STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WINSTON SALEM	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 6/20/22 to 6/23/22. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID# H2K911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 6/20/22 to 6/23/22. Event ID# H2K911. The following intakes were investigated: NC00188238, NC00188248, NC00185645, NC00186619, NC00186575, NC00186533, NC00182480, NC00185732, NC00188507. 6 of the 34 allegations were substantiated, resulting in deficiencies.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		7/21/22

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

Electronically Signed | 07/18/2022

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F 550	Continued From page 1 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: Based on observations, resident, record review and staff interviews, the facility failed to offer the use of glassware/tumblers to residents who received beverages in styrofoam cups, and/or desserts, vegetables, and fruit cocktail in styrofoam bowls during 2 of 2 meal service observations and failed to maintain dignity for a resident with a urinary catheter, the urine collection bag was visible from the hallway for 1 of 3 residents with urinary catheters (Resident #34). Findings included: 1. During an observation in the kitchen on 6/20/22	F 550	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. An assessment was completed on July	

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F 550	Continued From page 2 at 11:10 a.m., styrofoam beverage cups filled with iced tea were placed near the steamtable in preparation for the meal service to the residents. The dietary cook revealed styrofoam cups had been used during the residents' meal service for several months due to meal trays were not always returned to the kitchen after meal services. On 6/23/22 at 12:35 p.m., during the meal observation, residents were served beverages in styrofoam cups, and vegetable/desserts were served in styrofoam bowls. During an interview on 6/23/22 at 1:17 p.m., the Dietary Manager (DM) stated dishware was frequently not returned to the kitchen from residents' rooms after each meal service. He revealed 8-ounce beverage glasses/tumblers were ordered several months ago, but 7-ounce glasses/tumblers were delivered. The DM stated that 8-ounce beverage tumblers/glasses were reordered but were on back-order. He stated that bowls were also ordered. 2. Resident #34 was admitted to the facility on 02/02/22 with diagnoses that included neuromuscular dysfunction of the bladder. The most recent Minimum Data Set (MDS) revealed the was cognively intact and he had a suprapubic urinary catheter. On 06/20/22 at 10:00 AM observations made of Resident #34 in his room revealed his urine catheter bag attached to the bed visible from the hallway. The urine bag was half full of urine.	F 550	13, 2022, by the Director of Nursing for Resident #34 to ensure that the resident had been provided a urine collection device with privacy flap for their suprapubic catheter. All Styrofoam dishware that was in use has been discontinued, and new dishware was ordered and received. All residents have the potential to be affected. An audit of the current residents will be completed by Nursing to ensure residents with indwelling catheters have been given a privacy urine collection bag by July 15, 2022. The kitchen will not provide meals on paper products without prior permission of management and only for specific circumstances. Nursing staff will be educated by the Director of Nursing or designee by July 21, 2022, related to ensuring that residents are provided with a privacy urine collection bag upon admission if they admit with an indwelling catheter. All dietary staff were educated by DON and the contracted food service manager regarding the use of appropriate dishware and maintaining an adequate supply of dishware for food service. Education was completed by July 14, 2022. The ADON or designee will review five current residents weekly for 4 weeks and monthly for 2 months to ensure current residents have been given a privacy urine collection bag. If there are less than 5 current residents with indwelling catheters, the ADON or designee will audit all residents identified. The Administrator or designee with audit the meal service for proper dishware for five meals per week	

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F 550	Continued From page 3 06/21/22 at 3:45 PM a second observation was made of Resident #34 and his urine catheter bag remained visible from the hallway with urine in it. 06/22/22 at 9:37 AM a third observation was made of Resident #34 and his urine catheter bag remained visible from the hallway with urine in it. During an interview on 6/23/22 at 3:30 PM the Director of Nursing (DON) stated staff were trained to keep urinary catheters covered. She added that the urine bags should be placed in a privacy bag or turned toward the bed to prevent a resident's urine from being visible. On 06/20/22 at 10:00 AM Resident #34 was interviewed in his room about his urinary catheter. He explained he had a suprapubic catheter. He said knew the bag was visible from the hallway because staff were able to see when it needed to be emptied. He stated if he knew it was uncovered, he would ask for it to be covered.	F 550	for 30 day and then two meals weekly for 60 days. The ADON will submit the catheter bag findings and the Administrator will submit the proper dishware audits to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance. Date of Compliance: July 21, 2022	
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 553		7/21/22

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F 553	Continued From page 4 other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interview, the facility failed to invite 1 of 1 sampled resident (Resident #23) and/or her responsible party to the resident's care plan meeting. Findings included: Resident #23 was originally admitted to the facility on 4/1/20 and re-admitted on 4/20/22 with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, sepsis, bradycardia, and other complications of gastrostomy. The quarterly minimum data set dated 4/25/22	F 553	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. A care plan conference was completed on July 15, 2022, by the Social Service	

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F 553	Continued From page 5 indicated Resident #23 was moderately, cognitively impaired, required extensive to total assistance with activities of daily living, and received tube feeding. Resident #23's most recent care plan was dated 4/28/22. There was no documentation indicating the resident and/or family/responsible party attended a care plan meeting. On 6/21/22 at 10:00 a.m., during an interview Resident #23 revealed she was not invited to meetings involving her plan of care. During an interview on 6/23/22 at 3:11 p.m., Social Worker #1 explained she was responsible for the baseline care plan meetings and the other social worker, responsible for the quarterly and annual care plan meetings, no longer worked at the facility. After reviewing the facility's care plan meeting records, she stated there had not been a care plan invitation and/or meeting with Resident #23 and/or her family since 9/22/21.	F 553	Director for Resident #23 to ensure that the resident/responsible party participated in the development and planning of the person-centered care plan. All residents have the potential to be affected. An audit of the current residents will be completed by Social Services to ensure residents/responsible parties have been invited to participate in the development and planning of their person-centered care plan by July 15, 2022. Social Service staff will be educated by the Director of Nursing or designee by July 21, 2022, related to ensuring that residents participate in the development and planning of their care plan. New hire social services staff will also be required to complete the education prior to working in the facility. The Social Service Director will review five current residents weekly for 4 weeks and monthly for 2 months to ensure current residents and responsible parties are invited to participate in the development and planning of their care plan. The Social Service Director will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance. Date of Compliance: July 21, 2022	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must	F 561		7/21/22

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F 561	Continued From page 6 promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff and resident interviews, the facility failed to provide showers as preferred and scheduled for 2 of 4 residents (Residents #27 and #6) reviewed for activities of daily living. The findings included: 1. Resident #27 was admitted to the facility on 9/7/20218 with diagnoses that included a hydrocele, paraplegia, and chronic pain	F 561	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers	

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F 561	Continued From page 7 syndrome. The annual Minimum Data Set (MDS), dated 4/21/2022, indicated Resident #27 was cognitively intact for decision making, had no rejection of care and required minimal assistance of one staff member for transfers, personal hygiene and bathing and had impaired range of motion to the upper and lower extremities on one side. The rehabilitation assessment section of the MDS indicated the Resident required partial to moderate assistance from another person to complete bathing and shower activities. A review of the care plan, dated 4/25/2019, revealed a focused area that read: Resident #27 has an Activities of Daily Living (ADL) self care performance deficit related to recent joint replacement, osteoarthritis, and diabetes mellitus. The interventions included: provide a sponge bath when a full bath or shower cannot be tolerated, the Resident requires assistance of one staff with a shower. An interview was conducted with Resident #27, and he revealed he loved to take a shower and had not received a shower in a very long time. He stated the staff allow him to wash himself at the sink, but he cannot wash his back or legs and he cannot wash his hair at the sink. He stated he uses a washcloth and tries to wash his hair with the cloth. He stated he had told staff he prefers to take a shower and his days should be Tuesday, Thursday, and Saturday in the evenings before bed. He added the last time he had been offered a shower was when a previous Nursing Assistant worked at the facility, but she has not worked at the facility in months. He stated he was a late sleeper and does not like to shower in the mornings.	F 561	allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Resident #27 was offered a shower on July 14, 2022, by the certified nursing assistant. Resident #6 was offered a shower on July 14, 2022, by the certified nursing assistant. The charge nurse reviewed with residents #27 and #6 their shower preferences and schedules on June 28, 2022. All residents have the potential to be affected. An audit of the current residents shower schedules and preferences was completed by the Director of Nursing (DON) by July 15, 2022, to ensure showers are being given as required. The nursing staff to include agency nursing staff and new hire nursing staff will be reeducated by the DON/designee related to ensuring showers are given according to resident preferences and as scheduled by July 21, 2022. New hire and agency nursing staff will not be allowed to work until education is completed. The DON will review the shower schedule during morning clinical report to ensure that showers have been given per resident preferences and as scheduled for 4 weeks and monthly for 2 months. The DON will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance.	

