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	345442	A. BUILDING _____ B. WING _____	C 11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/07/22 through 11/10/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #F81K11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 11/07/22 through 11/10/22. Event ID# F1K11. The following intake was investigated NC00191218. 1 of 2 complaint allegations were substantiated resulting in a deficiency (F677).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		12/2/22

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

Electronically Signed | 12/02/2022

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to maintain residents ' dignity when meals were not provided to all residents at the same table for residents seated at the same time. This deficient practice affected Residents #20 and #13 and occurred during 2 of 3 lunch meals observed. The reasonable person concept was applied to example #3 as residents have an expectation of being treated with dignity in their home environment. The findings include:	F 550	F550- Resident Rights/Exercise of Rights: 1. Nurse Aide #1 and Nurse Aide #3 was educated on maintaining residents dignity by ensuring meals are provided to all residents at the same table for residents seated at the same time on 11-30-22. No adverse affects to resident #20 and #13. 2. A quality review was completed by the Director of Nursing of all residents in dining room to ensure meals are provided to all residents at the same table for residents seated at the same time on 11-30-22. On date of audit review all tables	

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F 550	Continued From page 2 1) Resident #20 was admitted to the facility on 05/26/22. Resident #20's quarterly Minimum Data Set (MDS) dated 09/02/22 indicated his cognition was moderately impaired. A continuous observation of lunch being served in the facility dining room was conducted on 11/07/22 at 12:38PM through 01:34PM. Observed Resident #26 being served their lunch tray at 12:25PM and another resident (Resident #20) at the same table was served at 12:40PM. Resident #20 was watching Resident #26 being fed by staff as he awaited his tray to be served. Resident #26 was approximately halfway through his meal when Resident #20 ' s tray was delivered to the table. An interview was conducted with Resident #20 on 11/09/22 at 09:25 AM. Resident #20 stated he wanted to be served his meal at the same time as other residents at the table. He further stated "it's not fair" to him when residents at the table were eating in front of him. An interview with Nursing Assistants (NAs) #1 and #3 was conducted on 11/08/22 at 12:25PM. NA # 3 stated when a resident ' s meal tray was not on the dining room meal cart, the NAs were supposed to go to the kitchen door and ask the kitchen staff for the tray. NA #3 also stated that the dietary staff would tell them they must wait for the hall carts to come out to get trays for residents that were in the dining room. NA #1 stated the dietary staff were very rude and hateful, so the NAs were scared to ask them anything. NAs #1 and #3 indicated when	F 550	were served at the same time. Updated dining room list provided to dietary manager of residents who eat in dining room for each meal on 12-1-22 by the Director of Nursing. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing educated nursing staff on residents rights related to dignity to ensure meals are being provided to all residents at the same time for residents seated at the same time by 12-6-22. Nursing staff that has not completed the education will completed the education prior to working next scheduled shift. Newly hired nursing staff will be educated upon hire during orientation. 4. The Director of Nursing/Nurse Manager will conduct random Quality reviews of residents in dining room during meal times 2 times a week for 8 weeks then weekly for 4 weeks to ensure meals are being provided to all residents at the same table for residents seated at the same times. The Director of Nursing will report the results of the quality monitoring (audit) and report to the (QAPI) Quality Assurance Performance Committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance □ 12-7-22	

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F 550	Continued From page 3	F 550		

residents were sitting at a table together the meal trays should be served to that table in a successive manner and that one person should not have to wait a period of time before getting their tray.

Interview with the Dietary Manager (DM) was conducted on 11/08/22 at 01:04PM. She stated if the staff in the dining room needed a resident ' s tray or anything else that they just needed to ask for it.

Interview with the Director of Nursing (DON) was conducted on 11/10/22 at 09:30 AM. She stated she was unaware the staff was not serving residents simultaneously when they were sitting at one table during meals. She stated NAs have reported that they do not go to the kitchen door to ask for anything because the staff were rude and mean. She further stated she had observed the dietary staff being very rude to staff. She also stated their behavior had gotten better since the new Administrator had started working at the facility.

Interview with Administrator was conducted on 11/10/22 at 09:45AM. She stated staff should serve residents simultaneously when they were sitting at one table, and she was unaware this issue was occurring. She also stated she received complaints on the attitudes of the kitchen staff. She further stated the District Dietary Manager had in-serviced the staff regarding attitudes and that the issue had been reported 3 times to the facility corporate office. She stated that the staff behaviors had gotten

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F 550	Continued From page 4	F 550		

better over the last couple of months.

2) Resident #13 was admitted to the facility on 01/18/21. Resident #13's quarterly Minimum Data Set (MDS) dated 09/02/22 indicated her cognition was severely impaired.

A continuous observation of lunch being served in the facility dining room was conducted on 11/07/22 at 12:38PM through 01:34PM, two residents were served at approximately 12:30PM and the third resident (Resident #13) was served at the same table at 12:50PM. Resident #13 was watching the two other Residents as they ate. The two other Residents were halfway through their meal when Resident #13 received her tray.

A continuous observation of lunch being served in the facility dining room was conducted on 11/08/22 at 12:17PM through 12:45PM. Observed one resident being served their lunch tray at 12:19PM and another resident (Resident # 13) at the same table was served at 12:32PM. Resident #13 was watching the other Resident eat her meal which she was a quarter of the way through, when Resident #13 received her tray.

An interview with Nursing Assistants (NAs) #1 and #3 was conducted on 11/08/22 at 12:25PM. NA # 3 stated when a resident ' s meal tray was not on the dining room meal cart, the NAs were supposed to go to the kitchen door and ask the kitchen staff for the tray. NA #3 also stated that the dietary staff would tell them they must wait for the hall carts to come out to get trays for

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F 550	Continued From page 5	F 550		

residents that were in the dining room. NA #1 stated the dietary staff were very rude and hateful, so the NAs were scared to ask them anything. NAs #1 and #3 indicated when residents were sitting at a table together the meal trays should be served to that table in a successive manner and that one person should not have to wait a period of time before getting their tray.

Interview with the Dietary Manager (DM) was conducted on 11/08/22 at 01:04PM. She stated if the staff in the dining room needed a resident ' s tray or anything else that they just needed to ask for it.

Interview with the Director of Nursing (DON) was conducted on 11/10/22 at 09:30 AM. She stated she was unaware the staff was not serving residents simultaneously when they were sitting at one table during meals. She stated NAs have reported that they do not go to the kitchen door to ask for anything because the staff were rude and mean. She further stated she had observed the dietary staff being very rude to staff. She also stated their behavior had gotten better since the new Administrator had started working at the facility.

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F 550	Continued From page 6 Dietary Manager had in-serviced the staff regarding attitudes and that the issue had been reported 3 times to the facility corporate office. She stated that the staff behaviors had gotten better over the last couple of months.	F 550		
F 565 SS=B	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have	F 565		12/8/22

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F 565	Continued From page 7 family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to record and resolve grievances which were reported in the Resident Council meetings for 8 out of 10 months reviewed (January 2022, February 2022, March 2022, April 2022, June 2022, July 2022, September 2022, October 2022). The findings included: Review of the grievance policy provided by the facility and dated last revised 10/24/22 read as follows: "The Center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/grievance and inform the resident of progress towards resolution ... The resident should have reasonable expectations of care and services and the center should address those expectations in a timely, reasonable, and consistent manner." Observation of a Resident Council meeting was conducted on 11/08/22 at 2:00 PM and revealed an issue with recording and resolution of grievances. All in the meeting were cognitively intact. The residents reported having expressed concerns about the food including temperature, variety, and overall quality of the food. The residents stated they had discussed their concerns of the food in Resident Council meetings as well as with the Dietary Manager (DM). Multiple members of the resident council	F 565	F565- Resident/Family Group and Response 1. The Executive Director, Social Services Director (SSD) and Activities Director (AD) reviewed last 3 months to include September, October, and November of resident council minutes and initiated a grievance for each concern. Follow-up completed on 11-22-22 and reported to Resident Council on next scheduled meeting on 11-22-22. 2. The Executive Director, AD and SSD conducted a Resident Council to discuss prompt response to grievances and to ensure residents are free to participate in Group Meeting and receive a prompt response on their grievance on 11-22-22. No new grievances captured during resident council pertaining to the previous 3 months which include September, October, and November. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director Market Leader educated the Executive Director (ED), Social Services Director (SSD) and Activities Director (AD) on timely response	

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F 565	Continued From page 8 explained for several months they had expressed a variety of concerns, many repeatedly, and had not received a response to their expressed concerns. Review of the Resident Council minutes dated 01/25/22 indicated dietary concerns regarding lack of food options and cold coffee. Review of the Resident Council minutes dated 02/22/22 indicated dietary concerns regarding food being served cold as well as lack of variety of food. Review of the Resident Council minutes dated 03/29/22 indicated dietary concerns regarding food being served cold as well as no condiments and missing utensils on the tray. Review of the Resident Council minutes dated 04/24/22 indicated dietary concerns regarding food being served cold. Review of the Resident Council minutes dated 06/28/22 indicated dietary concerns regarding residents receiving food that was not in their diet order. Review of the Resident Council minutes dated 07/26/22 indicated dietary concerns regarding food being served cold as well as lack of variety of food and vegetables sitting in water. Review of the Resident Council minutes dated 09/27/22 indicated dietary concerns regarding food being served cold as well as lack of taste, few choices, and not getting proper diet ordered. Review of the Resident Council minutes dated	F 565	and filing of Grievances/Concerns received during Resident Council and, ensure follow-up is reported to Resident Council at the next scheduled meeting on 11-30-22. 4. The Executive Director will review resident council minutes bimonthly for 2 months then monthly for 1 month to ensure resident□s grievances including dietary concerns are initiated and followed up timely. ED and DCS will attend Resident Group meetings (when invited) to ensure timely follow-up and response to grievances. Resident council meetings will be held every other week for 8 weeks then continue with monthly. Findings will be reviewed by QAPI committee monthly and Quality Monitoring updated as indicated. 5. Date of Compliance 12-7-22.	

