registered Nurse coverage per day. Results of the audits will be presented by the NHA or DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		6/17/22

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F 732	Continued From page 69 by: Based on observations and staff interviews, the facility failed to post the daily staffing schedule on 05/16/22, 05/17/22 and 05/18/22 for 3 of 5 days reviewed (5/16/22 through 5/20/22). Findings included: Observations conducted of the lobby and resident halls on 05/16/22 at 11:00am revealed no daily staffing schedule posted. Observations conducted of the lobby and resident halls on 05/17/22 at 11:00am revealed no daily staffing schedule posted. Observations conducted of the lobby and resident halls on 05/18/22 at 9:00am revealed no daily staffing schedule posted. During an interview conducted with the Scheduler on 05/18/22 at 10:00am, she stated it is her responsibility to post the daily staffing schedule in the front/back lobby and on resident halls by the elevator. The Scheduler stated she had not posted the daily staffing schedule due to construction. An interview conducted with the interim Director of Nursing on 05/18/22 at 10:15am stated she expected the daily staffing schedule to be posted regardless of current construction.	F 732	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F732 1. The facility is currently posting the staffing hours daily. 2. Residents residing in the facility have the potential to be affected. 3. On 6/21/22 the Scheduler was educated by the Nursing Home Administrator (NHA) to post the staffing hours daily. 4. Weekly for twelve weeks the NHA or Department Manager designee will audit the Staffing Hours Posting to validate hours are posted. Results of the audits	

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F 732	Continued From page 70	F 732	will be presented by the NHA in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 803 SS=C	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 803		6/21/22

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F 803	Continued From page 71 Based on observations, staff interviews and record reviews, the facility failed to follow the planned menu and document an approved menu substitution made during one of one meal observation conducted. This practice affected all residents receiving a regular-textured, mechanically-altered, or pureed diet. The findings included: A review of the dietary menu for Week 1 of the facility ' s cycle menu revealed the residents were to receive buttered green beans on 5/17/22 for lunch in addition to fish, rice, and a dinner roll. An observation of the noon meal on 5/17/22 revealed the residents were served spinach instead of the planned green beans as their vegetable. An interview was conducted on 5/17/22 at 11:30 AM with the Certified Dietary Manager (CDM). During the interview, the CDM reported spinach was served as the vegetable because green beans did not come in with their regularly scheduled food order received on 5/16/22. During a follow-up interview conducted on 5/18/22 at 12:15 PM, the CDM was asked if she utilized a menu substitution book or log where she would record any changes made to the menu (such as a menu substitution) and document the consultant Registered Dietitian's (RD's) approval for the substitution. She reported she did not. An interview was conducted on 5/18/22 at 12:30 PM with the Regional Culinary Director. Upon inquiry, the Director printed a copy of a "Menu Substitution Log" typically used by the corporate	F 803	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F803 1. The facility is currently following the planned menu or documenting an approved menu substitution if needed. 2. Residents residing in the facility who receive meals from the dietary department have the potential to be affected. 3. On 5/18/22 the Certified Dietary Manager was educated by the Regional Culinary Director on utilizing a menu substitution log which contained information that was to be documented. The following information was to be included on the Men Substitution log	

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F 803	Continued From page 72 service contracted to provide dietary services to the facility. The Menu Substitution Log indicated the following information was to be documented: Date, Meal, Planned Menu Item, Menu Item Substitution, Approved By, and Reason for Substitution (Optional). A follow-up interview was conducted on 5/18/22 at 2:08 PM with the CDM and the Regional Culinary Director. During the interview, the concern regarding menu substitutions being made without documentation and RD approval was discussed. The Director reported he would expect the Dietary Department to follow the process set forth by the contracted corporation. He stated if the product planned on the menu was not on hand, the CDM should call the consultant RD and explain the situation, tell her what was available for substitution, and inquire as to whether or not the substitution was of an equal nutritional value. If the RD approved the substitution, it would be recorded on the substitution log. If the RD happened to be in the building, she could record the menu substitution herself. Otherwise, the RD could sign off on the menu substitution the next time she was in the building. An interview was conducted on 5/18/22 at 5:00 PM with the facility's Administrator. During the interview, the Administrator reported she agreed with the expectation expressed by the Regional Culinary Director. The Administrator stated she would add an expectation to "ensure the residents would be informed" of menu substitutions made.	F 803	includes, date, meal planned, menu item substitution, and approval from the Registered Dietician. On or before 6/21/22 the Certified Dietary Manager educated dietary staff on the process and required documentation for meal substitutions. Effective 6/21/22 the Registered Dietician will be notified electronically by the Certified Dietary Manager for approval prior to utilizing meal substitutions. 4. Starting on 6/21/22 the NHA will monitor meal substitutions to include the log and Registered Dietician approval weekly x 8 weeks to include weekends, and then monthly x 2. Results of the audits will be presented by the NHA in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6)	F 807		6/17/22

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F 807	Continued From page 73 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to provide fresh ice water for 1 of 1 resident reviewed for fluid preferences. (Resident #73) The findings included: Resident # 73 admitted to the facility on 11/8/21 and had a history of chronic kidney disease, cerebral infarction, chronic obstructive pulmonary disease, type 2 diabetes mellitus, hemiplegia, and hypertension. Quarterly MDS dated 4/10/22 revealed Resident # 73 was cognitively intact and required dependent assistance with 2-person physical assist with bed mobility, transfers, limited assistance with 1-person physical assist with eating, dependent assistance with 1-person physical assist with toilet use. A review of care plan dated 10/30/18 and currently in place revealed Resident #73 had a potential for fluid deficit related to diuretic use. The goal was Resident would be free of symptoms of dehydration. Interventions included, administer medications as ordered, encourage the resident to drink fluids of choice, lab work: blood urea nitrogen (BUN), creatinine, monitor	F 807	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F807 1. Resident #73 is currently being provided fresh ice and water. 2. Residents residing in the facility who	

