STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING ______ B. WING ______	C 07/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CLEMMONS	**3905 CLEMMONS ROAD CLEMMONS, NC 27012**

(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 rectification and complaint investigation survey was conducted on 07/24/2022 through 07/29/2022. The facility was found in compliance with the requirement CFR 483.73 Emergency Preparedness. Even ID # 9VWD11	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 07/24/22 through 07/29/22. Event ID # 9VWD11 The following intakes were investigated NC 00190030, NC 00190785, NC 00190960, NC 00188255, NC 00187684, NC 001888518, NC 00188974, NC 00189160 and NC 00188220. 14 of the 32 complaint allegation were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	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	F 550		8/25/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/20/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, the facility failed to maintain a resident ' s dignity and respect by not providing assistance with showering resulting in the resident feeling "not happy" that he did not receive a shower but had to have a bed bath (Resident # 28) for 1 of 3 residents reviewed for dignity. Findings included: Resident #28 was admitted on 6/15/22. Resident #28 ' s Minimum Data Set for admission dated 6/20/22 documented an intact cognition	F 550	F-550 This plan of correction constitutes the facility's written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by State and Federal law. On July 26th, 2022, resident # 28 was provided a shower, facial hair was	

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F 550 Continued From page 2
and total dependence for activities of daily living.

Resident #28 ' s care plan dated 6/24/22 documented he required assistance with all his activities of daily living. The intervention was to assist with a shower or bathing.

On 07/24/22 at 11:30 am an observation was done of Resident #28. He was lying in his bed and was noted to have greasy unkempt hair with white flaking, his nails were long and jagged, and he had approximately 1 inch of facial hair. The resident was interviewed. He stated he requested a shower and was informed by the nursing assistants (NA) (could not remember their name) that there was not enough time, and the shower chair was broken. He also kept asking for a shower and received a bed bath since admission (6/15/22) and did not know why. Resident stated today was his shower day and he was expecting a shower. "I am not happy I did not get a shower."

On 7/25/22 at 3:15 pm an interview was conducted with Resident #28. The resident stated he had not received a shower yesterday as scheduled.

On 7/25/22 at 3:20 pm an interview was conducted with NA #2. NA #2 stated she was assigned to Resident #28. NA #2 stated she was agency staff, and this was her first day. NA #2 stated she gave the resident a bed bath. NA #2 stated the resident asked for a shower, but she was instructed by the nurse (Nurse #1) to provide a bed bath.

On 7/25/22 at 3:25 pm an interview was conducted with Nurse #1 and NA #2. Nurse #1

F 550

removed, and nails were trimmed.

0n August 9th, 2022, a full facility audit was completed on the dependent residents with the resident or the residents responsible party to determine bathing preferences by Activities and Nursing Administration. Point Click Care was updated on 8/11/2022 to reflect residents□ preferences.

DON or designee-initiated education for nursing staff to include contracted agency staff on the guidelines for self-determination on how residents have the right to make choices regarding aspects of their care with a focus on residents receiving showers/bathing, removal of facial hair and providing nail care on 8/8/2022 Certified Nursing Assistants in-serviced to notify the residents assigned licensed nurse if a resident declines a shower and chart in POC. Newly hired nursing staff will be in serviced in orientation. No nursing staff to include contracted agency staff will be allowed to work until in serviced on residents□ rights to make choices.
DON or Designee will conduct audits of 25% of dependent residents regarding F-Tag 550 twice weekly times 8 weeks. Any discrepancy will be reported to the Director of Nursing immediately for intervention

A Quality Assurance Improvement Plan meeting was conducted on August 4,2022 with the intradisciplinary team. Present were the Director of Nursing, Medical

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F 550	Continued From page 3 stated she was assigned to Resident #28 and was regularly assigned. She stated the shower chair was broken for about 2 weeks and the resident received a bed bath. On 7/25/22 at 3:15 pm an interview was conducted with the Administrator. She was not informed that the resident wanted a shower and did not receive a shower as requested. The resident was "not happy" that he had to have a bed bath and did not know why. On 7/26/22 at 9:15 am an interview and observation of Resident #28 was done. The resident stated he received a shower, shave, and had his nails cut last evening. Care was observed to have been provided.	F 550	Director, Rehabilitation Manager, Assistant Social Worker, Social Worker, Unit Managers, Medical Records Supervisor, Activity Director, Assistant Maintenance Director, and Administrator. The alleged deficit practice was discussed and monitoring and education with staff to continue . The interdisciplinary team will meet monthly times 2 months for review of the plan . The Director of Nursing or designee will report findings to the team for continuance ,modification or revision of plan to ensure compliance . The facility Director of Nursing is responsible for this plan of correction and the alleged date of compliance is August 19,2022.	
F 578 SS=D	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	F 578		8/25/22

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F 578	Continued From page 4 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. 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 document advanced directives (code status) throughout the medical record for 1 of 21 residents (Resident #30) reviewed for advanced directives. The findings included: Resident #30 admitted to the facility on 6/21/22 and had diagnosis of chronic obstructive pulmonary disease, hypertension, and convulsions. The admission Minimum Data Set (MDS) dated 6/24/22 revealed Resident #30 was cognitively	F 578	F-578 Resident # 30 Advance Directive was signed by the Medical Director and order obtained to change Advance Directive from Full Code to Do Not Resuscitate on 7/27/2022. On August 1,2022 a 100% audit was conducted by the Minimum Data Set Nurse Coordinator to ensure all residents had an order for Advance Directives on their medical chart. On 8/11/2022 an in- service was	

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F 578	Continued From page 5 intact. A review of Resident #30 ' s comprehensive care plan was conducted on 7/24/22 and it revealed no care plan for code status or advance directives. A review was completed of Resident #30 ' s June Physician orders and no order was observed for an advance directive or code status. On 7/29/22 at 2:15 pm, during an interview with Admission Coordinator (AC) it was indicated when Resident # 30 admitted to facility on 6/21/22 the Resident was a full code. AC indicated she informed the Social Worker (SW) of Resident #30 ' s full code status. 7/29/22 at 2:20 pm the SW indicated she did not recall Resident #30 being a full code on admission. On 7/27/22 at 11:49 am with the Social Worker (SW) indicted the Admission Coordinator usually got the code status from Resident/ family when they were signing paperwork on admission, and then the Admissions Coordinator would notify her. She would initiate a Medical Orders for Scope of Treatment (MOST) form or DNR/CODE status form and give it to the Physician to sign. The Social Worker indicated once the signed form it is was returned to her, she would give the signed document to Nursing to put an order in. The SW indicated she or the Medical Records staff would document in the medical record the code status. Regional Consultant #1 presented an undated form, which, indicated Resident #30 did not have an advance directive identified on admission. During the 7/27/22 at 11:49 am interview, the	F 578	conducted by the Administrator to the Social Workers, Admission Coordinator, Minimum Data Set Nurse and Director of Nursing on the policy to ensure all current residents have an advance directive . On 8/9/2022 the Director of Nursing initiated an in-service for all licensed nurses including contracted agency nurses to obtain an order related to ensuring for advance directives upon admissions , readmissions and change in status for all current residents. No licensed nurse to include contracted agency nurses will be permitted to work until in serviced on obtaining an order for advance directives. All new hired licensed nurse will be in serviced in orientation . Monitoring of all new admission and readmitted current residents started on 8/1/2022 by the Administrator to ensure all newly admitted / readmitted residents will have an order for advance directives. Monitoring of advance directives will be reviewed for new and readmissions weekly times 8 weeks by Administrator or designee. A Quality Assurance Improvement Plan meeting was conducted on August 4,20222 with the intradisciplinary team. Present were the Director of Nursing, Medical Director, Rehabilitation Manager, Assistant Social Worker, Social Worker, Unit Managers, Medical Records Supervisor, Activity Director, Assistant Maintenance Director, and Administrator. The alleged deficit practice was discussed	