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F 561	Continued From page 8 A review of the ADL task Kardex record for Resident #27 titled: ADL bathing had a schedule for Monday/Wednesday/Friday 7:00 a.m. - 3:00 p.m. and as needed. The Resident did not have a documented shower in the 30 days prior to 6/23/2022. An interview was conducted with the Director of Nursing (DON) on 6/23/2022 at 12:26 p.m. and she reviewed the ADL task documentation for Resident #27. She stated she observed Resident #27 did not have a documented shower in the last 30 days. She added that she had conducted a shower preference audit of the facility and Resident #27 had been included so she was very confused why the Resident had not been receiving his showers at his desired time of the day and on his preferred days. She provided a copy of the shower preference document for the second floor and the document indicated Resident #27 preferred to shower on Tuesday and Thursdays in the evening. The DON reviewed the ADL task Kardex for the Resident and indicated the Resident's preference was not reflected on his Kardex (the location that informs the nursing assistants (NA) of when a Resident's assigned task had been assigned to be completed). The DON added the Resident's electronic medical record would be updated immediately to reflect his choices and that it was her expectation that all residents receive a shower or be offered a shower on their scheduled days and if they had a preference, it would be honored by staff and be reflected in the electronic medical record. An interview was conducted with NA #1 on 6/23/2022 at 12:38 p.m. and she revealed she	F 561	Date of Compliance: July 21, 2022	

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F 561	Continued From page 9	F 561		

had been assigned to Resident #27 frequently. She stated Resident #27's routine was to stay awake late at night because he was a night owl and to sleep in, in the mornings. She added he prefers to take a shower in the evenings before bed and will turn down a shower in the morning and request to take it at night instead. She stated she had to document this request as a refusal of a shower in the electronic medical record because the system does not allow her to document the Resident prefers a different time of the day than what was scheduled. She revealed she had reported this to the nurses that the Resident likes to shower later in the day and not on day shift.

2. Resident #6 was admitted to the facility on 5/17/2021 with diagnoses that included a stroke with hemiplegia/hemiparesis, Parkinson's disease, osteoporosis, and depression.

A review of the comprehensive annual Minimum Data Set (MDS) dated 5/20/2022 indicated Resident #6 was cognitively intact for decision making, had no rejection of care, no behaviors, required moderate assistance of one staff member with personal hygiene and was totally dependent on staff for bathing. She had an impairment with range of motion on one side with the upper and lower extremity.

A review of the care plan dated 12/01/2021 revealed:

1) There was not a focused area for activities of daily living self care deficit identified.

2) A focused area for Parkinson's was present and had a goal that read: Resident #6 will remain

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F 561	Continued From page 10	F 561		

free of further signs and symptoms of discomfort or complications related to Parkinson's disease. The interventions included, to See the self-care deficit (however a self-care deficit focus did not exist).

3) A focused area for, Resident #6 had a cerebral vascular accident (Stroke) and included a goal that read: Resident #6 will be able to communicate her needs daily, show improvement to maximum potential to perform activities of daily living (ADL) by the review date. The interventions included: Monitor and document Resident's abilities for ADLs and assist resident as needed and anticipate and meet Resident #6's needs.

An interview was conducted with Resident #6 on 6/20/2022 at 10:25 a.m. and she stated she was paralyzed on her right side and required assistance with her bath and shower. She added she would like to get a shower two times a week but this had not occurred in greater than two weeks, but she could not remember the last time. She stated she preferred a female over a man to assist her due to her religion and the facility had told her they would be glad to accommodate this request. She stated she had a male on her assignment, and it made it very difficult for him to constantly go hunt another nursing assistant to complete her baths.

A review of the Activities of daily living task documentation Kardex report revealed no documentation of a shower in the last 30 days from 6/23/2022 for Resident #6 and only 3 full baths being completed.

An interview was conducted with the DON on 6/23/2022 at 4:31 p.m. and she revealed she had

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F 561	Continued From page 11 reviewed the ADL task documentation sheet for Resident #6 and stated a shower had not been documented and only three full bed baths had been documented in the last 30 days. She stated the Resident was to be care planned for a scheduled shower on Monday, Wednesday, and Friday with three showers a week offered to the Resident. She stated the Resident only desired a female for baths and a male had been assigned to her assignment. She added a solution to ensure the Resident had her choices met but still received a shower would be considered and then put into place immediately by the administrative team. She stated the administrative team had informed the Resident that they could accommodate her request to only have a female provide showers.	F 561		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir 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	F 578		7/21/22

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ACCORDIUS HEALTH AT WINSTON SALEM	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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F 578	Continued From page 12 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. 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 maintain accurate electronic medical records that matched the most recent advanced directive signed by a resident or their responsible party and the physician in 2 of 3 residents (Resident #19 and #10) reviewed for advanced directives. The findings included: 1. Resident #19 was originally admitted to the facility on 9/9/2016 and readmitted from the hospital on 3/30/2022. A review of a significant change Minimum Data set (MDS) assessment for Resident #19, dated	F 578	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Resident #19 and #10 advanced	

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F 578	Continued From page 13 5/9/2022 revealed the Resident had moderate cognitive impairment. A review of the advanced directives binder, that stored all original copies of advanced directive orders, at the 200-hall nursing station revealed Resident #19 had medical orders for scope of treatment (MOST) form that documented for Cardiopulmonary resuscitation to be attempted with limited additional interventions to included intravenous fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation, provide comfort measures and transfer to the hospital if indicated. Signed by the physician and spouse of Resident #19 dated 4/5/2022. A review of the electronic medical record revealed an order entered on 4/5/2022 entered by the Assistant Director of Nursing (ADON) that the Resident had an order for Do Not Resuscitate (DNR). An interview was conducted with the ADON on 6/22/2022 at 12:02 p.m. and she reviewed the electronic medical record and stated Resident #19 became a DNR on 4/5/2022. She stated any resident with a DNR would have a signed golden rod order in the advanced directive book at the nursing station and it would be scanned in the system. The ADON then opened the miscellaneous section of the electronic chart and stated the Resident's old full code was scanned in but not the DNR order. She was asked if she knew about the Resident's MOST form and she stated she does recall he had a MOST form but the electronic system does not have a place to document specific request. She stated she was not aware the Resident requested CPR. She	F 578	directives were reviewed by social services on June 23, 2022, to ensure that the medical record matched the most recent signed advanced directive. All residents have the potential to be affected. An audit of the current residents electronic medical record was completed on June 23, 2022, by the facility Director of Nursing to ensure that the most recent signed advance directive matches the medical record. The licensed nurses to include agency licensed nurses and social services will be reeducated by July 21, 2022, by the DON or their designee related to ensuring that the electronic medical record matches the most recent signed advance directive. New hires and agency licensed nurses will not be allowed to work until the education is completed. The DON/ designee will review five current residents weekly for 4 weeks and monthly for 2 months to ensure the most recent advance directive match the electronic medical record. The Director of Nursing will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance. Date of Compliance: July 21, 2022	

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stated a solution to resolve this would be discussed with the administrative team and solved immediately.

On 6/22/2022 at 1:58 p.m. a review of the electronic medical record revealed the Resident was still listed as a DNR but now had additional instructions to call the wife before doing anything. On 6/22/2022 at 2:25 p.m. an interview was conducted with the Director of nursing, and she reviewed the advanced directives book with the MOST form for Resident #19. She then reviewed the electronic medical record and stated the two do not match and she would immediately resolve this. She stated it was her expectation that all advanced directive orders be entered into the electronic medical record accurately according to the Resident's wishes.

2. Resident #10 was originally admitted to the facility on 4/7/20 and re-admitted on 3/3/22 with diagnoses which included: adult failure to thrive, diabetes mellitus with other neurological complications, other chronic pain, and opioid dependence.

Review of the significant change minimum data set dated 6/7/22 indicated Resident #10 was cognitively intact.

The review of the Physician's Order dated 5/10/22 revealed Resident #10's advance directive was at full code status (emergent measures in attempt to resuscitate the patient). The profile page of the resident's electronic medical record also indicated the resident had a

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F 578	Continued From page 15	F 578		

full code advance directive status.