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F 807	Continued From page 74 and document intake and output as per facility policy, monitor vital signs as ordered/per protocol and record, notify Medical Director (MD) of significant abnormalities, monitor/document bowel sounds and frequency of bowel movement, monitor/document/report to MD as needed, signs and symptoms of dehydration, obtain and monitor lab/diagnostic work as ordered, report results to MD and follow up as indicated. During tour of facility on 5/16/22 at what time an observation was made of Resident #73 ' s room without any fluids, water, or water pitcher/cup available to Resident. On 5/16/22 at 11:57 am an interview was conducted with Resident # 73, and she indicated the facility does not provide water/fluids like they should. Resident stated, "They don't bring water regularly and sometimes I ask for it and don ' t get it." An interview was conducted with NA #3 on 5/20/22 at 1:12 pm, and he indicated styrofoam cups of water with ice were to be passed out to residents on each shift and he was not sure why Resident # 73 did not have any fluids in the room. An interview was conducted with facility Administrator on 5/20/22 at 5:30 pm and she stated she expected the residents to be offered fresh water and ice at least once a shift.	F 807	can be drink water and have ice have the potential to be affected. The Unit Managers made rounds on 6/9/22 to validate the identified residents have fresh water and ice available. 3. On or before 6/21/22 the Certified Nursing Staff was educated by the Staff Development Coordinator (SDC), Assistant Director of Nursing (ADON) or Director of Nursing (DON), Unit Manager or Nursing Administration to offer fresh water and ice to residents who are able to be drink water and have ice. 4. Weekly for twelve weeks the Unit Managers, SDC, ADON or Nursing Administration Designee will audit three residents per week on each unit to validate fresh water and ice is being offered to residents who are able to be drink water and have ice. Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at	F 809		6/21/22

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F 809	Continued From page 75 regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff and consultant Registered Dietitian (RD) interviews and record review, the facility failed to obtain resident group approval for greater than 14 hours to elapse between the provision of a substantial evening meal and breakfast the following day for residents residing on 4 of 4 resident hallways (the 500 Hall, 200 Hall, 300 Hall, and 400 Hall). The findings included: A review of the facility ' s "Meal Service Times - Citadel Winston" indicated the meal cart delivery times were scheduled as follows: --The two meal carts for the 500 Hall were scheduled to be delivered at 4:45 PM and 5:00 PM for Dinner and at 7:45 AM and 8:00 AM for Breakfast (indicative of a 15 hour time span between the two meals); --The two meal carts for the 200 Hall were	F 809	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or	

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F 809	Continued From page 76 scheduled to be delivered at 5:15 PM and 5:30 PM for Dinner and at 8:15 AM and 8:30 AM for Breakfast (indicative of a 15 hour time span between the two meals); --The two meal carts for the 300 Hall were scheduled to be delivered at 5:45 PM and 6:00 PM for Dinner and at 8:45 AM and 9:00 AM for Breakfast (indicative of a 15 hour time span between the two meals); --The two meal carts for the 400 Hall were scheduled to be delivered at 6:15 PM and 6:30 PM for Dinner and at 9:15 AM and 9:30 AM for Breakfast (indicative of a 15 hour time span between the two meals); An interview was conducted on 5/17/22 at 2:20 PM with the facility's Activities Director (AD). During the interview, the AD reported she had worked at the facility for the past 10 years and was responsible for assisting Resident Council with their monthly meetings. When asked if she could recall whether or not the Resident Council had discussed the scheduling of the facility's meal times, she stated they had not. Upon further inquiry, the AD reiterated the Resident Council had not reviewed meal times, approved a change in meal times, or approved an extended period of time between meals as long as she had worked with them. The AD stated she did not need to review past meeting minutes to confirm this as she was certain she would have recalled the Resident Council discussing the meal schedule if it had occurred. A telephone interview was conducted on 5/17/22 at 4:20 PM with the facility's consultant Registered Dietitian (RD). The RD reported she began consulting to the facility in May of 2020. When asked about the facility's meal schedule	F 809	criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F809 1. The facility is currently serving meals with less than fourteen hours between the dinner and breakfast meals. 2. Residents residing in the facility who receive meals from the dietary department have the potential to be affected. 3. On 5/18/22 the Nursing Home Administrator educated the Certified Dietary Manager on lapse of meal time between substantial evening meal, and next day breakfast meal should not be greater than 14 hours, and that if it is greater than 14 hours, resident council must approve. On 5/18/22 the Certified Dietary Manger adjusted meal times to ensure the time between the substantial evening meal and next day breakfast was not greater than 14 hours. On or before 6/21/22 Dietary Staff was educated by the Nursing Home Administrator (NHA) to serve the meals with less than 14 hours between the dinner and breakfast meals per meal times as reviewed and approved by Resident Council. The Certified Dietary Manger will ensure current dietary staff members have been educated on the new meal times on or before 6/21/22. 4. The NHA or designee will audit the meal delivery times of (3) meals weekly (to include weekends) x8 and then monthly x2 to validate meals adhere to the new times with less than 14 hours between dinner and breakfast. Results of	

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THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(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 809	Continued From page 77 allowing greater than 14 hours to elapse between the provision of a substantial evening meal and breakfast the following day, the RD stated she had not been asked about the meal schedule at the facility but was aware of the regulation pertaining to the scheduling of meals. The RD reported she was not aware of any meal scheduling changes made since she had consulted to the facility. An interview was conducted on 5/17/22 at 4:45 PM with the facility's Certified Dietary Manager (CDM). During the interview, the CDM was asked if she had adjusted the meal schedule since she came to the facility approximately 4 weeks ago. The CDM stated she had not changed the scheduled meal cart delivery times. The 15-hour time span noted between the evening meal and breakfast meal of the following day was then discussed. The CDM was informed the Activities Director had reported Resident Council has not discussed nor addressed an extended span of time between the evening and breakfast meals (as required by the regulations). The CDM stated she was not aware that was a problem but commented there were snacks available for the residents in the nourishment room on each floor. An interview was conducted on 5/17/22 at 5:10 PM with the facility's Administrator. During the interview, the failure of the facility to provide meals within a time span specified by the regulations was discussed. The Administrator reported she was relatively new at the facility and had worked here for approximately 4 weeks (same as the CDM). She provided reassurance the identified concern would be addressed.	F 809	the audits will be presented by the NHA in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to: 1) seal, label/date, and/or discard expired food items in 1 of 1 walk-in cooler; 2) seal and label/date opened food items in 1 of 1 dry storage rooms; 3) seal and/or label/date opened food items stored in 1 of 1 walk-in freezer; 4) label/date opened food items and/or discard expired food in in 4 of 4 nourishment rooms (200 Hall, 300 Hall, 500 Hall and 400 Hall), keep the ice machines clean and free of gray residue (mold buildup) inside the machine in 2 of 4 nourishment rooms (500 Hall nourishment room and 400 Hall nourishment room), and keep 1 of 4 nourishment room refrigerators maintained with the proper	F 812	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a	6/21/22

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temperature (400 Hall nourishment room); and 5) keep the kitchen vents and fans, floor, and food service equipment clean within the Dietary Department. These practices had the potential to effect food served and distributed to all residents.