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F 578	Continued From page 6 surveyor informed the SW that Resident # 30 did not have a code status in electronic medical record when reviewed on 7/24/22. The SW indicated a what kind of form? form was generated and put in the Code Status Book at the Nurses desk. The SW left interview to retrieve the Code Status Book and returned with the Code Status Book. Review of the Code Status Book revealed Resident #30 had a DNR/Code status form and a MOST form dated 7/20/22. During an interview on 7/27/22 at 10:51 am with Nurse #7 it was noted an order was initiated for Do Not Resuscitate (DNR) code status in the electronic record dated 7/27/22. Nurse #7 indicated they just got the paperwork signed and Resident #30 would have been a full code until the paperwork was signed. No care plan was in place and Nurse #7 indicated the MDS Coordinator was responsible for initiating the code status/advance directive care plan. An attempt to interview the MDS Coordinator was unsuccessful. Interview with the Administrator on 7/29/22 at 2:22 pm indicated, Resident #30 was a full code on admission and the Physician signed the Do Not Resuscitate Code status and provided an order on 7/20/22. She indicated the staff aware if there was no order in place, then to treat the resident as a full code.	F 578	and monitoring and education with staff to follow. The intradisciplinary team will meet monthly times 2 months for review of the plan . The administrator or designee will report findings to the team for continuance ,modification or revision of plan to ensure compliance . The facility Administrator is responsible for this plan of correction and the alleged date of compliance is August 25,2022.	
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.	F 641		8/25/22

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F 641	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the quarterly Minimum Data Set (MDS) for 1 of 25 residents reviewed for MDS (Resident #20). Findings included: Resident #20 was admitted to the facility on 2/25/22 with the diagnosis of stroke. Resident #20 ' s physician diet order dated 4/13/22 was for nectar thick liquids and pureed foods regular diet. Resident #20 ' s quarterly MDS dated 6/14/22 documented the resident was not receiving a mechanically altered diet for his therapeutic diet. On 7/27/22 at 11:20 am an interview was conducted with the Corporate MDS Nurse. She was aware that Resident #20 ' s quarterly MDS dated 6/14/22 did not include his therapeutic diet was a mechanically altered diet as required. On 7/29/22 at 10:15 am an interview was conducted with the Administrator. The Administrator stated she was informed of the MDS error.	F 641	F-641 Resident # 20 obtained a modified assessment by the Regional Reimbursement Nurse Consultant on 7/28/2022 to reflect a mechanically altered diet. On 8/11/2022 an audit was performed by the Administrator for all residents receiving a mechanically altered diet to ensure that the coding is correct in section K on the MDS. On 7/28/2022 an in service was performed by the Regional Reimbursement Nurse Consultant to the facility Minimum Data Set Coordinator on required accurate assessment for mechanically altered diet. All new hired Minimum Data Set staff to include agency MDS will be in serviced in orientation. Monitoring of 5 current residents on mechanically altered diets to ensure accurate coding of Section K will be weekly time 8 weeks by the Director of Nursing or designee. Any discrepancy will be immediately reported to the Administrator for intervention . A Quality Assurance Improvement Plan meeting was conducted on August 4,2022 with the intradisciplinary team. Present were the Director of Nursing, Medical Director, Rehabilitation Manager, Assistant Social Worker, Social Worker, Unit Managers, Medical Records	

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F 641	Continued From page 8	F 641	Supervisor, Activity Director, Assistant Maintenance Director, and Administrator. The alleged deficit practice was discussed and monitoring and education with staff to continue . The intradisciplinary team will meet monthly times 2 months for review of the plan . The Director of Nursing or designee will report findings to the team for continuance ,modification or revision of plan to ensure compliance . The facility Director of Nursing is responsible for this plan of correction and the alleged date of compliance is August 25,2022.	
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	F 656		8/25/22

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F 656	Continued From page 9 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop the resident ' s comprehensive care plan for the diagnosis and care of epilepsy (Resident #28) for 1 of 25 care plans reviewed. Findings included: Resident #28 ' s Minimum Data Set (MDS) for admission dated 6/20/22 documented an intact cognition. The diagnosis included epilepsy. Review of Resident #28 ' s care plan revealed there was no care plan for epilepsy or seizures. Review of the physician orders for June 2022	F 656	F-656 F-656 On 7/29/2022residnet # 28 comprehensive care was updated to reflect a diagnosis of seizure disorder to include epilepsy by the Minimum Data Set Nurse(MDS). On 8/11/2022 an audit was completed for all current residents with a diagnosis of seizure disorder to include epilepsy are care planned appropriately by the Administrator.	

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F 656	Continued From page 10 revealed Resident #28 was receiving medication for seizure. On 7/29/22 at 9:31 am an interview was conducted with the Minimum Data Set Coordinator. She stated Resident #28 did not have a care plan for epilepsy/seizure and that she would develop one. She stated the epilepsy care plan was missed. On 7/29/22 at 10:15 am an interview was conducted with the Administrator. The Administrator stated she was informed of the missed epilepsy care plan and expected staff to create one upon admission.	F 656	Education was provided by the Regional Reimbursement Clinical Nurse to the Minimum Data Set Nurse to include agency MDS nurses on 8/12/2022 on care plans for residents with a diagnosis of seizure disorder or epilepsy .Any newly hired Minimum Data Set Nurse will be in serviced in orientation for development of a care plan pertaining to diagnosis of seizure disorder. Monitoring of development of comprehensive care plans for current residents to ensure diagnosis of seizure disorder to include epilepsy weekly times 8 weeks by the Director of Nursing or designee. Five (5) new admissions, readmissions and newly diagnosed current residents with seizure disorder to include epilepsy. Any discrepancy will be immediately reported to the Administrator for intervention. A Quality Assurance Improvement Plan meeting was conducted on August 4,2022 with the intradisciplinary team. Present were the Director of Nursing, Medical Director, Rehabilitation Manager, Assistant Social Worker, Social Worker, Unit Managers, Medical Records Supervisor, Activity Director, Assistant Maintenance Director, and Administrator. The alleged deficit practice was discussed and monitoring and education with staff to continue . The intradisciplinary team will meet monthly times 2 months for review of the plan . The Director of Nursing or	