The residents' portable medical forms, maintained at the nurse's station in the Advance Directives' notebook, documented Resident #10's advance directive status as DNR (Do Not Resuscitate) with the same effective date of 5/10/22.

During an interview on 6/21/22 at 10:46 a.m., Nurse #3 revealed she referred to a resident's profile page in the electronic medical record when checking the resident's advance directive due it was more accurate. She stated that a resident's advance directive status information was also maintained in a notebook located at the nurse's station and was sent with the resident when transferred out of the facility.

During an interview on 6/21/22 at 2:42 p.m., the Administrator acknowledged the discrepancy between the physician's order, the portable advance directive and Resident #10's electronic profile record. She stated that her expectation was for each resident's advance directive to be correct and all documents with this information "matches".

On 6/21/22 at 4:24 p.m., during an interview, Nurse #4 revealed Resident #10 returned from the hospital on 5/10/22 with the advance directive status of Full Code. She stated that when the nurse practitioner visited the resident the next and explained to the resident her condition and repeated hospitalizations within two to three months, the resident made the decision to change her advance directive code status to DNR. Nurse #4 further explained that after the nurse practitioner completed the portable medical

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F 578	Continued From page 16 form, she failed to write the order to change the resident's advance directive status from Full Code to DNR. She also stated that once the nurse practitioner completed the DNR form, it was the nurse's responsibility to update the resident's code status in her medical record.	F 578		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582		7/21/22

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F 582	Continued From page 17 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to provide a CMS-10123 (Centers for Medicare and Medicaid Services) Notice of Medicare Non-Coverage Letter (NOMNC) prior to discharge from Medicare part A services with benefit days remaining to three of three residents (Resident #346, Resident #347 and Resident #345) reviewed for SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review. Findings included: 1. Resident #346 was admitted to the facility and Medicare part A services began on 1/13/22. She discharged to the community on 2/25/22.	F 582	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Residents # 345, 346 and 347 were	

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F 582	Continued From page 18 The medical record revealed a CMS-10123 NOMNC was not provided to the Resident or Resident Representative when part A Medicare services ended and Medicare benefit days remained. An interview was completed with Social Worker (SW) #1 and SW #2 on 6/22/22 at 3:50 PM. SW #2 explained the interdisciplinary team met weekly and discussed the progress of residents who received services under the Medicare part A benefit. She said the social workers were notified when a resident was coming off Medicare part A services, at which time they initiated the NOMNC form and provided it to the resident or resident representative. SW #1 stated when Resident #346 came off Medicare part A services, no one on the interdisciplinary team instructed her to initiate the NOMNC form and therefore, it was not completed. During an interview with the Administrator on 6/22/22 at 11:25 AM, she explained the social workers were responsible to complete and provide the NOMNC form to the resident or resident representative who had traditional Medicare and came off the Medicare part A benefit with benefit days remaining. 2. Resident #347 was admitted to the facility and Medicare part A services began on 2/23/22. She discharged to the community on 3/17/22. The medical record revealed a CMS-10123 NOMNC was not provided to the Resident or Resident Representative when part A Medicare services ended and Medicare benefit days remained.	F 582	previously discharged and unable to confirm or deny if a letter of non-coverage had been given. Copies of letters of non-coverage were not filed with the chart or in a log. All residents with pending discharges or dates of non-coverage were reviewed and letters issued as appropriate. The Social workers and Business office Manager were in-serviced by the Administrator on 6/22/2022 on the regulation and implementation of timely serving of letters of non-coverage, as well as saving a copy by either uploading it into the chart or in a binder. The IDT team will hold regular meetings to review all residents on a Medicare part A or Insurance stay to determine when a letter needs to be issued. Audits by the Administrator, DON, SDC or designee will be conducted by reviewing all pending discharges three times weekly for 30 days and then weekly for 60 days. Results of these audits will be reviewed by the QAPI committee monthly for three months and then as indicated. Date of Compliance: July 21, 2022	

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F 582	Continued From page 19	F 582		

An interview was completed with Social Worker (SW) #1 and SW #2 on 6/22/22 at 3:50 PM. SW #2 explained the interdisciplinary team met weekly and discussed the progress of residents who received services under the Medicare part A benefit. She said the social workers were notified when a resident was coming off Medicare part A services, at which time they initiated the NOMNC form and provided it to the resident or resident representative. SW #1 stated when Resident #347 came off Medicare part A services, no one on the interdisciplinary team instructed her to initiate the NOMNC form and therefore, it was not completed.

During an interview with the Administrator on 6/22/22 at 11:25 AM, she explained the social workers were responsible to complete and provide the NOMNC form to the resident or resident representative who had traditional Medicare and came off the Medicare part A benefit with benefit days remaining.

3. Resident #345 was admitted to the facility and Medicare part A services began on 3/28/22. She discharged to the community on 5/4/22.

The medical record revealed a CMS-10123 NOMNC was not provided to the Resident or Resident Representative when part A Medicare services ended and Medicare benefit days remained.

An interview was completed with Social Worker (SW) #1 and SW #2 on 6/22/22 at 3:50 PM. SW #2 explained the interdisciplinary team met weekly and discussed the progress of residents who received services under the Medicare part A

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F 582	Continued From page 20 benefit. She said the social workers were notified when a resident was coming off Medicare part A services, at which time they initiated the NOMNC form and provided it to the resident or resident representative. The social workers were unable to state why a NOMNC form was not completed when Resident #345 came off the Medicare part A benefit. During an interview with the Administrator on 6/22/22 at 11:25 AM, she explained the social workers were responsible to complete and provide the NOMNC form to the resident or resident representative who had traditional Medicare and came off the Medicare part A benefit with benefit days remaining.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		7/21/22

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F 584	Continued From page 21 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to ensure the room and floor was clean in a resident room (Room 204), and failed to maintain the wall in good repair in a resident room (Room 219). The findings included: 1. An observation on 6/20/22 at 11:09 AM of Room 204-B revealed bagged clothing on the floor, the windowsill and counter area observed with dried substances, a thick layer of dust on the overbed light and the floor with debris black marks. On 6/21/22 at 9:30 AM, an observation of Room 204-B revealed the room had not been cleaned	F 584	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Room 204 was deep cleaned on 7/05/2022, which included removing dried	

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F 584	Continued From page 22 from the previous day. On 6/21/22 at 9:45 AM, observation and interview were conducted with Housekeeper #1. She stated she is responsible for cleaning Room 204-b. She stated she gets a list in the morning of rooms that must be deep cleaned (discharges) and she cleans those rooms first. She stated she begins cleaning the room by wiping down all the horizontal areas. She stated the horizontal surfaces included the windowsill, overbed light and counter. She stated she then will dust mop, sweep, gets the trashed picked up and mops. She observed the dust on the overbed light and stated that should be clean. She added she had to work around the resident if they were in the room. Regarding the black marks on the floor, she stated those would not come up. On 6/21/22 at 10:00 AM, the Environmental Services Director was interviewed. He stated he just started working as the Director and they currently did not have a floor tech. He was shown Room 204-B and stated that should all be cleaned during daily cleaning. Regarding the floor, he stated it would need to be stripped to get the black marks up. He stated he was going to have the housekeepers review the video and script on how to clean and he would be putting a floor cleaning schedule into place and would like to have the rooms deep cleaned including stripped and waxed twice a month. 1. On 06/21/22 at 3:26 PM an observation of Room 219 revealed gouged sheetrock damage on wall at the head of resident's bed. The	F 584	substances from the windowsills and counter tops. Dust was cleaned from the overbed lights. A bag of clothing was removed from the floor. The floor was scrubbed, removing the debris and black marks, on 7/05/2022. Room 219, which had a wall with gouged sheet rock at the head of the bed, was repaired on 7/13/2022. Maintenance inspected all resident rooms for walls with gouged sheet rock and began the process of repairing them. The housekeeping supervisor will inspect each room to ensure that all overbed lights, windowsills, and counters have been cleaned and not missed during the daily housekeeping room service. The housekeeping Supervisor was educated by his supervisor from Next level Services on cleaning of rooms, cleaning of floors, supervising staff, and inspecting rooms routinely. The Housekeeping staff will be reeducated on daily room care and deep cleaning by July 21, 2022. Housekeeping and nursing will be educated on not placing any clothing bags on the floor and that dirty laundry or linen should be taken to the laundry room. If clean items are brought in by the family, nursing should assist the resident in storing them properly. The Maintenance Man will be in-serviced by the Administrator on maintaining walls in residents□ rooms in good condition by July 21, 2022. The Administrator, Housekeeping Supervisor, Maintenance Director, or designee will audit resident rooms for cleanliness, marked floors, and gouges in	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 23 Resident stated the wall had been damaged since she was admitted to the room. 2. On 06/22/22 at 9:39 AM an observation of Room 219 revealed the sheetrock damage not been repaired. 3. On 06/22/22 at 3:42 PM an observation revealed the sheetrock damage in Room 219 had not been repaired. During an on 6/23/22 at 3:30 PM with the Director of Maintenance and the Administrator they explained that they had requested funding for an additional maintenance personnel and funding for the supplies to complete the drywall repairs interview needed in the facility. The Director of Maintenance revealed he was aware of multiple areas that needed repairs. He explained he made weekly rounds to assess for needed repairs. The Administrator stated it is her expectation that repairs be completed as soon as funds are available.	F 584	sheetrock. Ten rooms a week will be audited for 4 weeks. After 4 weeks, five rooms will be audited weekly for a total of 8 weeks. The audits will be reviewed by the QAPI committee monthly for 3 months. Date of Compliance: July 21, 2022	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified	F 636		7/21/22