The findings included:

1. Accompanied by the Certified Dietary Manager (CDM), an initial tour of the kitchen was conducted on 5/16/22 at 10:55 AM. Observations made of the walk-in cooler identified the following concerns:
--A 1/4 food pan of pureed beef stored in the cooler was not dated.
--A full-size food pan of coleslaw was not labeled with either a prepared or discard date;
-- One large prep bowl of vanilla pudding was covered with plastic wrap but was not labeled with either the date it was prepared or an expiration date;
--One -16 ounce container of beef base was opened but not dated with the date opened or the shortened expiration date;
--Three (3)-quart containers of a pasteurized egg product were opened but not dated with either an opened date or labeled with a shortened expiration date;
--A 1-inch stack of ham was partially wrapped in plastic wrap directly above the bottom shelf in the cooler. When picked up, the meat leaked juices. It was noted boxes of quart-sized containers of pasteurized eggs were located directly below the ham on the bottom shelf in the cooler. The ham was not dated as to what it had been opened and/or would be expired.
--A full-size food pan of cooked beef was only partially covered with plastic wrap in the walk-in cooler. The pan of beef was not labeled or dated

waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents
F812
1. The Dietary Manager discarded food items that were expired, improperly stored or improperly labeled in the Dietary Department and in the Nourishment Rooms on 5/17/22. Each ice machine in the facility was cleaned by on 5/17/22. The 400 Hall Nourishment Refrigerator was replaced on 5/17/22. The kitchen fans, floor and food service equipment was cleaned by the Dietary Manager on or before 6/17/22. Kitchen is scheduled to be deep cleaned on 7/3/22.
2. Residents residing in the facility who receive meals from the Dietary Department, or the nourishment refrigerators have the potential to be affected.
3. On or before 6/21/22 Dietary Staff was educated by the Nursing Home Administrator (NHA) to store food items in a sealed, labeled container and to discard expired food items in the Dietary Department and Nourishment Refrigerators on or before the expiration date, to check the ice machine weekly for cleanliness, to check the Nourishment Refrigerators temperatures daily and to keep kitchen vents, fans, floor and food

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F 812	Continued From page 80 as to when it had been prepared or when it needed to be discarded; --A full pan of pasta salad partially covered with plastic wrap was not labeled or dated as to when it had been prepared or when it needed to be discarded; --A 1/8-size food pan of applesauce was dated 5/9/22 with a use by 5/12/22 date (expired); --A small bowl containing tomato soup was dated 5/9/22 (expired). An interview was conducted with the CDM during the tour of the walk-in cooler on 5/16/22 at 10:55 AM. At that time, the CDM reported all food items in the walk-in cooler needed to be covered, labeled and dated. Both undated food items and expired foods needed to be discarded. The CDM was observed as she removed the undated and expired foods from the walk-in cooler. 2. Accompanied by the Certified Dietary Manager (CDM), an initial tour of the kitchen was conducted on 5/16/22 at 10:55 AM. Observations made of the dry goods storeroom identified the following concerns: --A 1-inch high package of tortillas were observed to be opened and wrapped in plastic. The tortillas were not dated as to when the package had been opened. --A 10-pound box of lasagna noodles was opened with the flaps of the box open enough to view the contents of the box, leaving the noodles open to air. The noodles were not wrapped in plastic. When asked, the CDM reported this was "not ok" and they would need to be discarded. --A 50-pound bag of sugar (nearly full) was opened. The opening of the bag was approximately 8-inches wide leaving the sugar unsealed and open to the air. Upon inquiry, the	F 812	service equipment clean. Effective 6/21/2022 Staff development coordinator educated current nursing staff on labeling and dating items in nourishment refrigerator. Items that are not labeled and dated will be discarded appropriately. 4. Weekly for twelve weeks to include random weekends the NHA, Dietary Manager or Department Manager designee will conduct observational audits to validate food items are stored in a sealed, labeled container, expired food items in the Dietary Department and Nourishment Refrigerators are discarded on or before the expiration date, ice machine cleanliness, Nourishment Refrigerators temperatures are within the acceptable range and kitchen vents, fans, floor, and food service equipment clean. Weekly for twelve weeks NHA will inspect kitchen to ensure cleanliness. Results of the audits will be presented by the NHA in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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CDM stated she had seen this bag earlier and needed help to get it off of the shelf to discard it.
--A 10-pound box of graham cracker crumbs were observed to be stored with its inner plastic liner visibly open, exposing the graham cracker crumbs to the air. The graham cracker crumb box was not dated.

An interview was conducted with the CDM during the tour of the dry goods storeroom on 5/16/22 at 10:55 AM. At that time, the CDM reported all food items in the dry goods storeroom needed to be sealed, labeled and dated. Undated and unsealed food items needed to be discarded. The CDM was observed as she removed the undated and unsealed foods from the storeroom.

3. Accompanied by the Certified Dietary Manager (CDM), an initial tour of the kitchen was conducted on 5/16/22 at 10:55 AM. Observations made of the walk-in freezer identified the following concerns:
--One opened, unsealed, undated bag of a cauliflower/broccoli/carrots mix (approximately 5 pounds) was stored open to the air in the freezer;
--One box with an opened and unsealed plastic bag contained approximately 10-count of omelets. A second opened and unsealed plastic bag contained approximately 30-count cheese omelets. The omelets were open to air in the freezer. Upon consultation with the CDM, the omelets in both plastic bags appeared discolored with possible freezer burn;
--Approximately 4 pounds of French fries were stored in an opened and unsealed plastic bag in the freezer (not dated);
--Approximately 12 pieces of fish patties were stored in an opened and unsealed plastic bag open to air in the freezer. The bag was not

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dated;
--Approximately 20-count hot dogs were stored in an opened and unsealed plastic bag which was open to air in the freezer. The same plastic bag also contained approximately 20-count of hamburger patties. The bag was labeled or not dated.

