STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345304	A. BUILDING _____ B. WING _____	C 12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT MIDWOOD, LLC	2727 SHAMROCK DRIVE CHARLOTTE, NC 28205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/12/22 through 12/15/22. The survey team returned to the facility on 12/30/22 to validate the credible allegation of IJ removal. Therefore, the exit date was changed to 12/30/22 The facility was found in compliance with the requirements CFR 483.73, Emergency Preparedness. Event ID# IRC211.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/12/22 through 12/15/22. The survey team returned to the facility on 12/30/22 to validate the credible allegation of IJ removal. Therefore, the exit date was changed to 12/30/22. Event ID# IRC211. The following intakes were investigated: NC00190563, NC00190586, NC00192161, NC00193748, NC00194754, NC00194856, NC00195336, NC00195346, NC00195444, NC00195609, NC00195811, NC00195831 and NC00195913. 22 of the 43 complaint allegations were substantiated resulting in deficiencies. Intakes NC00195444, NC00195811, NC00195831 and NC00195609 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/17/22 and was	F 000		

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

Electronically Signed | 01/18/2023

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F 000	Continued From page 1 removed on 12/21/22. An extended survey was conducted.	F 000		
F 550 SS=G	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 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.	F 550		2/9/23

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews the facility failed to provide care in a manner that maintained the resident's dignity by not providing incontinence care when needed. This is evidenced by Resident #266 feeling "violated". This occurred for 1 of 4 residents reviewed for dignity. (Resident #266) The findings included: Resident #266 was readmitted to the facility on 5/24/22 with diagnoses that included stroke, muscle weakness, lack of coordination and major depressive disorder. Resident #266's most recent Minimum Data Set dated 11/7/22 revealed he was cognitively intact with no refusals of care. He required extensive assistance with bed mobility, toileting, and personal hygiene. He had functional limitations on one side for the upper and lower extremities. Resident #266 was frequently incontinent of bladder and always incontinent of bowel. While touring the 200 hall on 12/12/22 at 10:15 AM there was a noticeable odor of feces when passing Resident #266's room. An observation was made from the hall and the resident's privacy curtains were pulled closed. During an observation and interview with	F 550	1. Facility failed to provide timely services to resident #266 in a manner to maintain the¿resident□s dignity by not providing incontinence care when needed.¿ Nurse Manager validated incontinent care was provided for resident #266 12/12/22. The DON/RDCS provided education to Nurse #4 and Nurse Aide #4 on the facility policy for maintaining dignity on 12/12/22. ¿ 2. All residents have the potential to be affected by the alleged deficient practice. ¿ Current Licensed Nurses and Nurse Aides were re-educated by the DON and Nurse Manager on the facility policy for maintaining resident dignity to include responding to call lights and providing incontinent care. This education was completed on 1/20/23 3.The DON or Nurse Manager will conduct an ADL/Dignity audit of 5 random residents per week for 12 weeks to ensure resident satisfaction. 4. To monitor the effectiveness of the above plan, the DON will report the results of these audits to the QAPI committee who will evaluate monthly x3 months beginning February 10, 2023.	

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F 550	Continued From page 3 Resident #266 on 12/12/22 at 10:37 AM there was still a strong odor of feces in his room. Resident #266 revealed he was not having a good day because he had been waiting for 2 hours to be changed. He explained this occurs frequently, and he had waited up to 5 hours in the past. He further explained that staff would come in and turn off the call light and say they would be right back but would take a long time to return. He had reported this to the Director of Nursing (DON) in the past, but nothing had changed. Resident #266 stated he knew he had been waiting 2 hours because he always looked at the clock when he pushed his call light. He did this because staff were slow to come in. Resident #266 explained he had a stroke in 2010 and he could not get out of bed my himself to go to the bathroom, therefore he had to wait on staff for help. He stated, "I don ' t like to lay here in my urine and feces, it makes me feel violated". He revealed he initially called for assistance approximately 2 hours ago. Sometime after his initial call Nurse #4 came in his room and said she would send in the nurse aide, but no one had come in yet. At 10:40 AM Resident #266 activated his call light. At 10:50 AM Nurse Aide (NA) #4 entered the room. An interview was conducted on 12/12/22 at 11:00 AM where Nurse #4 stated Resident #266 told her he needed to be changed, but she was unsure of how long it had been since he asked. She revealed she told NA #4 that Resident #266 needed incontinence care. During an interview on 12/12/22 at 11: 10 AM NA #4 revealed she was not aware that Resident #266 had been waiting 2 hours for care. She explained she had 2 residents that she had	F 550	Date of completion: 2/9/23	