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by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission,

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F 636	Continued From page 25 excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete comprehensive resident assessments in the areas of cognition, behaviors, and pain for 2 of 25 sampled residents (Resident #146 and Resident #10). The findings included: a. Resident #146 was admitted to the facility on 5/26/22 with a diagnosis of, in part, dementia without behaviors. The Admission Minimum Data Set (MDS) assessment dated 6/1/22 revealed Sections C and E were coded as "not assessed" or "no information". On 6/23/22 at 7:50AM, an interview was conducted with Social Worker #2. She stated she started working in the facility in March and did not have any previous experience with the MDS. She stated her training was "choppy". She stated she could not get Resident #146 to answer her questions, so she answered not assessed and she now understands the correct way to complete the portions of the MDS assessment she is responsible for. 2. Resident #10 was originally admitted to the	F 636	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to complete a Comprehensive Minimum Data Set assessment section C & E for resident #146 & Section J pain interview for resident # 10, timely & coded not assessed. Resident #146 Comprehensive assessment on 6/1/2022. Resident #10 Comprehensive	

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F 636	Continued From page 26 facility on 4/7/20 and re-admitted on 3/3/22 with diagnoses which included: adult failure to thrive, diabetes mellitus with other neurological complications, other chronic pain, and opioid dependence. Review of the significant change minimum data set dated 6/7/22 indicated Resident #10 was cognitively intact; received scheduled pain medication. Review of the facility records revealed a pain assessment interview was not completed with Resident #10 during the significant change assessment period. During an observation on 6/21/22 at 11:41 a.m., Resident #10 was awake in bed with a grmacing facial expression grimacing. The resident revealed she received pain medication at 8:30 a.m. that morning but continued to experience pain in her shoulder and on her bottom. The Director of Nursing entered the resident's room and after assessing the resident stated she would check with the resident's nurse if she was able to have a when needed pain medication. The Director of Nursing also informed the resident she would have the nurse practitioner visit with her this day. During an interview on 6/22/22 at 2:42 p.m., the Corporate Clinical Reimbursement Consultant revealed that at the time of Resident #10's significant change assessment, the Minimum Data Set (MDS) Coordinator only worked part-time at the facility. He stated that the pain management sections (J0200 through J0850) required a resident interview and the facility staff had not completed a pain assessment on the	F 636	assessment on 6/7/2022. How the facility will identify other residents having the potential to be affected by the same deficient practice: Effective 6/29/2022, current residents were reviewed by Regional MDS Nurse to ensure the BIMS & Pain interviews were conducted. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 6/29/2022, the Regional MDS Consultant educated MDS nurses & Social service Directors on completing the comprehensive MDS interviews for Pain & BIMS timely. DON or Designee will audit weekly to ensure pain UDA are Done in accordance with scheduling of quarterly assessments that pull into the MDS per PCC program. Nursing will complete the pain assessments as scheduled. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator/designee will audit five comprehensive assessments weekly to ensure comprehensive assessment interviews are completed within the required timeframe. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of	

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F 636	Continued From page 27 resident during the look-back period of five days.	F 636	weekly audits to ensure any issues identified are corrected. Date of Compliance: July 21, 2022	
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 observation, record review and staff interviews the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 of 2 residents (Resident #7) reviewed for tube feedings. The findings included: Resident #7 was admitted to the facility on 12/21/2021 with diagnoses that included gastritis, adult failure to thrive, dysphagia of the oropharyngeal phase, pancytopenia, and unspecified protein calorie malnutrition. A review of the physician orders revealed from 6 p.m. to 6 a.m. osmolite 1.5 ml at 70 ml an hour. Give 200 milliliters after of water before and after feeding. Ordered 3/18/2022. A review of the physician orders revealed enteral feed in the morning for the gastro tube feeding, remove at 6:00 a.m. ordered on 4/13/2022. A review of the quarterly Minimum Data Set dated 6/3/2022 documented Resident #7 did not have a feeding tube and received a mechanically altered diet.	F 641	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The facility failed to accurately code the Minimum Data Set for resident #7 by not coding tube feedings. The facility modified resident #7 to reflect appropriate coding on 6/22/2022. Effective 6/21/2022, the Regional Minimum Data Set Nurse reviewed 30 days of quarterly assessments to ensure accuracy of coding for residents receiving tube feedings.	7/21/22

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F 641	Continued From page 28 A review of the daily nursing assessment dated 6/14/2022 documented Resident #7 had a gastrointestinal tube (GT). A review of the care plan dated 6/3/2022 revealed a focused that read: Resident #7 has a nutritional problem related to diet restrictions and was a peg tube only. An interview was conducted with MDS #1 on 6/21/2022 and revealed the quarterly MDS for Resident #7 under section K should have been documented as having enteral feedings. She stated a correction MDS was being completed at that time.	F 641	Effective 6/21/2022, the Regional MDS Consultant educated MDS nurses & Dietary Manager on coding MDS assessments accurately. Administrator or their designee will audit three quarterly assessments weekly, to ensure tube feeding is coded accurately, for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Date of Compliance: July 21, 2022	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.	F 644		7/21/22

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F 644	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to refer 1 of 1 sampled resident (Resident #21) with the diagnosis of paranoid schizophrenia, to the state-designated authority for Level II PASARR (Preadmission Screening Resident Review) evaluation. Findings included: Resident #21 was originally admitted to the facility on 10/16/14 and re-admitted on 5/25/22 with diagnoses which included: paranoid schizophrenia, cerebral infarction, and epilepsy. Review of the quarterly minimum data set dated 5/31/22 indicated Resident #21 was cognitively intact and had no behaviors. Review of the facility's records indicated Resident #21 was not referred to the state- designated authority for a Level II PASARR evaluation. During an observation on 6/21/22 at 11:20 a.m., Resident #21 was sitting in one of the chairs in the television/dayroom. The resident was alert, soft spoken but responsive to questions. During an interview on 6/22/22 at 11:37 a.m., Social Worker #1 stated that at the time of Resident #21's admission to the facility, the Social Worker was responsible for ensuring the resident was admitted with updated PASARR information based on his diagnosis. She acknowledged the resident should have had a PASARR II on admission to the facility. She	F 644	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Social Services submitted information for resident #21 Preadmission Screening and Resident Review (PASRR) for a level 2 evaluation on June 23, 2022. A response was received by Social Services on June 27, 2022. All current residents have the potential to be affected. An audit will be completed by July 15, 2022, by Social Services of the current residents to ensure PASRRs for level 2 reevaluation has been submitted for identified residents with mental disorder or intellectual disability. Social Service staff will be reeducated by the DON/ designee by July 21, 2022, related to ensuring that PASRR level 2 reevaluation screening are being submitted as required. New hires and contract staff will not be allowed to work until the education is completed. The Social Service Director will complete audits weekly for 4 weeks and monthly for	

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F 644	Continued From page 30 stated that she and the other Social Worker would begin auditing PASARR information on all of the current residents in the facility, immediately.	F 644	2 months to ensure that PASRR level 2 reevaluation screenings are being completed as required. The Social Service Director will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance. Date of Compliance: July 21, 2022	
F 655 SS=F	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §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	F 655		7/21/22

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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 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, resident and staff interviews the facility failed to develop a baseline care plan within 48 hours of admission for 4 of 5 new admissions reviewed Resident # ' s 154, 146, 9 and 201).

The findings included:

a. Resident #154 was admitted to the facility on 6/7/22.

