STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345449	A. BUILDING _____ B. WING _____	C 09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	115 WHITE ROAD KING, NC 27021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 08/14/2022 through 09/02/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# LT0D11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 08/14/2022 through 09/02/2022. Event ID# LT0D11. 3 of the 16 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated: NC00184673, NC00186814, NC00188621, NC00189905, NC00190659, and NC00191422. Immediate Jeopary was identified at: CFR 483.10 at tag F580 at a Scope and Severity J CFR 483.25 at tag F684 at a Scope and Severity J CFR 483.55 at tag F791 at a Scope and Severity J Tag F684 constituted Substandard Quality of Care. Immediate Jeopardy for F580 began on 08/15/2022 and was removed on 08/27/2022. Immediate Jeopardy for F684 began on 08/15/2022 and was removed on 08/27/2022. Immediate Jeopardy for F791 began on 08/15/2022 and was removed on 08/28/2022. An extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		9/20/22

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

Electronically Signed | 09/20/2022

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F 580	Continued From page 1 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 2 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, Dentist, Nurse Practitioner (NP), and Physician interviews the facility failed to immediately inform the physician when a resident (Resident #51) reported to the facility staff that he had oral pain and the facility staff observed a new onset of oral redness, during oral care. This was identified in 1 of 1 resident reviewed for dental care. Resident #51 was seen by a dentist on 10/28/2021 and received a recommendation for follow up dental care in 2 - 6 months. The facility failed to schedule the recommended appointment. Resident #51 reported oral pain and inflammation (redness and swelling) present for one week on 8/15/2022 (8/8/2022 through 8/15/2022) that Resident #51 and two Nursing Assistants (NA) (NA #4 and NA #5) stated was reported to the clinical staff. Interviews with two physicians (Medical Director and Physician #2) and the NP revealed they were not notified of the oral pain and inflammation during the week of 8/8/2022 through 8/15/2022. The recommended follow up care, oral pain and inflammation was identified by the surveyor and brought to the facilities attention. The facility then scheduled a dental visit on 8/17/2022 that resulted in diagnoses of two gingival abscesses (infection), dental pain and a	F 580	F 580 Notify of Changes The facility Social Worker contacted the in-house dentist for resident #51 on 8/16/2022. The dentist recommended continuing acetaminophen for pain, Peridex mouth wash twice daily x 14 days, and a referral to an oral surgeon. The nurse practitioner ordered Cleocin 300mg four times per day X 7 days for dental infection. Additionally, the nurse practitioner ordered Tramadol 50mg twice per day, for pain not controlled by acetaminophen. The Director of Nursing and administrative nurses conducted an oral health visual observation and assessment for all current residents in the facility on 8/25/22. Additionally, the DON and administrative nurses completed an oral health questionnaire. The DON and administrative nurses reviewed the 24-hour reports for the last 60 days for any other concerns that require physician notification as of 8/25/22.	

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F 580	Continued From page 3 recommendation by the dentist for a full mouth extraction (the removal of the teeth). Physician orders were provided for Tramadol (an anti-inflammatory pain medication and two antibiotics (Cleocin and Rocephin). The failure to notify the physician immediately resulted in prolonged, unresolved oral pain and infection that was left untreated. The MD and Dentist revealed infection in the mouth could lead to pneumonia due to a bacterium, weaken the overall immune system, lead to a blood infection or sepsis and can cause severe pain. Immediate Jeopardy began on 8/15/2022 when unresolved oral pain and inflammation was noted in Resident #51's mouth by the surveyor and it was discovered the facility staff had been notified by the Resident during the week of 8/8/2022 through 8/15/2022 and failed to notify the physician or NP. Immediate Jeopardy was removed on 8/27/2022 when the facility implemented a credible allegation of immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D, that is not actual harm with potential for more than minimal harm that is not immediate jeopardy. The findings included: Resident #51 was admitted to the facility on 5/11/2021 with diagnoses that included a tracheostomy, aphonia (the loss of the ability to speak through disease or damage to the larynx or mouth), protein calorie malnutrition, hemiplegia, and a gastrostomy. A review of the annual Minimum Data Set (MDS) dated 4/6/2022 revealed Resident #51 was	F 580	The Director of Nursing and Administrative nurses were educated by the Regional Nurse Consultant on 8/26/22 on responsibility of physician notification regarding resident change of condition related to dental concerns. The DON or administrative Nurses will be responsible for notification of the residents' attending physician of dental recommendations and any emergent dental care needs. As of 8/26 the Director of Nursing and Administrative Nurses provided education to the licensed nurses and nursing assistants, including the contract nursing staff, on completing oral cavity observations for red swollen gums, foul odor, and/or other abnormal teeth issues on admission, during routine care, and when residents complain of mouth pain. They were instructed to report any identified concerns to the attending physician for future treatment orders. Additionally, any identified concerns will be reported to the Director of Nursing and/or administrative nurses. Employees who have not received training from the Director of Nursing, Assistant Director of Nursing, or designee will not be permitted to work until education has been completed. As of 8/26/22, Regional Nurse Consultant also completed education with Director of Nursing, Assistant Director of Nursing and administrative nurses, related to their responsibility to review twenty-four-hour report daily Monday-Friday during the clinical meeting	

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F 580	Continued From page 4 assessed to have cognitive impairment, no issues with his teeth, no pain, and no refusal of care. A review of the staffing schedule for Resident #51, for the dates of 8/8/2022 through 8/25/2022, was conducted with the Director of Nursing (DON) on 8/25/2022. The nurses that worked during the dates were identified as Nurse #3 - Nurse #10. Phone numbers were provided for Nurse #4 - #7 and Nurse #9. Seventeen nursing assistants (NA) were identified to work with the Resident during the dates and phone numbers were provided for NA #2 - NA#10. A call was placed to NA#2, NA #10, Nurse #4, Nurse #6, and Nurse #9 without success. A telephone interview was conducted with NA #4 and NA #5. An interview was conducted with NA #4 on 8/25/2022 at 3:22 p.m. and she revealed she had worked with Resident #51 on multiple occasions and had worked with him over the past month. She stated she did oral mouth care each shift she worked and about two weeks ago, the week of 8/8/2022 through 8/15/2022, the Resident began to shake his head and pull away when she tried to clean his mouth. She stated she reported this information to the hall nurse but did not recall the nurse's name because she was with an agency. An interview was conducted with NA #5 on 8/25/2022 at 3:44 p.m. and she stated she had worked with Resident #51 numerous times. She added that she swabbed his mouth, during oral care, with a lemon swab. She stated that recently he had begun to shake his head, "No," or pull away when she tried to clean his mouth and she asked the Resident if he had pain and he nodded, "Yes." She added that she observed a red area to the right side of his mouth and reported the	F 580	for any noted concerns for physician notification. MDS will audit 5 resident records daily for 4 weeks and then 10 residents weekly for 4 weeks for any notations of pain or follow up notification to physician for any reported pain. Director of Nursing/Nurse Manager will review 24-hour report daily for 4 weeks and then M-F during clinical meeting ongoing for any notations of pain and notification to the physician. The DON and/or Administrative will complete a summary of the audit results and present them at the monthly facility QAPI meeting to ensure continued compliance.	

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redness to an agency hall nurse because the night shift supervisor had been out of work due to an injury. She revealed this had begun two weeks ago.

An observation was conducted on 8/15/2022 at 10:54 a.m. of Resident #51's teeth and revealed the upper right half of the palette was red with an inflamed swollen area to a front tooth and gum area.

A review of Resident #51's electronic medical record and nurse progress notes for 60 days, did not include documentation for oral pain or inflammation.

An interview was conducted on 8/16/2022 at 3:20 p.m. with the MDS Director. The MDS Director reviewed the Resident's dental exam notes from the 10/28/2021 visit, that documented the Resident had multiple missing teeth, 7 teeth that were root tips, and two non-restorable teeth. The surveyor and the MDS Director walked to Resident #51's bedside for an observation of his oral cavity. The MDS Director requested the Resident open his mouth for an observation and then she stated she observed he had inflamed gums to the top right side with multiple tooth fragments and obvious black areas on his teeth.

An interview was conducted on 8/16/2022 at 4:02 p.m. with the Administrator, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the MDS director, the social worker (SW) and the regional consultant present in the office. The administrative team was made aware of the concerns the surveyor had discovered during the investigation for Resident #51. The DON and Administrator revealed they both had

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not been aware the Resident had oral pain or inflammation in his mouth. The DON revealed the Resident can communicate his pain and had communicated his gastrointestinal pain in the past. The administrative staff all stated they will schedule a follow up dental appointment, ensure his pain was assessed, and as needed pain medication provided as ordered.

A review of the nursing progress notes had been conducted on 8/25/2022 and revealed a nurse progress note written by the ADON on 8/17/2022 for the date of 8/16/2022. The progress note read Resident #51 was assessed for oral pain and denied the pain three times with a head shake.