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10/25/22 indicated dietary concerns regarding having a few good meals then the meals go back to previous experiences.

Review of a facility Grievance Report from 01/01/22 through 11/07/22 revealed no grievances from the Resident Council meeting.

An interview was conducted with the Activities Director on 11/08/22 at 2:35 PM. She indicated she assists the residents with the monthly Resident Council meetings. She stated residents in the Resident Council meetings have told her they feel like the Dietary Manager (DM) was not open to suggestions or concern since the food concerns had been ongoing for several months. She further indicated she was familiar with how to write up grievances because she was recently trained. She acknowledged she had not been filing out grievances on behalf of the Resident Council. She stated she was not aware she needed to write a grievance on behalf of Resident Council.

An interview with the Social Worker on 11/09/22 at 2:12 PM revealed she did not receive any grievances from the Resident Council.

A joint interview was conducted with the DM and the District Dietary Manager on 11/08/22 at 1:03 PM. The DM stated she met with the Resident Council after their meeting each month. The DM further stated she had not taken any notes or minutes from meetings she had attended. She indicated residents had stated the food has gotten better and did not recall any complaints about food being cold, taste, or lack of variety. She indicated to keep food warm, they put the food in the oven, check the temperature, utilize

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F 565	Continued From page 10 plate warmers, plate covers, and insulated bowls. She stated she felt like the residents' complaints were being resolved even though there were repeated concerns regarding the food. The District Dietary Manager indicated the corporate office made the menus. She stated she was instructed to go through one 4-week cycle before making changes to the menu. She indicated there had been supply chain issues which were causing some items to be unavailable, including condiments. An interview was conducted with the Administrator on 11/10/22 at 10:45 PM. The Administrator stated she was aware of the ongoing food issues; however, she had seen improvement as evidenced by completing routine test trays. She stated she had done test trays and had provided feedback to the Dietary Manager. She indicated all staff members can complete grievance forms. She further stated she expected the facility to complete a grievance form on behalf of the Resident Council and to resolve the food concerns which had been ongoing for several months.	F 565		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		12/8/22

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charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the

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F 582	Continued From page 12 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF-ABN) Form Centers for Medicare Services (CMS) 10055 prior to discharge from Medicare Part A Services for 2 of 3 sampled residents reviewed for beneficiary protection notification review (Resident #48 and Resident #16). Findings included: 1. Resident #48 was admitted to the facility on 02/28/22 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was issued on 06/13/22 to Resident #48 which explained Medicare Part A coverage for skilled services would end on 06/15/22. Resident #16 had Medicare Part A days remaining. Resident #48 remained in the facility at the time the survey was being performed from 11/07/22 through 11/10/22. A review of the medical record revealed a CMS-10055 SNF-ABN (Skilled Nursing Facility Advanced Beneficiary Notice) was not provided to Resident #48 or their Responsible Party. On 11/09/22 at 2:12 PM the Social Services Director confirmed they issued the CMS-10123 NOMNC once notified a resident's Medicare Part A coverage for skilled services. She stated she was unaware the CMS-10055 SNF-ABN was also required to be given to a resident prior to	F 582	F582 1. The Business Office Manager, Social Services Director and the Executive Director had education provided by the Regional Director of Business Office regarding providing Advanced Beneficiary Notices to current residents when there is a change in payer status that may affect their charges on 12-1-22. Resident #16 and #48 were provided Advanced Beneficiary Notices on 12-7-22. 2. A quality review was conducted on 11-11-22 by the Executive Director that revealed that Advanced Beneficiary Notices had not been provided to any current residents. Two residents that required an Advanced Beneficiary Notice was provided on 11-11-22. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Business Office Manager, the Social Services Director and the Executive Director had education provided by the Regional Director of Business Office regarding providing Advanced Beneficiary Notices to residents when there is a change in payer status that may affect their charges on 12-1-22. This education will be provided to any newly hired Business Office staff members during their orientation process. 4 The Executive Director will complete quality monitoring of 5 residents□ per	

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	345442	A. BUILDING _____ B. WING _____	C 11/10/2022

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F 582	Continued From page 13 Medicare Part A services ending. An interview with the Minimum Data Set (MDS) Nurse on 11/10/22 at 10:38 AM revealed the Social Worker typically provided the SNF-ABN form. She stated she is the backup person to provide the form but has never provided a SNF-ABN form since she had started working at the facility in June 2022. She stated it was an oversite for Resident #48 to not receive a SNF-ABN form. On 11/09/22 at 09:53 AM an interview with the Administrator revealed she did not know where the CMS SNF-ABN forms were located and believed the facility did not have them. An additional interview with the Administrator on 11/10/22 at 10:45 AM revealed the facility should provide SNF-ABN forms if the resident had Medicare A days remaining and remained at the facility. 2. Resident #16 was admitted to the facility on 05/27/22 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was issued on 07/25/22 to Resident #16 which explained Medicare Part A coverage for skilled services would end on 07/28/22. Resident #16 had Medicare Part A days remaining. Resident #16 remained in the facility at the time the survey was being performed from 11/07/22 through 11/10/22. A review of the medical record revealed a CMS-10055 SNF-ABN (Skilled Nursing Facility Advanced Beneficiary Notice) was not provided to	F 582	month with payer changes that remain in the facility for 6 months. The Executive Director will report on the results of the quality monitoring to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring updated as indicated. 5. Date of Compliance □ 12-7-22	

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F 582	Continued From page 14 Resident #16 or their Responsible Party. On 11/09/22 at 2:12 PM the Social Services Director confirmed they issued the CMS-10123 NOMNC once notified a resident's Medicare Part A coverage for skilled services. She stated she was unaware the CMS-10055 SNF-ABN was also required to be given to a resident prior to Medicare Part A services ending. An interview with the Minimum Data Set (MDS) Nurse on 11/10/22 at 10:38 AM revealed the Social Worker typically provided the SNF-ABN form. She stated she is the backup person to provide the form but has never provided a SNF-ABN form since she had started working at the facility in June 2022. She stated it was an oversite for Resident #48 to not receive a SNF-ABN form. On 11/09/22 at 09:53 AM an interview with the Administrator revealed she did not know where the CMS SNF-ABN forms were located and believed the facility did not have them. An additional interview with the Administrator on 11/10/22 at 10:45 AM revealed the facility should provide SNF-ABN forms if the resident had Medicare A days remaining and remained at the facility.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		12/8/22

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F 583	Continued From page 15 §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to provide privacy to a resident by not closing the door causing the resident to be exposed from the waist down for 1 of 1 sampled resident observed (Resident #10). The findings included: Resident #10 was initially admitted to the facility	F 583	F583- Personal Privacy/Confidentiality of Records 1. Privacy curtain placed in Resident #10 room on 11-10-22. No adverse affects noted to resident #10. 2. A quality review was completed by the Nurse Manager by observation of staff	

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F 583	Continued From page 16 on 12/27/21. Review of Resident #10's quarterly Minimum Data Set (MDS) dated 10/03/22 revealed the resident was cognitively intact. An observation was conducted of Resident #10 from the hallway on 11/07/22 at 12:52 PM. The resident was observed to have been lying in bed, awake, and speaking with a staff member with the door opened approximately 10 inches. The resident's legs and private area were exposed; the resident was not wearing a brief or pants; and the resident did not have a cover, sheet, or other linen covering her. Resident #10 was in a private room. There was not a privacy curtain pulled and Resident #10 had been seen from the hallway. An interview with Resident #10 on 11/07/22 at 2:15 PM revealed she was speaking with the facility's dietitian. She stated she had removed her covers and brief during the conversation. She stated it bothered her knowing she was exposed to anyone who walked by her room. She further stated she felt embarrassed about the incident and did not want anyone to see her unclothed. An interview was conducted with the Dietitian on 11/07/22 at 12:54 PM. The Dietitian stated the Resident #10 was unclothed from the waist down, and the door was opened while she was speaking with Resident #10. She stated the Resident #10 requested assistance from a Nurse Aide (NA) and was going to get a NA to help Resident #10. She did not indicate why she left the door open while Resident #10 was not clothed from the waist down. An interview with NA #1 on 11/09/22 at 2:27 PM	F 583	providing care and or if resident provides self- care by closing door and privacy curtains on 11-14-22. No concerns identified during review. An ADHOC Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. Registered Dietician was educated by Executive Director on Residents Rights regarding providing privacy by closing of resident□s door to ensure personal privacy is maintained on 11-21-22.The Director of Nursing and or Nurse Manager educated current staff and Registered Dietician including all shifts, part time and prn and on personal privacy related to ensuring privacy is provided by closing of door and privacy curtain when care is being provided and or resident provides self-care by 12-6-22. Newly hired nursing staff will be educated upon hire during orientation. Staff will not be allowed to return to work until education complete 4. The Nurse Manager will conduct random Quality reviews by observation of staff providing care and or resident performing self-care to ensure privacy being provided by closing of door and privacy curtain of 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality	