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F 656	Continued From page 11	F 656	designee will report findings to the team for continuance ,modification or revision of plan to ensure compliance . The facility Director of Nursing is responsible for this plan of correction and the alleged date of compliance is August 25,2022.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff and resident, the facility failed to provide a resident who was dependent on activities of daily living resident (ADL) washed hair, cut nails, cleaned glasses and shaved facial hair (Resident #28) for 1 of 7 residents reviewed for ADLs. Findings included: Resident #28 was admitted to the facility on 6/14/22 with the diagnosis of epilepsy. Resident #28 ' s Minimum Data Set for admission dated 6/20/22 documented an intact cognition, no behaviors or refusal of care, and total dependence for ADLs. Resident #28 ' s care plan dated 6/24/22 documented the resident required assistance with all his activities of daily living. The intervention	F 677	F-677 On July 25th, 2022, resident # 28 was provided a shower, facial hair was removed, and nails were trimmed. On 7/25/2022 a visual audit was performed by Facility Administrative team to ensure no other residents had greasy unkept hair with white flaking, long jagged fingernails, facial hair approximately 1 inch in length or dirty glasses. No other resident identified , therefore 1 out of 7 residents as stated . On 8/12/2022 an in-service was initiated by the Director of Nursing or designee to ensure cleansing of eyeglasses and washing greasy unkempt hair. Newly hired nursing staff will be in serviced in orientation. No nursing staff	8/25/22

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F 677

Continued From page 12

was to assist with a shower or bathing.

A review of Resident #28 ' s nursing assistant care documentation revealed he received a bed bath 3 to 4 times a week from admission to 7/24/22.

A review of Resident #28 ' s bathing/shower documentation revealed he had a bed bath 3 to 4 times a week. No shower was documented.

On 07/24/22 at 11:30 am an observation was done of Resident #28. He was lying in his bed and was noted to have greasy unkempt hair with white flaking, his nails were long and jagged, his glasses were visibly dirty, and he had approximately 1 inch of facial hair. The resident was interviewed. He stated he requested a shower and was informed by nursing assistants (NA) (could not remember their names) that there was not enough time and was provided a bed bath. Resident #28 stated that he asked for a hair wash, shave, and nail cut and the NA would inform him they would return, and they had not returned to help him. Resident #28 thought there was not enough staff to assist to the shower. The resident stated he only had bed baths instead of his shower.

On 7/25/22 at 3:15 pm an interview and observation were done with Resident #28. The resident stated and was observed that his hair was not washed, nails cut, or face shaved. His glasses remained visibly dirty.

On 7/25/22 at 3:20 pm an interview was conducted with NA #2. NA #2 stated she was assigned to Resident #28. NA #2 stated she was agency staff, and this was her first day. NA #2

F 677

will be allowed to work until in serviced on grooming of residents to include hair, nails, and facial hair conducted.

DON or designee-initiated education for nursing staff to include contracted agency staff on the guidelines for self determination on how residents have the right to make choices regarding aspects of their care with a focus on residents removal of facial hair ad providing nail care on 8/8/2022.Certified Nursing Assistants in serviced to notify the residents assigned licensed nurse if a resident declines a shower and chart in Pint Click Care. On 8/12/2022 an in service was initiated by the Director of Nursing or designee to ensure cleansing of eyeglasses and washing greasy unkept hair. Newly hired nursing staff will be in serviced in orientation. No nursing staff to include contracted agency staff will be allowed to work until in serviced on grooming of residents to include hair, nails, and facial hair.

DON or Designee will conduct audits of 25% of dependent residents regarding F-Tag 677 twice weekly times 8 weeks. Any discrepancy will be reported to the Director of Nursing immediately for intervention .

A Quality Assurance Improvement Plan meeting was conducted on August 4,2022 with the intradisciplinary team. Present were the Director of Nursing, Medical Director, Rehabilitation Manager, Assistant Social Worker, Social Worker, Unit Managers, Medical Records

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F 677	Continued From page 13 stated when asked she gave the resident a bed bath and did not wash the resident's hair, cut his nails, or offer a facial shave. NA #2 stated the resident asked for a shower, but she was instructed by the nurse (Nurse #1) to provide a bed bath. On 7/25/22 at 3:25 pm an interview was conducted with Nurse #1 and NA #2. Nurse #1 stated she was assigned to Resident #28 and was regularly assigned. Nurse #1 had not stated when asked why NA #2 had not cut the resident ' s long, jagged nails or shaved his face. Nurse #1 stated we do not usually wash the resident ' s hair in the bed but that could be done. NA #2 stated she does not know how to wash hair in the bed. Nurse #1 was observed to explain to NA #2 how to wash the resident ' s hair in the bed. On 7/25/22 at 3:15 pm an interview was conducted with the Administrator. The hair washing, nail cutting, and long male facial hair was discussed for Resident #28. The Administrator stated she was not aware that care was not completed. On 7/26/22 at 9:15 am an interview and observation were done of Resident #28. The resident stated he received a shower with hair wash, facial shave, and nails cut last evening (7/25/22). The resident ' s glasses remained visibly dirty. On 7/26/22 9:30 am an interview was conducted with the Administrator. She stated that there was a shower chair on the other halls that could have been used for the resident to have a shower with hair wash as desired and not wait for a replacement. She stated, "the resident had a	F 677	Supervisor, Activity Director, Assistant Maintenance Director, and Administrator. The alleged deficit practice was discussed and monitoring and education with staff to continue . The interdisciplinary team will meet monthly times 2 months for review of the plan . The Director of Nursing or designee will report findings to the team for continuance ,modification or revision of plan to ensure compliance . The facility Director of Nursing is responsible for this plan of correction and the alleged date of compliance is August 25,2022.	

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F 677	Continued From page 14 shower and care last evening, I made sure of this" (Resident #28).	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and resident interview, the facility failed to apply the resident ' s left-hand splint as ordered (Resident #28) for 1 of 3 residents. Findings included: Resident #28 ' s Minimum Data Set for admission dated 6/20/22 documented an intact cognition and total dependence for ADLs. The diagnosis was epilepsy. Resident #28 had a physician order dated 7/17/22	F 688	F 688 Increase/Prevent Decrease in ROM/Mobility What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident # 28 was evaluated by therapy services on 7/26/2022and the left-hand splint is in place as ordered. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.	8/25/22

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for left-hand splint placement 4 hours on and 4 hours off as tolerated. An order for knee splint was not in the record.

A review of Resident #28 ' s medication treatment record (MAR) for July 2022 had no initials documented for 7/24/22 left-hand splint placement.

On 07/24/22 at 11:30 am an observation and interview were done of Resident #28. The resident had a left hand that was spastic. He was not wearing his left-hand splint. The resident stated that staff was not applying his splint for a couple of days now that therapy had provided for him, and he did not know why. The resident also stated that he had knee splints too that were not placed. The knee splint was from the prior facility to support the knee.