An interview was conducted with Dentist #1 on 8/26/2022 at 3:03 p.m. and he revealed he had conducted a dental assessment of Resident #51 on 8/17/2022 because the facility called his practice on 8/16/2022 to schedule the appointment. He stated the Resident had two areas with purulent exudate (any fluid or semisolid that has exuded out of a tissue because of injury or inflammation) and when the two areas were probed (pressed on with a device) the Resident squeezed his hand to indicate pain. He added, the concern with not being notified sooner about the dental pain, was that infection in the mouth could lead to pneumonia due to a bacterium, weaken the overall immune system, lead to a blood infection or sepsis and can cause severe pain. He revealed it was his expectation for the dentist or medical provider to be notified of oral changes that include redness or pain at the time the changes were identified. He revealed on 8/17/2022 he verbally ordered peridex (an antiseptic) oral rinse, swab the mouth twice a day

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x 14 days, Acetaminophen for pain in combination with ibuprofen intermittently and provided a referral to an oral surgeon for a full mouth extraction (removal of teeth).

An interview was conducted on 8/25/2022 at 1:40 p.m. with the Nurse Practitioner (NP) and she revealed each of her visits to Resident #51, in the past two months had been acute visits related to another health concern and she had not conducted an oral exam. She revealed Resident #51's dental situation had been reported to her on 8/25/2022. She revealed it was her expectation for the facility staff to report any clinical changes that included inflammation or pain at the time the Resident reported this to a staff member.
An interview was conducted with Physician #2 on 8/25/2022 at 2:54 p.m. via telephone and he revealed he had been at the facility on 8/17/2022 and had been in to see Resident #51 just to check on him. He stated this was not a scheduled visit and he had not conducted an oral exam of the Resident because this was a visit to follow up for other conditions. He added that Resident #51 does not communicate with him and prefers other providers for care. He stated he had not been informed of the Resident's reported oral pain or inflammation during the week of 8/8/2022 through 8/15/2022.

An interview was conducted on 8/26/2022 at 1:37 p.m. with the Medical Director (MD) and He revealed he had not been informed of Resident #51's oral pain or inflammation during the week of 8/8/2022 through 8/15/2022. He added, in relation to Resident #51's dental exam on 8/17/2022, that the concern with an abscess/dental infection, or any infection, would be that it can spread to the bloodstream and lead to sepsis. He stated the

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infection contains bacteria that could be a contributor to the Resident's possible aspiration pneumonia, diagnosed on 8/25/2022. He stated on the date of 8/16/2022, when the Resident expressed, he had pain of a 5 on a scale of 0 to 10, his expectation was for the Resident to be offered and provided his breakthrough, as needed medication or the provider notified for further instructions. He added, it was his expectation that when the pain and inflammation was reported to the facility staff, a provider should (physician, nurse practitioner, or dentist) be notified of the change in condition.

An interview was conducted with the ADON on 8/25/2022 at 10:07 a.m. and she revealed she had been present during the meeting with the administrative team on 8/16/2022 at 4:02 p.m. She revealed the statement that this was when the facility first learned of the oral pain and the need to schedule a follow up appointment was accurate and on the date of 8/16/2022.

An interview was conducted with the ADON on 8/25/2022 at 10:42 a.m. and she revealed she had written a late entry progress note after the survey team had exited the facility on 8/17/2022 that stated she had conducted an oral investigation on 8/16/2022. When asked why she conducted an oral investigation prior to learning the Resident had oral pain and inflammation she stated, "but I did, I promise!"

The Administrator was notified of immediate jeopardy on 8/26/2022 at 4:45 p.m.

The facility provided a credible allegation of immediate jeopardy removal dated 8/27/2022.

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Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non- compliance:
The facility failed to immediately inform the physician or dentist when resident #51 reported to the staff that he had pain in his mouth with redness that resulted from two gingival abscesses.

On 8/16/22 the in-house dental provider, was contacted by the Social Worker regarding resident #51 and the need for emergency dental services. The in-house dental provider conducted an on-site evaluation and developed a treatment plan on 8/17/22. The Dentist recommended that resident #51 be seen by oral surgeon for extraction of the remaining teeth. The Facility worked with the Medical Director from 8/17 until 8/25, to find a location for resident #51's tooth extractions, due to resident #51 having a tracheostomy tube and tubing feeding there are challenges involved with this procedure. On 8/25/22 the facility located an oral surgeon in Raleigh, NC to schedule an appointment for tooth extraction.

The resident was seen on 8/17 by in-house Dentist who ordered acetaminophen for pain and Peridex. The Nurse Practitioner (NP) saw resident #51 for possible pneumonia on 8/25/2022 and examine resident #51's mouth. Upon examination NP wrote orders for Tramadol 50 mg twice a day as needed for pain not controlled by acetaminophen, and the NP ordered: 1) Cleocin 300 mg four times a day x 7 days for potential aspiration pneumonia, and stated this would also cover a dental infection, and 2) Rocephin 1-gram IV everyday x 7 days for pneumonia. A chest x-ray on 8/26/2022 shows

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no signs of pneumonia. The antibiotic was continued for the dental issues.

On 8/25/2022, the Director of Nursing and administrative nurses conducted an Oral Health visual observation and assessment for all current facility residents to identify if any other resident(s) that could be having any dental issues/concerns. The DON and administrative nurses also completed an Oral Health questionnaire, which included the following questions. 1) Are you having any issues with your teeth 2) Are you having dental pain 3) Are you having trouble eating. Any identified issues or concerns will be addressed, and dental consultations will be initiated to ensure residents are treated appropriately utilizing the in-house dental services if recommended by the attending physician. Director of Nursing and/or Nurse managers completed review of 24-hour reports for last 60 days for any other concerns that require physician notification as of 8/26/2022.

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

As of 8/26/22 the Director of Nursing and Administrative Nurses, were educated by the Regional Nurse Consultant regarding the responsibility of physician notification regarding the resident change of condition, related to dental concerns. The Director of Nursing and/or Administrative Nurses will be responsible for notification of the residents' attending physician of dental recommendations and any emergent dental care needs.

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F 580	Continued From page 11	F 580		

As of 8/26 the Director of Nursing and Administrative Nurses provided education to the licensed nurses and nursing assistants, including the contract nursing staff, on completing oral cavity observations for red swollen gums, foul odor, and/or other abnormal teeth issues on admission, during routine care, and when residents complain of mouth pain. They were instructed to report any identified concerns to the attending physician for future treatment orders. Additionally, any identified concerns will be reported to the Director of Nursing and/or administrative nurses, by documenting on the 24-hour report. Employees who have not received training from the Director of Nursing, Assistant Director of Nursing, or designee will not be permitted to work until education has been completed. The Staff Development Nurse and RN Weekend Supervisor will track and monitor staff training for completeness.

As of 8/26/22, Regional Nurse Consultant also completed education with Director of Nursing, Assistant Director of Nursing and administrative nurses, related to their responsibility to review twenty-four-hour report daily Monday- Friday during the clinical meeting for any noted concerns for physician notification.

Alleged Date of IJ removal: 8/27/2022

Validation of the Credible Allegation occurred on 9/2/2022 and was evidenced by Resident, Dentist, and Physician interviews, observation, and facility training. The resident interviews and observations included an oral assessment of all residents that identified 6 additional residents in need of dental care. The notification of the dentist and medical provider was verified. The facility

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F 580	Continued From page 12 training included an Inservice for the responsibility of physician notification regarding a change in condition and focused on dental concerns. The facility policies for notification of changes, and dental services were reviewed with all clinical staff. The Resident had an oral surgery appointment scheduled. The immediate jeopardy was removed on 8/27/2022.	F 580		
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. §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	F 584		9/20/22

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	345449	A. BUILDING _____ B. WING _____	C 09/02/2022

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F 584	Continued From page 13 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, resident and staff interviews, the facility failed to maintain 1. furniture in good repair (Room 108A and B) and 2. failed to maintain a clean floor in a resident room for 2 of 8 resident rooms (Room 120A Room 108) and reviewed for environment. The findings included: 1. On 8/14/22 at 12:11 PM, an observation of Room 120A revealed the floor in the resident ' s room and bathroom appeared dirty and dull. The area around the toilet in the bathroom had a large, blackened area. The floor of the residents room appeared dirty and the corners were observed to have a buildup of dirt and debris. On 8/14/22 at 12:11 PM, the resident in Room 120A was interviewed. She stated the housekeeper came in and drug the broom and the mop around the room. She stated there was no pressure applied and the dirt would not come up anything because it was ground in. On 8/17/22, the Housekeeping Director was	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment: The furniture in room 108A & 108B; as well as a malfunctioning light were repaired on 8/17/2022. In room 120, all furnishings were removed, and floors were thoroughly cleaned then stripped and waxed on 8/20/2022. All residents have the potential to be affected by this alleged deficient practice. The Maintenance Director will audit all resident rooms for any maintenance issues as of 9/9/2022. Any identified repairs or cleaning have been completed by 9/19/2022. Administrator will re-educate the Plant Operations Manager, Maintenance Technician, and Housekeeping Supervisor, and Assistant Housekeeping Supervisor on the facilities policies and procedures for maintaining a clean, safe, home like environment as of 9/19/2022.	