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F 550	Continued From page 4 gotten ready for appointments this morning. Both residents needed baths and dressed before their appointments, and she had spent a lot of time in those resident's rooms that morning. When she exited the last resident's room, she saw Resident #266 call light on and went in and provided care. NA #4 stated no one told her Resident #266 needed to be changed. She indicated the reason he did not get care sooner was she was working with the other 2 residents, and she did not know he was soiled. During an interview on 12/15/22 at 5:26 PM the DON revealed all staff were to answer call lights and the call lights should be answered as soon as possible. She further revealed if a resident needed incontinence care it should be provided as soon as possible. If the NA was unavailable the nurse should provide care or delegate to someone else that could. An interview was conducted on 12/15/22 at 7:00 PM the Administrator revealed call lights should be answered and incontinence care should be provided in a timely manner. She indicated residents should be treated in a dignified manner.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews with	F 558	1. The Facility failed to provide	2/9/23

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F 558	Continued From page 5 family member, and staff, the facility failed to provide foot pedal on a wheelchair for a resident transported by the facility to a specialist appointment for one of one resident reviewed for accommodation of needs (Resident #114). The findings included: Resident #114 was admitted to the facility on 11/09/22 and discharged to the hospital on 11/18/22. Her admission diagnoses included left above the knee amputation, diabetes, and osteoporosis. Resident #114's admission MDS dated 11/16/22 revealed she was moderately cognitively impaired but was alert and oriented to person, place and situation and was able to make all needs known. The MDS also revealed the resident required extensive assistance of 1 to 2 staff members for all activities of daily living (ADL) except eating. Interview on 12/13/22 at 11:30 AM with Resident #114's family member revealed she met the resident at her specialist's appointment on 11/17/22. The family member stated Resident #114 had been transported to the appointment without a foot pedal on her wheelchair. The family member further stated she had to hold the resident's leg up with a towel because she was in pain with her leg not elevated and at rest on a foot pedal. Interview on 12/14/22 at 9:11 AM with the Transporter revealed she remembered taking Resident #114 out for her specialist appointment but could not recall if the resident had a foot pedal on her wheelchair for her right leg. She	F 558	reasonable accommodations for resident #114 by failing to provide a footrest on a wheelchair while being transported by the facility to a specialist appointment. The Transportation employee was educated on 12/14/22 by the DON and NHA regarding the need to ensure footrests are in place on the wheelchair of resident #114 when being transferred out of the facility. All staff educated on footrest needed for transport on 2/9/23 by DNS or Designee. 2. All residents utilizing a wheelchair have the potential to be affected by the alleged deficient practice. The Transportation employee was educated on 12/14/22 by the DON and NHA regarding the need to ensure footrests are in place for all residents in wheelchairs requiring transport outside of the facility. 3. The Transportation employee will keep a log of transports and document the use of footrests when a wheelchair is used. DON/Manager will observe residents daily for 12 weeks. 4. To monitor the effectiveness of the above plan, the DON will report the results of these audits to the QAPI committee will evaluate monthly x3 months beginning January 31,2023. Date of completion: 2/9/23	

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F 558	Continued From page 6	F 558		

stated she had never been told that residents going out in wheelchairs for appointments needed to have foot pedals on their wheelchairs. The Transporter further stated the resident had her own wheelchair and one that had been provided by the facility, but that morning neither of them could be found so she had to use another wheelchair to transport the resident.