On 6/20/22 at 11:45 AM, during an interview with Resident #154, he stated he was getting his antibiotics so he could go out and smoke. Intravenous antibiotics were observed hanging in a bag and being administered to Resident #154.

A record review revealed no evidence a baseline care plan was completed for Resident #154.

The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.

Resident #154 and #146 Baseline Care Plans were completed by 7/18/2022 by nursing staff.
Resident #9 had a baseline care plan completed on 3/16/2022 by nursing staff.

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F 655	Continued From page 32 On 6/23/22 at 3:30 PM an interview was conducted with Nurse #2 who stated the Unit Manager completed the baseline care plans. On 6/23/22 at 4:10 PM, an interview with the Director of Nursing who stated when a new admission arrives, the nurse on the hall completing the admission is responsible to completing the baseline care plan. She stated the Unit Manager was responsible for making sure they were complete. b. Resident #146 was admitted to the facility on 5/26/22 with diagnoses of dementia, chronic obstructive pulmonary disease, and protein calorie malnutrition. A record review revealed Resident #146 received a pureed diet with nectar thickened liquids. The medical record did include a baseline care plan for Resident #146. On 6/23/22 at 3:30 PM an interview was conducted with Nurse #2 who stated the Unit Manager completed the baseline care plans. On 6/23/22 at 4:10 PM, an interview with the Director of Nursing who stated when a new admission arrives, the nurse on the hall completing the admission is responsible to completing the baseline care plan. She stated the Unit Manager was responsible for making sure they were complete. c. Resident #9 was admitted to the facility on 3/16/22. Diagnoses included pressure ulcer of sacral region, stage 4, pressure ulcer of right hip, stage 3, and colostomy.	F 655	Resident #201 had a baseline care plan completed on 6/8/2022 and again on 6/23/2022 by nursing staff. All current residents have the potential to be affected. The Director of Nursing will complete audits of the current residents admitted in the last 30 days by July 21, 2022, to ensure baseline care plans are being completed within 48 hours of admission. Licensed nurses to include agency licensed nurses will be educated by July 21, 2022, by the Director of Nursing/designee to ensure baseline care plans are being completed within 48 hours of admission. New hire and agency licensed nurses will not be able to work until the education has been completed. The Director of nursing will complete audits of the new admissions weekly for 4 weeks and monthly for 2 months to ensure base line care plans are completed within 48 hours of admission. The Director of Nursing will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facility compliance. Date of Compliance: July 21, 2022	

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An observation on 6/20/22 at 10:55 AM revealed Resident #9 had a colostomy in place. Resident #9 stated his wound vac wasn't in place because it malfunctioned over night.

A review of the medical record revealed a baseline care plan was not completed for Resident #9.

On 6/23/22 at 3:30 PM an interview was conducted with Nurse #2 who stated the Unit Manager completed the baseline care plans.

On 6/23/22 at 4:10 PM, an interview with the Director of Nursing who stated when a new admission arrives, the nurse on the hall completing the admission is responsible to completing the baseline care plan. She stated the Unit Manager was responsible for making sure they were complete.

d. During an interview on 6/20/22 at 10:30 AM with Resident #201, she stated she was admitted with a left lower leg fracture. She stated she was non-weight bearing and required two staff members, along with a trapeze above her bed, to transfer from one surface to another.

A record review revealed Resident #201 was admitted on 6/8/22 and there was a baseline care plan still marked as "in progress" for Resident #201 that did not address her leg fracture or activities of daily living needs.

During an interview and review of record with the director of nursing on 6/22/22 at 11:25 AM, she stated that the unit manager was in charge of

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F 655	Continued From page 34 completing those. She stated that she was aware all baseline care plans should be completed within 48 hours of admission to the facility.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		7/21/22

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	345149	A. BUILDING _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WINSTON SALEM	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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F 656	Continued From page 35 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a care plan that addressed falls, urinary incontinence, pressure ulcers and pain for 1 of 17 residents (Resident #46) reviewed for comprehensive care plans. Findings included: Resident #46 was admitted to the facility on 1/28/22 with diagnoses that included, in part, hip fracture and dementia. She discharged to the hospital on 3/17/22. The admission Minimum Data Set (MDS) assessment dated 2/1/22 revealed Resident #46 had severely impaired cognition. She had no falls since admission to the facility, endorsed pain and received as needed pain medication. The assessment further indicated Resident #46 was incontinent of bladder and had no pressure ulcers. A Care Area Assessment (CAA), completed 2/12/22 by MDS Nurse #2, was reviewed in the area of falls and indicated that a care plan would be developed that addressed falls related to a recent hip fracture. A CAA, completed 2/12/22 by MDS Nurse #2,	F 656	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The facility failed to develop a care plan for risk for falls from a previous fracture, urinary incontinence, pressure ulcer prevention, and pain management and assessment for resident #46. Resident #46 was discharged from the facility on 3/17/2022. Effective 7/19/2022, the Regional Minimum Data Set Nurse reviewed current residents with comprehensive assessments for the past 30 days to ensure the care plan reflects what is triggered on the CAA□s.	

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F 656	Continued From page 36 was reviewed for urinary incontinence and stated a care plan would be written that addressed urinary incontinence issues. A CAA, completed 2/12/22 by MDS Nurse #2, was reviewed for pressure ulcers and indicated a care plan would be developed for pressure ulcer prevention. A CAA, completed 2/12/22 by MDS Nurse #2, was reviewed for pain and stated would proceed to care plan for assessment and management of pain. The comprehensive care plan, updated 3/16/22, did not include information that addressed falls, urinary incontinence, pressure ulcers or pain. On 6/22/22 at 11:33 AM an interview was completed with MDS Nurse #2. She explained she had worked at the facility since September 2021 on an as needed (prn) basis since the former MDS Nurse had gone out on medical leave. MDS Nurse #2 said she completed the MDS assessments and CAA's but had not developed comprehensive care plans since she was instructed by facility administration that the former MDS Nurse completed the comprehensive care plans. She added that facility staff informed her most residents wouldn't need a comprehensive care plan since they weren't staying past fourteen days at the facility and the baseline care plans were able to be used for the residents' stay at the facility. During an interview with the Clinical Reimbursement Consultant on 6/22/22 at 1:59 PM, he shared from December 2021 until June 2022 the facility had a prn MDS nurse who helped	F 656	Effective 7/19/2022, the Regional MDS Consultant educated MDS nurse & IDT updating care plan to reflect triggers on the CAA□s. Administrator or their designee will audit two residents weekly, to ensure care plan reflects CAA triggers, for 12 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. Administrator will review the results of weekly audits to ensure any issues identified are corrected. Date of Compliance: July 21, 2022	

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F 656	Continued From page 37 with MDS assessments since there had not been a permanent MDS nurse at the facility. He stated the process was that the MDS Nurse who completed the assessments and CAAs also completed the care plans. He and the newly hired permanent MDS Nurse had begun auditing charts for completion of assessments and care plans and were working on a performance improvement project that addressed timely completion of MDS assessments and care plans.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		7/21/22

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F 657	Continued From page 38 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review the facility failed to update the care plan to reflect the accurate shower schedule and preferences for 2 of 7 residents (Resident #27 and #6) reviewed for Activities of Daily Living. The findings included: 1. Resident #27 was admitted to the facility on 9/7/2018 with diagnoses that included a hydrocele, paraplegia, and chronic pain syndrome. The annual Minimum Data Set (MDS), dated 4/21/2022, indicated Resident #27 was cognitively intact for decision making, had no rejection of care and required minimal assistance of one staff member for transfers, personal hygiene and bathing and had impaired range of motion to the upper and lower extremities on one side. The rehabilitation assessment section of the MDS indicated the Resident required partial to moderate assistance from another person to complete bathing and shower activities. A review of the care plan, dated 4/25/2019, revealed a focused area that read: Resident #27 has an Activities of Daily Living (ADL) self-care performance deficit related to recent joint replacement, osteoarthritis, and diabetes mellitus. The interventions included: provide a sponge bath when a full bath or shower cannot be tolerated, the Resident requires assistance of one staff with a shower. An interview was conducted with Resident #27,	F 657	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Resident #27 care plan was updated to include the shower schedule and preferences on June 28, 2022, by nursing staff. Resident #6 care plan was updated to include the shower schedule and preferences on June 28, 2022, by nursing staff. All current residents have the potential to be affected. The Director of Nursing or their designee will complete audits by July 15, 2022, of the current residents care plans to ensure shower schedules and preferences are being care planned as required. Licensed nurses to include agency licensed nurses will be educated by July 21, 2022, by the Director of Nursing/designee to ensure shower schedules and preferences are being care	