An interview was conducted with the CDM during the tour of the walk-in freezer on 5/16/22 at 10:55 AM. At that time, the CDM reported all food items in the walk-in freezer needed to be sealed, labeled and dated. Undated and unsealed food items needed to be discarded. The CDM was observed as she removed the undated and unsealed foods from the freezer.

4-a. An observation was made of the 200 Hall Nourishment Room on 5/16/22 at 12:34 PM. The refrigerator was observed to contain a partially eaten fruit platter with two plastic forks stored inside the container. The container's label read, "sell by 5/6/22." The fruit platter was not labeled with a resident's name.

4-b. An observation was made of the 300 Hall Nourishment Room on 5/16/22 at 12:48 PM. The refrigerator was observed to contain one fruit-on-bottom yogurt container with a manufacturer expiration date of 4/17/22 (not labeled with a resident ' s name); 4-smoothie cups stored in the bottom crisper section of the refrigerator with an expiration date of 2/14/22 (not labeled with a resident ' s name); and 1/2 of an opened 12-ounce broccoli cheddar soup container (not dated as to when it was opened). The soup was not labeled with a resident's name.

4-c. An observation was made of the 500 Hall

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Nourishment Room on 5/16/22 at 1:10 PM. The refrigerator was observed to store two, 2-ounce covered cups containing a brown liquid (not dated or labeled with a resident ' s name); and ½ of an undated container with a casserole-appearing food item. The container was labeled with a first name only (not the first name of a resident on the floor).

The observation of the 500 Hall Nourishment Room on 5/16/22 at 1:10 PM also included the ice machine. A gray substance appearing to be a mold buildup was seen on the plastic shield inside the ice machine.

4-d. An observation was made of the 400 Hall Nourishment Room on 5/16/22 at 1:25 PM. A dial thermometer inside the refrigerator had a reading of 60 degrees Fahrenheit (o F). The contents of the refrigerator included two opened 46-ounce containers of thickened juice. The manufacturer instructions printed on the container indicated once opened, the product should be refrigerated. The bottom crisper drawer of the refrigerator contained a partially eaten bucket of fried chicken with 3 pieces remaining in the bucket. The bucket was labeled and dated for a resident (dated 5/10/22). Additionally, an undated container containing 3 pieces of chicken, a small salad with a white creamy dressing was stored in the refrigerator. This container was labeled with a name (not a resident); it was not dated.

The observation of the 400 Hall Nourishment Room on 5/16/22 at 1:25 PM also included the ice machine. A gray substance appearing to be a mold buildup was seen on the plastic shield inside the ice machine.

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Accompanied by the Certified Dietary Manager (CDM), a follow-up observation was conducted on 5/16/22 at 3:40 PM of the 400 Hall Nourishment Room refrigerator. At the time of this observation, the temperature of the refrigerator was 70 degrees Fahrenheit. The CDM stated she would report the refrigerator ' s failure to adequately cool to the Administrator and be sure servicing of the refrigerator would be done. The CDM was observed as she discarded the food stored in this nourishment refrigerator.

A review of the 400 Hall Nourishment Room "Refrigeration Checklist" posted on the front of refrigerator was conducted. The temperatures were recorded twice daily and included a morning (AM) and afternoon/evening (PM) reading as follows:
--On 5/1/22 AM = 49 o F; PM = 50 o F.
--On 5/2/22 AM = 50 o F; PM = 51 o F.
--On 5/3/22 AM = 49 o F; PM = 49 o F.
--On 5/4/22 AM = 44 o F; PM = 50 o F.
--On 5/5/22 AM = 43 o F; PM = 45 o F.
--On 5/6/22 AM = 44 o F; PM = 48 o F.
--On 5/7/22 AM = 48 o F; PM = 49 o F.
--On 5/8/22 AM = 48 o F; PM = 48 o F.
--On 5/9/22 AM = 46 o F; PM = 44 o F.
--On 5/10/22 AM = 48 o F; PM = 40 o F.
--On 5/11/22 AM = 46 o F; PM = 48 o F.
--On 5/12/22 AM = 48 o F; PM = 48 o F.
--On 5/13/22 AM = 42 o F; PM = 41 o F.
--On 5/14/22 AM = 48 o F; PM = 60 o F.
--On 5/15/22 AM = 48 o F; PM = 72 o F.
--On 5/16/22 AM = 48 o F; PM = 58 o F.
A notation on the checklist read, "Temperature must be maintained at or below 41o F." Only two (2) of the 32 recorded temperatures documented thus far for May met the parameter of being at or below 41o F.

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A follow-up interview was conducted with the facility's Certified Dietary Manager (CDM) on 5/16/22 at 4:10 PM. During the interview, the CDM reported the undated and expired food stored in the Nourishment Room refrigerators needed to be discarded. When asked, the CDM stated the Maintenance Department was responsible for the ice machine. Nursing staff were responsible to check the temperatures of the nourishment refrigerators and to log them in on the "Refrigeration Checklist" posted on the front of refrigerator. The CDM stated the Dietary Department staff was responsible to discard any food items expired (or not labeled) in the nourishment room refrigerators and she would have expected this to have been done.