Interview on 12/13/22 at 12:39 PM with Nurse #2 who was assigned to care for Resident #114 on 11/17/22 revealed she was not aware the resident had been sent out to her appointment without a foot pedal on her wheelchair. She stated she had not seen the resident when the Transporter took her out of the building for her appointment. Nurse #2 stated she thought all residents went out with foot pedals on their wheelchairs.

Interview on 12/14/22 at 10:42 AM with the Therapy Manager revealed if therapy was aware of resident's going out for appointments, they made sure their wheelchairs were equipped for their transport; however, she stated sometimes nursing made appointments they were not aware of and were not able to set their wheelchairs up with what they needed for transport. The Therapy Manager stated as she recalled Resident #114 was being seen by therapy for trunk weakness and said she would need a leg rest on her wheelchair when going out for appointments for her safety.

Interview on 12/15/22 at 5:33 PM with the Director of Nursing (DON) revealed she knew the resident had a specialist appointment and the facility Transporter took her to the appointment but stated she didn't know whether the resident had a footrest on her wheelchair when taken for

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F 558	Continued From page 7 her appointment. The DON stated the staff knew if the resident needed a footrest, one was to be attached to the wheelchair. She further stated the Transporter had been educated on the need for footrests on wheelchairs when transporting residents prior to this incident. Interview on 12/15/22 at 7:02 PM with the Administrator revealed she would expect residents going out to appointments to have foot pedals on their wheelchairs. She stated the Transporter had been educated on the need for foot pedals on wheelchairs when transporting residents to appointments prior to this incident and they would provide more one on one education to her.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		2/9/23

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F 584	Continued From page 8 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to maintain a home like environment and wall integrity in residents' rooms for 2 of 9 sampled residents (Rooms 314 and 316) on 1 of 3 hallways. The findings included: 1. Observation on 12/12/22 at 12:10 PM revealed the bathroom for Room 316 and Room 314 was shared by three residents and had a light fixture wrapped in paper with blue paint tape, wet towel on the floor lying beside the toilet, the toilet paper holder was hanging off the wall with sharp edges showing, the light over the sink had dirt and dust in the light fixture, and the emergency call light cord had broken off with approximately 1 inch of	F 584	1. Facility failed to provide a safe/ Clean/ Comfortable/ Homelike environment to residents #40 and #21.¿ Corrective action for the alleged deficient practice started on 12/14/22¿by the Maintenance Director by repairing toilet paper holder and removing blue tape from light and cleaning dust from light fixture.¿ Resident #21 received wall repair on 1/20/23. 2. All residents have the potential to be affected by the alleged deficient practice. An audit was completed to ensure there were no other toilet paper holders broken, lights were clean without tape and walls that need repair. Maintenance Director educated on work order system and	

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F 584	Continued From page 9 the cord remaining. A roll of toilet paper was observed on the handrail near the toilet. An observation and interview were conducted with Resident #40 on 12/13/22 at 11:45 am and revealed the light fixture wrapped in paper with blue paint tape, toilet paper holder was hanging off the wall with sharp edges showing, the light over the sink had dirt and dust in the light fixture, and the emergency call light cord had broken off with approximately 1 inch of the cord remaining. Resident #40 was cognitively intact and stated she felt that her bathroom had been "yucky" for several weeks and had reported the issues to staff but could not recall names. A roll of toilet paper was observed on the handrail near the toilet. An interview with the facility Housekeeper on 12/13/22 at 3:00 PM revealed she had cleaned the bathroom to Room #314 and #316 on 12/12/22 and 12/13/22. The Housekeeper further revealed she did not recall a towel on the floor on 12/12/22. The Housekeeper indicated she did not recall issues in the bathroom. An observation and interview conducted with Maintenance Director on 12/13/22 at 2:50 PM revealed he had been working in the facility for three weeks and was not informed there were issues with the shared bathroom for Room 316 and Room 314. The Maintenance Director further revealed staff put a ticket in a binder at the nurses' station if there was an issue. The Maintenance Director observed the light fixture wrapped in paper with blue paint tape, the toilet paper holder was hanging off the wall with sharp edges showing, the light over the sink had dirt and dust in the light fixture, and the emergency	F 584	prioritizing by Admnistrator on 1/20/23. All staff will be reeducated on maintenance work orders by Administrator at Feb 21st 2023 all staff meeting.¿ 3. The administrator completed an intital audit of the all resident rooms on 1/24/23 and entered work orders by priority. The administrator will round 10 resident rooms weekly for 12 weeks and enter any new work orders into maintenance system. 4. To monitor the effectiveness of the above action plan, The Administrator will report the results of these audits and the¿QAPI committee will evaluate the process monthly for 12 weeks. ¿ Date of Completion 2/9/23	