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F 583	Continued From page 17 revealed Resident #10, at times, does not like to wear clothes from the waist down. She stated if a resident does disrobe, she encourages privacy by closing the door. An interview with Nurse #1 on 11/09/22 at 2:24 PM revealed she was familiar with Resident #10. She indicated she was not aware of Resident #10 having episodes of disrobing with her door open. She stated she would encourage privacy by assisting the resident and closing the door. The Director of Nursing (DON) was interviewed on 11/09/22 at 3:39 PM. She stated she has observed Resident #10 remove clothing while speaking to her in the room. She indicated the Dietitian should had closed the door when she noticed Resident #10 was removing her clothing. During an interview conducted with the Administrator on 11/10/22 at 10:45 AM she stated the Dietitian should had closed the door when she saw Resident #10 disrobing. She stated staff should preserve and protect residents' privacy at all times.	F 583	monitoring (audit) updated as indicated. 5. Date of Compliance □ 12-7-22	
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	F 584		12/2/22

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F 584	Continued From page 18 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 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 ensure bathrooms were clean and in good repair for 2 of 8 bathrooms observed for environmental concerns (Room 132 and Room 134's bathroom and Room 140 and Room 142's bathroom). The findings included:	F 584	F584- Safe/Clean/Comfortable/Homelike Environment: 1. Room 132 and room 134 bathroom and room 140 and 142 bathroom was cleaned by Housekeeping Director on 11-10-22. Room 132 and room 134 bathroom seal around toilet was replaced by the	

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F 584	Continued From page 19 1) On 11/7/22 at 9:50 AM, the resident in Room 140 stated the floor around her toilet was dirty and had strong smell of urine. An observation of the toilet for Rooms 140 and 142, revealed an amber colored ring around the base of the toilet and a smell of urine was noticeable. Resident stated this had been an ongoing issue since her admission in October 2022. An observation and interview was made with the Housekeeping Director on 11/9/22 at 11:20 AM. She acknowledged there was an amber yellow color ring around the base of the toilet and would have someone in housekeeping clean it immediately. The Housekeeping Director stated housekeeping staff wipe down the fixtures in the bathroom and mop around the toilet but was sometime difficult to get stains up around the base of the toilet. The Administrator was interviewed on 11/10/22 at 11:21 AM and stated she was expected the facility to be clean. 2) On 11/7/22 at 10:35 AM, an observation of the shared bathroom for Rooms 132 and 134 revealed a dark black and yellow substance on the floor around the toilet and the silicone seal coming out from the left side of the toilet base. An observation and interview was made with the Housekeeping Director on 11/9/22 at 11:15 AM. She stated the seal wound be a maintenance issue and the yellow/dark substance was due to the silicone ring coming away from the base of the toilet. She stated, "We could clean it, but it would just get that way again". She stated normally either the housekeeping staff or nursing	F 584	Maintenance Director on 11-11-22. 2. A quality review was completed by the Housekeeping Director and Executive Director to identify any other resident's bathrooms needing cleaning on 11-21-22. No concerns identified. A quality review was completed by Maintenance Director and Executive Director to identify any bathrooms needing repairs on 11-21-22. No bathrooms identified needing seal around toilet replaced. An ADHOC Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Executive Director educated the Housekeeping Director on ensuring bathrooms are clean and sanitary on 11-21-22. The Executive Director educated the new Maintenance Director on timely identifying and repairing of bathrooms (seals around toilet) on 11-21-22. 4. The Executive Director will conduct random Quality reviews by observation of 5 resident's bathrooms to ensure they are clean, sanitary and in good repair 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 12-7-22.	

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F 584	Continued From page 20 staff would report the maintenance concern but was unable to state if any of the housekeeping staff had done so. On 11/9/22 at 11:26 AM, an interview and observation was made with the Maintenance Director. He observed the silicone ring coming out of the left side of the toilet base and stated he was unaware of this. The Maintenance Director stated the nursing or housekeeping staff should have reported this when it was noticed. He further stated that neither he nor his assistant made routine observations of the rooms for maintenance concerns. He denied receiving any work orders for this issue. The Administrator was interviewed on 11/10/22 at 11:21 AM and stated she was unaware of the condition of the bathroom for Rooms 132 and 134, but expected the facility to be clean and in good repair.	F 584		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to	F 585		12/2/22

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F 585	Continued From page 21	F 585		

resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those

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F 585	Continued From page 22 grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:	F 585		

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F 585	Continued From page 23 Based on record review and family and staff interviews, the facility failed to provide a written grievance response summary for 2 of 2 residents reviewed for grievances (Residents #4 and #34). The findings included: A review of the facility grievance policy, dated 11/30/14, included, in part, "The individual voicing the grievance will receive follow up communication with the resolution, a copy of the grievance resolution will be provided to the resident upon request. Note: North Carolina will provide a copy of the resolution." 1. Resident #4 was admitted to the facility 11/13/20. A quarterly Minimum Data Set (MDS) assessment dated 10/14/22 indicated she was cognitively intact. A grievance form was dated 5/18/22 for Resident #4 filed by a family member indicated a grievance regarding her meal tray being delivered to her roommate. The form was signed by the Social Worker (SW) on 5/18/22. There was no indication a written response was offered, requested, or provided. On 11/8/22 at 1:15 PM, an interview occurred with Resident #4, who stated she could not recall receiving verbal resolution of the grievance and had not been offered or provided a summary in writing. A phone interview occurred on 11/9/22 at 12:37 PM, with the Responsible Party (RP) for Resident #4. She stated she had initiated the grievance from 5/18/22 on behalf of Resident #4 and had not received a written summary. However, she	F 585	F585- Grievances 1. Resident #34 and #4 grievances were reviewed and a written resolution provided on 11-18-22 by the Social Services Director (SSD). Resident #34 and #4 were interviewed by SSD to ensure any concerns with care were followed up, resolved with written resolution. No additional grievances voiced. 2. The SSD completed interviews of interview able residents, and the responsible party of un-interview able residents, to ensure grievances are captured with follow up, resolved and written resolution provided on 11-21-22 and 11-22-22. 2 grievances were identified written and response completed. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice 3. The Executive Director educated the Social Services Director on the federal regulations and guidelines related to the resident's right to ensure grievances are resolved, followed up and a written resolution provided on 11-21-22. The Executive Director and Director of Nursing will provide the facility staff, including all shifts, part-time and prn, re-education on the federal regulations and guidelines related to the resident's right to ensure grievances are resolved, followed up and a written summary by 12-6-22. Staff will not be allowed to return	

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F 585	Continued From page 24 indicated receiving a phone call that the grievance was resolved. The SW was interviewed via the phone on 11/9/22 at 2:07 PM. She stated she maintained the facility grievance log and had been in the position since March 2022. She stated when a grievance resolution was received she only provided it verbally and was unaware a written notice was required to be provided. On 11/10/22 at 9:05 AM, the Administrator was interviewed and stated she was unaware the SW was not providing written grievance resolution summaries but would expect for the facility to adhere to the regulatory guidelines. 2. Resident #34 was admitted to the facility on 10/12/20. An annual Minimum Data Set (MDS) assessment dated 8/3/22 indicated he was cognitively intact. A grievance form was dated 9/29/22 for Resident #34 filed by their family member indicated a grievance regarding housekeeping concerns. The form was signed by the SW on 10/1/22 indicating a verbal resolution was provided. There was no indication a written response was offered, requested, or provided. On 11/8/22 at 1:30 PM, an interview occurred with Resident #34, who stated he could not recall receiving verbal resolution of the grievance and had not been offered or provided a summary in writing. He stated the grievance had been resolved. A phone interview occurred on 11/9/22 at 9:07 AM, with the Responsible Party (RP) for Resident	F 585	to work until education complete. 4. SSD will conduct five resident interviews 3 times per week for 4 weeks, then weekly for 3 months to ensure resident's grievances are captured, resolved and followed up with written resolution. The Executive Director will complete quality monitoring on 3 grievances twice weekly for 8 weeks then weekly for 4 weeks to ensure grievance resolved with written summary provided. The SSD will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 12-7-22.	

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F 585	Continued From page 25 #34. She stated she had initiated the grievance from 9/29/22 on behalf of Resident #34 and had not received a written summary. The SW was interviewed via the phone on 11/9/22 at 2:07 PM. She stated she maintained the facility grievance log and had been in the position since March 2022. She stated when a grievance resolution was received she only provided it verbally and was unaware a written notice was required to be provided. On 11/10/22 at 9:05 AM, the Administrator was interviewed and stated she was unaware the SW was not providing written grievance resolution summaries but would expect for the facility to adhere to the regulatory guidelines.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set assessment accurately in the areas of Activities of Daily Living (ADLs), pressure ulcer and oxygen for 2 of 19 resident records reviewed (Residents #19 and #53). The findings included: 1. Resident #19 was admitted to the facility on 8/28/18 with diagnoses that included Alzheimer's disease, lack of coordination, non-pressure chronic ulcer of buttock and non-pressure chronic	F 641	F641 – Accuracy of Assessments: 1. Resident #19 Minimum Data Set (MDS) was corrected in the areas Activities of Daily Living (ADLs) and pressure ulcers to accurately reflect the resident and submitted by the Minimum Data Set Coordinator (MDS Coordinator) on 12-1-22. Resident #53 MDS was corrected in oxygen therapy to accurately reflect the resident and submitted by the MDS Coordinator on 11-10-22.	12/2/22