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F 657	Continued From page 39 and he revealed he loved to take a shower and had not received a shower in a very long time. He stated the staff allow him to wash himself at the sink, but he cannot wash his back or legs and he cannot wash his hair at the sink. He stated he uses a washcloth and tries to wash his hair with the cloth. He stated he had told staff he prefers to take a shower and his days should be Tuesday, Thursday, and Saturday in the evenings before bed. He added the last time he had been offered a shower was when a previous Nursing Assistant worked at the facility, but she has not worked at the facility in months. He stated he was a late sleeper and does not like to shower in the mornings. A review of the ADL task Kardex record (the electronic location that informs the nursing assistant of a Resident's assigned care planned task) for Resident #27 titled: ADL bathing had a schedule for Monday/Wednesday/Friday 7:00 a.m. - 3:00 p.m. and as needed. The Resident did not have a documented shower in the 30 days prior to 6/23/2022. An interview was conducted with the Director of Nursing (DON) on 6/23/2022 at 12:26 p.m. and she reviewed the ADL task documentation for Resident #27. She stated she observed Resident #27 did not have a documented shower in the last 30 days. She added that she had conducted a shower preference audit of the facility and Resident #27 had been included so she was very confused why the Resident had not been receiving his showers at his desired time of the day and on his preferred days. She provided a copy of the shower preference document for the second floor and the document indicated Resident #27 preferred to shower on Tuesday	F 657	planned. New hire and agency licensed nurses will not be able to work until the education has been completed. The Director of nursing will complete audits of the ten residents weekly for 4 weeks and monthly for 2 months to ensure shower schedules and preferences are being care planned. The Director of Nursing will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facility compliance. Date of Compliance: July 21, 2022	

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F 657	Continued From page 40	F 657		

and Thursdays in the evening. The DON reviewed the ADL task Kardex for the Resident and indicated the Resident's preference was not reflected on his Kardex. The DON stated the task to update the Kardex and care plan had been assigned to another member of the administrative team. She did not state which member and had not been completed based on these findings. The DON added the Resident's electronic medical record would be updated immediately to reflect his choices and that it was her expectation that all residents receive a shower or be offered a shower on their scheduled days and if they had a preference, it would be honored by staff and be reflected in the electronic medical record.

2. Resident #6 was admitted to the facility on 5/17/2021 with diagnoses that included a stroke with hemiplegia/hemiparesis, Parkinson's disease, osteoporosis, and depression.

A review of the comprehensive annual Minimum Data Set (MDS) dated 5/20/2022 indicated Resident #6 was cognitively intact for decision making, had no rejection of care, no behaviors, required moderate assistance of one staff member with personal hygiene and was totally dependent on staff for bathing. She had an impairment with range of motion on one side with the upper and lower extremity.

A review of the care plan dated 12/01/2021 revealed:

1) There was not a focused area for activities of daily living self-care deficit identified.

2) A focused area for Parkinson's was present and had a goal that read: Resident #6 will remain

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F 657	Continued From page 41	F 657		

free of further signs and symptoms of discomfort or complications related to Parkinson's disease. The interventions included, to See the self-care deficit (however a self-care deficit focus did not exist).

3) A focused area for, Resident #6 had a cerebral vascular accident (Stroke) and included a goal that read: Resident #6 will be able to communicate her needs daily, show improvement to maximum potential to perform activities of daily living (ADL) by the review date. The interventions included: Monitor and document Resident's abilities for ADLs and assist resident as needed and anticipate and meet Resident #6's needs.

An interview was conducted with Resident #6 on 6/20/2022 at 10:25 a.m. and she stated she was paralyzed on her right side and required assistance with her bath and shower. She added she would like to get a shower two times a week, but this had not occurred in greater than two weeks. She could not remember the last time she received a shower. She stated she preferred a female over a man to assist her due to her religion and the facility had told her they would be glad to accommodate this request.

A review of the Activities of daily living task documentation Kardex report revealed no documentation of a shower in the last 30 days from 6/23/2022 for Resident #6 and only 3 full baths being completed.

An interview was conducted with the DON on 6/23/2022 at 4:31 p.m. and she revealed she reviewed the care plan for Resident #6 and the Resident did not have a focused area for Activities of daily living self-care deficit and the

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F 657	Continued From page 42 Resident required assistance with all activities of daily living that included a shower or bed bath due to her disease process/diagnoses. The DON then reviewed the ADL task documentation sheet for Resident #6 and stated a shower had not been documented and only three full bed baths had been documented in the last 30 days. She stated the Resident was to be care planned for a scheduled shower on Monday, Wednesday, and Friday with three showers a week offered to the Resident. She stated the Resident only desired a female for baths and a male had been assigned to her assignment. She stated this would be a preference to be added to the care plan for the Resident. She added a solution to ensure the Resident had her choices met but still received a shower would be considered and then put into place immediately by the administrative team. She stated the administrative team had informed the Resident that they could accommodate her request to only have a female provide showers.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff and Nurse Practitioner (NP) interviews the facility failed to request an x-ray be completed as	F 684	The statements included are not an admission and do not constitute agreement with the alleged deficiencies	7/21/22

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F 684	Continued From page 43 ordered for 5 days after the order was provided by the NP in 1 of 2 residents (Resident #27) reviewed for pain. The findings included: Resident #27 was admitted to the facility on 9/7/2018 with diagnoses that included a hydrocele, paraplegia, synovium and tendon of the left shoulder disorder, osteoarthritis, and chronic pain syndrome. The annual Minimum Data Set (MDS), dated 4/21/2022, indicated Resident #27 was cognitively intact for decision making. The pain assessment section of the MDS revealed the Resident did not receive scheduled pain medication and had pain at a baseline during the lookback period of a 1 out of 10 with 0 being no pain and 10 being the worst pain ever. A review of the nursing progress note dated 6/16/2022 at 12:36 p.m. written by Nurse #6 read, Resident #27 complained of right shoulder pain and requested an x-ray. This nurse asked the Resident what was causing his pain and if he had fallen and he stated, "no, I don't know why, it just hurts." This writer stated, "I will definitely let the doctor know so we can get that order placed for you. An as needed pain medication was provided and was effective. The Nurse Practitioner was called and made aware of the Resident's concern at 12:20 p.m. Resident was placed on the physician book for a visit. A review of the Nurse Practitioner orders revealed an order dated 6/17/2022 at 11:58 p.m. that read, X-ray right should if the Resident continues to complain of pain. Created on 6/17/2022 at 11:58	F 684	herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The x ray on resident #27 was completed on June 22, 2022, by the contracted x ray provider. All current residents have the potential to be affected. The DON/designee will complete an audit by July 15, 2022, of the current residents to ensure x rays are being completed timely. Licensed nurses to include agency licensed nurses will be educated by July 21, 2022, by the Director of Nursing/designee to ensure x rays are being completed timely. New hire and agency licensed nurses will not be able to work until the education has been completed. The DON will review the physician orders during morning clinical report to ensure that x rays have been completed timely for 4 weeks and monthly for 2 months. The DON will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance. Date of Compliance: July 21, 2022	

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p.m. and confirmed in the electronic medical record as received on 6/20/2022 at 4:36 p.m. by the Unit Manager #1.

An interview was conducted with Resident #27 on 6/20/2022 at 3:22 p.m. and he stated he had pain in his right arm and back. He added he had requested x-rays and informed the staff and the physician. He was told x-rays were ordered but they had not occurred, and this was some time ago. He stated it felt like a month ago but he could not remember how long ago. He revealed when he went to lay down the pain became an 8 out of 10. He stated the staff will get him an as needed pain medication if requested.

A review of a nursing assessment dated 6/21/2022 at 4:11 p.m. documented Resident#27 complained of pain in the right shoulder with intensity a 4-5 out of 10.