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F 584	Continued From page 10	F 584		

call light cord had broken off with approximately 1 inch of the cord remaining. The Maintenance Director stated he normally checked the work binder daily and would also make daily rounds but was unable to since he had started. The Maintenance Director indicated the bathroom was not acceptable and should have been in better shape.

An interview conducted with the Director of Nursing (DON) on 12/15/22 at 5:50 PM revealed she had assisted a resident several times to the bathroom in Room 316 and had observed the call light string to be broken, but it had worked. The DON further revealed she did not report this to maintenance and had gone through vacant rooms to check for issues but had not been through occupied rooms. The DON stated she expected for residents to be comfortable and be in a homelike environment.

Observation and interview were conducted with Administrator on 12/13/22 at 3:15 PM. The observation of the shared bathroom for Room 316 and Room 314 revealed the light fixture wrapped in paper with blue paint tape, the toilet paper holder was hanging off the wall with sharp edges showing, the light over the sink had dirt and dust in the light fixture, and the emergency call light cord had broken off with approximately 1 inch of the cord remaining. The Administrator stated the light fixture was covered with paper and tape from a paint job a few weeks ago and the facility had a plan to make improvements. The Administrator indicated the bathroom was not acceptable and the facility was working to make improvements throughout the facility.

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2. Observation and interview was conducted on 12/12/22 at 12:03 PM with Resident #21 in room 208. There were 2 large areas behind her bed (one area was 2 feet by 3 feet and the other area was 2 feet by 1 foot) that were patched with white material and had not been sanded and painted and the surfaces were uneven. The resident stated it had been that way for the past 3 years. She stated she had asked about getting it repaired and painted but it had not been done.

A list with no date was received from the Director of Nursing for repairs that had been identified as needed throughout the building on 12/15/22 at 9:50 AM was reviewed. Room 208 was listed as needing to be painted.

Interview and observation on 12/15/22 at 2:50 PM with the Maintenance Director in room 208 revealed he was not aware of the holes in the wall that had been patched. He stated the room was on the list for painting but the areas behind the bed would require more patching, sanding, and painting. The Maintenance Director stated he had been given a priority list and room 208 had just been recorded as needing painting but he said he would need to make some repairs to the areas behind the bed before the room was painted.

Interview on 12/15/22 at 5:48 PM with the

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F 584	Continued From page 12	F 584		

Director of Nursing (DON) revealed the list that was provided was developed by her and the Assistant Director of Nursing (ADON) going through the empty rooms on the 200 hall to identify what was needed to make them livable. She stated the goal was to move residents on the 300 hall to the 200 hall and renovate the 300 hall for new admissions. The DON further stated they had looked at whether the TV was in the room, proper functioning bed, bedside table and overbed tables were in the room and the overall aesthetics of the room such as paint in good condition, closets in good condition with locks on them, no holes in the wall, blinds in good condition, proper functioning toilet in the bathroom and working call lights in the room and bathrooms. The occupied rooms were not evaluated but the DON explained the nurses and nursing assistants were in those rooms on a daily basis and if there were issues, they should be identifying them and writing them in the book for maintenance.