5. An observation was made on 5/17/22 from 9:20 AM to 9:55 AM of the facility's Dietary Department. The facility's Regional Culinary Director was present during the time of the walk-through observation. Concerns were identified related to the facility's failure to keep the kitchen vents and fans, ceiling and floor, and food service equipment clean as follows:
--The ceiling above the prep sink and prep table were noted to have multiple dark brown spots of debris.
--The front of the toaster (including the knobs) had light to dark brown spots which were tacky to touch.
--The cords, electrical plugs, and plug covers behind the toaster and food processor had multiple splatters of a sticky tan/brown substance over them.
--An air exchange filter in the corner of the kitchen (located above and between the toaster and deep fat fryer) had black and dark brown

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substances stuck on the grates.
--A gas connection and tubing located behind the deep fat fryer and gas stove were covered with a heavy coating of grease and debris throughout its length.
--The floor under the deep fat fryer and gas stove each had an area approximately 18 inches in diameter with a dark brown, greasy appearing coating on the floor.
--The grease tray of the gas stove could not be pulled open more than 3-4 inches. The grease tray was observed to be full of a charred black substance which appeared to prevent the tray from being pulled out. Additionally, the sides and handles of the gas oven had multiple areas of tan, brown and black sticky substances/debris on them. Upon inquiry, the Regional Culinary Director reported the gas stove and oven, "needs some detailing."
--A large white exhaust system had a heavy layer of a gray substance on all surfaces. This substance could be partially wiped off with a paper towel. Clean stainless preparation equipment (bowls, pans) were stored under this exhaust system.
--A wire rack stored to the left of the 3-compartment sink contained food pans and large baking sheets. The wire shelves on the rack were coated with a grease build-up that was tacky to the touch.
--The floor under the 3-compartment sink and prep sinks had a rust-colored substance and brown and black debris.
--The front plastic guard inside the ice machine in the kitchen was missing one of three screws to anchor it in place. Both sides of the ice machine were observed to have a buildup of a dark tan substance.
--The stainless steel table holding the coffee

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machine had two shelves underneath containing unused coffee filters and disposable cups. The inside back of the stainless steel shelving appeared dirty with a brown and tan substance on its surface.
--The vent runs on the ceiling of the kitchen exposed 3 vents. The vents themselves were covered with a black/brown substance on the grates. The surface of the runs were observed to have multiple spots and areas of a dark gray substance.
--Approximately 6 inches of the floor molding around the perimeter of the dish room was missing. The entire exposed surface was black and wet.

An observation was made on 5/17/22 at 12:57 PM of the Maintenance Staff Member #1 and Maintenance Staff Member #2 as they cleaned the sides of the ice machine in the kitchen. Upon his request, an interview was conducted with Maintenance Staff Member #1 at that time. The staff member reported the insides of all ice machines in the nourishments rooms had been thoroughly cleaned after two ice machines were identified as having visible mold inside of them. He reported he had not been previously aware it was the Maintenance Department's responsibility to clean the ice machines. However, he assured the surveyor the ice machines would be taken care of from this point going forward.

An observation was conducted on 5/17/22 at 1:55 PM of the dish room in the presence of the Regional Culinary Director and the Certified Dietary Manager (CDM). During the observation, the air vent on the clean side of the dish machine had a significant amount of black substance coating the vertical slats. The fan on the clean

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side of the dish machine had a screen (filter) covering its outer surface with a thick gray buildup on the entire surface of this filter.

The Regional Culinary Director was observed on 5/17/22 at 1:57 PM as he showed Maintenance Staff Member #1 the dirty vent and fan located on the clean side of the dish machine. The maintenance staff member reported he would have to take the vent slat cover down to scour it clean and he could remove and clean or replace the filter (screen) on the fan unit.

A review of the Dietary Department's "Weekly Cleaning Schedule for May 2022 was conducted. The cleaning schedule designated individual cleaning tasks and the Responsible Party for completion of each task.

An interview was conducted on 5/17/22 at 4:45 PM with the facility's CDM. When asked, the CDM reported she utilized approximately 72 staff hours each day. Upon further inquiry, the CDM reported she felt she had an adequate number of hours allotted for her dietary staff to meet the needs of the residents' and the tasks associated with the department (including cleaning tasks).

An interview was conducted on 5/17/22 at 5:10 PM with the facility's Administrator During the interview, the Administrator was informed of the concerns identified in the Dietary Department and Nourishment Rooms. Concerns expressed included cleaning/sanitation in the kitchen and nourishment rooms. The Administrator reported she was relatively new at the facility and had worked here for approximately 4 weeks (same as the CDM). She provided reassurance the concerns identified would be addressed.

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F 812	Continued From page 89 A follow-up interview was conducted on 5/18/22 at 5:00 PM with the Administrator. During the interview, the Administrator reported she would expect the Dietary Department to have a cleaning schedule, stick to that schedule, and make sure all the areas were cleaned and sanitized. She added the Dietary Department needed to follow all of the company's and facility's policies and procedures, as well as the Health Department and Centers for Medicare and Medicaid Services (CMS) regulatory guidelines.	F 812		
F 835 SS=G	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility administration failed to provide effective oversight and leadership to ensure residents were treated with dignity and respect during care and to maintain a supply of adult briefs to meet the needs of residents (Resident #77 and Resident #53). The facility administration additionally failed to provide effective oversight and leadership to ensure residents received incontinence care, nail care and bathing (Resident #77, Resident #111 and Resident #50) and were provided with clean and dry linens (Resident #77, Resident #111 and Resident #610). This was evident for 2 of 12 residents reviewed for dignity, 2 of 2 residents	F 835	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a	6/17/22

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F 835	Continued From page 90 reviewed for accommodation of needs and 4 of 19 residents reviewed for activities of daily living Findings Included: This tag is cross-referenced to: 1. F550 - Based on observations, record review, staff and resident interview the facility failed to treat residents who required assistance with incontinence care in a dignified manner. Resident #77 expressed feelings of embarrassment because she did not have on a brief, was wet and had no linen on her bed. Resident #53 expressed feelings of embarrassment because the staff used 2 briefs and a towel to manage her incontinence because the facility did not have the correct size brief for her. This was evident for 2 of 8 residents reviewed for dignity. 2. F558 - Based on observations, record reviews, resident and staff interviews, the facility failed to provide the proper size briefs for 2 of 3 residents reviewed for accommodation of needs (Resident #53 and Resident #77). This resulted in the residents expressing they felt bad and embarrassed. 3. F677 - Based on observations, record review, staff and resident interviews the facility failed to provide incontinence care (Resident #77, Resident #111), failed to provide clean and dry linens (Resident #77, Resident #111, Resident #610), failed to keep dependent residents' fingernails trimmed and clean (Resident #111), failed to shave a male resident (Resident #111) and failed to provide a shower (Resident #50) for 4 of 7 residents reviewed for activities of daily living (ADL) care.	F 835	waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents F835 1. The Facility Administration will provide increased oversight on direct care including provision of dignity and respect, incontinence management including appropriate size brief, provision of clean and linen, nail care, shaving facial hair and bathing, to validate needs are being met including resident rights, accommodation of needs and provision of activities of daily living. 2. Residents residing in the facility have the potential to be affected. 3. On or by 6/21/22 Department Managers and the Nursing Leadership Team were educated by the NHA to provide increased supervision and observations, within their respective scope of practice, of provision of dignity and respect, incontinence management including appropriate size brief, provision of clean and linen, nail care, shaving facial hair and bathing, to validate needs are being met including resident rights, accommodation of needs and provision of activities of daily living. On 6/13/22 the Nursing Home Administrator (NHA) implemented a Customer Service Program which includes Department	