On 07/24/22 at 1:30 and 4:15 pm an observation was done of Resident #28. He was not wearing his left-hand splint.

On 7/25/22 at 3:30 pm an observation and interview were done of Resident #28. The resident was not wearing his splint. The resident stated he had not worn his splint today.

A review of Resident #28 ' s July MAR documented his left-hand splint was placed on 7/25/22 signed by Nurse #1.

On 7/26/22 at 9:15 am an observation and interview were done of Resident #28. The resident was not wearing his splint. The resident stated he had not had his splint (left-hand splint) in quite a while and would like to wear it. "They have not been putting them on."

F 688

Current resident splints and their splint orders were reviewed by the Regional Nurse Consultant on 7/26/2022.
What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur
Licensed nurses to include agency nurses will be educated by 8/24/22 to ensure splints are being applied as ordered and splint orders are being reviewed. Newly hired licensed nurses and agency staff licensed nurses will not be allowed to work until the education is completed.
How the corrective action will be monitored to ensure the deficient practice will not recur
DON or Designee will conduct audits 5 current residents regarding FTAG 688 weekly times 8 weeks.
Findings of audit will be discussed with the interdisciplinary team at the monthly Quality Assurance Performance Improvement meetings until such substantial compliance has been determined.

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On 7/26/22 at 9:20 am an interview was conducted with Nurse #1. Nurse #1 stated she was not familiar with the resident and would check the order and make sure the resident had his splints placed today.

On 7/26/22 at 11:15 am an observation was done of Resident #28. He had splints to his bilateral knees and not his left hand. He stated the nursing assistant placed the knee splints and he did not know if the left-hand splint was missing.

On 7/26/22 at 11:20 am an interview was conducted with Nurse #1. Nurse #1 stated she asked Nurse #2 to place Resident #28 ' s splints yesterday (7/25/22) and did not know about the hand splint, where it was. She stated no response to documenting her initials on the resident's MAR for physician order to place left-hand splint each day on 7/25/22.

On 7/26/22 at 1:30 pm an interview was conducted with the Administrator. The Administrator stated she was not aware that Resident #28 was not receiving placement of his left-hand splint.

On 7/27/22 at 8:55 am an interview and observation were done of Resident #28. He had his left-hand and bilateral knee splints in place. The resident stated the staff were placing his splints now.

On 7/27/22 at 9:00 am an interview was conducted with Nurse #2. Nurse #2 stated she did not work on Monday 7/25/22 and was asked to place Resident #28's splints on today, 7/26/22, and placed them.

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F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide a nutritional supplement as recommended and ordered by the physician to 1 of 1 resident reviewed for nutrition. (Resident #40). Findings included: Resident #40 was admitted on 6/2/2022 from the hospital with accumulative diagnoses that included renal insufficiency, closed fracture of femur, and unspecified dementia. Review of Care Plan initiated on 6/6/2022	F 692	F692 Nutritional/Hydration Status Maintenance What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #40's medication orders were reviewed and updated to include a nutritional supplement per registered dietician (RD) recommendation on 7/28/22 by the Regional Director of Clinical Services (RDCS). The physician was notified on 7/28/22 by the RDCS and is in agreement with the recommendation.	8/25/22

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indicated Resident #40 had a poor appetite and impaired skin integrity. Interventions put into place included encourage good nutrition, monitor, and report changes in behavior related to appetite loss, weight loss, nausea or vomiting.

The admission Minimum Data Set (MDS) dated 6/8/2022 indicated Resident #40 was severely cognitively impaired and required set up help with meals. On admission, the MDS showed Resident #40 had a weight of 134 pounds. The MDS indicated Resident #40 had no weight loss of 5% or more in the past month. Resident #40 received a mechanical soft diet.

A Registered Dietician's (RD) progress note dated 6/15/2022 read in part "recommendation for a dialysis nutritional shake due to a varied appetite and wounds."

A Physician's progress note dated 6/20/2022 read in part "based on RD's recommendation one can of a nutritional drink for dialysis residents was ordered to be given twice a day."

Physician order dated 6/20/2022 read in part "nursing staff please add a supplemental dialysis nutritional shake twice a day". The supplemental nutritional shake was ordered one time only for 999 days.

The Medication Administration Record for June 2022 indicated a nutritional shake was administered on 6/20/2022 at 11:59 P.M. The nutritional shake was not administered after that date.

Resident #40's electronic medical record under weights read on 7/4/2022 Resident #40 weighed

F 692

How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.

The Director of Nursing (DON) completed an audit on 8/4/22 of the RD recommendations for the current residents' nutritional supplements to include dialysis resident supplements for the last 60 days.

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur

The DON/ designee will complete education by 8/24/22 with the licensed nurses to include the agency licensed nurses related to ensuring RD recommendations for nutritional supplements are being implemented as required. New hire licensed Nurses to include new agency licensed nurses will be educated in orientation and will not be allowed to work until education is completed.

How the corrective action will be monitored to ensure the deficient practice will not recur

DON or Designee will conduct audits on 10 current residents regarding F 692 weekly times 8 weeks.

Findings of the audit will be discussed with Interdisciplinary team at Quality Assurance Performance Improvement meetings until such substantial compliance has been determined.

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F 692	Continued From page 19 131.2 pounds. The weights were collected using a mechanical lift. A telephone interview was conducted on 7/27/2022 at 9:22 A.M. with Nurse #6, who entered the order and administered the first can of the supplemental nutritional shake to Resident #40. The Nurse indicated she did not recall if Resident #40 had an order for a nutritional shake or if she had entered the order into the electronic medical record. Nurse #6 stated she had not seen a supplement ordered as a one time dose and indicated the order may have been incorrectly entered. When the order was read to Nurse #6, she stated 999 days sounded like a recurring order. A telephone interview was conducted on 7/27/2022 at 10:46 A.M. with Registered Dietician #2. During the interview, she indicated she completed a review of Resident #40's medical chart and determined Resident #40 would benefit from a nutritional shake designed for dialysis residents given twice a day to meet Resident #40's nutritional needs. RD #2 stated without the addition nutritional value, Resident #40's wounds may heal slower, and she may lose weight. An interview was conducted with the Physician on 7/28/2022 at 3:35 P.M. During the interview, the Physician indicated no harm came to Resident #40 due to not receiving the nutritional shake. The Physician further stated Resident #40 had a weight loss related to adjustments of being in a long-term care facility. An interview was conducted with the Administrator on 7/29/2022 at 11:35 A. M. During the interview, the Administrator indicated staff	F 692		

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F 692	Continued From page 20 were responsible to enter orders and follow orders as prescribed by the physician.	F 692		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview of staff and residents, the facility failed to provide sufficient nursing staff to meet the needs of the residents. The facility did not	F 725	F725 Sufficient Nursing Staff 1. On 7/25/2022, the certified nursing assistant assisted resident #28 with a shower, facial hair removal and trimming	8/25/22

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promote dignity for a resident who received a bed bath in lieu of a shower, provide nail care, shave, and hair wash (Resident #28). This affected 1 of 7 sampled residents reviewed for activities of daily living.