An interview was conducted with the Unit Manager #1 on 6/22/2022 at 4:59 p.m. and she revealed she discovered Resident #27 had an order in the pending orders awaiting confirmation on the evening of 6/20/2022. She stated she went to the Resident and asked him if he still had pain and he confirmed he did. She stated she confirmed the order for the x-ray and entered an order in the system with the radiological company at that time. She revealed the order should have been confirmed over the weekend, but staff did not go to the appropriate location in the electronic medical record, in her opinion as the unit manager which delayed the confirmation of the order. She added that the x-ray should have been completed on 6/21/2022 and the facility was awaiting the results. When asked to provide the results, she stated she did not have the results for

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F 684	Continued From page 45 the x-ray. An interview was conducted with the NP on 6/22/2022 at 5:06 p.m. and she stated she was informed Resident #27 had pain in his right arm and entered an order for the Resident over the weekend. She stated in the Radiology lab system she was able to visualize the Resident was rescheduled for his x-ray and did not receive it on 6/21/2022 when they arrived at the facility. A call was placed to the Director of Nursing (DON) during this interview by the Unit Manager and the NP, and the DON stated It was discovered the lab company was called to the facility to conduct the x ray when the Resident was not at the facility and was not rescheduled to return. The Resident was not informed the x-ray was scheduled. The NP stated, the Resident will be sent to the Hospital for the x ray or the lab company will be called back out immediately. On 6/23/2022 at 10:30 a.m. an interview was conducted with the DON and she revealed Resident #27 received his x-ray on 6/22/2022 at 5:21 p.m. and the Resident had no fracture to the shoulder but showed evidence of osteoarthritis to the right shoulder joint.	F 684		
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	F 812		7/21/22

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	345149	A. BUILDING _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WINSTON SALEM	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(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 812	Continued From page 46 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the kitchen and in 1 of 2 nourishment rooms by not ensuring food items were not stored on the floor; by not ensuring food items were dated and labeled; by not maintaining the food service equipment in clean and debris-free condition; dishware were stacked clean and in good condition; by not ensuring staff were wearing hair coverings and chin guards for facial hair during food preparations; and by not preventing cross contamination of cleaned dishware when using the dishwashing machine. Findings included: 1a. During the initial tour of the kitchen on 6/20/22 at 9:37 a.m., the following observations were made: 5-missing floor tiles around the floor drains throughout the kitchen; 1-broom and dustpan propped against the wall in the kitchen; 1-mop propped against the wall with the mop's head on the floor in the cleaning supply room;	F 812	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. The five floor tiles around the floor drain were replaced on 7/13/2022. The broom, mop, and dustpan were removed from touching the floor and hung in the janitor□s closet. The large plastic measuring cup was removed from the sugar bin and placed in the dish machine. Two chipped plates were removed from the plate warmer and thrown in the trash. A new top panel for the ice machine was ordered to replace the cover with a broken	

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F 812	Continued From page 47 1-large sugar bin with a large plastic measuring cup flushed in the sugar; 2-chipped plates stacked in the plate warmer next to the steamtable; --Ice machine-top panel cover with broken corner pieces; and --deep fryer-deep dark brown grease build-up inside and outside. On 6/20/22 at 10:15 a.m., the dietary cook stated new plates were ordered to replace the chipped plates but the plates received were too large for the food warmer. 1b. On 6/22/22 at 3:55 p.m., the following observations were made in the 100-hall nourishment room: 1-large bag of trash on the floor with brown liquid leaking from the bottom of the bag; the floor was sticky and littered with food crumbs; 1-empty meatball bowl box on top of the microwave; --inside of the microwave was dirty with food stains; --countertop with sticky, stains of red, yellow substances; --all shelves and the crisper in the refrigerator were dirty with yellow sticky substances. 4-boxes of partially eaten pizzas were stored on top of the refrigerator/freezer; and, 1-uncovered ice scoop stored faced down in opened case of multiple single serve thickened coffee mix on top of refrigerator/freezer. 06/23/22 at 8:58 a.m., the Dietary Manager revealed the housekeeping staff were responsible for cleaning the nourishment rooms.	F 812	corner on 7/14/2022. The grease from the deep fryer was discarded and the interior and exterior were cleaned. The #10 can of tomatoes was picked up from the floor. In the Nourishment Kitchen on 100-hall, on 6/22/2022 through 6/23/2022, the trash bag was removed from the floor and the floor was swept and mopped. The empty bowl was removed from the microwave and the microwave cleaned. The countertops were cleaned and free of sticky substances. Shelves in the refrigerator were cleaned, including the removal of sticky substances in the crisper. Pizza boxes on the top of the refrigerator were thrown out. One uncovered ice scoop was removed, cleaned, and returned covered. All non-resident, or non-labeled and dated food was removed from the nourishment kitchen. The seven cases of food in the portable refrigerator were placed on shelves. The pork loin was placed in a pan in the refrigerator. The employee washing dishes was addressed about changing gloves between loading the dish machine and emptying it. Staff were immediately reeducated about hair nets and facial hair coverings. The 200-hall nourishment kitchen, microwave and refrigerator were cleaned. The refrigerator and cupboards were checked for non-resident or non-labeled and dated food. Hairnets were placed at the entrance of the kitchen to be available before entering. The kitchen, dry storage, refrigerators, freezers, and janitors closet were checked to see if related	

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F 812	Continued From page 48 2a. During and observation on 6/20/22 at 10:40 a.m., 7-cases of food items were stacked on the floor of the temporary portable freezer and a sleeve of pork loin was stored directly on the storage rack in the temporary portable refrigerator. 2b. On 6/23/22 at 12:25 p.m., during a follow-up in the kitchen, 1(#10) can of tomatoes was observed on the floor to hold the door open into the storage room. Also, the large plastic measuring cup remained in the sugar bin as observed during the initial tour. 3. The observation of the 100-hall residents' nourishment refrigerator/freezer on 6/22/22 at 3:55 p.m., revealed multiple food/beverage items that were not labeled with the resident's name, room number, and date stored: 1(20 ounce) bottle sports drink; 1-small plastic container of a red, unidentifiable substance; 1-partially eaten candy bar in small in a plastic bag; 1(16.9 ounce) soda; 3(1.5 quart) sherbet; 2(16.9 ounce) bottled water; 1-bag containing a precooked chicken pot pie; 1(1.05 quart bottled lemonade); 1-precooked beef broccoli bowl; and 1-bag containing an opened bag of single 8 ounce sealed bags of fruit pieces. During this observation a staff member entered and placed 3(11.5 ounce) bottles of lemonade (not labeled) in the freezer. During an interview on 6/23/22 at 8:58 a.m., the Dietary Manager stated dietary staff responsible for supplying supplements and snacks in both nourishment rooms which are checked twice per day (between 9:00 a.m.-10:00 a.m. and 2:00 p.m.-3:00 p.m.). He stated that a resident's	F 812	items noted above also needed corrections elsewhere. Maintenance will check the kitchen for other floor tiles needing replaced or items needing repaired. The Housekeeping Manager was in-serviced about his responsibility in maintaining the Nourishment Kitchens by his Next Level supervisor on 7/15/2022. The Housekeeping supervisor will be re-educating his staff on daily cleaning of the nourishment kitchens. The Dietary Manager and Dietary staff were educated on maintaining the nourishment kitchen refrigerators; hair and face coverings; proper glove wearing and changing to avoid cross contamination; food storage; cleaning schedules; maintaining dishware that is not chipped; storing brooms, mops and dust pans in the janitor closet by hanging so they are not touching the floor; and proper storage of measuring cups or scoops when not in use. Re-education was completed by the DON on 7/14/2022. The Dietary Manager was educated by his Next Level Food Service Supervisor, as to his responsibility as the manager to supervise staff, maintaining a kitchen and meal service in a way to promote proper sanitation, food preparation, and maintaining equipment clean and in good condition, on 7/18/2022. Audits of the kitchen□s food procurement, storage, preparation, and sanitation will be audited two times weekly for 4 weeks and then weekly for 2 months. This will be completed by the Administrator, Next Level Manager, SDC or designee. The results of the Audits will be reported to	

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F 812	Continued From page 49 personal food items must be labeled with the resident's name, room number, and the date the food item was stored. Any items not labeled would be discarded by dietary staff. 4. On 6/20/22 at 10:03 a.m. during the initial kitchen tour, one dietary staff was observed operating the high-temperature dishwashing machine. He was observed wearing plastic gloves and placing dirty dishware into the dishwasher then crossing to the end of the dishwasher and removing a rack of cleaned plate lid covers from the dishwasher, placing them on the storage rack without removing his soiled gloves and washing his hands. When asked, the staff indicated the lids were clean and ready for use. 5a. On 6/20/22 at 10:20 a.m., one male dietary staff observed assisting in the kitchen had facial hair that was not covered. 5b. On 6/23/22 at 11:45 a.m., during meal tray preparation in the kitchen, the Maintenance Director accompanied by another male entered the kitchen without hair coverings.	F 812	and reviewed by the QAPI committee Monthly for 3 months. Date of Compliance: July 21, 2022	
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the doors of 1 of 1 trash dumpster and 1 of 1 cardboard dumpster	F 814	The statements included are not an admission and do not constitute agreement with the alleged deficiencies	7/21/22