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F 584	Continued From page 14 interviewed. She stated Room 120 is on the B hall and that is the worst in the facility. She stated the facility doesn ' t have anyone on staff to do the floors right now; their last employee quit. She stated they are in the process of hiring someone. On 8/17/22 at approximately 4:00 PM, the Administrator was interviewed. He stated the facility was having a hard time hiring staff but he did expect the resident rooms to be clean, including the floors. 2. An observation was made of room #108, Resident #23's room, on 11/15/2022 at 10:37 AM. The resident was observed lying in her bed alert and looking at a magazine. It was observed the bedside nightstand had a broken handle on the top drawer. An interview was conducted with Resident #23 at that time. She explained she couldn't open the drawer because the handle was broken and because of her tremor and muscle weakness she could not pull the drawer out from the sides. She stated she was scared to use the drawer for fear of cutting herself on the broken metal. The Resident further stated she was unable to recall to whom she had reported the broken handle. She said it would be nice to be able to use the top drawer without fear of being injured. On 08/17/2022 at 2:26 PM the Maintenance Director was interviewed. He stated he had been in position of Maintenance Director for two months. He further stated he had hired a new helper two weeks ago. He explained he did daily environmental rounds to assess for needed repairs but must have missed the broken drawer	F 584	Housekeeping Supervisors will re-educate all Housekeeping employees on the facilities polices and procedures for maintaining a clean, safe, home-like environment as of 9/19/2022. Additionally, the facility will re-educate all facility employees, including contract staff, as of 9/19/2022 on the need to timely report identified or reported maintenance and housekeeping concerns; as well as, on the proper procedure for reporting any identified or third party (residents, families, staff, contractors, and visitor) reported concerns. The maintenance/housekeeping work order logs will be reviewed daily Monday through Friday as well as weekly room rounds by the plant operations manager and housekeeping supervisor or facility administrator, to ensure repairs/housekeeping issues have been resolved timely. All identified issues will be resolved in no less than 72 hours. In addition, issues requiring an outside contractor will be resolved as soon as possible with a referral for the service needed to be made within 24 hours. This process will be a permanent change to the system for identifying and resolving environmental concerns. The Plant Operations Manager and Housekeeping Supervisor will provide a summary weekly of all actions taken to resolve reported issues including resolutions of identified concerns to the administrator for review and additional	

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F 584	Continued From page 15 handles. He further explained when Corporate visited, they assessed the need to replace bedside nightstands and they had ordered eighty new ones. He revealed he did not know when the tables would be delivered. On 08/17/2022 at 2:35 PM during an observation of Resident #23's with the Maintenance Director he agreed the drawer handle needed to be repaired. He also observed missing drawer handles to bed A's bedside table and a malfunctioning fluorescent light. He stated he was going to repair the issues immediately. On 08/17/2022 at 2:49 PM Executive Director was interviewed. He stated he was made aware of the environmental concerns in Resident #23's room. He explained it was his expectation that the facility policies and procedures were sufficient to overcome human error. He stated the issues would be repaired immediately.	F 584	actions as needed for a period of 3 months. The administrator will report all findings to the QAPI Committee monthly for their review and input, to ensure continued compliance.	
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 1 resident (Resident #51) reviewed for dental care. The findings included: Resident #51 was admitted to the facility on 5/11/2021.	F 641	F 641 Accuracy of Assessments: The MDS for resident #51 was revised on 8/25/2022 to reflect the correct dental health status of the residents utilizing both direct observation and a review of the medical records. The MDS coordinators and director of	9/20/22

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F 641	Continued From page 16 A review of the facility dental visits for the past 12 months revealed Resident #51 had a comprehensive dental visit on 10/28/2021. The Dental progress note documented the Resident was missing 16 teeth and had only root tips present on tooth 6, 7, 14, 23, 24 and 26 with heavy plaque and heavy inflammation. A review of the annual Minimum Data Set (MDS), dated 4/6/2022, revealed the dental assessment documented Resident #51 had no cavities or broken natural teeth, An interview was conducted on 8/16/2022 at 3:20 p.m. with the MDS Director. The MDS Director reviewed the Resident's dental exam notes from the 10/28/2021 visit, that documented the Resident had multiple missing teeth, 7 teeth that were root tips, and two non-restorable teeth. The surveyor and the MDS Director walked to Resident #51's bedside for an observation of his oral cavity. The MDS Director requested the Resident open his mouth for an observation and then she stated she observed he had inflamed gums to the top right side with multiple tooth fragments and obvious black areas on his teeth. She added, the dental exam visit from 10/28/2021, that stated he had multiple missing teeth and broken teeth matched the oral assessment conducted on 8/16/2022 and she would create a correction to the 4/6/2022 MDS. An interview was conducted on 8/25/2022 at 3:03 p.m. with the Responsible Party (RP) for Resident #51 and she revealed the resident had issues with his teeth prior to the facility admission on 5/11/2021, that included several broken teeth.	F 641	nursing conducted an audit of all current residents in the facility for their current dental health status utilizing direct observation and a review of the medical record. MDS and Care Plans were updated with any abnormal findings. Current resident dental consultations will be reviewed at the AM Clinical meeting, by the Director of Nursing, MDS Coordinator and/or administrative nurses to ensure all recommendations have follow-up timely. As the facility recognizes the potential for this alleged deficient practice to affect all residents the MDS coordinators were re-educated by the Regional MDS consultant on the correct process for completing the MDS proper coding of MDS for identified dental concerns on 8/25/2022. The MDS coordinators will complete 5 random dental assessments weekly for 4 weeks then 5 random dental assessments biweekly for 4 weeks then 5 assessments monthly for 1 month and take correct action for any identified issues. The MDS coordinator will report a summary of findings to the QAPI Committee for their review and input.	

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F 658	Continued From page 17	F 658		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to apply a bunny boot as ordered by the physician for 1 of 4 residents reviewed for pressure ulcers (Resident #70). The findings included: Resident #70 was admitted to the facility on 5/12/20. Review of a physician ' s order dated 6/16/22 read: bunny boot to right foot to use in bed to keep toes from pushing against bed. A review of the MAR for August 2022 revealed the order for bunny boot to right foot to use in bed to keep toes from pushing against bed was signed off as completed for 8/1/22 to 8/14/22 and 8/17/22. An observation 8/14/22 10:45 AM revealed Resident #70 lying in bed. Resident #70 ' s feet were observed lying flat on the mattress and there was not a bunny boot on Resident #70 ' s right foot. An observation on 8/17/22 at 8:30 AM revealed Resident #70 lying in bed. He did not have a	F 658	F 658 Services Provided Meet Professional Standards: Resident #70's order for bunny boots to be applied was reviewed by DON, spoke with provider and due to refusal by resident, order was discontinued on 8/17/2022. Audit completed by DON/designee of current residents with bunny boots to ensure they are being applied as ordered. Director of Nursing in-serviced all nursing staff, including contract, on applying bunny boots as ordered and accurately documenting administration and refusals as of 9/19/2022. Also, all new admits will be evaluated upon admission for use of bunny boots. DON/designee will monitor 5 residents MARs and visually verify three times weekly x 4 weeks, twice weekly x 4 weeks, and once weekly x 4 weeks to ensure bunny boots have been applied as ordered. The DON will bring a summary of findings	9/20/22

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F 658	Continued From page 18 bunny boot in place to his right foot. During an interview with Resident #70, he stated he did not have a bunny boot for the right foot and the staff never offered to put it on. On 8/17/22 at 8:42 AM, an interview was conducted with Nurse #1. She stated she worked Sunday 8/14/22 and signed off on the MAR that she put on Resident #70 ' s bunny boot but did not. She stated she signed on the MAR for 8/17/22 that she applied the bunny boot to Resident #70 ' s right foot because she just got in a hurry and signed it off, but she had not applied it. On 8/17/22 at 8:28 AM, an interview was conducted with the Director of Nursing. She stated when a nurse signs or checks off the MAR that indicated the task was completed. She stated the nurse should not sign that she complete something if she did not.	F 658	of audits and monitoring to QAPI monthly to ensure that the process is in place and effective and discuss for further updates as warranted.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b)	F 676		9/20/22

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F 676	Continued From page 19 of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews the facility failed to provide a communication board to maintain communication during activity of daily living care in 1 of 1 resident (Resident #51) reviewed for communication. The findings included: Resident #51 was admitted to the facility on 5/11/2021 with diagnoses that included protein calorie malnutrition, tracheostomy, aphonia (an absence of speech related to disease or injury to the larnyx or mouth), hemiplegia, and gastrostomy.	F 676	F 676 Activities Daily Living (ADLs): As of 9/9/2022 a communication tool is in place for resident #51 for staff utilization to provide effective communication by the Director of Nursing. Education given to staff members on communication tools. An audit completed by DON/designee of all current residents that are care planned for communication tools to ensure that all those residents have the correct tool in place for effective communication on 8/16/2022.	