Findings included:

Cross refer to:

1. F550: Based on observation, record review, and staff and resident interview, the facility failed to maintain a resident's dignity and respect by not providing assistance with showering resulting in the resident feeling "not happy" that he did not receive a shower but had to have a bed bath (Resident # 28) for 1 of 3 residents reviewed for dignity.

2. F677: Based on observation, record review, and staff and resident interviews, the facility failed to provide a resident who was dependent on activities of daily living resident (ADL) washed hair, cut nails, cleaned a glasses and shaved facial hair (Resident #28) for 1 of 7 residents reviewed for ADLs.

On 7/24/22 at 10:30 am an interview was conducted with Resident #28. "I waited for nursing staff to arrive to set up for my shower. Sometimes staff forgets because they were too busy."

On 7/26/22 at 2:10 pm an interview was conducted with the Administrator. She stated she only had 23 facility employees for all areas and was using agency nursing staff to fill full-time nursing employee slots. When there were nurse staff call outs, it would take time for the

F 725

of nails. Resident #28 will be monitored for continuous compliance during the facility manager round observations and follow up as needed

2. On August 24, 2022, an audit was completed by the Administrator, Director of Nursing, and the Interdisciplinary team (IDT) to assess the facility current resident care acuity requirements to include showers, facial hair, and nail care and develop a plan to ensure the facility is providing sufficient staffing.

The Regional Director of Clinical Serviced reviewed the plan on August 24, 2022, with the Administrator to ensure implemented measures are in place to maintain adequate staffing levels.

3. The interdisciplinary team and the Director of Nursing were educated on 8/24/22 by the Administrator on the facility staffing plan. Newly hired Director of Nursing, Administrator, and interdisciplinary team staff will be educated on hire.

4. The Administrator will review the facility staff plan to ensure measures remain in place for adequate staffing for 4 weeks and monthly for 2 months. The Administrator will report findings of the monitoring to the interdisciplinary team during QAPI meetings monthly for 3 months and will make changes to the plan as necessary to maintain compliance.

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F 725	Continued From page 22 replacement nurse to arrive. Frequently, the call outs were at the last minute or a scheduled person did not show up to work. She commented that even when she did have agency staff, "No one wants to work."	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		8/25/22

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F 756	Continued From page 23 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Medical Director, and consulting Pharmacists interviews, the facility failed to act on recommendations made by the consultant pharmacist for 1 of 5 resident (Resident #34) reviewed for unnecessary medications. Findings included: Resident #34 was admitted to the facility on 12/31/2020 with diagnoses included renal insufficiency. The comprehensive Minimum Data Set (MDS) dated 5/27/2022 indicated Resident #34 was able to make decisions about activities of daily living. A physician order dated 4/21/2022 and discontinued on 6/14/2022 indicated Sevelamer (used to control high blood levels of phosphorus in people on dialysis) 800 milligrams (mg), give one tablet by mouth four times a day for supplement with meals and one snack. A physician order dated 6/14/2022 read in part "Sevelamer tablet 800mg give one tablet by mouth two times a day and give one tablet with snacks." A physician order dated 6/16/2022 read in part "Sevelamer 800mg tablet place and dissolve two	F 756	F-756 On 7/28/2022 resident # 34 Sevelamer medication order was clarified from Medical Director by Regional Director of Clinical Services and noted in Point Click Care. An audit for all residents with a diagnosis of renal insufficiency receiving Sevelamer was conducted on 8/16/2022 by the Director of Nursing . On 7/26/2022 education initiated by the Regional Director of Clinical Services for licensed nurses on Medication regime Review. All licensed nurses to include contracted agency licensed nurses will not be allowed to until in serviced. All newly hired nurses will be in serviced in orientation to ensure continued compliance. Weekly monitoring eight times weeks by the Director of Nursing or designee on all residents prescribed Sevelamer for the identification of any unnecessary by way of duplication.	

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F 756	Continued From page 24 tablets in cheek three times a day." A physician order dated 6/16/2022 read in part "Sevelamer 800mg tablet place and dissolve one tablet in cheek two times a day with snacks." A physician order dated 7/20/2022 read in part "Sevelamer 800mg give three tablets by mouth with meals for elevated phosphorus levels give one tablet with all snacks." A copy of the Pharmacist's Consultation Reports dated 7/20/2022 was provided by the facility for review on 7/27/2022 in in part "Resident #34 had the following Sevelamer orders which may represent a duplication of therapy." - Ordered 6/14/2022 Sevelamer tablet 800mg give one tablet by mouth two times a day with snacks. - Ordered 6/16/2022 Sevelamer 800mg tablet place and dissolve two tablets in cheek three times a day and dissolve one tablet buccally two times a day with snacks. - Ordered 7/20/2022 Sevelamer tablet 800mg give three by mouth with meals for elevated phosphorus level give one tablet with all snacks. A telephone interview was conducted on 7/29/2022 at 9:14 A.M. with the consulting Pharmacist. During the interview, the consulting Pharmacists indicated she completed a review of Resident #34's MRR once a month. The Pharmacists indicated she had sent a review in July 2022 for Resident #34's Sevelamer to be reviewed. The Pharmacist stated she would not follow up to see if the review had been completed by the facility until the MRR was completed in August.	F 756	A Quality Assurance Improvement Plan meeting was conducted on August 4,2022 with the intradisciplinary team. Present were the Director of Nursing, Medical Director, Rehabilitation Manager, Assistant Social Worker, Social Worker, Unit Managers, Medical Records Supervisor, Activity Director, Assistant Maintenance Director, and Administrator. The alleged deficit practice was discussed and monitoring and education with staff to continue . The interdisciplinary team will meet monthly times 2 months for review of the plan . The Director of Nursing or designee will report findings to the team for continuance ,modification or revision of plan to ensure compliance . The facility Director of Nursing is responsible for this plan of correction and the alleged date of compliance is August 25,2022.	

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F 756	Continued From page 25 A telephone interview was conducted on 7/29/2022 at 12:34 P.M. with the Medical Director. During the interview, the Medical Director stated the Director of Nursing (DON) printed off the monthly MRRs and gave the reports to him for review. The Medical Director stated he had not received the July 2022 pharmacy recommendations due to the DON not being at the facility. The Director of Nursing was unavailable for an interview. An interview was conducted on 7/29/2022 at 11:35 A.M. with the Administer. During the interview, the Administrator indicated the pharmacy consultant, nursing staff, and the Medical Director should review entered orders to ensure no duplicates were listed and the Medical Director should be contacted with any discrepancies.	F 756		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview, the facility failed to administer insulin, check the blood glucose, and administer insulin according to the blood glucose value as ordered by the physician for 1 (Resident # 15) of 2 residents reviewed for medication administration. Findings include:	F 760	F 760 Residents are Free of Significant Errors What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Nurse # 5 for the days in question was educated on July 28th, 2022, related to ensuring blood glucose monitoring and	8/25/22

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F 760

Continued From page 26

Resident # 15 was admitted to the facility on 11/4/20 with diagnosis of diabetes mellitus.