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F 814	Continued From page 50 remained closed when not in use and the area surrounding the dumpsters remained free from garbage, refuse and foul odors. Findings included: During the tour of the facility's garbage and refuse disposal area on 6/20/22 at 10:30 a.m., accompanied by the Administrator, 2-dumpsters were observed overflowing with bags of trash from the opened side doors and from the opened tops of the dumpsters. There was a sign posted on the side of one of the trash-filled dumpsters which read "cardboard only". Also, there were soiled diapers, napkins, cardboard, plastic lids on the ground surrounding the dumpsters. Multiple flies and foul odors permeated the area. On 6/20/22 at 10:35 a.m., the Administrator stated that the trash service provider would be contacted immediately and the dumpsters emptied. She indicated the area surrounding the dumpsters would also be cleaned by facility staff. On 6/22/22 at 8:45 a.m., the side door of the trash dumpster was observed open with bags of trash inside.	F 814	herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. On June 20, 2022, the Administrator called the waste management company immediately to confirm that they were picking up that day, per their regular schedule. The Administrator also inquired about the pick-up on the prior Friday due to the amount of trash noted. The area around the dumpster was immediately cleaned by the Housekeeping Director of all debris. The Administrator confirmed the dumpsters would be serviced three times weekly and both dumpsters would be used for trash instead of having one for cardboard only. These are the only dumpsters located at the facility at this time. The Directors of Housekeeping, Maintenance, and the Kitchen were educated on 6/20/22 about keeping the trash contained within the dumpster with the lids closed, and to pick up any debris in the dumpster area immediately when noted. The Maintenance and Housekeeping Directors will incorporate checking the dumpster area into their daily rounds to ensure compliance. Their	

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F 814	Continued From page 51	F 814	staff was in-serviced on July 14, 2022. Audits of the dumpster area will be completed by the Administrator, Maintenance Director, or Designee 3 times a week for the first 30 days and then Weekly for 2 months. The audits will be brought to the QAPI committee for review monthly for 3 months. Date of Compliance: July 21, 2022	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		7/21/22

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F 842	Continued From page 52 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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F 842	Continued From page 53 Based on staff interviews and record review, the facility failed to 1. accurately document a physician (MD) ordered assessment and site care in 1 of 2 residents (Resident #7) reviewed for tube feedings, 2. maintain a complete medical record in the area of diagnoses for 1 of 5 residents (Resident #8) reviewed for unnecessary medications, 3. document a completed physician (MD) ordered treatment in the electronic health record (EHR) for 1 of 3 residents (Resident #45) reviewed for pressure ulcers. The findings included: 1. Resident #7 was admitted to the facility on 12/21/2021 with diagnoses that included gastritis, adult failure to thrive, dysphagia of the oropharyngeal phase, pancytopenia, and unspecified protein calorie malnutrition. A review of the quarterly Minimum Data Set dated 6/3/2022 documented Resident #7 did not have a feeding tube and received a mechanically altered diet. A correction was completed on 6/21/2022 to revealed the Resident had a enteral feeding tube. A review of the care plan dated 6/3/2022 revealed a focused that read: Resident #7 has a nutritional problem related to diet restrictions and was a peg tube only. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness of the gastrointestinal tube (GT) and report results to the MD and follow up as indicated. A review of the June Medication administration record revealed the following orders: 1. Every shift elevate head of bed 30-45 degrees	F 842	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. Resident #7□s medical records were reviewed by the DON to ensure that documentation accurately reflected that the resident has a tube feeding on June 21, 2022. Resident #8□s medical record was reviewed by the DON to ensure that the pertinent medical diagnosis is included in the medical record on June 23, 2022. Resident #45 is no longer at the facility, with a discharge date of 3/10/2022. Other resident treatment records (TAR) were reviewed by the DON for the past 30 days to ensure treatments have been documented on the TAR as ordered on July 15, 2022. Licensed nurses, to include agency licensed nurses, will be educated by July 21, 2022, by the Director of Nursing/designee to ensure the electronic medical record is accurate to include accurate documentation of tube feeding, medical diagnosis, and treatment records. New hire and agency licensed nurses will	

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F 842	Continued From page 54 during feedings to prevent aspiration/pneumonia. 2. For the order enteral feed order: Observe for signs of intolerance (diarrhea, Nausea and vomiting, constipation, abdominal distention, cramping, dehydration, fluid overload, aspiration, increased gastric residual, hypo/hyperglycemia) every shift. 3. Inspect surround skin of the GT stoma for redness, tenderness, swelling irritation, drainage or signs of infections. For each of these orders, on the dates of June 1, 2, 6, 7, 8, 9, 14, 15, and 16 Nurse #5 documented a 7 in the area other nurses had documented a checkmark. A review of the MAR key revealed a 7 indicated the Resident was not available due to sleeping. An interview was conducted with Nurse #5 on 6/22/2022 at 10:54 a.m. and she revealed she had conducted assessments of Resident #7 during her night shift and had meant that the Resident was sleeping during that time frame. When asked how she would demonstrate she had completed or given a medication on the MAR she stated, by signing it off with a checkmark. She added that the place a nurse can document a resident was allowed to rest or sleep would be in a nursing progress note and she stated she did not write a nursing progress note for this Resident on those nights to reveal she had slept. She stated this would be confusing documentation if she was following behind another nurse. She indicated Point click care has instruction on each page and she received training during orientation. An interview was conducted with the	F 842	not be able to work until the education has been completed. The DON will review the electronic medical records of five current residents weekly 4 weeks and monthly for 2 months to ensure the record is accurate to include accurate documentation of tube feeding, medical diagnosis, and treatment records. The DON will submit the findings to the QAPI committee meeting monthly for 3 months for review and recommendations to ensure the facilities continued compliance. Date of Compliance: July 21, 2022	

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Administrator on 6/22/2022 at 11:06 a.m. and she revealed it was her expectation that the electronic medical record has accurate documentation that was easy to understand. She stated she would provide education to her staff.

2. Resident #8 was admitted to the facility 3/16/22 with two diagnoses per electronic health record (EHR): encounter for other orthopedic aftercare and generalized muscle weakness.

A review of his 5-day minimum data set dated 3/23/22, showed that Resident #8 was admitted with daily insulin, antipsychotic, and an antidepressant.

A review of Resident #8's current medication administration record showed he received insulin four times daily, and an antipsychotic and antidepressant daily.

During an interview and review of record with the director of nursing on 6/22/22 at 11:25 AM, she stated that Resident #8 did have the following pertinent diagnoses: above the knee left leg amputation, insulin-dependent diabetes mellitus, anxiety, and depression. She stated the unit nurse, who quit during our survey, was responsible for making sure all resident's records were accurate and complete. She stated they will be complete going forward.

3. Resident #45 was admitted to the facility on 8/30/21 with diagnoses that included, in part, pressure ulcer of sacral region (an area at the base of the spine). Resident #45 discharged to the hospital on 3/10/22.

The quarterly Minimum Data Set (MDS) assessment dated 12/28/21 revealed Resident

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#45 had four pressure ulcers. The assessment indicated the resident received pressure ulcer care which included application of an ointment.

The comprehensive care plan, updated 1/11/22, was reviewed and included a focused area of pressure ulcers. An intervention to address the pressure ulcers included, "Administer treatments as ordered and monitor for effectiveness."

A MD order dated 2/22/22 stated, "Sacrum: apply Zinc Oxide (an ointment used to treat minor skin irritations) every shift for wound care preventative."

The EHR's Treatment Administration Record (TAR) was reviewed for March 2022. There was no documentation on the record that indicated Resident #45 received the Zinc Oxide on 3/4/22 (second shift), 3/7/22 (second shift), 3/8/22 (second shift), or 3/9/22 (third shift).

During a phone interview with Nurse #5 on 6/22/22 at 10:40 AM, she confirmed she applied the Zinc Oxide to Resident #45 as ordered on 3/4/22, 3/7/22, 3/8/22 and 3/9/22 and that it was an oversight that she did not document it on the TAR. She said she knew she was supposed to check off in the EHR that the treatment was completed.

On 6/22/22 at 10:00 AM an interview was completed with the Director of Nursing during which she stated Nurse #5 should have accurately documented in the EHR when she applied the Zinc Oxide to Resident #45. She added Nurse #5 had been immediately educated about documentation in the EHR.