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F 641	Continued From page 26 ulcer of the back. A) A Significant Change in Status Minimum Data Set (MDS) assessment dated 7/29/22 indicated Resident #19 had severely impaired decision-making skills and required extensive assistance with eating, dressing, toileting, and personal hygiene. She was dependent on staff for bathing. Review of the facility shower records for 8/24/22 through 8/30/22 revealed Resident #19 had a bed bath provided on 8/26/22 A quarterly MDS assessment dated 8/30/22 revealed Resident #19 had long and short-term memory problems and severely impaired decision-making skills. She was coded as activity did not occur for bathing during the seven day look back period. An interview was completed with Nurse Aide (NA) #4 on 11/8/22 at 1:10 PM. She stated Resident #19 received a sponge bath every morning with personal care and complete bed baths twice a week in August 2022. The MDS Nurse was interviewed on 11/10/22 at 10:22 AM. After reviewing the MDS data for 8/30/22, she confirmed the assessment was coded incorrectly for bathing. She stated it was an oversight. During an interview on 11/10/22 at 11:21 AM, the Administrator indicated it was her expectation for the MDS to be coded accurately. B) Review of Resident #19's medical record indicated she had the following wounds/skin	F 641	2. A quality review was completed on the current residents' MDSs in the areas of ADLS, pressure ulcers and oxygen therapy to validate the most recent MDS assessment have been coded to accurately reflect the status of the residents by the Regional Minimum Data Set Nurse on 11-28-22. 50 Minimum Data Sets reviewed, less than 2% error rate noted in the areas of cognition, ADLS, pressure ulcers and oxygen. Most current MDS will be corrected and submitted by 11-28-22. An ADHOC Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Regional Minimum Data Set Nurse educated the MDS Coordinator on accurately coding of ADLS, pressures ulcers and oxygen therapy on 11-28-22. 4. The Regional Minimum Data Nurse will conduct random Quality reviews of 5 random residents' MDS assessments of ADLS, pressure ulcers and oxygen therapy to ensure MDS coded accurately 2 times a week for 8 weeks then weekly for 4 weeks. The MDS Coordinator will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 12-7-22.	

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impairments from 8/24/22 through 8/30/22:
* An autoimmune skin condition to the left lateral hip
* An autoimmune skin condition to the back
* An autoimmune skin condition to the right hip
* An abrasion to the abdomen
* An abrasion to the left lower leg
* A skin tear to the left calf
* A deep tissue injury to the right foot
* A deep tissue injury to the right heel
* A deep tissue injury to the left heel

A quarterly MDS assessment dated 8/30/22 revealed Resident #19 had long and short-term memory problems and severely impaired decision-making skills. The number of pressure ulcers present was not coded for nor was she coded for having a skin tear.

The MDS Nurse was interviewed on 11/10/22 at 10:22 AM. After reviewing the MDS data for 8/30/22, she confirmed the assessment was coded incorrectly for pressure ulcers and other skin impairments. She stated it was an oversight not to have included the deep tissue pressure injuries, skin tears/abrasions and other open lesions.

During an interview on 11/10/22 at 11:21 AM, the Administrator indicated it was her expectation for the MDS to be coded accurately.

2. Resident #53 was admitted to the facility on 4/4/2022 with diagnoses that included chronic obstructive pulmonary disease (COPD).
Resident #53's active orders included an order for 2 liters per minute continuously. The order was dated 7/27/2022.
Resident #53 had a significant change Minimum Data Set (MDS) completed 9/21/2022. The MDS

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F 641	Continued From page 28 indicated the resident did not receive oxygen therapy. On 11/08/22 at 11:32 AM Resident #53 was observed wearing oxygen at 2 liters per minute via nasal cannula. An interview was conducted with the resident at that time and she stated she wore oxygen continuously. 11/9/22 at 10:00 AM Resident #53 was observe in bed wearing oxygen via nasal cannula at 2 liter per minute. On 11/10/22 at 10:48 AM Resident #53 was observed in bed wearing oxygen via nasal cannula at 2 liter per minute. Resident #53 had a significant change Minimum Data Set (MDS) completed 9/21/2022. The MDS indicated the resident did not receive oxygen therapy. On 11/10/22 atv10:25 AM an interview was conducted with MDS nurse. She reviewed the 9/21/2022 significant change MDS and stated it should have been coded to reflect the resident had received oxygen therapy during the assessment period. The MDS was coded in error. An interview was conducted with the Administrator on 11/10/2022 at 11:28 AM. She stated it was her expectation that all MDS be coded correctly.	F 641		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		12/8/22

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F 657	Continued From page 29 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to review and revise care plans in the areas of falls (Resident #17), hydration, (Resident #30), and nutrition (Resident #30). This was for 2 of 19 residents reviewed. The findings included: 1) Resident #17 was originally admitted to the facility on 08/31/22. His diagnoses included acute respiratory failure with hypoxia, abnormalities of gait and mobility, muscle weakness, lack of	F 657	F657- Comprehensive Care Plan 1. Resident #17 care plan was updated by Minimum Data Set (MDS) Coordinator reflect interventions related to falls on 11-10-22. Fall mats order was discontinued and reflected on care plan on 11-9-22. Resident #30 care plan was updated by the MDS Coordinator to reflect current interventions for hydration and nutrition on 11-10-22.	

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F 657	Continued From page 30 coordination, and right-sided weakness. Review of the physician's order dated 07/16/22 indicated a fall mat was to be placed to left side of bed when in bed every day and night shift for fall intervention. A quarterly Minimum Data Set (MDS) assessment dated 09/07/22 indicated Resident #31 was moderately cognitively impaired and required supervision with 1-person physical assistance with transfers and locomotion on and off unit. He was coded as not having any falls since the last assessment. A review of Resident #17's care plan last reviewed on 09/20/22 revealed a focus area for falls with interventions which included bed in low position and anticipate and meet the resident's needs. The care plan did not indicate utilizing a fall mat for fall intervention as ordered in the 7/16/22 physician's order. Observations were made of Resident #17 on 11/08/22 at 8:26 AM, 11/08/22 at 9:46 AM, and 11/08/22 at 12:01 PM. Resident #31 was in bed, sleeping, and the bed was not in a low position nor was there a fall mat in place at the left side of the bed. The fall mat was located propped up against a wall and a dresser. An interview occurred with Nurse Aide (NA) #2 on 11/08/22 at 1:25PM revealed she was not familiar with Resident #17's care needs as she just started working at the facility on 11/07/22. She stated there was a fall mat in Resident #17's room, but it was not in use. She further stated she did not know why the fall mat was not in use or why the bed was not in the lowest position when	F 657	2. A quality review was conducted by Regional MDS Coordinator and MDS Coordinator of current residents to ensure care plans accurately reflect fall interventions, hydration and nutrition on 11 -28-22. Care Plans reviewed, less than 2% noted in fall interventions and 0% noted in hydration and nutrition. An ADHOC Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Regional MDS Coordinator provided re-education to the MDS Coordinator and Interdisciplinary Team to include Director of Nursing and Nurse Manager on accuracy of care plans including interventions for fall interventions, hydration and nutrition on 11 -28-22. 4. The MDS Coordinator will conduct random Quality reviews of 5 residents care plans to ensure the fall interventions, hydration and nutrition accurately reflects the resident□s plan of care 3 times a week for 8 weeks then weekly for 4 weeks. The MDS Coordinator will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance □ 12-7-22	

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Resident #17 was in it. She stated she would ask the nurse if she needed to know his care needs.

An interview on 11/09/22 at 11:25 AM with Nurse Aide #3 revealed she was familiar with Resident #17's care needs. She indicated the reason why the fall mat was not in use was because he was able to get in and out of the bed by himself. She indicated the fall mat prevented him from becoming active and independent with transfers. She indicated she can review a resident's Kardex (a computer system that gives a brief overview of each resident's care needs) to determine which type of fall interventions are in place.

On 11/09/22 at 11:34 AM an interview with Nurse #1 revealed she was familiar with Resident #17's care needs. She indicated he was at risk for falling due to right sided weakness. She stated the MDS Nurse would update the care plan if there was a new order for a fall mat. She did not indicate why the fall mat was not in place or why the bed was not in the lowest position when Resident #17 was in it. She stated she was not familiar with Resident #17's care plan but can review it in his electronic medical chart.

The MDS Nurse was interviewed on 11/10/22 at 10:35 AM. She indicated she assisted with making care plans. She indicated if the fall mat was ordered it should had been on the care plan as a fall intervention. She stated not putting the fall mat intervention on the care plan was an oversight. She did not indicate when the care plan was last reviewed.

An interview occurred with the Director of Nursing (DON) on 11/10/22 AM. She stated the fall mat was not on the care plan because it should not

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had been ordered. She indicated Resident #17 was active and able to transfer himself from bed to wheelchair independently; therefore, the fall mat would be a fall risk for him. She stated the order should had been discontinued; however, if it was ordered it should had been on the care plan if the fall mat was an intervention to reduce falls.

The Administrator was interviewed on 11/10/22 at 10:45 AM. She stated the fall mat order should had been transferred to the care plan and care plans should be updated to provide and accurate picture of residents' care needs.

2. Resident #30 was readmitted to the facility on 05/28/2022 with diagnoses that included cerebral infarction (a stroke) and presence of a gastrostomy tube, frequent falls, and Arterial fibrillation.

The most recent Annual Minimum Data Set (MDS) dated 09/09/22 revealed Resident #30 was noted as severely cognitively impaired. He received nutrition and hydration via Gastrostomy Tube (G-tube) and totally dependent on staff for hydration and nutrition via G-tube. He received anticoagulants for 7 days during the look back period.

a. Record review revealed tube feeding orders were discontinued 09/20/22.

Resident #30 ' s active care plan revised on 09/27/22. A focus was initiated on 06/16/22 that read Resident #30 required tube feeding for all nutrition and fluids. A focus was added on

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09/27/22 that read Resident #30 was ordered PO (by mouth) diet. The goal noted that Resident #30 will remain free of side effects or complications related to tube feedings. Approaches included: administer feedings and flushes as ordered, elevate head of bed at least 45 degrees during and thirty minutes after tube feed, and elevate head of bed at least 45 degrees during and thirty minutes after tube feed.