Resident #15's annual MDS (Minimum Data Set) dated 5/9/22 revealed Resident was cognitively intact and required supervision with 1-person physical assist with bed mobility, eating, toilet use, supervision with setup help with transfers.

A review of Resident #15's care plan dated 6/28/22 revealed Resident #15 had Diabetes Mellitus and required insulin and medications to manage their blood sugar. The goal was for Resident to be free from any signs or symptoms (s/sx) of hypoglycemia, and to be free from any s/sx of hyperglycemia. The interventions included, diabetes medication as ordered by physician, monitor/document for side effects and effectiveness.

A review of Physician orders for the month of June 2022 revealed an order for Humalog mix 75/25 100 unit/ml pen-injector, inject 18 units subcutaneously two times a day for type 2 diabetes mellitus and an order for Novolin R Flex Pen, inject as per sliding scale subcutaneously before meals related to type 2 diabetes medication.

A review of June 2022 medication administration record revealed it was not documented that Resident #15 received insulin as ordered on 6/7/22, 6/14/22, 6/15/22 and did not have blood glucose checks as ordered for 4:30 pm on 6/7/22, 6/15/22, 6/17/222, and 6/28/22.

On 7/27/22 at 2:30 pm an interview was conducted with the Administrator. She stated if

F 760

insulin is administered as ordered.
Resident #15's physician was notified of the omissions related to resident's blood sugar monitoring and administration of insulin on July 27th, 2022, no new orders received.
How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.
An audit was completed on 8/18/22 by the Director of Nursing (DON) of the current residents to ensure blood glucose monitoring and insulin administration are being completed as ordered.
What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur
The Director of Nursing/ Designee will complete education by 8/24/22 of the licensed nurses and the certified medication aides (CMA) to include agency licensed nurses and agency CMAs regarding ensuring blood glucose monitoring and insulin is administered as ordered. CMAs will alert the Unit manager/ DON if insulin not given as ordered for follow up. Newly hired and agency staff Licensed Nurses and certified medication aides will not be allowed to work on the medication cart if education is not completed.
How the corrective action will be monitored to ensure the deficient practice will not recur
During clinical morning meeting, medication orders will be reviewed for blood glucose monitoring and insulin

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F 760	Continued From page 27 the blood glucose and insulin was not signed in June as being completed for Resident #15 it was not done. On 7/27/22 at 3:05 pm an interview was conducted with Physician, the primary for Resident #15 and facility Medical Director. He stated he knew Resident #15 well, and he indicated Resident had diabetes and sliding scale insulin to coincide with before meals blood glucose check. The Physician stated he was not aware that the resident had missed blood glucose checks and insulin according to scale on several occasions in June 2022 as documented by the medication administration record. The Physician stated a lack of administration of ordered insulin was serious. The order needed to be implemented as written and given in a timely fashion. The Physician stated he was not aware when the Resident had an elevated blood glucose of 443 on 6/16/22 after missing his blood glucose check with scale insulin the day before. On 7/27/22 at 3:42 pm an interview was conducted with Resident #15, and he stated, "staff was not always checking my blood glucose before meals due to not having enough nursing staff. Last month my blood glucose went over 400 and I did not feel well, it made me sick. I was nauseated and thirsty." On 7/28/22 at 11:44 am an interview with Medication Aide/Nursing Assistant (NA)#1 and she indicated she signs off the medication that it was given and put the location of where the site the insulin was administered by the nurse and then would document in the progress note the nurse administered the medication. She also indicated she did not recall Resident #15 to not	F 760	administration omissions. The physician or nurse practitioner will be notified if omissions were noted for follow up for 8 weeks. Findings of the audits will be discussed with Interdisciplinary team at the monthly Quality Assurance Performance Improvement meetings until such substantial compliance has been determined.	

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receive his insulin, on the days I administered medication to him. NA #1 indicated she may have forgot to sign off that the medication was administered, or the nurse might have forgot to sign off that she administered the medication.

During an interview on 7/28/22 at 11:57 am with NA #3 and she indicated she signs off the insulin when the nurse gives it and sometimes the nurse will sign off the insulin when they give the insulin. She indicated Resident #15 always got his insulin, unless the blood glucose was low, and insulin was not needed. NA #3 also indicated she was not aware of Resident not getting ordered insulin.

On 7/28/22 at 2:29 pm an interview was conducted with Nurse #5, and she indicated she was the nurse that cared for the Resident #15 on the stated dates. She stated Resident would be downstairs in activities and if was gone too long she would not administer the ordered insulin. Nurse #5 indicated she did not call the Physician when Resident did not receive the ordered insulin. During the interview Nurse #5 was presented with the blank dates on the MAR for the insulin that was ordered and at that time she then indicated she did not work all the days the insulin was not administered.

On 7/28/22 at 3:14 pm a follow -up interview was conducted with the Physician, and it was indicated Resident #15 was not available and that may have been why Resident did not receive insulin as ordered. He also expected the staff to follow the orders that were in place and if Resident did not receive the insulin, they should have informed him. Physician indicated It was a concern that Resident did not receive the insulin

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and blood glucose checks were not done, however he did not believe it caused bodily harm as the Resident has been a diabetic for years, was noncompliant and had behavior that sometimes was not approachable by staff.

During an interview on 7/28/22 at 4:00 pm with Administrator, it was indicated she expected the Nursing staff to follow the orders as ordered by the Physician.

On 7/29/22 at 11:16 am a follow-up interview was conducted with NA #3 in reference to the missed blood glucose checks and she indicated if Resident #15 was not in the room or if the nurse did the blood glucose check she would not document it. She indicated Resident may have been on a leave of absence or at activities. She indicated she did not remember what happened on the days the blood glucose checks were missed.

On 7/29/22 at 11:55 am a follow-up interview was conducted with the Administrator and Regional Consultants in attendance, and it was indicated the missing documentation for blood glucose checks was a communication problem and they believe they were getting done but was not being documented. It was indicated Nurse #5 told them she had worked the days indicated; however, they were aware that she told the Surveyor that she had not worked all the days that were identified as when Resident #15 missed the insulin that was ordered. They stated they believed, because Nurse #5 was inexperienced with dealing with Surveyors it caused the miscommunication as they had verified Nurse #5 had worked the dates that were identified for the missed insulin.

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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; (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	F 842		8/25/22

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F 842	Continued From page 31 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: Based on records review, resident interview, and staff interviews, the facility failed to maintain accurate documentation on the Medication Administration Record (MAR) for a medication prescribed for a resident on dialysis for 1 of 5 resident (Resident #34) reviewed for unnecessary medication. Findings Included: Resident #34 was admitted to the facility on	F 842	FTAG F842 Residents Records – Identifiable Information What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? The Regional Director of Clinical Services reviewed the documentation and the medication administration records and clarified the medication orders of resident # 34 on 7/28/22.	