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F 676	Continued From page 20 A review of the quarterly Minimum Data Set (MDS), dated 7/11/2022, revealed Resident #51 had no speech, was limited to making concrete request only but understood speech with clear comprehension. The Resident required extensive assistance of two staff members with bed mobility and total assistance of one staff member with dressing, eating, toilet use, personal hygiene, and bathing. A review of the care plan dated 7/11/2022 identified focused areas that read Resident #51 had difficulty expressing his needs related to being nonverbal and required assistance with activity of daily living (ADL) needs related to limited mobility due to a recent cardiovascular accident with left hemiplegia, the use of a gastrostomy tube and a tracheostomy with speech impairment. The interventions included a communication board. An interview was conducted with Resident #51 on 8/15/2022 at 10:27 a.m. and the Resident used gestures and nodded for communication and required lip reading to understand. When asked if he had a communication board, he shook his head no. An observation of Resident #51's room on 8/15/2022 at 10:28 a.m. was conducted and a communication board was not present in the closet, bedside table, end table or on the walls. An interview was conducted with Nurse #2 on 8/16/2022 at 9:42 a.m. and she revealed communication for Resident #51 takes time and causes frustration and anxiety for the Resident. She denied ever seeing a communication board	F 676	Staff will be in-serviced on proper use of communication tool and the importance of ensuring that it is in place to utilize for effective communication with resident as of 9/19/2022. DON/designee will monitor the placement of communication tools three times weekly x 4 weeks, twice weekly x 4 weeks, and weekly x 4 weeks. The DON will bring a summary of findings of audits and monitoring to QAPI monthly to ensure that the process is in place and effective and discuss for further updates as warranted for 3 months.	

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F 676	Continued From page 21 or device to be used with the Resident while providing daily care. An interview was conducted on 8/16/2022 at 1:52 p.m. with Nursing Assistant #1, assigned to Resident #51. She revealed she had been assigned to the Resident many times and had not seen a communication board for the Resident and had not utilized one during his daily care. An observation of Resident #51's room on 8/16/2022 at 1:57 p.m. was conducted and a communication board was not present. An interview was conducted on 8/16/2022 at 2:02 p.m. with Speech Therapist #1 and she revealed she had worked with Resident #51 intermittently since his admission. She stated a communication board was recommended, and provided at the bedside, for communication on 5/12/2021, again on 10/1/2021 and in July 2022. She revealed the Resident had moments of anxiety when the communication board was not used. She added all recommendations were provided to the nursing team and to the interdisciplinary team. She stated the communication board should have been added to the care plan when first recommended. She conducted a room observation at 2:23 p.m. and revealed she did not see the communication board that she had provided. An interview was conducted with the Administrator on 8/16/2022 at 4:02 p.m. and he revealed his expectation was for all residents and staff to be provided with the necessary tools for communication.	F 676		
F 684 SS=J	Quality of Care	F 684		9/20/22

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F 684	Continued From page 22 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 observation, record review, staff, Dentist, Nurse Practitioner (NP), and Physician interviews the facility failed to ensure a resident's well-being by not providing care and services to prevent oral abscesses and unresolved dental pain for 1 of 1 resident (Resident #51) reviewed for dental care. Resident #51 was seen by the dentist on 10/28/2021 and received a recommendation for follow up dental care in 2 - 6 months. The facility failed to schedule the recommended appointment. Resident #51 reported oral pain and inflammation (redness and swelling) present for one week on 8/15/2022 (8/8/2022 through 8/15/2022) that Resident #51 and two Nursing Assistants (NA) (NA #4 and NA #5) stated was reported to the clinical staff. Resident #51 reported pain to facility staff on 8/16/2022 and did not receive a dose of his ordered, breakthrough as needed, pain medication. The recommended follow up care, oral pain and inflammation was identified by the surveyor and brought to the facilities attention. The facility then scheduled a dental visit on 8/17/2022 that resulted in diagnoses of two gingival abscesses (infection), dental pain and a recommendation by the dentist for a full mouth	F 684	F 684 Quality of Care: The facility Social Worker contacted the in-house dentist for resident #51 on 8/16/2022. The dentist recommended continuing acetaminophen for pain, Peridex mouth wash twice daily x 14 days, and a referral to an oral surgeon. The nurse practitioner ordered Cleocin 300mg four times per day X 7 days for dental infection. Additionally, the nurse practitioner ordered Tramadol 50mg twice per day, for pain not controlled by acetaminophen. The Director of Nursing and administrative nurses conducted an oral health visual observation and assessment for all current residents in the facility on 8/25/22. Additionally, the DON and administrative nurses completed an oral health questionnaire. Moreover, the DON and administrative nurses reviewed the 24-hour reports for the last 60 days for any other concerns that require physician notification on 8/25/22.	

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F 684	Continued From page 23 dental extraction (the removal of teeth). Immediate Jeopardy began on 8/15/2022 when unresolved oral pain and inflammation was noted in Resident #51's mouth by the surveyor and it was discovered the follow up dental appointment had not been scheduled in the timeframe recommended, that resulted in two gingival abscesses, pain, and a recommendation for a full mouth dental extraction. 0Immediate Jeopardy was removed on 8/27/2022 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and level of D-that is not actual harm with potential for more than minimal harm that is not immediate jeopardy. The findings included: Resident #51 was admitted to the facility on 5/11/2021 with diagnoses that included a tracheostomy, aphonia (loss of ability to speak through damage to the larynx or mouth), protein calorie malnutrition, hemiplegia, and a gastrostomy. A review of the dental exam notes for the past 12 months revealed Resident #51 was seen by Dentist #1 on 10/28/2021, the facility Dental Service Provider. Resident #51 was assessed to have heavy calculus (a form of hardened dental plaque) and heavy inflammation. He was missing several teeth, had 7 root tips, 3 restorations and 2 non-restorable teeth present. A recommendation was made for a cleaning in 2-6 months and to receive oral dental exams. The 10/28/2021 dental exam was his only dental visit and he had not been seen by the hygienist.	F 684	The Director of Nursing and Administrative nurses were educated by the Regional Nurse Consultant on 8/26/2022 on responsibility of physician notification regarding a resident change of condition related to dental concerns. The DON or administrative Nurses will be responsible for notification of the residents' attending physician of dental recommendations and any emergent dental care needs. As of 8/26 the Director of Nursing and Administrative Nurses provided education to the licensed nurses and nursing assistants, including the contract nursing staff, on completing oral cavity observations for red swollen gums, foul odor, and/or other abnormal teeth issues on admission, during routine care, and when residents complain of mouth pain. They were instructed to report any identified concerns to the attending physician for future treatment orders. Additionally, any identified concerns will be reported to the Director of Nursing and/or administrative nurses, by documenting the 24-hour report. Employees who have not received training from the Director of Nursing, Assistant Director of Nursing, or designee will not be permitted to work until education has been completed. As of 8/26/22, Regional Nurse Consultant also completed education with Director of Nursing, Assistant Director of Nursing and administrative nurses, related to their responsibility to review twenty-four-hour reports daily Monday- Friday during the	

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F 684	Continued From page 24 A review of the annual Minimum Data Set (MDS) dated 4/6/2022 revealed Resident #51 was assessed to have no issues with his teeth, cognitive impairment, no speech, and no pain present. The assessment indicated the Resident had no behaviors or rejection of care. A review of Resident #51's care plan, dated 4/6/2022, revealed a focused area that read, Resident required assistance with activities of daily living (ADL) related to limited mobility due to a cerebrovascular accident with left hemiplegia, use of a percutaneous endoscopic gastrostomy {PEG) tube and a tracheostomy with a speech impairment. The interventions included oral care daily and as needed, routine dental assessment and dental consults as needed. A review of the physician orders for Resident #51 revealed: 1) Scheduled Acetaminophen 325 milligram (mg), take two tablets by PEG tube three times a day for pain ordered on 7/18/2022 and 2) Acetaminophen 160 mg/5 milliliters (ml) liquid, take 20 ml via peg tube every 4 hours as needed for pain, ordered on 7/4/2022. A review of the staffing schedule for Resident #51, for the dates of 8/8/2022 through 8/25/2022, was conducted with the Director of Nursing (DON) on 8/25/2022. The nurses that worked during the dates were identified as Nurse #3 - Nurse #10. Phone numbers were provided for Nurse #4 - #7 and Nurse #9. Seventeen nursing assistants (NA) were identified to work with the Resident during the dates and phone numbers were provided for NA #2 - NA#10. A call was placed to NA#2, NA #10, Nurse #4, Nurse #6, and Nurse #9 without success. A telephone interview was conducted with NA #4 and NA #5.	F 684	clinical meeting for any noted concerns for physician notification. MDS will audit 5 resident records daily for 4 weeks and then 10 residents weekly for 4 weeks for any notations of pain or follow up notification to physician for any reported pain. Director of Nursing/Nurse Manager will review 24-hour report daily for 4 weeks and then M-F during clinical meeting ongoing for any notations of pain and notification to the physician. The Administrator will bring a summary of findings of audits and monitoring to QAPI monthly to ensure that the process is in place and effective and discuss for further updates as warranted for 3 months.	