Resident #30 ' s active care plan revised on 09/27/22. A focus was initiated on 06/16/22 that read Resident #30 was on anticoagulant therapy related to atrial fibrillation. Use of medication increases resident risk for abnormal bruising/bleeding. The goal read Resident #30 will be free from discomfort or adverse reactions related to anticoagulant use. Approaches included: administer anticoagulant medication as ordered by physician, monitor for side effects and effectiveness, labs as ordered, and report abnormal lab results to the MD, and monitor/document/report as needed adverse reactions.

b. Apixaban anticoagulant was discontinued on 09/28/22.

An interview on 11/10/22 at 10:45AM, with MDS Nurse #2 revealed she amended the care plan when there was a change in the residents ' status. She stated the focus related to tube feedings and anticoagulated medication should have been removed when the orders were changed.

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F 657	Continued From page 34 An interview with the Director of Nursing (DON) on 11/10/22 at 09:55AM indicated the care plan should be an accurate representation of the resident.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transcribe the correct medication administration route for 1 of 2 residents reviewed for gastric feeding tube (Residents #44). The findings included: Resident #44 was admitted to the facility on 6/16/21 with diagnoses that included cerebral infarction (a stroke) and presence of a gastrostomy tube. A Significant Change in Status Minimum Data Set (MDS) assessment dated 10/14/22 indicated Resident #44 had severely impaired decision-making skills. She required total assistance with eating and received all nutrition and fluids via a feeding tube. Review of the active care plan, last reviewed 10/28/22, revealed Resident #44 required tube feeding for all nutrition and fluids. The active November 2022 physician orders	F 658	F658- Services Provided Meet Professional Standards: 1. Resident #44 physician orders was updated to reflect correct route of medication via G-tube on 12-1-22 by Nurse Manager. 2. A quality review was completed by the Nurse Manager/Director of Nursing of current resident's physician orders to ensure accurate route of medication noted on 12-1-22. No further concerns noted. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Nurse Manager/Director of Nursing educated current nurses including all shifts, part time and prn on ensuring orders written accurately to reflect correct route of medication by 12-6-22. Staff will not be allowed to return to work until	12/2/22

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F 658	Continued From page 35 included the following orders: - An order dated 6/9/22 for Multivitamin 1 tablet by mouth once a day for wound healing. - An order dated 7/16/22 for Norvasc 10 milligrams (mg) 1 tablet by mouth one time a day for hypertension. All other medications were written to be provided through the gastric feeding tube. The physician orders indicated Resident #44 was to have nothing by mouth (NPO). On 11/9/22 at 8:45 AM, an interview occurred with Nurse #1 who was working the medication cart for Resident #44's hall and had administered her medications earlier. The nurse confirmed Resident #44 did not receive any medications by mouth and she had not provided the morning doses of Multivitamin or Norvasc by mouth. Nurse #1 acknowledged the Medication Administration Record (MAR) read for those particular medications to be provided by mouth, which was inaccurate as all medications were provided via the gastric feeding tube. A phone interview was conducted with Nurse #2 on 11/9/22 at 3:36 PM. She was the nurse that transcribed both orders for Resident #44. Nurse #2 explained she entered the medication, dose and frequency into the Electronic Medical System but failed to change the medication route to gastrostomy tube (G-tube). Stated the default route was by mouth. The Director of Nursing (DON) was interviewed on 11/9/22 at 3:10 PM. She reviewed Resident #44's physician orders and confirmed the route for the Multivitamin and Norvasc was entered as oral instead of via G-tube. She further explained when entering the medication into the electronic	F 658	education complete 4. The Nurse Manager will conduct random Quality reviews of current physician orders to ensure correct route of medication noted on order on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the Quality Assurance and Performance Improvement committee (QAPI). Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of compliance – 12-7-22	

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F 658	Continued From page 36 medical system the default route was oral and she felt it was an oversight that the nurse failed to change the route to G-tube. The DON stated it was her expectation for all medication administration routes to be entered correctly when the order was received.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to trim and clean a dependent resident's nails (Resident #19) for 1 of 4 residents reviewed for Activities of Daily Living (ADL's). The findings included: Resident #19 was admitted to the facility on 8/28/18 with diagnoses that included Alzheimer's disease, cerebral infarction (a stroke) and muscle weakness. A review of Resident #19's active care plan, last reviewed on 8/22/22, included a focus area for ADL self-care performance deficit related to advanced aging and dementia, history of a stroke with lower extremity weakness. One of the interventions included to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. A quarterly Minimum Data Set (MDS)	F 677	F677- ADL Care Provided for Dependent Residents 1. Resident #19 was provided nail care to include cleaning and trimming their nails on 11-9-22. 2. A quality review was completed by the Nurse Manager on current residents on Activities of Daily Living (ADL) care specific to nail care on 11-22-22. Identified residents were provided nail care to include cleaning and trimming at that time. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing re-educated nursing staff including al shifts, part-time and prn on ADL care specific to nail care	12/2/22

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F 677	Continued From page 37 assessment dated 8/30/22 indicated Resident #19 had severely impaired decision-making skills and had no behaviors or refusal of care. She was dependent on staff for personal hygiene tasks. A review of Resident #19's nursing progress notes from 1/1/22 to 11/9/22 revealed no refusals of nail care documented. On 11/7/22 at 11:50 AM, Resident #19 was observed while lying in bed. She was noted to have long fingernails to the right and left hand as well as a dark substance under them. An observation occurred of Resident #19 on 11/8/22 at 3:27 PM while she was lying in bed. She was observed with long fingernails to both hands with a dark substance under them. She was also observed to use her right hand to scratch at her leg and hip. Resident #19 was observed on 11/9/22 at 9:00 AM while lying in bed. Her nails to both hands remained unchanged from previous observations. On 11/9/22 at 11:30 AM, an interview occurred with Nurse Aide (NA) #6 who was familiar with Resident #19. He stated he was not assigned to care for her, but nail care should be rendered on shower days and during personal care if the need was present. He was unable to state why her nail care had not been completed. On 11/9/22 at 11:33 AM, NA #7 was interviewed. She was familiar with Resident #19 and was assigned to care for her. During an observation of Resident #19's fingernails, the NA confirmed they were long and had a dark substance underneath them. She added she had not noticed	F 677	by 12-6-22. Nail care will be monitored on shower list sheet to ensure nail care offered and completed. Staff will not be allowed to return to work until education is complete. 4. The Nurse Manager will conduct random Quality Reviews of residents to ensure residents are provided nail care with Activities of Daily Living (ADL) care on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of compliance – 12-7-22	

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F 677	Continued From page 38 the need during Resident #19's morning care. NA #7 stated nail care should be completed during showers and personal care if the need was present. NA #5 was interviewed on 11/9/22 at 3:20 PM and stated nail care was to be done with showers and during personal care if the need was present. The NA stated she hadn't been assigned to care for Resident #19. The Director of Nursing (DON) was interviewed on 11/9/22 at 3:10 PM and stated she was not aware of any refusals for nail care from Resident #19 or that nail care had was needed. She added that she would expect fingernails to be observed on shower days and during personal care with nail care rendered as needed.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		12/8/22

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F 688	Continued From page 39 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide application of bilateral hand roll splints according to therapy recommendations for 1 of 3 residents reviewed for limited range of motion (Resident #44). The findings included: Resident #44 was admitted to the facility on 6/16/21 with diagnoses that included cerebral infarction (a stroke) and muscle weakness. An Occupational Therapy (OT) initial evaluation dated 1/26/22 indicated Resident #44 would receive therapy for bilateral upper extremity flexion contractures. Review of an Education In-Service Attendance Record dated 3/9/22 indicated nursing staff were educated on hand splints for Resident #44. The in-service record read, in part, "Hand carrots six to eight hours each shift, check skin before and after for red areas." An OT discharge summary dated 3/23/22 and authored by OT #1, indicated Resident #44 received OT therapy for flexion contractures of the bilateral upper extremities. Upon discharge, the OT recommendation was for the resident to wear bilateral hand splints six to eight hours a day. Education and training were provided to staff in splinting/orthotic schedule, safety precautions and self-care/skin checks in order to wear the splints. A Significant Change in Status Minimum Data Set	F 688	F688- Increase/Prevent Decrease in ROM/Mobility 1. Resident #44 hands assessed with no negative outcome and hand roll splints placed by NURSE on 11-9-22. Resident #44 Care Plan and Kardex updated on 12-8-22 to reflect hand roll/splints. Current residents Care Plan and Kardex's updated to reflect hand rolls/splints 2. The Director of Nursing/Nurse Manager completed a quality review of current residents with hand rolls splints to ensure splints applied per therapy recommendations on 12-2-22. No further residents were identified. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing/Nurse Manager educated nursing staff including all shifts, part time, and prn on ensuring hand roll splint are in place to prevent flexion contractures and to provide extension of the fingers to prevent/reduce skin breakdown by 12-6-22. Staff will not be allowed to return to work until education complete. 4. Director of Nursing/Nurse Manager will conduct random quality monitoring (audit) of 5 residents with hand roll splints 3 times per week for 8 weeks, then	

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F 688	Continued From page 40 (MDS) assessment dated 10/14/22 indicated Resident #44 had impaired memory and severely impaired decision-making skills. She had limited range of motion to both upper extremities. The care plan, updated 10/28/22, revealed a focus area for limited physical mobility related to disease process. The intervention read, "Provide supportive care, assistance with mobility as needed." An observation of Resident #44 was completed on 11/7/22 at 10:35 AM. The resident was in bed and her hands were on top of the bed covers. The right and left hands/wrists were observed to flexed inwards, with her fingers folded towards the palm of the hands. Resident #44 was non-verbal and unable to follow commands when asked to straighten her fingers. There was no hand splinting device located in Resident #44's room. On 11/8/22 at 9:30 AM, Resident #44 was observed while lying in bed. Her hands were on top of the bed covers and were without hand splinting device or rolled washcloth. There was no hand splinting device located in Resident #44's room. The Rehab Director was interviewed on 11/8/22 at 1:56 PM and stated Resident #44 was treated OT for bilateral upper extremity contractures from 1/26/22 until 3/18/22. She shared Resident #44 should either have hand carrots (devices that are shaped like a carrot and fit into the palm of the hand) or rolled washcloths in her hands. Upon discharge from therapy, nursing staff were educated and trained on the application of the hand carrots to Resident #44's hands. The Rehab Director added the therapy department typically	F 688	weekly for 4 weeks to ensure hand roll splints are in place to prevent flexion contractures and provide extension of fingers to prevent/reduce skin breakdown. The Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 12-7-22.	