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F 842	Continued From page 32 12/31/2020 with cumulative diagnoses that included renal insufficiency. Resident #34's physician orders active on 7/24/2022 showed the following Sevelamer (used to control high blood levels of phosphorus in people on dialysis) medication orders. - Ordered 6/14/2022 Sevelamer tablet 800 milligrams (mg) give one tablet by mouth two times a day with snacks. - Ordered 6/16/2022 Sevelamer 800mg tablet place and dissolve two tablets in cheek three times a day - Ordered 6/16/2022 Sevelamer 800mg tablet place and dissolve one tablet in cheek two times a day with snacks. - Ordered 7/20/2022 Sevelamer tablet 800mg give three by mouth with meals for elevated phosphorus level give one tablet with all snacks. An interview was conducted with Nurse #7 on 7/27/2022 at 1:12 P.M. During the interview, Nurse #7 stated the Medication Aide (MA) #1 assigned Resident #34 on 7/24/2022 questioned Resident #34's Sevelamer order. Nurse #7 reviewed the order and advised MA #1 the order entered on 7/20/2022 was the correct order. During the interview, the July 2022 MAR was reviewed with Nurse #7. Nurse #7 indicated she reviewed the MAR on 7/24/2022 with MA #1 and had not observed the multiple orders for Sevelamer. She further indicated the previous Sevelamer orders should have been discontinued when an updated order was entered into the electronic medical record, and she was unsure why this had not been completed with Resident #34's orders. Resident #34's Medication Administration	F 842	How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Current residents receiving the medication sevelamer Medication Administration Record (MAR) was reviewed for accuracy by the Director of Nursing (DON). What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur The Director of Nursing/ Designee will education the licensed nurses to include agency licensed nurses to ensure the medical record is accurate and free of unnecessary medications to include sevelamer. The education will be completed by 8/24/22. The licensed Nurses will be required to complete the education in orientation. How the corrective action will be monitored to ensure the deficient practice will not recur DON or Designee will conduct audits of at least 10 current resident regarding F 842 weekly for 8 weeks. Findings of audit will be discussed with the Interdisciplinary Team at the monthly Quality Assurance Performance Improvement meetings until such substantial compliance has been determined.	

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F 842	Continued From page 33 Records (MAR) reviewed dated 7/24/2022 and 7/26/2022 indicated the following Sevelamer orders that should have been discontinued were documented as administered on 7/24/2022: - 8:00 A.M., 1:00 PM, and 5:00 PM Sevelamer 800mg tablet place and dissolve two tablets in cheek - 10:00 A.M. and 2:00 P.M. Sevelamer 800mg tablet place and dissolve one tablet in cheek with snacks. An interview was conducted with Resident #34 on 7/29/2022 at 12:34 P.M. During the interview, Resident #34 indicated staff brought him three tablets of Sevelamer with each of his three meals and one tablet if he ate a snack. Resident #34 stated staff had not offered more than three pills during a meal or administered Sevelamer when he had not eaten a snack. An interview was conducted with MA #1 on 7/27/2022 at 12:54 P.M who was assigned Resident #34 during the first shift on 7/24/2022. During the interview, MA #1 stated she looked at the order and realized there were multiple orders. MA #1 asked the supervisor nurse, Nurse #7, about Resident #34's medications orders. After reviewing with Nurse #7, MA #1 administered three Sevelamer with meals and one with snacks. MA #1 stated on the MAR, she should have only documented the Sevelamer order she followed as administered. The other Sevelamer orders should have been documented as not given. An interview was conducted with Nurse #1 on 7/28/2022 at 2:27 P.M. who was assigned Resident #34 during the first shift on 7/26/2022. During the interview, Nurse #1 indicated Resident #34 was administered three tablets with meals on	F 842		

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F 842	Continued From page 34 7/26/2022. Nurse #1 indicated she had not observed multiple orders on the MAR for Resident #34's Sevelamer and must have checked them off during her medication pass. Nurse #1 stated each of the Sevelamer orders should not have been documented as administered because she only administered the newest order. An interview was conducted on 7/29/2022 at 11:35 A.M. with the Administer. During the interview, the Administrator indicated the pharmacy consultant, nursing staff, and the Medical Director should review entered orders to ensure no duplicates were listed and the Medical Director should be contacted with any discrepancies.	F 842		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following recertification and complaint survey conducted on 09/04/20. This was for 5 deficiencies that was cited in the areas of Resident Rights/Exercise , Resident Assessment/Accuracy of Assessment Provision	F 867	F-867 F-550 – Based on observation , record review, and staff and resident interview, the facility failed to maintain a resident 's on 09/04/2020 the facility failed and respect by not providing assistance with showering resulting in the resident feeling " not happy" that he did receive a shower	8/25/22

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F 867	Continued From page 35 of activities of daily living for dependent residents, Quality of Care/Increase/Prevent Decrease in ROM/Mobility and Nutrition/Hydration Status Maintenance on 09/04/20 and cited on the current recertification and complaint survey of 07/29/22. The QAA committee additionally failed to maintain implemented procedures and monitor intervention the committee put in place following recertification and complaint survey conducted on 02/28/20. This was evident for 1 deficiency in the area of Quality of Care/Increase/Prevent Decrease in ROM/Mobility and recited on the current recertification and complaint survey of 07/29/22. The QAA additionally failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint survey conducted on 02/26/21. This was evident of 2 deficiencies that were cited in the areas of Resident Assessment/Accuracy of Assessment and Comprehensive Resident Centered Care Plans/Develop/Implement Comprehensive Care Plan were cited on 02/26/21 and recited on the current recertification and complaint survey of 07/29/22. The QAA additionally failed to maintain implemented procedures and monitor interventions the committee put in place following complaint 09/27/19. This was evident of 1 deficiency in the area of Resident assessment/Accuracy of Assessment Provision of activities of daily living for dependent residents were cited on 09/27/19. The QAA committee additionally failed to maintain implemented procedures and monitor intervention the committee put in place following recertification and complaint survey conducted on 01/10/19 and recited on the current recertification and complain survey of 07/29/22. This was evident for 1 deficiency in the area of Resident	F 867	but had to have a bed bath for 1 of 3 residents reviewed for dignity. During the recertification and compliant survey on 09/04/2020 the facility failed to provide dignified dining experience by standing over a resident while providing assistance with feeding for 1 of 5 residents. F 641 Based on the record review and staff interview, the facility failed to accurately code the quarterly Minimum Data Set (MDS) for 1 of 25 residents reviewed for MDS. During the recertification and complaint survey conducted on 9/4/2020 the facility failed to accurately code a MDS assessment of a wander/elopement alarm and for hospice service. The facility additionally failed to code a MDS assessment for a fall with injury. Furthermore, during the recertification and complaint survey on 2/26/2021 the facility failed to code a therapeutic diet on the MDS assessment for 1 of 6 residents. F-677 Based on observation , record review and staff and residents' interviews, the facility failed to provide a dependent activity of daily living (ADL) resident hair wash, nail cut, glasses cleaned, and facia hair shaved for 1 of 7 residents reviewed for ADL's. During the recertification and complaint survey conducted on 9/4/2020 the facility failed to cut and file long jagged fingernails and ensure residents nails	