Interview on 12/15/22 at 5:43 PM with the Regional Director of Clinical Services revealed they were trying to get 200 hall acceptable so they could move all the residents on the 300 hall onto the 200 hall and renovate the 300 hall for new admissions and then start working on the 200 hall. She stated they were getting rid of the popcorn ceilings, so she didn't want residents on the hall getting exposed to the dust. She further stated the 200 hall probably was not perfect in the real world but they were trying to make updates and identify issues to get started on repairs.

Interview on 12/15/22 at 7:07 PM with the Administer revealed their plan was to move the 300 hall residents to the 200 hall and renovate

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F 584	Continued From page 13 the 300 hall and when that was finished to renovate the 200 hall. She stated she was not aware of the condition of room 208 and said it should have been repaired before now if it had been that way for 3 years.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff	F 657	1. Facility failed to provide a	2/9/23

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F 657	Continued From page 14 interviews, the facility failed to invite a resident and/or her representative to participate and provide input in care planning for 1 of 3 sampled residents (Resident #18) and failed to update the care plan to reflect the current advance directive for 1 of 3 residents reviewed (Resident #13). The findings included: 1. Resident #18 was admitted to the facility on 10/26/21. The quarterly Minimum Data Set (MDS) assessment dated 10/7/22 indicated Resident #18 was moderately cognitively impaired. A review of Resident #18's electronic medical record indicated the last documented care plan meeting was held on 5/31/22 with Resident #18's family member in attendance. Further review revealed no evidence of Resident #18, or her family member being invited to attend a care plan meeting to discuss and provide input regarding her plan of care following the completion of the quarterly MDS assessment dated 10/7/22. An interview with Resident #18 on 12/12/22 at 11:38 AM revealed she had not been invited or participated in her care plan meetings. An interview with the MDS Coordinator on 12/15/22 at 3:55 PM revealed care plan meetings were supposed to be done quarterly and they were supposed to be scheduled by the Social Worker. The Social Worker was supposed to be sending an invitation to the care plan meeting to both residents and family members. However, the facility had not had a Social Worker since December 2022.	F 657	comprehensive care plan for residents #18 and #13.¿¿ Next care plan meeting was scheduled for resident #18 by SS for 2/14/23. The care plan for resident #13 was revised by the MDS Nurse on 12/15/22 to reflect the current advanced directives. 2. All residents have the potential to be affected by the alleged deficient practice. An audit was completed on 12/14/22 to ensure that any care plan meetings that were missed, were scheduled. Education was provided to the Social Services Director and IDT by the Administrator on 01/19/23 regarding completing and documenting invitations to care conferences and accurate care planning of advance directives. 3. The administrator will audit 2 care conferences weekly for resident and or representative invites for care conferences and advance directive discussion at care conferences for 12 weeks.¿¿ 4. To monitor the effectiveness of the above action plan, The Administrator will report the results of thse audits to the¿QAPI committee and will evaluate the process monthly for 12 weeks. Date of Completion 2/9/23.	

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An interview with the Regional Clinical Resident Coordinator on 12/15/22 at 6:35 PM revealed he was aware that the last care plan meeting for Resident #18 was held on 5/31/22 and she should have had at least two care plan meetings since then. He stated he identified an issue with care plan meetings not being scheduled in October 2022 and had started a plan to get care plan meetings scheduled. He did not know why Resident #18 still had not had a care plan meeting since. He further stated that since Resident #18 was not listed as responsible for herself, they normally invited just her responsible party to her care plan meetings.

An interview with the Administrator on 12/15/22 at 6:55 PM revealed she was aware that care plan meetings were not being held on a routine basis due to changes in staffing especially with the MDS Coordinator and Social Worker positions. She stated that residents and families should be invited to the care plan meetings regardless of who was listed as the responsible party. The residents needed to be involved in their care if they chose to do so.

2. Resident #13 was admitted to the facility on 4/29/13.

A DNR (Do Not Resuscitate) form dated 4/12/22 for Resident #13 was in the advance directive book at the nurses' station.