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F 688	Continued From page 41	F 688		

did not enter orders into the resident's chart regarding splinting devices but would have provided a referral form to nursing when the resident was discharged.

An interview occurred with the Wound Nurse/Unit Manager and Nurse #1 on 11/9/22 at 10:10 AM and stated they have seen hand carrots and rolled washcloths in Resident #44's hands but not consistently. They both were unable to state if the device should be worn daily or for how long.

Nurse Aide (NA) #9 was interviewed on 11/9/22 at 11:23 AM. She indicated it was her first day back from the weekend and that Resident #44 had carrots that were placed in her hands daily. An observation was made with NA #9 that revealed Resident #44 had carrot devices to both of her hands. She was unable to state why they were not present before today either in the room or in Resident #44's hands but stated she had gone to laundry to retrieve them. NA #9 added that if the carrots were not available in the room she would roll a washcloth to place in both of Resident #44's hands.

The Director of Nursing (DON) was interviewed on 11/9/22 at 3:09 PM and explained if a resident wore a splinting device there would be an order in the chair. She was reviewed Resident #44's medical record and stated there was not an order for the splint application to the resident's hands. The DON stated she was unaware if the staff had been using the hand carrots or rolled washcloth for Resident #44's hands. The DON also stated it was possible the staff who were educated by therapy in March 2022 may no longer be employed at the facility and there might be new staff. She was unable to recall if a referral form

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F 688	Continued From page 42 was provided by the therapy department at the time Resident #44 was discharged from OT services. On 11/9/22 at 3:33 PM, evening shift NA's #5 and #10 were interviewed. They stated that Resident #44's carrots had been missing, but they would roll up washcloths and place in her hands. OT #1 was not available for interview during the course of the survey.	F 688		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to administer oxygen at the prescribed rate for 3 of 4 residents reviewed for respiratory care (Residents #19, #35 and #306). The findings included: 1. Resident #19 was admitted to the facility on 8/28/18 with diagnoses that included Alzheimer's disease and history of a stroke. A quarterly Minimum Data Set (MDS)	F 695	F695- Respiratory/Tracheostomy Care and Suctioning 1. Resident #19 oxygen was placed on oxygen at 3 liters per minute per physicians order on 11-9-22. Resident #35 and Resident #306 no longer reside at facility. 2. The Director of Nursing completed a quality review (audit) of residents using oxygen to ensure current residents receiving oxygen liters per minute as	12/2/22

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F 695	Continued From page 43 assessment dated 8/30/22 indicated Resident #19 had impaired memory and severely impaired decision-making skills. She was not coded with the use of oxygen. A review of Resident #19's medical record revealed she had recently been diagnosed with COVID-19 on 9/19/22. A review of the November 2022 physician orders for Resident #19 included an order dated 9/19/22 for continuous oxygen at 3 liters via nasal cannula related to positive COVID-19. On 11/7/22 at 11:50 AM, Resident #19 was observed while lying in bed. The oxygen regulator on the concentrator was set at 2.5 liters flow when viewed horizontally, eye level. Resident #19 was observed sitting up in bed being assisted with lunch by Nurse Aide (NA) #4 on 11/8/22 at 1:10 PM. NA #4 stated Resident #19 was dependent on oxygen. The oxygen regulator on the concentrator was set at 2.5 liters flow when viewed horizontally at eye level. On 11/9/22 at 9:00 AM, Resident #19 was observed lying in bed with her eyes closed. The oxygen regulator on the concentrator was set at 2 liters flow when viewed horizontally at eye level. An observation was made with Nurse #1 of Resident #19's oxygen concentrator on 11/9/22 at 12:00 PM, who stated the oxygen regulator on the concentrator was set at 2 liters when viewed horizontally at eye level. Nurse #1 adjusted the flow to administer 3 liters of oxygen as ordered. Nurse #1 stated that oxygen rates were checked when she provided medications through out the	F 695	ordered on 12-1-22. No negative findings were identified. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing will provide education to current licensed nurses, including all shifts, part-time and prn, on ensuring residents are receiving oxygen per orders of liters per minute on oxygen concentrator and or oxygen tank by 12-6-22. Staff will not be allowed to return to work until education complete. 4. The Director of Nursing/Nurse Manager will conduct random quality monitoring (audit) of resident's with physician orders for oxygen per liters of minute to ensure residents receiving oxygen per ordered on oxygen concentrator or oxygen tank 3 times per week for 8 weeks, then weekly for 4 weeks. The Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 12-7-22.	

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F 695	Continued From page 44	F 695		

day.

During an interview with the Director of Nursing on 11/9/22 at 3:10 PM, she indicated it was her expectation for oxygen to be delivered at the ordered rate.

2. Resident #35 was admitted to the facility on 10/20/22 with diagnoses that included pneumonia and chronic obstructive pulmonary disease (COPD).

A review of the November 2022 active physician orders revealed an order for oxygen continuously at 2 liters via nasal cannula.

The admission Minimum Data Set (MDS) assessment dated 10/27/22 indicated Resident #35 had moderately impaired cognition and was coded with receiving oxygen.

Resident #35's active care plan, last reviewed 11/7/22, included a focus area for potential for altered respiratory status/difficulty breathing related to COPD and respiratory failure. The interventions included to administer oxygen as ordered.

On 11/8/22 at 1:06 PM, Resident #35 was observed while sitting up in bed eating lunch and indicated she was dependent on oxygen. The oxygen regulator on the concentrator was set at 1.5 liters flow when viewed horizontally, eye level.

Resident #35 was observed lying in bed watching TV on 11/9/22 at 9:00 AM. The oxygen regulator on the concentrator was set at 1.5 liters flow when viewed horizontally at eye level.

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F 695	Continued From page 45	F 695		

An observation was made with Nurse #1 of Resident #35's oxygen concentrator on 11/9/22 at 12:05 PM, who stated the oxygen regulator on the concentrator was set at 1.5 liters when viewed horizontally at eye level. Nurse #1 adjusted the flow to administer 2 liters of oxygen as ordered. Nurse #1 stated that oxygen rates were checked when she provided medications throughout the day.

During an interview with the Director of Nursing on 11/9/22 at 3:10 PM, she indicated it was her expectation for oxygen to be delivered at the ordered rate.

3. Resident #306 was admitted to the facility on 10/26/22 with diagnoses that included pneumonia, heart failure and chronic obstructive pulmonary disease (COPD).

Resident #306's baseline care plan included a focus area, dated 10/26/22, for potential for altered respiratory status/difficulty breathing related to pneumonia and COPD. The interventions included to administer oxygen as ordered.

A review of the November 2022 active physician orders revealed an order dated 10/28/22 for oxygen continuously at 2 liters via nasal cannula.

On 11/7/22 at 9:50 AM, Resident #306 was observed while sitting up in a wheelchair and indicated she was dependent on oxygen. The oxygen regulator on the concentrator was set at 1.5 liters flow when viewed horizontally, eye level.

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F 695	Continued From page 46 Resident #306 was observed lying in bed watching TV on 11/8/22 at 9:40 AM. The oxygen regulator on the concentrator was set at 1.5 liters flow when viewed horizontally at eye level. On 11/9/22 at 8:30 AM, Resident #306 was observed lying in bed watching TV. The oxygen regulator on the concentrator was set at 1.5 liters flow when viewed at eye level, horizontally. An observation was made with Nurse #1 of Resident #306's oxygen concentrator on 11/9/22 at 12:10 PM, who stated the oxygen regulator on the concentrator was set at 1.5 liters when viewed horizontally at eye level. Nurse #1 adjusted the flow to administer 2 liters of oxygen as ordered. Nurse #1 stated that oxygen rates were checked when she provided medications throughout the day. During an interview with the Director of Nursing on 11/9/22 at 3:10 PM, she indicated it was her expectation for oxygen to be delivered at the ordered rate.	F 695		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		12/8/22