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An interview was conducted with NA #4 on 8/25/2022 at 3:22 p.m. and she revealed she had worked with Resident #51 on multiple occasions and had worked with him over the past month. She stated she did oral mouth care each shift she worked and about two weeks ago, the week of 8/8/2022 through 8/15/2022, the Resident began to shake his head and pull away when she tried to clean his mouth. She stated she reported this information to the hall nurse but did not recall the nurse's name because she was with an agency.

An interview was conducted with NA #5 on 8/25/2022 at 3:44 p.m. and she stated she had worked with Resident #51 numerous times. She added that she swabbed his mouth, during oral care, with a lemon swab. She stated that recently he had begun to shake his head, "No," or pull away when she tried to clean his mouth and she asked the Resident if he had pain and he nodded, "Yes." She added that she observed a red area to the right side of his mouth and reported the redness to an agency hall nurse because the night shift supervisor had been out of work due to an injury. She revealed this had begun two weeks ago.

An interview and observation were conducted with Resident #51 on 8/15/2022 at 10:24 a.m. The Resident responded through a nod and required lip reading when he mouthed a response. When asked if he received dental visits, he shook his head no multiple times. The Resident then opened his mouth and pointed at the front right side and to a tooth. When asked if this area hurt, he nodded yes, several times. When asked if he had reported the oral pain, he shook his head "yes" and mouthed to the nurses.

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An observation was conducted on 8/15/2022 at 10:54 a.m. of Resident #51's teeth and revealed the upper right half of the palette was red with an inflamed swollen area to a front tooth and gum area.

A review of Resident #51's electronic medical record and nurse progress notes for July and August 2022 did not include documentation for oral pain or inflammation.

An interview was conducted on 8/16/2022 at 3:20 p.m. with the MDS Director. The MDS Director reviewed the Resident's dental exam notes from the 10/28/2021 visit, that documented the Resident had multiple missing teeth, 7 teeth that were root tips, and two non-restorable teeth. The surveyor and the MDS Director walked to Resident #51's bedside for an observation of his oral cavity. The MDS Director requested the Resident open his mouth for an observation and then she stated she observed he had inflamed gums to the top right side with multiple tooth fragments and obvious black areas on his teeth. The MDS Director was not observed to offer anything for pain.

An interview was conducted on 8/16/2022 at 3:21 p.m. with Resident #51. The MDS Director was present at the bedside. The Resident indicated his pain was a 5 on a scale of 0-10 with 0 being no pain and 10 being the worst pain ever.

A review of the August Medication Administration Record (MAR) revealed there was no administration documented for the ordered as needed Acetaminophen 1) when the NA's reported this to the hall nurses the week of

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8/8/2022 through 8/15/2022 or 2) when the Resident reported to the MDS Director that he had pain at a 5 out of 10, on the date, 8/16/2022. On the date of 8/16/2022 the last dose of scheduled acetaminophen had been provided at 1:00 p.m.

An interview was conducted on 8/16/2022 at 4:02 p.m. with the Administrator, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), the MDS director, the social worker (SW) and the regional consultant present in the office. The administrative team was made aware of the concerns the surveyor had discovered during the investigation. The DON and Administrator revealed the facility had not been aware Resident #51 had a dental recommendation for follow up in 2-6 months. They both stated the facility had not been aware the Resident had oral pain or inflammation in his mouth. The DON revealed the Resident can communicate his pain and had communicated his gastrointestinal pain in the past. The administrative staff all stated they will schedule a follow up dental appointment, ensure his pain was assessed, and as needed pain medication provided as ordered.

An interview was conducted with the Dentist #1 on 8/17/2022 at 12:00 p.m. and he revealed his practice received a call on 8/16/2022 to schedule the visit due to the Resident reporting pain in his mouth. He said an assessment was completed on 8/17/2022 with Resident #51 and there was a change from the previous visit in October 2021. He stated the Resident now had two gingival abscesses, located on the upper right and lower left of the mouth. He revealed the failure to schedule a follow up visit per his recommendation

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on 10/28/2021 was very concerning to him.

A review of the August MAR for the date of 8/17/2022 revealed Resident #51 had not been provided his breakthrough as needed pain medication as ordered and his last dose of scheduled Acetaminophen, prior to the dental exam had been at 9:00 a.m. The Resident was documented to receive his next dose of Acetaminophen at 1:00 p.m.

A review of the nursing progress notes had been conducted on 8/25/2022 and revealed a nurse progress note written by the ADON on 8/17/2022 for the date of 8/16/2022. The progress note read Resident #51 was assessed for oral pain and denied the pain three times with a head shake.

An interview was conducted with Resident #51 on 8/25/2022 at 1:06 p.m. and he revealed he had pain in his jaw and the pain had been present for a week before the first interview with the surveyor on 8/15/2022.

An interview was conducted with the MDS Director on 8/25/2022 at 10:22 a.m., with the Director of Nursing present, and she was read the 8/16/2022 interview statement of her observation of Resident #51 and what was reported to her. She acknowledged the statement was accurate. When asked what she did with the information that the Resident had pain a 5 out of 10 she revealed she did not offer or provide Resident #51's ordered as needed pain medication. She added she reported this information, regarding the oral redness and pain to the administrative nursing team during the time the surveyor revealed the multiple concerns discovered during the investigation. She stated she was unaware of

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what the administrative nursing team did with the reported information. She revealed she had not written a progress note, as of 8/25/2022, to document what she observed or what the Resident reported. She added she would document a late entry progress note to reflect what she observed, what was reported to her and the staff she reported to about the pain.

An interview was conducted with the Director of Nursing (DON) on 8/25/2022 at 10:31 a.m., in reference to the MDS Director interview on 8/25/2022 at 10:22 a.m. The DON stated to the MDS Director she did not recall the MDS director reporting the Resident had pain a 5 out of 10 that had not been reported to the hall nurse for pain medication to be provided. She stated this had not been clearly communicated to the team. She then stated it was the hall nurse that should receive this information with a follow up report to the administrative nursing team that there was a change of condition to a resident. The DON was read the summarized statement from 8/16/2022 at 4:02 p.m. and she revealed the statement was accurate that this was when the team first learned the Resident had oral pain and redness and had a recommendation that had not been scheduled.

A second interview was conducted with Dentist #1 on 8/26/2022 at 3:03 p.m. and he revealed on 8/17/2022 Resident #51 had two areas with purulent exudate (any fluid or semisolid that has exuded out of a tissue because of injury or inflammation) and when the two areas were probed (pressed on with a device) the Resident squeezed his hand to indicate pain. He stated facility staff had been present at the bedside when Resident #51 expressed he had pain. He revealed he recommended Acetaminophen for

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pain in combination with ibuprofen intermittently. He stated the reason he had previously, on 8/17/2022, stated the failure to schedule a recommended follow up visit was concerning to him was because the lack of care can lead to dental issues that included infection. He added when taking care of dental infection, the concern was that it could lead to pneumonia due to bacteria, weaken the overall immune system, and lead to a blood infection or sepsis. He revealed dental abscesses cause severe pain.

An interview was conducted on 8/25/2022 at 1:37 p.m. with the Nurse Practitioner (NP) and she revealed each of her visits to Resident #51 in the last two months had been acute visits related to another health concern and she had not conducted an oral exam. The NP then walked, with the Surveyor, to the Resident's room to assess Resident #51's mouth. She asked the Resident if he hurt and where the pain was located. The Resident pointed to the right side of his jaw and when asked about his pain he indicated his pain was a 5 out of 10 on a 0-10 pain scale. When asked if the pain was in his mouth, he nodded yes. She revealed the dental situation had been reported to her on 8/25/2022, by the administrative nursing team. She ordered Tramadol 50 mg twice a day as needed for pain not controlled by acetaminophen and ordered 1) Cleocin, an anti-infective medication, 300 mg four times a day x 7 days for aspiration pneumonia and stated this would also cover a dental infection and 2) Rocephin, an antibiotic, 1 gram intravenous (IV) everyday x 7 days for pneumonia. She stated she preferred the Dentist make a recommendation and add for a follow up visit with the primary care physician within a time frame to reevaluate the gums and pain.

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An interview was conducted with Physician #2 on 8/25/2022 at 2:54 p.m. via telephone and he revealed he had been at the facility on 8/17/2022 and had been in to see Resident #51 just to check on him. He stated this was not a scheduled visit and he had not conducted an oral exam of the Resident because this was a visit for other conditions. He added that Resident #51 does not communicate with him and prefers other providers for care.

A telephone interview was conducted with the Dental Provider services, Vice President (VP) of operations and the Director of Dental Services on 8/25/2022 at 4:53 p.m. and a referral was made by the Dentist #1 on 8/17/2022 that read, Patient (Resident #51) had pain and an abscess present with infection. A recommendation was made for a full mouth extraction at an outside oral surgeon.

An interview was conducted on 8/26/2022 at 1:37 p.m. with the Medical Director (MD) and he revealed, in relation to Resident #51's dental exam on 8/17/2022, that the concern with an abscess/dental infection, or any infection would be that it can spread to the bloodstream and lead to sepsis. He stated the infection contains bacteria that could be a contributor to the Resident's possible aspiration pneumonia, diagnosed on 8/25/2022. He stated on the date of 8/16/2022, when the Resident expressed, he had pain of a 5 on a scale of 0 to 10, his expectation was for the Resident to be offered and provided his breakthrough, as needed medication or the provider notified for further instructions. He added the lack of dental care that was recommended could be a contributor to the infection the Resident had been diagnosed with.