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F 835	Continued From page 91	F 835	Managers or Nursing Leadership Team meeting with each resident two times weekly to perform observation audits and / or inquiries about provision of dignity and respect, incontinence management including appropriate size brief (observations for Nursing Leadership), provision of clean and linen, nail care, shaving facial hair and bathing (observations for Nursing Leadership), to validate needs are being met including resident rights, accommodation of needs and provision of activities of daily living. Any concerns from the observations or inquiries will be placed on a Concern Form and the Director of Nursing (DON) and NHA will be notified immediately for follow up / corrective action. 4. Weekly for twelve weeks the NHA will review the results of the Customer Service Audits. Results of the audits will be presented by the NHA in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 867 SS=H	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced	F 867		7/14/22

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F 867	Continued From page 92 by: Based on observations, record review, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 4/27/21. This was for 4 deficiencies that were cited in the areas of Resident Rights / Exercise of Rights (F550), Reasonable Accommodation of Needs / Preferences (F558), Provision of activities of daily living (ADLs) for dependent residents (F677) and Food procurement, storage, preparation and service under sanitary conditions (F812) on 4/27/21 and recited on the current recertification and complaint survey of 5/24/22. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint survey conducted on 7/29/19. This was evident for 1 deficiency in the area of Maintaining Essential Equipment in Safe Operating Condition (F908) originally cited on the recertification and complaint survey on 7/29/19 and recited on the current recertification and complaint survey of 5/24/22. The duplicate citations during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag is cross referenced to: 1.F550 - Based on observations, record review, staff and resident interview the facility failed to treat residents who required assistance with incontinence care in a dignified manner. Resident	F 867	Corrective actions. On or before June 21, 2022 the Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding F550, F 5667 and F812. Corrective action for those potentially affected. On or before June 21, 2022, the Regional Director of Operations educated the Nursing Home Adminsitrator on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identify issues and correct deficiencies related to F550 and F812, and F667. Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review of rounding tools, daily review of Point Click Care documentation, and observation during leadership rounds. Systemic Changes. On or before June 21, 2022, the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Support Nurses, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, , Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision	

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F 867	Continued From page 93 #77 expressed feelings of embarrassment because she did not have on a brief, was wet and had no linen on her bed. Resident #53 expressed feelings of embarrassment because the staff used 2 briefs and a towel to manage her incontinence because the facility did not have the correct size brief for her. This was evident for 2 of 8 residents reviewed for dignity. During the recertification and complaint survey 4/27/21 the facility failed to provide a dignified dining experience by talking on a cell phone while aiding with feeding for 1 of 8 residents (Resident #114) reviewed for dining. An interview with the Administrator on 5/24/22 at 5:15 pm revealed she was new to the facility and had only been there for 4 weeks. She stated she was not aware of any active QAPI (quality assurance and performance improvement) plans in place at the facility. She added the facility had conducted one QA meeting since she had started, and the committee was determining what areas needed to have a QAPI plan. 2. F558- Based on observations, record reviews, resident and staff interviews, the facility failed to provide the proper size briefs for 2 of 3 residents reviewed for accommodation of needs (Resident #53 and Resident #77). This resulted in the residents expressing they felt bad and embarrassed. During the recertification and complaint survey 4/27/21 the facility failed to ensure 1 of 35 residents (Resident #118) reviewed for call light accessibility was able to reach their call light. Resident #118 was unable to reach for his call light due to left sided weakness and contracture	F 867	needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. Quality Assurance. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the facility's progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions	

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F 867	Continued From page 94	F 867		

of the left hand.

An interview with the Administrator on 5/24/22 at 5:15 pm revealed she was new to the facility and had only been there for 4 weeks. She stated she was not aware of any active QAPI (quality assurance and performance improvement) plans in place at the facility. She added the facility had conducted one QA meeting since she had started, and the committee was determining what areas needed to have a QAPI plan.

3.F677 - Based on observations, record review, staff and resident interviews the facility failed to provide incontinence care (Resident #77, Resident #111), failed to provide clean and dry linens (Resident #77, Resident #111, Resident #610), failed to keep dependent residents' fingernails trimmed and clean (Resident #111), failed to shave a male resident (Resident #111) and failed to provide a shower (Resident #50) for 4 of 7 residents reviewed for activities of daily living (ADL) care.

During the recertification and complaint survey 4/27/21 the facility failed to provide a dependent resident with assistance with eating for 2 of 6 residents (Resident #114 and Resident #129) reviewed for activities of daily living.

An interview with the Administrator on 5/24/22 at 5:15 pm revealed she was new to the facility and had only been there for 4 weeks. She stated she was not aware of any active QAPI (quality assurance and performance improvement) plans in place at the facility. She added the facility had conducted one QA meeting since she had started, and the committee was determining what

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F 867	Continued From page 95 areas needed to have a QAPI plan. 4.F812 - Based on observations, staff interviews and record reviews, the facility failed to: 1) seal, label/date, and/or discard expired food in 1 of 1 walk-in cooler; 2) seal and label/date opened food items in 1 of 1 dry storage rooms; 3) seal and/or label/date opened food items stored in 1 of 1 walk-in freezer; 4) label/date opened food items and/or discard expired food in in 4 of 4 nourishment rooms (200 Hall, 300 Hall, 500 Hall and 400 Hall), keep the ice machines clean and free of gray residue (mold buildup) inside the machine in 2 of 4 nourishment rooms (500 Hall nourishment room and 400 Hall nourishment room), and keep 1 of 4 nourishment room refrigerators maintained with the proper temperature (400 Hall nourishment room); and 5) keep the kitchen vents and fans, floor, and food service equipment clean within the Dietary Department. These practices had the potential to effect food served and distributed to all residents During the recertification and complaint survey 4/27/21 the facility failed to ensure 7 of 15 dishware were dry before stacked and ready for use. The facility additionally failed to discard 26 of 30 expired milk cartons stored in 1 of 2 refrigeration units. These practices had the potential to affect food served to residents. An interview with the Administrator on 5/24/22 at 5:15 pm revealed she was new to the facility and had only been there for 4 weeks. She stated she was not aware of any active QAPI (quality assurance and performance improvement) plans in place at the facility. She added the facility had conducted one QA meeting since she had	F 867		