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F 727	Continued From page 47 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours a day, 7 days a week for 8 out of 30 days reviewed for staffing. The findings included: The nurse postings and staffing sheets for 10/6/2022 through 11/6/2022 revealed there was no RN coverage on the following days: 11/6/2022 the census was 56 11/5/2022 the census was 56 10/30/2022 the census was 56 10/29/2022 the census was 56 10/15/2022 the census was 54 10/10/2022 the census was 58 10/9/2022 the census was 58 10/8/2022 census was 59 On 11/09/2022 at 3:35 PM an interview was conducted with the Director of Nursing (DON). She stated she was aware they did not have RN coverage on some weekends. She further stated they tried agency RNs, but they did not work out. She hired an Assistant Director of Nursing (ADON) but she was unreliable and did not show up for her scheduled weekends. The DON stated the facility was continuing to hire and employee reliable RNs to provide RN coverage on the weekends. An interview was conducted with the	F 727	F727- RN 8Hrs/7 days/week 1. The Regional Director of Nursing educated the Executive Director, Director of Nursing, Nurse Manager and Staffing Coordinator there must be 8 consecutive hours a day for 7 days a week of Registered Nurse coverage on 12-1-22. 2. The Director of Nursing/Nurse Manager, Staffing Coordinator and Executive Director completed a quality review of staffing coverage for 30 days on 12-1-22 to ensure there is at least 8 consecutive hours a day for 7 days a week of Registered Nurse coverage. It was noted that 2 days were noted without 8 consecutive hours of RN coverage. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The Regional Director of Nursing educated the Executive Director, Director of Nursing, Nurse Manager and Staffing Coordinator there must be 8 consecutive hours a day for 7 days a week of Registered Nurse coverage on 12-1-22. Labor meeting will be held daily Monday-Friday during morning meeting with Executive Director, Director of Nursing, Nurse Manager and Staffing Coordinator to discuss open nursing shifts and ensure	

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F 727	Continued From page 48 Administrator on 11/10/2022 at 11:28 AM. She stated she was aware there were weekends the facility did not have RN coverage. The last day the facility employed contracted nursing staff was end of September. They are currently trying to hire. They are offering sign on bonuses and other incentives.	F 727	8 consecutive hours of RN coverage daily occurs. 4. Director of Nursing/Nurse Manager will conduct quality monitoring (audit) of daily schedule to ensure there is 8 consecutive hours for 7 days a week of Registered Nurse coverage daily for 4 weeks then three times weekly for 8 weeks. The Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 12-7-22.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		12/2/22

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F 812	Continued From page 49 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain the refrigerator temperature of 41 degrees (°) Fahrenheit (F) or below, failed to store opened and cooked foods within safe temperature ranges, failed to discard expired foods stored ready for use and failed to label and date opened foods in 1 of 1 reach-in refrigerators which had the potential to affect food served to residents. The findings included: 1. An initial tour of the kitchen was conducted with the Dietary Manager (DM) on 11/07/22 at 10:16 AM, the thermometer in the reach-in refrigerator read 58° F. Recheck of reach-in refrigerator temperature on 11/07/22 at 10:45 AM, thermometer read 52° F. Follow-up visit to recheck temperature of reach in refrigerator on 11/08/22 at 11:58 AM, thermometer read 52°F. The temperature flow sheet was located on the outside of the refrigerator door which listed the date and temperature. All temperatures documented were 41°F or below. The following concerns were identified with the temperature of the reach-in refrigerator: · One dozen bagged hard boiled eggs, not opened. · (2) 5-pound (lb) containers of parmesan cheese, one which was opened and dated 08/02/22 and the other was opened and dated 10/18/22. Another 5-lb container of parmesan cheese opened and dated 8-2-22. DM threw item in trash.	F 812	F812- Food Procurement, Store/Prepare/Serve-Sanitary 1. On 11-10-22 reach in refrigerator was repaired. One dozen hard boiled eggs, parmesan cheese, shredded cheddar cheese, bacon, 1 gallon bottle of syrup and any food unlabeled was discarded by Dietary Manager(DM) on 11-8-22. 2. On 11-21-22 the Executive Director and DM inspected the kitchen storage facilities to ensure all foods are labeled and dated, cooked food and stored food were at appropriate temperature, and reach in refrigerator is at appropriate temperature with refrigerator is working properly. No negative findings were identified. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice. 3. The District Dietary Manager provided re-education to the DM in safe storage, preparation and serving of foods on 11-9-22. The Dietary Manager will provide education to the dietary staff on safe storage, preparation and service of foods by 12-6-22. Staff will not be allowed to work until education complete. The Dietary Manager provided re-education to dietary staff on appropriate refrigerator temperature and ensure checking temperature two times daily by 12-6-22.	

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F 812	Continued From page 50 · A quarter of an opened bag of shredded cheddar cheese with the opened date not legible. · A box of approximately 20 pieces of bacon with the opened and dated 11/2/22. Interview on 11/07/22 at 10:22 AM was conducted with the DM. She stated she checks the temperatures of the reach-in refrigerator every morning upon arrival. The DM stated she had checked the temperature of the refrigerator on the morning of 11/07/22 and documented the temperature on the flow sheet located on the outside of the refrigerator door which was within normal range. She then stated the thermometer that is visible from the outside of the reach-in refrigerator currently reads 40°F. On 11/08/22 at 11:58 AM an observation of the reach-in refrigerator ' s internal thermometer read 52 degrees Fahrenheit. The DM was interviewed during the observation and stated she would request maintenance to service the unit. On 11/08/22 at 12:02 PM an observation of the reach-in refrigerator revealed a posted sign that read, "Do not use" and there was no food stored inside the refrigerator. DM notified surveyor on 11/08/22 at 01:58 PM that all the food in the reach-in refrigerator was discarded into the trash and they will have it repaired. Interview with DM on 11/09/22 at 10:24 PM was conducted. She stated the thermometers on the outside and inside of all refrigerators and freezers should match. Temperatures listed on flow sheets	F 812	. 4. The Executive Director (ED) will conduct quality monitoring (audit) of the kitchen area and dietary storage facilities, 3 times per week for 8 weeks, then weekly for 4 weeks to ensure all foods labeled and dated. The ED will conduct quality monitoring on the refrigerator temperatures 3 times per week for 8 weeks then weekly for 4 weeks to ensure refrigerator is at appropriate temperature. The Executive Director will conduct quality monitoring of cooked food and stored food to ensure at appropriate temperature 3 times per week for 8 weeks, then weekly for 4 weeks. The ED will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance 12-7-22.	

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posted on doors of refrigerators and freezers indicate the temperatures obtained from the thermometers located on the inside of the refrigerators and freezers.

2. The following items were observed on 11/07/22 at 10:16AM in the reach-in refrigerator available for use. The DM threw 1-gallon bottle of syrup with no open date and a 5-lb container of parmesan cheese dated 08/02/22 in the trash.

· No opened date on a 1-gallon bottle of pancake syrup.

· Out of date items included 2 containers of parmesan cheese one with open date of 10-18-22, and another container of parmesan cheese with open date of 08-02-22.

Interview on 11/07/22 at 10:22 AM was conducted with the DM. She stated the dates labeled on the opened items refer to the dates that the item was opened. No discard label was present on any of the items. She further stated items should be discarded 3 days after the opened date, but cheese should be discarded 1 month after the opened date. She stated she had checked the dated items the morning of 11/07/22 but overlooked the out-of-date items and she discarded them. The DM also stated she checks the refrigerators every morning for items that need to be discarded.

3. On 11/07/22 at 01:04 PM through 01:24PM a continuous observation revealed a Pimento cheese sandwich, no date labeled on item, laying on metal shelf above hot food items on serving line. Requested temperature to be taken of center of sandwich which revealed an internal

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F 812	Continued From page 52 temperature of 58°F. DM stated the sandwich should not have been on the shelf above the hot items. Pimento cheese sandwich was discarded into the trash can by staff. Interview with Administrator on 11/10/22 at 09:45 AM was conducted. She stated her expectation was for all food to be stored and served at temperatures per regulation guidelines. She further stated dietary staff were to maintain the refrigerators and freezers at the appropriate temperatures per guidelines and to notify administration if appliances were not working properly. She also stated staff were to discard expired foods, and they are to label, and date opened items.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet	F 849		12/2/22

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professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice

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representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible

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for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.

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F 849	Continued From page 56 (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with a Hospice Nurse, the Hospice Business Office Manager and staff, the facility failed to have all hospice information including progress notes and care plan available in the medical record to assure that the services provided were coordinated for 2 of 2 residents reviewed for Hospice (Residents #44 and #50). The findings included: 1. Resident #44 was admitted to the facility on 6/16/21 with diagnoses that included a cerebral infarction (a stroke), presence of a feeding tube, and anoxic brain damage. A review of Resident #44's November 2022 physician orders included an order dated 10/4/22 to admit to Hospice services.	F 849	F849 Hospice Services 1. Resident #44 and Resident #50 Hospice progress notes and Hospice care plans was uploaded to resident's medical record on 11-9-22 by the Medical Records Clerk. 2. The Director of Nursing/Nurse Manager completed a quality review of current residents receiving Hospice Services to ensure Hospice progress notes and visits were noted in medical record on 12-1-22. No further concerns were identified. An Ad hoc Quality Assurance Performance Improvement Committee was held on 11-30-22 to formulate and approve a plan of correction for the deficient practice.	