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An interview was conducted with the ADON on 8/25/2022 at 10:07 a.m. and she revealed she had been present during the meeting with the administrative team on 8/16/2022 at 4:02 p.m. She revealed the statement that this was when the facility first learned of the oral pain and the need to schedule a follow up appointment was accurate and on the date of 8/16/2022.

An interview was conducted with the ADON on 8/25/2022 at 10:42 a.m. and she revealed she had written a late entry progress note after the survey team had exited the facility on 8/17/2022 that stated she had conducted an oral investigation on 8/16/2022. When asked why she conducted an oral investigation prior to learning the Resident had oral pain and inflammation she stated, "but I did, I promise!"

An interview was conducted with the Administrator on 8/25/2022 at 5:58 p.m. and he stated it was his expectation that the facility policy and procedures overcome human error. This error with not getting the hygienist scheduled per the dental recommendation 10/28/2021 was an error from an outside agency. He stated it was his expectation that agency nurses and outside organizations meet the facility policy and protocols in place for the delivery of care at the facility. He revealed if a nurse received a new report of pain, he expected this information to be passed on to the MD and the administrative nursing team along with documentation.

The Administrator was notified of immediate jeopardy on 8/26/2022 at 4:45 p.m.

Identify those recipients who have suffered, or

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are likely to suffer, a serious adverse outcome because of the non- compliance:

The facility failed to ensure that a resident (Resident #51) received treatment and care, when the facility failed to schedule the recommended follow up dental care which resulted in two gingival abscesses (infection) and pain. There was a delay in reporting a change in condition of a resident (Resident #51) when the facility failed to report pain, changes, or redness to the Dentist or Medical Director when it was first discovered by the clinical staff.

The resident was seen on 8/17 by in-house Dentist who ordered acetaminophen for pain and Peridex. The Nurse Practitioner (NP) saw resident #51 for possible pneumonia on 8/25/2022 and examine resident #51's mouth. Upon examination NP wrote orders for Tramadol 50 mg twice a day as needed for pain not controlled by acetaminophen, and the NP ordered: 1) Cleocin 300 mg four times a day x 7 days for potential aspiration pneumonia, and stated this would also cover a dental infection, and 2) Rocephin 1-gram IV everyday x 7 days for pneumonia. A chest x-ray on 8/26/2022 shows no signs of pneumonia. The antibiotic was continued for the dental issues.

On 8/16/2022 Assistant Director of Nursing completed an oral assessment of resident #51 after the Director of Nursing informed her of resident prior complaint of pain. The Assistant Director of Nursing, on 8/16/2022, ask resident #51 3 times if he had any mouth pain, and resident # 51 responded no with a head nod. On 8/17/2022 the physician was contacted by the Director of Nursing to see resident #51 regarding

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the dental examination, and the residents' complaint of oral pain. Resident #51 refused to allow the physician to examine him at that time 8/17/22. What are we doing about this part
This resident often refuses treatment from the attending physician. The Nurse Practitioner (NP) was asked by the Director of Nursing on 8/25/2022 to examine resident #51 regarding for this resident's complaint of pain during her weekly visit. Upon examination the NP wrote an order for Tramadol 50 mg twice a day as needed for pain not controlled by acetaminophen and ordered: 1) Cleocin 300 mg four times a day x 7 days for potential aspiration pneumonia, and stated this would also cover a dental infection, and 2) Rocephin 1-gram IV everyday x 7 days for pneumonia.

On 8/25/2022 the Director of Nursing and Unit Managers conducted an Oral Health observation via visual inspection, and assessment for all current residents to identify if any other resident was having any dental issues/pain. The DON and administrative nurses also completed an Oral Health questionnaire, which included the following questions. 1) Are you having any issues with your teeth 2) Are you having dental pain 3) Are you having trouble eating. Any identified issues or concerns will be addressed, and a dental consultation will be initiated to ensure residents are treated appropriately utilizing the in-house dental services or community dentist if recommended by the attending physician
Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

As of 8/26 the Director of Nursing and

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F 684	Continued From page 35	F 684		

Administrative Nurses provided re-education to licensed nurses and nursing assistants, including contract nursing staff which included reporting pain, signs of infections, notifying physician, as well as the monitoring of pain and the effectiveness of the pain treatment. Any identified concerns will be reported to the Director of Nursing and/or administrative nurses, by documenting on the 24-hour report. Employees who have not received training from the Director of Nursing, Assistant Director of Nursing or Unit Manager/designee will not be permitted to work until education has been completed.
The Staff Development Nurse and RN Weekend Supervisor will track and monitor staff training for completeness.

As of 8/26/22, Regional Nurse Consultant also completed education with Director of Nursing, Assistant Director of Nursing and administrative nurses, related to their responsibility to review the twenty-four-hour report daily, Monday-Friday, during the clinical meeting for any noted concerns to include reports of any dental issues.

Alleged IJ Removal Date 8/27/22

Validation of the Credible Allegation occurred on 9/2/2022 and was evidenced by Resident, Dentist, and Physician interviews, observation, and facility training. The resident interviews and observations included an oral assessment of all residents that identified 6 additional residents in need of dental care. The notification of the dentist and medical provider was verified. The facility training included an Inservice for the responsibility of physician notification regarding a change in condition and focused on dental concerns. The facility policies for notification of changes, and

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F 684	Continued From page 36 dental services were reviewed with all clinical staff. A review of the August MAR was conducted to verify the ordered medication were being administered to Resident #51, as ordered, with no concerns identified. The Resident had an oral surgery appointment scheduled. The immediate jeopardy was removed on 8/27/2022.	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the	F 761	F 761 Label/Store Drugs and Biologicals:	9/20/22

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F 761	Continued From page 37 facility failed to discard expired medications from 1 of 1 medication storage room reviewed for medication storage. The findings included: On 8/17/2022 at 3:24 p.m. a review of the medication storage room was conducted with the Nurse Supervisor #1. An observation of the cabinets revealed a store grocery bag that contained four home medications prescribed to a discharged resident. Two of the four medications were expired. Medication #1 was Oxycodone 5 mg with 30 tablets inside the bottle with an expiration date printed on the prescription label of 5/5/2022. Medication #2 was valacyclovir with an expiration date printed on the prescription label to discard after 5/5/2022. An interview was conducted with Nurse Supervisor #1 on 8/17/2022 at 3:26 p.m. and she revealed the medications were from a discharged Resident. She stated it was the facility practice to request a family member take home medications with them or to lock them up for the Resident until discharge if they did not have family to take the medications home. She added the narcotics should not have been in the cabinet but locked in an area designated for controlled medications. She stated it was her expectation that all expired medications be discarded according to the current recommended practice. An interview was conducted with the Administrator on 8/17/2022 at 4:02 p.m. and he revealed it was his expectation for medications to be stored per the facility protocols and for expired medications to not be stored in the medication room.	F 761	Expired medications were immediately removed on 8/17/2022 from the medication storage room, medications were disposed of per facility policy by nursing supervisor. Audit completed as of 9/19/2022 of all medications and supplies in medication room by DON/designee to ensure that there are not any medications to be disposed of. As of 9/19/2022, Director of Nursing and/or administrative nurses, including Staff Development Director, re-educated all nursing staff, including contract staff, on disposing of expired medications and disposing of medications when not claimed by residents or families upon death or discharge of a resident. Nursing management educated on checking medication room routinely to ensure that there are no expired medications in the medication room by the Director of Nursing as of 9/19/2022. DON and/or administrative nurse will complete observation audits of medication room and medication carts, three times a week x 4 weeks, twice weekly x 4 weeks, and once per week for 4 weeks. The Administrator will report all findings to the QAPI Committee monthly for review and input.	