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F 867	Continued From page 96 started, and the committee was determining what areas needed to have a QAPI plan. 5.F908 - Based on observations and staff interviews, the facility failed to maintain 1 of 1 food steamer, 1 of 1 upright food warmer, and 2 of 2 lowerator plate warmers in safe operating condition During the recertification and complain survey 7/29/19 the facility failed to maintain one of one walk-in refrigerator in operating condition. An interview with the Administrator on 5/24/22 at 5:15 pm revealed she was new to the facility and had only been there for 4 weeks. She stated she was not aware of any active QAPI (quality assurance and performance improvement) plans in place at the facility. She added the facility had conducted one QA meeting since she had started, and the committee was determining what areas needed to have a QAPI plan.	F 867		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883		6/21/22

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F 883	Continued From page 97	F 883		

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical

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F 883	Continued From page 98 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to offer the influenza and pneumococcal vaccine and include documentation in the resident's medical record of education or vaccination status for the influenza or pneumococcal vaccination for one (Resident #20) of five residents reviewed for the influenza and pneumococcal vaccinations. The findings included: The facility Influenza Vaccination policy implemented on 11/1/2020 read in part "Influenza vaccinations will be routinely offered annually from October 1st through March 31st, unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine". The facility Pneumococcal Vaccine (Series) policy implemented on 11/1/2020 read in part "Each resident will be offered a pneumococcal immunization" and "The resident's medical record shall include documentation that indicates at a minimum, the following: The resident received the pneumococcal immunization or did not receive due to medical contraindications or refusal". 1. Resident #20 was admitted to the facility on 11/19/2021. The resident's cumulative diagnoses included diabetes. A review of the resident's most recent quarterly Minimum Data Set (MDS) assessment dated 2/22/2022 indicated Resident #20 influenza	F 883	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F883 1. On 12/19/21 Resident #20 declined the pneumonia vaccine. Resident #20 physician declined to order the flu vaccine at this time. 2. Residents residing in the facility who are eligible for flu and pneumonia vaccines have been identified and have the potential to be affected. Eligible residents were offered the pneumonia vaccine on or before 6/21/22 by the	

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F 883	Continued From page 99 vaccine was not received and was noted as "resident not in this facility during this year's influenza vaccination season". The MDS indicated the pneumococcal vaccine was not up to date and was noted as "not offered". A review of Resident #20's medical record revealed there was no documentation to indicate whether the resident received or refused the influenza vaccine or the pneumococcal vaccine. An interview was conducted on 5/20/2022 at 10:13 A.M. with the Staff Development Coordinator (SDC). During the interview the SDC stated she was responsible for identifying newly admitted residents that needed vaccines. The SCD revealed she reviewed a list of newly admitted resident daily, and within the first week of admission, she followed up with residents that were missing vaccinations. The SDC stated she provided residents with immunization information and consent forms. The SDC stated after discussing the vaccinations with each resident or their responsible party, then she updated the resident's medical record to reflect their decision about the offered vaccines. During the interview the SDC stated Resident #20 was admitted to the facility when staff were changing roles, and his vaccination status was not addressed. During the interview the SDC further stated based off Resident #20's admission date, he should have been offered the influenza and pneumonia vaccines. An interview was conducted on 5/20/2022 at 5:30 P.M. with the Administrator. During the interview, the Administrator stated the vaccination status for new admissions should be validated during the admission process and residents should be	F 883	Infection Preventionist. The residents that were offered the pneumonia vaccine were educated by the Infection Preventionist, and the education is documented under the Immunization tab in the EHR. Dr. Grover, medical director decided not to administer the flu vaccine due to the fact that the best coverage is for the vaccine to be administered early during the flu season, and flu season has ceased. 3. On or before 6/21/22 the Infection Preventionist and Unit Managers were educated by the Director of Nursing to offer flu and pneumonia vaccines as indicated, and upon admission and to provide the resident or resident responsible party with education on the vaccine. The education provided on the vaccine should be documented under the Immunization tab in the EHR. The Infection Preventionist will be responsible for tracking vaccines. Residents that consented for the pneumonia vaccine have been scheduled for administration by the Infection Preventionist. 4. On 6/21/22 the Director of Nursing will conduct audits weekly x8 and then monthly x2 to validate new admissions have been offered the pneumonia vaccine and flu vaccine, and the education for the vaccine is documented under the immunization tab in the EHR. Results of the audits will be presented by the NHA in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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F 883	Continued From page 100 offered any vaccines they have not already received. The Administrator revealed the resident's medical records should accurately reflect the resident's vaccination history.	F 883		
F 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)	F 888		6/21/22

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F 888	Continued From page 101 (1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;	F 888		

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F 888	Continued From page 102 (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19.	F 888		

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F 888	Continued From page 103 Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to implement the facility's process for tracking COVID-19 vaccination status for four of four laborer construction staff (Laborer #1, Laborer #2, Laborer #3, and Laborer #4). The findings included: The facility Employee COVID-19 Vaccination Appendix: Actionable Checklist read "Develop list of licensed practitioners, students, volunteers, and contract employees (including Next Level, Adaptive, agency, construction staff) that work in the facility and request verification of vaccination status from vendor. Vendor must be able to produce required documentation upon request. The due date read 11/26/2021 and the date of completion was documented as 11/26/2021. The facility's Healthcare Personnel COVID-19 Vaccination line list provided by the Infection Control Preventionist on 5/17/2022, showed the names of 2 supervisory construction staff who were fully vaccinated. The list did not include vendor contracted laborer construction staff.	F 888	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F888	