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F 849	Continued From page 57 A Significant Change in Status Minimum Data Set (MDS) assessment dated 10/14/22 indicated Resident #44 had impaired memory and severely impaired decision-making skills. She was coded as receiving Hospice services and a condition or chronic disease resulting in six months or less life expectancy. A review of Resident #44's active care plan, last reviewed 10/28/22, included a focus area for having a terminal prognosis related to anoxic brain injury and is receiving Hospice services for end-of-life care. One of the interventions was to work cooperatively with Hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. A review of Resident #44's medical record, both the hard chart and Electronic Medical Record-EMR) did not reveal any progress notes from Hospice staff nor a plan of care. On 11/8/22 at 3:44 PM, an interview occurred with Nurse #1, who was aware Resident #44 was under Hospice care. She stated the Hospice nurse and Nurse Aide (NA) did not have access to the facility EMR system nor did the facility staff have access to the Hospice documentation. She was unable to locate any Hospice staff notes or Hospice care plan in Resident #44's medical record. Nurse #1 stated if she needed any Hospice information she would have to call the Hospice agency and have the notes faxed over. She added the Hospice nurse came to the facility weekly and would verbally touch base with the facility nurse staff. An interview occurred with the Hospice Nurse on	F 849	3. The Director of Nursing (DON) educated the Medical Records Clerk on ensuring Hospice progress notes and visits are uploaded in residents' medical record timely on 11-21-22. New procedure was implemented on 11-17-22 by Hospice of Stanly that progress notes will be delivered to facility twice monthly. The Director of Nursing or Unit Manager will review notes then give to Medical Records Clerk to upload into residents' medical record. 4. Director of Nursing/Nurse Manager will conduct random quality monitoring (audit) of 5 residents receiving Hospice Service 3 times per week for 8 weeks, then weekly for 4 weeks to ensure Hospice progress notes and visits uploaded in medical record. The Director of Nursing will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. 5. Date of Compliance – 12-7-22	

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11/9/22 at 10:35 AM, who explained that when she came to the facility weekly she spoke with the nursing staff regarding the care of the resident. She hand delivered the plan of care in an envelope to the Social Worker (SW) but wasn't sure where they were kept in the facility. The Hospice Nurse further stated the Hospice Business Office Manager faxed over the progress notes to the facility.

A phone interview was completed with the Hospice Business Office Manager (BOM) on 11/9/22 at 10:41 AM. She explained that she emailed a "batch" of information to the facility every one to two weeks which included nursing and social work progress notes as well as Hospice orders and were sent to the Medical Records staff member. She stated progress notes were last sent on 10/19/22 for Resident #44.

On 11/9/22 at 10:50 AM, an interview was conducted with the Medical Records staff member, who stated she had started in the position at the end of September 2022. She stated she received emails from Hospice asking for the orders to be signed and returned to them. She stated she didn't copy these or place them in the charts as she wasn't aware this was needed. She stated she couldn't recall seeing any progress notes in the emails.

The Human Resources staff member was interviewed on 11/9/22 at 10:50 AM and explained she had been the former Medical Records from April 2022 to August 2022. She stated she would copy off the orders and progress notes emailed to her from the Hospice agency and place in the resident's medical

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records. She was unsure what happened to these records now.

A second interview occurred with the Medical Records on 11/9/22 at 11:01 AM. She stated she had not received training regarding Hospice records but maybe the Admissions Director or SW had been receiving them.

An interview was held with the Admissions Director on 11/9/22 at 11:10 AM. She stated that she had been at the facility for two years and had never received Hospice records for the medical records, until today. She added, she was asked by the SW to have the records sent over from Hospice.

A phone interview took place with the SW on 11/9/22 at 2:07 PM. She explained she had been in the role of the SW since March 2022. She acknowledged the Hospice nurse delivered the plan of care to her weekly and then it was provided to the Medical Records. She was unsure what happened to them after that.

The Director of Nursing (DON) was interviewed on 11/9/22 at 3:09 PM, who stated the Hospice nurse hand delivered the plan of cares weekly to the SW. She was unsure what happened to them after that but would expect them to be part of the medical record. She would expect the progress notes and orders to be placed in the medical records as well. The DON stated she was unaware Resident #44's Hospice records were not in her facility medical records.
2. Resident #50 was admitted on 2/1/2022 with diagnoses that included dementia.

Resident #50 had a change in condition Minimum

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Data Set (MDS) completed 10/11/2022. The MDS indicated the resident was severely cognitively impaired and dependent on staff for all activities of daily living, toileting, and personal hygiene. The resident was coded for hospice services during the assessment period.

The resident's comprehensive care plan, last revised 10/25/2022, had a focus for hospice services and end of life services related to senile degenerative disorder of the brain.

A review of Resident #50's active physician orders included an order dated 10/25/22 to admit to Hospice services. Interventions included facility would work cooperatively with Hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met.

A review of Resident #50's medical record, both the hard chart and Electronic Medical Record-EMR) did not reveal progress notes from Hospice staff or a plan of care.

On 11/08/22 at 3:35 PM and interview was conducted with Nurse Assistant (NA) #4, who was assigned to Resident #50. She stated she did not know where to find notes from Hospice NA. She stated they are not in the resident's EMR and she did not find them in the resident's hard chart. She further stated if she needed to know, she would have to call hospice and have the notes sent over.

An interview was conducted with Nurse #1, who was assigned to Resident #50. She stated the Hospice nurse and NA do not have access to the facilities EMR and the facility staff do not have access to Hospice's documentation either. She

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stated if she needed information from Hospice nurse or NA she would call hospice and have the notes faxed over.

An interview occurred with the Hospice Nurse on 11/9/22 at 10:35 AM, who explained that when she came to the facility weekly. She further stated she spoke with the nurse and NAs regarding the care of the resident. She hand delivered the plan of care in an envelope to the Social Worker (SW). The Hospice Nurse further stated the Hospice Business Office Manager faxed over the progress notes to the facility.

A phone interview was completed with the Hospice Business Office Manager (BOM) on 11/9/22 at 10:41 AM. She explained that she emailed a "batch" of information to the facility every one to two weeks which included nursing and social work progress notes as well as Hospice orders and were sent to the Medical Records staff member. She stated progress notes were last sent on 10/19/22 for Resident #50.

On 11/9/22 at 10:50 AM, an interview was conducted with the Medical Records staff member, who stated she had started in the position at the end of September 2022. She stated she received emails from Hospice with orders but she stated she did not recall seeing progress notes in the emails.

An interview was held with the Admissions Director on 11/9/22 at 11:10 AM. She stated that she had been at the facility for two years and had never received Hospice records for the medical records, until today. She added, she was asked by the SW to have the records sent over from

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F 849	Continued From page 62 Hospice. A phone interview took place with the SW on 11/9/22 at 2:07 PM. She explained she had been in the role of the SW since March 2022. She acknowledged the Hospice nurse delivered the plan of care to her weekly and then it was provided to the Medical Records. She was unsure what happened to them after that. The Director of Nursing (DON) was interviewed on 11/9/22 at 3:09 PM, who stated the Hospice nurse hand delivered the plan of cares weekly to the SW. She expect them to be uploaded into the resident's medical record. She would expect the progress notes and orders to be placed in the medical records as well. The DON stated she was unaware Resident #50's Hospice records were not in her medical records.	F 849		
F 867 SS=E	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 record reviews, observations, and staff interviews, the facility ' s Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification and complaint survey conducted on 10/2019. This was for 2 deficiencies that were cited in the areas	F 867	F867 - QAPI/QAA Improvement Activities 1. The Executive Director held a Quality Assurance Performance Improvement meeting on 11-21-11 with the Interdisciplinary Team including the Director of Clinical Services, Social Services, Dietary Manager, Admissions Director, MDS Coordinator, Activities	12/2/22

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F 867	Continued From page 63 of Grievances and Accuracy of Assessments, previously cited on 10/2019 and recited on the current recertification and complaint survey of 11/10/2022. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint survey conducted on 05/20/2021. This was evident for 1 deficiency in the area of Activities of Daily Living (ADL) Care Provided for Dependent Residents, previously cited on 05/20/2021 and recited on the current recertification and complaint survey of 11/10/2022. The duplicate citations during three federal surveys of record shows a pattern of the facility ' s inability to sustain an effective QAPI program. The findings included: This citation is cross referenced to: 1. F585- Based on record review and family and staff interviews, the facility failed to provide a written grievance response summary for 2 of 2 residents reviewed for grievances (Residents #4 and #34). During the facility ' s recertification survey of 10/31/2021 the facility failed to provide evidence that a written grievance investigation summary with resolution was provided to 2 of 2 residents reviewed for grievances. An interview with the Administrator on 11/10/2022 at 11:16 AM revealed the facility had experienced some challenges due to staff and administrative turnover, which she thought contributed to the repeat citation.	F 867	Director, Medical Records Director and Business Office Manager focusing on the areas of Grievances not providing a written response at F585, accuracy of Minimum Data Set in the areas of Activities of Daily Living, pressure ulcers and oxygen therapy at F641, and Activity of Daily Living Care Provided for Dependent Residents not providing nail care at F677. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance in these areas. 2. During the Quality Assurance Performance Improvement on 11-21-22 the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. 3. The Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Executive Director Market Leader and or the Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities will be corrected as identified by the Executive Director. 4. The results of these reviews will be	

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F 867	Continued From page 64 2. F641- Based on record review and staff interviews, the facility failed to code the Minimum Data Set assessment accurately in the areas of Activities of Daily Living (ADLs), pressure ulcer and oxygen for 2 of 19 resident records reviewed (Residents #19 and #53). During the facility ' s recertification survey of 10/31/2021 the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of Activities of Daily Living (ADL's) and medication for 1 of 23 sampled residents. An interview with the Administrator on 11/10/2022 at 11:16 AM revealed the facility had experienced some challenges due to staff and administrative turnover, which she thought contributed to the repeat citation. 3. F677- Based on record reviews, observations and staff interviews, the facility failed to trim and clean a dependent resident ' s nails (Resident #19) for 1 of 4 residents reviewed for Activities of Daily Living (ADL ' s). During the facility ' s recertification survey of 05/20/2021 the facility failed to ensure a resident who was dependent on staff assistance for incontinence care received assistance when needed for 1 of 3 residents reviewed for Activities of Daily Living (ADLs). An interview with the Administrator on 11/10/2022 at 11:16 AM revealed the facility had experienced some challenges due to staff and administrative turnover, which she thought contributed to the repeat citation.	F 867	submitted to the QAPI Committee by the Executive Director for review by IDT members each month for 12 months. The QAPI Committee will evaluate the effectiveness and amend as needed. 5. Date of Compliance – 12-7-22	