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F 791 SS=J	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	F 791		9/20/22

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F 791	Continued From page 39 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, Dentist and Medical Director interviews, the facility failed to schedule a dental cleaning and examination for Resident #51 after he had a recommendation from Dentist #1 on 10/28/2021 for a routine follow up in 2-6 months. Ten months after the recommendation, an 8/17/22 dental assessment identified two gingival abscesses, infection, and pain. A week later, a diagnosis of possible aspiration pneumonia was added. This was present in 1 of 1 resident reviewed for dental care. Immediate Jeopardy began on 8/15/22 when dental pain and swollen areas were noted in Resident #51's mouth and it was discovered the follow-up dental appointment had not been schedule in the timeframe recommended. Immediate Jeopardy was removed on 8/28/22 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D to implement corrections for Resident #51, ensure the monitoring of the systems put into place and to complete facility employee training. The findings included: Resident #51 was admitted to the facility on 5/11/2021 with diagnoses that included a tracheostomy, aphonia, protein calorie malnutrition, hemiplegia, and a gastrostomy.	F 791	F 791 Routine/Emergency Dental Services in NFs: The facility Social Worker contacted the in-house dentist for resident #51 on 8/16/2022. The dentist recommended continuing acetaminophen for pain, Peridex mouth wash twice daily x 14 days, and a referral to an oral surgeon. The nurse practitioner ordered Cleocin 300mg four times per day X 7 days for dental infection. Additionally, the nurse practitioner ordered Tramadol 50mg twice per day, for pain not controlled by acetaminophen. On 8/25/2022 the Director of Nursing, Nurse Managers and administrative nurses conducted Oral Health observations, visual examinations, and assessments for all current residents to identify if any other residents that were having any dental issues/concerns. The DON and Unit managers also completed an Oral Health questionnaire, which included the following questions. 1) Are you having any issues with your teeth 2) Are you having dental pain 3) Are you having trouble eating. Any identified issues or concerns that will be addressed, and dental consultations will be initiated to ensure residents are treated appropriately utilizing the in-house dental services if	

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F 791	Continued From page 40 A review of the Dental exam notes for the past 12 months revealed Resident #51 was seen by Dentist #1 on 10/28/2021, the facility Dental Service Provider. Resident #51 was assessed to have heavy calculus (a form of hardened dental plaque) and heavy inflammation. He was missing several teeth, had 7 root tips, 3 restorations and 2 non-restorable teeth present. A recommendation was made for a cleaning in 2-6 months and to receive oral dental exams. The 10/28/2021 dental exam was his only dental visit and he had not been seen by the hygienist. A review of the annual Minimum Data Set (MDS) dated 4/6/2022 revealed Resident #51 was assessed to have no issues with his teeth, cognitive impairment, no speech and no pain present. A review of the physician orders for Resident #51 revealed: 1) Scheduled Acetaminophen 325 milligram (mg), take two tablets by peg tube three times a day for pain ordered on 7/18/2022 and 2) Acetaminophen 160 mg/5 milliliters (ml) liquid, take 20 ml via peg tube every 4 hours as needed for pain, ordered on 7/4/2022. An interview was conducted with Nursing Assistant (NA) #4 on 8/25/2022 at 3:22 p.m. and she revealed she had worked with Resident #51 on multiple occasions and had worked with him over the past month. She stated she did oral mouth care each shift she worked and about two weeks ago, the Resident began to shake his head and pull away when she tried to clean his mouth. She stated she reported this information to the hall nurse but did not recall the nurse's name because she was with an agency.	F 791	recommended by attending physician. As of 8/27/2022 the facility social worker completed a review of dental consultant recommendations for follow up appointments and outside dental referrals for October 2021 through August 2022 to ensure that residents follow up appointments were scheduled. As of 8/26/22 the Director of Nursing, Assistant Director of Nursing and the administrative nurses were educated by the Regional Nurse Consultant, regarding the responsibility of physician notification regarding the results of the dental questionnaires. On 8/26/22 the Director of Nursing determined the Unit Manager would be accountable for physician notification. The physician will determine if an emergent dental consultation is needed, or if routine dental services are sufficient. As of 8/26/22 the Director of Nursing and nurse managers are accountable for inputting the order for consultation into the electronic medical record and will oversee the schedule process which will be completed by the transportation aide. Emergent dental consultations will be sent to In-house Dental Services by Social Worker or Director of Nursing following recommendation by physician, or the resident will be sent to an appropriate outside dental service provider as determined by the medical provider. On 8/26/22 the Director of Nursing,	

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F 791	Continued From page 41 An interview was conducted with NA #5 on 8/25/2022 at 3:44 p.m. and she stated she had worked with Resident #51 numerous times. She added that she swabbed his mouth, during oral care, with a lemon swab. She stated that recently he had begun to shake his head, "No," or pull away when she tried to clean his mouth and she asked the Resident if he had pain and he nodded, "Yes." She added that she observed a red area to the right side of his mouth and reported the redness to an agency hall nurse because the night shift supervisor had been out of work due to an injury. She revealed this had begun two weeks ago. An interview and observation were conducted with Resident #51 on 8/15/2022 at 10:24 a.m. The Resident responded through a nod and required lip reading when he mouthed a response. When asked if he received dental visits, he shook his head no multiple times. The Resident then opened his mouth and pointed at the front right side and to a tooth. When asked if this area hurt, he nodded yes, several times. An observation was conducted on 8/15/2022 at 10:54 a.m. of Resident #51's teeth and revealed the upper right half of the palette was red with an inflamed swollen area to a front tooth and gum area. A review of Resident #51's electronic medical record and nurse progress notes July and August 2022 did not include documentation for oral pain or inflammation. An interview was conducted on 8/16/2022 at 3:21 p.m. with Resident #51. The MDS director was present at the bedside. The Resident indicated	F 791	Assistant Director of Nursing and administrative nurses provided education to nurses and nursing assistants, including contract nursing staff, to complete oral cavity observations for red swollen gums, foul odor, and/or other abnormal teeth issues on admission, during routine care, and with residents that complain of mouth pain. Any identified concerns will be reported to the Director of Nursing, Assistant Director of Nursing or Unit Manager by the nurse or nursing assistant. Assessments completed with any identified issues will be reported to physician by charge nurse for further recommendations related to treatments. Employees who have not received training from the Director of Nursing, Assistant Director of Nursing or Unit Manager/designee will not be permitted to work until education has been completed. The Staff Development Nurse and RN Weekend Supervisor will track and monitor staff training for completeness. The Administrator will validate current employees and agency staff have been educated on 8/26/22. The Administrator will also validate all clinical employees, including agency staff, are educated prior to working. As of 8/26/22 Regional Nurse Consultant also completed education to include, the Director of Nursing, Assistant Director of Nursing and Unit Manager, related to their responsibility to review Dental Consults and recommendations daily Monday-	

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F 791	Continued From page 42 his pain was a 5 on a scale of 0-10 with 0 being no pain and 10 being the worst pain ever. The MDS Director was not observed to offer anything for pain. A review of the August Medication Administration Record (MAR) revealed there was no administration documented for the as needed Acetaminophen on the date, 8/16/2022, when the Resident indicated he had pain at 5 out of 10. An interview was conducted with the Dentist #1 on 8/17/2022 at 12:00 p.m. and he revealed his practice received a call on 8/16/2022 to schedule the visit due the Resident reporting pain in his mouth. He said an assessment was completed on 8/17/22 with Resident #51 and there was a change from the previous visit in October 2021. He stated the resident now had two gingival abscesses, located on the upper right and lower left of the mouth. He added his expectation would be for the follow up to occur as recommended last October and then to receive follow up information, as needed, from the hygienist. He added the lack of scheduling of the recommendation follow up visit was a concern to him. A second interview was conducted with Dentist #1 on 8/26/2022 at 3:03 p.m. and he revealed on 8/17/2022 Resident #51 had two areas with purulent exudate and when the two areas were probed (pressed on with a device) the Resident squeezed his hand to indicate pain. He revealed he recommended Acetaminophen for pain in combination with ibuprofen intermittently. He added when taking care of dental infection, the concern was that it could lead to pneumonia due to bacteria, weaken the overall immune system,	F 791	Friday during the clinical meeting. As of 8/17/22, the Director of Nursing, Assistant Director of Nursing or designee will review the consultations to ensure they have been addressed and the appointments have been scheduled with the dental provider. The appointment schedule and schedule book, as well orders, recommendations, consultations, and follow-ups will be brought to the clinical meeting by the Director of Nursing or Assistant Director of nursing. They will be compared, to validate that the orders, recommendations, consults, and follow ups are accounted for, and match the scheduled appointments. This will be monitored Monday through Friday x 4 weeks, twice weekly x 4 weeks, and weekly x 4 weeks. The schedule list for the in-house dental provider will be maintained and updated by the social worker, and the outside appointment book will be maintained and updated by the transportation aide under the supervision of the Director of Nursing and Assistant Director of Nursing. The Social Worker will monitor all appointments for dental services daily for a period of six months. The Social Worker will provide a summary of findings and corrective actions monthly to the QAPI Committee for their review & discuss any further updates for 3	

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and lead to a blood infection or sepsis. He revealed dental abscesses cause severe pain.

An interview was conducted with Resident #51 on 8/25/2022 at 1:06 p.m. and he revealed he had pain in his jaw and the pain had been present for a week before the first interview on 8/15/2022. An interview was conducted on 8/25/2022 at 1:37 p.m. with the Nurse Practitioner (NP) and she revealed each of her visits to Resident #51 in the last two months had been acute visits related to another health concern and she had not conducted an oral exam. The NP then walked to the Resident's room to assess Resident #51's mouth. She asked the Resident if he hurt and where the pain was located. The Resident pointed to the right side of his jaw and when asked about his pain he indicated his pain was a 5 out of 10 on a 0-10 pain scale. When asked if the pain was in his mouth, he nodded yes. She revealed the dental situation had been reported to her on 8/25/2022. She ordered Tramadol 50 mg twice a day as needed for pain not controlled by acetaminophen and ordered 1) Cleocin, an anti-infective medication, 300 mg four times a day x 7 days for aspiration pneumonia and stated this would also cover a dental infection and 2) Rocephin, an antibiotic, 1 gram intravenous (IV) everyday x 7 days for pneumonia. She stated she preferred the Dentist make a recommendation and add for a follow up visit with the primary care physician within a time frame to reevaluate the gums and pain.