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F 888	Continued From page 104 The facility was in outbreak status with one positive staff member identified on 5/16/2022 and no resident was positive with COVID-19. During an observation made on 5/19/2022 at 11:16 A.M. of the first-floor common corridor area. This area was the corridor used to connect the main entrance of the building to elevators required to be used by all persons entering the building to travel to one of the five floors of the facility. Laborer #1 and Laborer #2 were observed wearing masks while they worked on the floor space in front of the elevators. Laborer #1 and Laborer #2 were observed moving about a space of estimated 4 feet to 30 feet from the elevators. During the observation there was no resident or visitor within 6 feet of Laborer #1 or Laborer #2. An interview was conducted on 5/19/2022 at 8:40 A.M. with the Infection Control Preventionist (ICP), who revealed all staff and contract workers were required to submit their COVID-19 vaccination cards to her. The ICP stated she had requested the vaccination cards for the construction laborer employees and had not received the information. The ICP further stated when she followed up with the construction foreman, she was told he had submitted everything he needed to his corporate office and was waiting on a reply about the laborer's vaccination requirements. During the interview, the ICP stated the two-construction foreman had provided her with their vaccination cards and she was unsure of the vaccination status of the laborers who worked in the facility. The ICP revealed when she received COVID-19 vaccination cards, she updated the staff vaccination line list. The ICP stated she had not	F 888	1. Construction Laborers working in the facility are currently vaccinated. 2. Residents residing in the facility who potentially interact with contracted construction staff have the potential to be affected. 3. On 5/18/22 Infection Preventionist was educated by the Nursing Home Administrator (NHA) regarding the facility's process for tracking Covid-19 vaccination status for contracted laborer construction staff. The Infection Preventionist obtained a master list and vaccination cards of Contracted Laborer Construction Staff on 5/18/22. As a result of that audit, only contracted laborers construction staff were allowed to return to the facility. As of 6/21/22 the Administrator will communicate to the Infection Preventionist prior to contracted laborer construction staff entering the building to ensure COVID vaccine and cards are validated prior to entering the facility. The Administrator will also educate any contracted laborer construction company that contracted staff need COVID vaccines and cards prior to entering the facility. 4. Starting on 6/9/22 the Director of Nursing will conduct audits on contracted laborer construction staff to ensure they are on the master list with vaccination cards weekly x8 and then monthly x2. Results of the audits will be presented by the NHA in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure	

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F 888	Continued From page 105 received the vaccination records for the vendor laborer construction workers. A telephone interview was conducted on 5/20/2022 at 4:22 P.M. with the Construction Project Manager. During the interview the Project Manager stated the two construction site leaders were required to show proof of being vaccinated against COVID-19, but at this time the company did not have a way to regulate the laborers who worked under them, and he was unsure if the laborers were vaccinated. The Project Manager stated the laborers were currently working on the lobby atrium and entrance corridor on the first floor inside the building. The Project Manager stated the space currently being remodeled was an awkward space to remodel and a partition wall was not able to be used which resulted in staff and residents having some interactions with the laborers. An interview was conducted on 5/30/2022 at 5:30 P.M. with the Administrator. During this interview the Administrator stated the facility should have the appropriate documentation for all contractor's vaccination status and the facility should maintain a record of every vaccination.	F 888	compliance is sustained ongoing.	
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain 1 of 1 food steamer, 1 of 1 upright food warmer, and 2 of 2 lowerator plate	F 908	The Plan of correction is not to be construed as an admission of any wrongdoing or liability. The facility	6/21/22

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F 908	Continued From page 106 warmers in safe operating condition. The findings included: An observation was made on 5/17/22 from 9:20 AM to 9:55 AM of the facility's Dietary Department. The facility's Regional Culinary Director was present during the time of the walk-through observation. The following pieces of kitchen equipment were noted to be in disrepair: --One (1) of 1 food steamer had a food pan placed under it for catching water leaked from the machine. The handle on the front of the steamer was fastened with an elastic cord running from the front of the machine around to its side to keep the door closed. The steamer was still being used. --One (1) of 1 upright food warmer with two doors (for individual upper and lower sections of the warmer) was observed to be missing the control knobs on the control panel located at the bottom of the warmer. Upon inquiry, the Regional Culinary Director reported the food warmer could be turned "On and Off" but the temperature could not be adjusted due to the missing knobs; the warmer was still being used. The bottom door of the warmer was observed to be missing one of two hinges, causing difficulty with the bottom door to open/close properly. An observation was conducted on 5/17/22 at 11:20 AM of the final food preparation before the initiation of the lunch tray line. During the tray line observation, two (2) of 2 lowerator plate warmers were observed to be plugged in with the "on" light illuminated. However, neither of the plate warmers were warm to the touch. Dietary Staff Member #1 reported the lowerator plate warmers	F 908	reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. F908 1. The Food Steamer, Upright Food Warmer and Lowerator Plate Warmers have been ordered and will be put into service when delivered. 2. Residents residing in the facility who receive meals from the dietary department have the potential to be affected. 3. On 6/16/22 Dietary Manager was educated by the Nursing Home Administrator (NHA) to report any equipment that is not in safe operating condition to the NHA. 4. Weekly for twelve weeks the Dietary Manager, NHA or Administrative Designee will conduct observational audits of the kitchen equipment to validate equipment	

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F 908	Continued From page 107 did not work. The Regional Culinary Director confirmed the lowerator plate warmers were not working and was observed to unplug the plate warmers. An interview was conducted on 5/18/22 at 10:28 AM with Maintenance Staff Member #1 and Maintenance Staff Member #2. During the interview, the maintenance staff members reported they had to "rig" the food steamer ' s door to close. The staff members also stated they were aware the two lowerator plate warmers were inoperable. They reported the heat sensor on one lowerator plate warmer was not working and the heating element on the second one "has gone bad." An interview was conducted on 5/17/22 at 5:10 PM with the facility's Administrator During the interview, the Administrator was informed of the concerns identified in the Dietary Department. Concerns included essential food preparation and food service equipment identified to be inoperable or in disrepair. The Administrator reported she was relatively new at the facility and had worked here for approximately 4 weeks (same as the CDM). A follow-up interview was conducted on 5/18/22 at 5:00 PM with the facility's Administrator. During the interview, the Administrator reported she would expect to be informed when a piece of equipment was not operational so it could be repaired and if it was not repairable, the equipment would need to be replaced.	F 908	is in safe operating condition. Results of the audits will be presented by the Dietary Manager in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	