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F 867	Continued From page 36 Assessment/Accuracy of Assessment and Comprehensive Resident Centered Care Plans/Develop/Implement Comprehensive Care Plan were cited on 02/26/21 and recited on the current recertification and complaint survey of 07/29/22. The duplicate citations during six federal surveys of record shows a pattern of the facility's inability to sustain and effective QAA program. Findings included: This tag is cross reference to: 1.F550-Based on observation, record review, and staff and resident interview, the facility failed to maintain a resident ' s dignity and respect by not providing assistance with showering resulting in the resident feeling "not happy" that he did not receive a shower but had to have a bed bath (Resident # 28) for 1 of 3 residents reviewed for dignity. During the recertification and complaint survey 09/04/20 the facility failed to provide a dignified dining experience by standing over a resident while providing assistance with feeding. 2.F641-Based on record review and staff interview, the facility failed to accurately code the quarterly Minimum Data Set (MDS) for 1 of 25 resident reviewed for MDS (Resident #20). During the recertification and complaint survey conducted on 09/04/20 the facility failed to accurately code a minimum data set assessment for the use of a wander/elopement alarm and for hospice service. The facility additionally failed to code a minimum data set assessment for a fall	F 867	were clean and free from debris for 1 of 3 residents. F 688 Based on record review , observations, and staff and resident interviews , the facility failed to apply the residents left hand splint as ordered for 1 of 3 residents. During the recertification and complaint survey conducted on 9/4/2020 the facility failed to apply a physician ordered resting hand for 1 of 1 resident. F-692 Based on record review ad staff interviews the facility failed to provide a nutritional supplement as recommended and ordered by the physician to 1 of 1 resident reviewed for nutrition. During the recertification and complaint survey conducted on 9/4/2020 the facility failed to obtain weekly weights recommended by the Registered Dietitian and as identified in the facility risk team meeting notes, failed to obtain weekly weights as ordered by the physician and failed to provide a nutritional supplement as ordered by the physician to address weight loss. F 656 Based on the record review and staff interview , the facility failed to develop the residents comprehensive care plan for the diagnosis and care of epilepsy for 1 of 25 care plans reviewed. During the recertification and complaint survey conducted on 2/26/2021 the facility	

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with injury.

During the recertification and complaint survey conducted on 02/26/21 the facility failed to code a therapeutic diet on the Minimum Data Set (MDS) assessment

3.F 677-Based on observation, record review, and staff and resident interviews, the facility failed to provide a dependent activity of daily living resident (ADL) resident hair wash, nail cut, glasses cleaned, and facial hair shave (Resident #28) for 1 of 7 residents reviewed for ADLs.

During the recertification and complaint survey conducted on 09/04/20 the facility failed to cut and file long jagged fingernails and ensure resident fingernails were clean and free from debris

4.F688-Based on record review, observation, and staff and resident interviews, the facility failed to apply the resident's left-hand splint as ordered (Resident #28) for 1 of 3 residents.

During the recertification and complaint survey conducted on 09/04/20 the facility failed apply a physician ordered resting hand splint.

5. F692-Based on record review and staff interviews the facility failed to provide a nutritional supplement as recommended and ordered by the physician to 1 of 1 resident reviewed for nutrition. (Resident #40).

During the recertification and complaint survey conducted on 09/04/20 the facility failed to obtain weekly weights as recommended by the Registered Dietitian (RD) and as identified in the

F 867

failed to develop a plan of care for an indwelling urinary catheter.
During the recertification and complaint survey conducted on 1/10/2019 the facility failed to develop a care plan for resident's who had behavioral and psychiatric symptoms
On 8/4/22, the Interdisciplinary Team (IDT) conducted an Ah Hoc Quality Assurance Performance Improvement (QAPI) meeting to discuss findings of repeat citations for F550 and F-641 F-676 F-677, F-688 ,and F-692 , and necessary corrective action to ensure the facility has an effective QAPI program in place to prevent repeat citations. The IDT team consist of the Medical Director, Director of Nursing, Administrator, Admission Coordinator, Medical Records Supervisor, Minimum Data Set Nurse, Social Workers, Activity Director, Maintenance Director, Environmental Director, Dietary Manager , Business Office Manager and Supple Clerk.

On 7/29/22, the Regional Director of Operation provided education to the Administrator on maintaining an effective QAPI program to prevent repeat citations.
On 8/4/2022 the Administrator provided education on maintaining an effective QAPI program to prevent repeat citations to the interdisciplinary team.
Effective 8/19/22, the facility IDT will meet weekly for eight (8) weeks to review results of ongoing monitoring tools to ensure the current plan is effective. Changes will be made to the plan if

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facility risk team meeting notes, failed to obtain weekly weights as ordered by the physician and failed to provide a nutritional supplement as ordered by the physician to address weight loss.

6.F688--Based on record review, observation, and staff and resident interviews, the facility failed to apply the resident's left-hand splint as ordered (Resident #28) for 1 of 3 residents.

During the recertification and complaint survey conducted on 02/28/20 the facility failed apply a resting hand splint as ordered physician.

7.656 Based on record review and staff interview, the facility failed to develop the resident's comprehensive care plan for the diagnosis and care of epilepsy (Resident #28) for 1 of 25 care plans reviewed.

During the recertification and complaint survey conducted on 02/26/21 the facility failed to develop a plan of care for an indwelling urinary catheter.

During the recertification and complaint survey conducted on 01/10/19 the facility failed to develop a care plan for residents who had behavioral and psychiatric symptoms.

8. F677-Based on observation, record review, and staff and resident interviews, the facility failed to provide a dependent activity of daily living resident (ADL) resident hair wash, nail cut, glasses cleaned, and facial hair shave (Resident #28) for 1 of 7 residents reviewed for ADLs.

During the complaint survey conducted on 09/27/19 the facility failed to provide incontinence

F 867

compliance is not being maintained per corrective plan.

The Regional Director of Clinical Services and/or Regional Director of Operations will attend QAPI meetings weekly for eight (8) weeks to validate the effectiveness of the facility QAPI program and its ongoing compliance with preventing repeat citations and make recommendations to the facility IDT as appropriate to maintain compliance with QAA improvement activities.
The Administrator is responsible for this plan of correction and the alleged date of compliance is 8/25/2022.

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F 867	Continued From page 39 care for residents reviewed for activities of daily living. An interview with the Administrator was conducted on 07/29/22 at 5:15 pm revealed that her expectation was to sustain an effective QAPI Committee to ensure the facility does not recite a previous deficient practice.	F 867		