An effort to interview the agency nurses that worked with Resident #51 8/8/2022 through 8/15/2022 via telephone was conducted, without success.

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A telephone interview was conducted with the Dental Provider services, Vice President (VP) of operations and the Director of Dental Services on 8/25/2022 at 4:53 p.m. and a referral was made by the Dentist #1 on 8/17/2022 that read, Patient (Resident #51) had pain and an abscess present with infection. A recommendation was made for a full mouth extraction at an outside oral surgeon. The VP added their company was responsible for scheduling all follow up visits but stated they had been unable to obtain consent to treat for Resident #51. The Director of Dental Services stated a letter to acquire consent to treat had been mailed to the Resident at the facility.

An interview was conducted on 8/26/2022 at 1:37 p.m. with the Medical Director (MD) and he revealed, in relation to Resident #51's dental exam on 8/17/2022, that the concern with an abscess/dental infection, or any infection would be that it can spread to the bloodstream and lead to sepsis. He stated the infection contains bacteria that could be a contributor to the Resident's possible aspiration pneumonia, diagnosed on 8/25/2022. He stated on the date of 8/16/2022, when the Resident expressed, he had pain of a 5 on a scale of 0 to 10, his expectation was for the Resident to be offered and provided his breakthrough, as needed medication or the provider notified for further instructions. He added the lack of dental care that was recommended could be a contributor to the infection the Resident had been diagnosed with.

The Administrator was notified of immediate jeopardy on 8/26/2022 at 4:45 p.m.

The facility provided a credible allegation of immediate jeopardy removal dated 8/28/2022.

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Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non- compliance:

The facility must ensure all residents receive dental services as required to meet their needs. Facility failed to schedule a follow up dental appointment for resident # 51 following dental consult on 10/28/21.

On 8/16/22 the inhouse dental provider, was contacted by the Social Worker regarding resident #51 and the need for emergency dental services following identification needed services. The in-house dental provider conducted an on-site evaluation and treatment plan on 8/17/22. In-house dental consultant recommended the resident be seen by an oral surgeon for the remaining teeth to be extracted. The Facility worked with the Medical Director to locate an oral surgeon for resident #51's recommended tooth extraction from August 17 to August 25, 2022. Due to resident #51 having a tracheostomy tube and tubing feeding there are challenges with this procedure. On 8/25/22 the facility working with the Medical Director located an oral surgeon in Raleigh, NC. The Facility completed all required paperwork to schedule the appointment 8/25/22 for tooth extraction. The paperwork for the oral surgeon was completed by nurse practitioner and family then returned to the oral surgeon so that the appointment can be scheduled on 8/25/2022.

On 8/25/2022 the Director of Nursing, Nurse Managers and administrative nurses conducted Oral Health observations, visual examinations and assessments for all current residents to identify if any other residents that were having

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any dental issues/concerns. The DON and Unit managers also completed an Oral Health questionnaire, which included the following questions. 1) Are you having any issues with your teeth 2) Are you having dental pain 3) Are you having trouble eating. Any identified issues or concerns that will be addressed, and dental consultations will be initiated to ensure residents are treated appropriately utilizing the in-house dental services if recommended by attending physician

As of 8/27/2022 the facility social worker completed a review of dental consultant recommendations for follow up appointments and outside dental referrals for October 2021, through August 2022 to ensure that residents follow up appointments were scheduled.

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

As of 8/17/22, the Director of Nursing, Assistant Director of Nursing or designee will review the consultations to ensure they have been addressed and the appointments have been scheduled with the dental provider. The appointment schedule and, schedule book, as well orders, recommendations, consultations, and follow ups will be brought to the clinical meeting by the Director of Nursing or Assistant Director of nursing. They will be compared, to validate that the orders, recommendations, consults, and follow ups are accounted for, and match the scheduled appointments. The schedule list for the in-house dental provider will be maintained and updated by the social worker, and the outside

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	345449	A. BUILDING _____ B. WING _____	C 09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/KING	115 WHITE ROAD KING, NC 27021

(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 791	Continued From page 47	F 791		

appointment book will be maintained and updated by the transportation aide under the supervision of the Director of Nursing and Assistant Director of Nursing.

As of 8/26/22 the Director of Nursing, Assistant Director of Nursing and the administrative nurses were educated by the Regional Nurse Consultant regarding the responsibility of physician notification regarding the results of the dental questionnaires. On 8/26/22 the Director of Nursing determined the Unit Manager would be accountable for physician notification. The physician will determine if an emergent dental consultation is needed, or if routine dental services are sufficient. As of 8/26/22 the Director of Nursing and nurse managers are accountable for inputting the order for consultation into the electronic medical record and will oversee the schedule process which will be completed by the transportation aide. Emergent dental consultations will be sent to In-house Dental Services by Social Worker or Director of Nursing following recommendation by physician, or the resident will be sent to an appropriate outside dental service provider as determined by the medical provider.

On 8/26/22 the Director of Nursing, Assistant Director of Nursing and administrative nurses provided education to nurses and nursing assistants, including contract nursing staff, to complete oral cavity observations for red swollen gums, foul odor, and/or other abnormal teeth issues on admission, during routine care, and with residents that complain of mouth pain. Any identified concerns will be reported to the Director of Nursing, Assistant Director of Nursing or Unit Manager by the nurse or nursing assistant.

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Assessments completed with any identified issues will be reported to physician by charge nurse for further recommendations related to treatments. Employees who have not received training from the Director of Nursing, Assistant Director of Nursing or Unit Manager/designee will not be permitted to work until education has been completed. The Staff Development Nurse and RN Weekend Supervisor will track and monitor staff training for completeness.

The Administrator will validate current employees and agency staff have been educated on 8/26/22.

The Administrator will also validate all clinical employees, including agency staff, are educated prior to working.

As of 8/26/22 Regional Nurse Consultant also completed education to include, the Director of Nursing, Assistant Director of Nursing and Unit Manager, related to their responsibility to review Dental Consults and recommendations daily Monday- Friday during the clinical meeting

Alleged Date of IJ Removal: 8/28/2022

Validation of the Credible Allegation occurred on 9/2/2022 and was evidenced by Resident, Dentist, and Physician interviews, observation, and facility training. The resident interviews and observations included an oral assessment of all residents that identified 6 additional residents in need of dental care. The notification of the dentist and medical provider was verified. The facility training included an Inservice for the responsibility of physician notification regarding a change in condition and focused on dental concerns. The facility policies for notification of changes, and

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F 791	Continued From page 49 dental services were reviewed with all clinical staff. A review of the August MAR was conducted to verify the ordered medication were being administered to Resident #51, as ordered, with no concerns identified. The Resident had an oral surgery appointment scheduled. The immediate jeopardy was removed on 8/28/2022.	F 791		
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 interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint surveys conducted on 2/25/21, and 1/17/20. This was for one deficiency that was cited in the areas of Accuracy of Assessments (F641) cited on 2/25/21 and 1/17/20 and recited on the current recertification and complaint survey of 9/2/22. The duplicate citation during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag is cross referenced to: F641 - Based on observation, record review, and	F 867	F 867 QAPI/QAA Improvement Activities: The MDS for resident #51 was revised on 8/25/2022 to reflect the correct dental health status of the residents utilizing both direct observation and a review of the medical records. Additionally, the MDS coordinators and director of nursing conducted an audit of all current residents in the facility for their current dental health status utilizing direct observation and a review of the medical record. MDS and Care Plans were updated with any abnormal findings. As the facility realizes the potential for the alleged deficient process to affect other residents of the facility QAPI Committee were re-educated by the Regional Operation Director on the proper QAPI	9/20/22

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F 867	Continued From page 50 staff interviews the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 of 1 resident (Resident #51) reviewed for dental care. During the recertification and complaint survey of 2/25/21, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of skin conditions for 1 of 1 resident. During the recertification and complaint survey of 1/17/20, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of medications for 2 of 5 residents. An interview with the Administrator on 08/17/22 at 6:10 PM revealed the Quality Assessment and Assurance (QAA) committee met at least quarterly but usually monthly. Some of the issues reviewed during the monthly meetings were identified through rounds, trends with grievances and quality measures as well as MDS issues. An interview was conducted with the Administrator on 9/2/2022 at 11:00 a.m. and he revealed: The inaccuracies occurred prior to the Administrator being assigned to this facility and he stated he would need to review the citations before speaking on what the previous concerns had been. Regarding the MDS inaccuracy with the dental/oral assessment on the 4/6/2022 annual MDS, He stated the nursing staff and MDS coordinator will be reeducated on how to conduct a proper dental assessment.	F 867	processes on 8/25/2022. The facilities established QAPI policies will continue to be followed monthly, in addition all identified areas of concern will be followed until a complete resolution is established then identified areas of concern will continue to be reviewed quarterly or more frequently if needed to ensure that the QAPI process is maintained. The Regional Director of Operations or their designee will monitor the QAPI process monthly for three months then quarter for two quarters, to ensure continued compliance.	