Resident #13's care plan last revised on 12/12/22 indicated Resident #13 and his family desired full code status at this time.

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F 657	Continued From page 16 An interview with the MDS (Minimum Data Set) Coordinator on 12/15/22 at 2:56 PM revealed when she updated Resident #13's care plan 12/12/22, she overlooked his code status, and she should have updated his care plan to reflect his current code status. An interview with the Director of Nursing (DON) on 12/15/22 at 5:26 PM revealed the MDS Coordinator was responsible for updating the care plans and she should have updated Resident #13's care plan to reflect his current advance directive.	F 657		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews, the facility failed to provide incontinence care, which resulted in resident #266 feeling "violated" for 1 of 6 dependent residents reviewed for activities of daily living (ADL). (Resident #266) The findings included: Resident #266 was readmitted to the facility on 5/24/22 with diagnoses that included stroke, diabetes, muscle weakness, lack of coordination and major depressive disorder. Resident #266's most recent Minimum Data Set dated 11/7/22 revealed he was cognitively intact	F 677	1. The Facility failed to provide incontinent care to resident #266. The Nurse Manager validated incontinent care was provided for resident #266 on 12/12/22. The DON and RDCS provided education to Nurse #4 and Nurse Aide #4 on providing ADLs including incontinent care on 12/12/22. 2. All residents requiring assistance with ADLs have the potential to be affected by the alleged deficient practice. The DON and Nurse Manager conducted an audit of alert and oriented residents to ensure residents are satisfied with care on 12/16/22. Current Licensed Nurses and	2/9/23

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F 677	Continued From page 17 with no refusals of care. He required extensive assistance with bed mobility, toileting, and personal hygiene. He had functional limitations on one side for the upper and lower extremities. Resident #266 was frequently incontinent of bladder and always incontinent of bowel. Review of Resident #266's was care plan revised on 12/12/22 revealed the following: -Resident #266 had an ADL self-care deficit related to hemiplegia. The interventions included resident needs extensive 1 staff assist with bed mobility and resident uses the trapeze bar. -Resident needs extensive 1 staff assist with personal hygiene and toileting. Encourage the resident to use the call bell for assistance. -Resident #266 had a stroke affecting his right side. The interventions included, monitor, and document the resident's abilities for ADLs and assist as needed. -Resident #266 had bowel and bladder incontinence. The interventions included cleanse peri-area with each episode of incontinence. While touring the 200 hall on 12/12/22 at 10:15 AM there was a noticeable odor of feces when passing Resident #266's room. An observation was made from the hall revealed the resident's privacy curtains were pulled closed. During an observation and interview with Resident #266 on 12/12/22 at 10:37 AM there was still a strong odor of feces in his room. Resident #266 revealed he was not having a good day because he had been waiting for 2 hours to be changed. He explained this occurs frequently, and he had waited up to 5 hours in the past. He further explained that staff would come	F 677	Nurse Aides were re-educated by the DON or Nurse Manager on providing ADLs including incontinent. This education was completed on 12/13/22.¿ 3. DON and/or designee will conduct audits of ADL care 5x weekly for 12¿weeks.¿ 4. To monitor the effectiveness of the above action plan,The DON will report the results of these audits to the¿QAPI committee and will evaluate the process monthly for 12 weeks. Date of Completion 2/9/23	

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in and turn off the call light and say they would be right back but would take a long time to return. He had reported this to the Director of Nursing (DON) in the past, but nothing had changed. Resident #266 stated he knew he had been waiting 2 hours because he always looked at the clock when he pushed his call light. He did this because staff were slow to come in. Resident #266 explained he had a stroke in 2010 and he could not get out of bed my himself to go to the bathroom, therefore he had to wait on staff for help. He stated, "I don't like to lay here in my urine and feces, it makes me feel violated". He revealed he initially called for assistance approximately 2 hours ago. Sometime after his initial call Nurse #4 came in his room and said she would send in the nurse aide, but no one had come in yet.

At 10:40 AM Resident #266 was observed to activate his call light. At 10:50 AM Nurse Aide (NA) #4 entered the room. While observing incontinence care Resident #266 was noted to have a large bowel movement that was difficult for NA #4 to remove from his skin. The nurse aide had to leave the room because she needed a 2nd pack of wipes to complete the incontinence care. NA #4 completed the incontinence care and applied a clean brief. She then assisted Resident #266 to his wheelchair.

An interview was conducted on 12/12/22 at 11:00 AM where Nurse #4 stated Resident #266 told her he needed to be changed, but she was unsure of how long it had been since he asked. She revealed she told NA #4 that Resident #266 needed incontinence care. She further revealed that NA #4 was working in another resident's room.

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F 677	Continued From page 19 During an interview on 12/12/22 at 11: 10 AM NA #4 revealed she was not aware that Resident #266 had been waiting 2 hours for care. She explained she had 2 residents that she had gotten ready for appointments this morning. Both residents needed baths and dressed before their appointments, and she had spent a lot of time in those resident's rooms that morning. When she exited the last resident's room, she saw Resident #266 call light on and went in and provided care. NA #4 stated this was the first time she had seen Resident #266 on that day, no one told her Resident #266 needed to be changed. She indicated the reason he did not get care sooner was she was working with the other 2 residents, and she did not know he was soiled. During an interview on 12/15/22 at 5:26 PM the DON revealed all staff were to answer call lights and the call lights should be answered as soon as possible. She further revealed if a resident needed incontinence care it should be provided as soon as possible. If the NA was unavailable the nurse should provide care or delegate to someone else that could. An interview was conducted on 12/15/22 at 7:00 PM the Administrator revealed call lights should be answered and incontinence care should be provided in a timely manner.	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	F 687		2/9/23

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F 687	Continued From page 20 (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and Care Coordinator for Podiatry interviews, the facility failed to ensure toenails were trimmed and to refer residents to podiatry services for 2 of 2 diabetic residents reviewed for foot care. (Resident #30 and Resident #50) The findings included: 1. Resident #30 was admitted to the facility on 9/20/22 with diagnoses that included diabetes and dementia. The most recent quarterly Minimum Data Set for Resident #30 dated 10/26/22 revealed he was cognitively intact. He required extensive assistance with personal hygiene. Review of Resident #30's care plan revised on 12/12/22 revealed the following: Resident #30 had an ADL self-performance deficit. The interventions included check the resident's nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. The resident required 1 staff for personal hygiene and oral care. Physician orders for Resident #30 included: May initiate evaluation and treatment by	F 687	1. Facility failed to provide foot care for resident #30 and resident #50 by not providing a podiatry consult as required.¿. A podiatry consult was scheduled by the DON for resident #30 on 12/21/22 and resident #50 on Jan 18th 2023. 2.All residents have the potential to be affected by the alleged deficient practice.¿An audit was completed by the DON and Nurse Manager on 12/14/22 to identify any other residents who may require podiatry services. Podiatry services were notified of residents who needed treatment. On 12/13/23 the DON or Nurse Manager educated current Licensed Nurses and Nurse aides on importance of notifying DON/Nurse Managers when podiatry needs are identified. 3.DON and/or Designee to audit 5 residents weekly¿x12 weeks despite their diabetic status and create a list of who needs to see podiatrist and schedule a podiatrist clinic as needed. ¿ 4.To monitor the effectiveness of the above action plan, the DON will report the	

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F 687	Continued From page 21 Podiatry/Dental/Ophthalmology/Optometry/Audiology consult care per regulation 9/30/22 An observation of Resident #30 on 12/12/22 at 11:26 AM revealed he was resting in bed with a gown on. Resident #30's toenails were long, thick, and extended approximately ½ inch past the tips of his toes. An observation was made of Resident #30 on 12/13/22 at 8:49 AM he was in his bed being fed by a nurse aide. His toenails were long, thick, and extended approximately ½ inch past the tips of his toes. During an interview on 12/13/22 at 3:07 PM Nurse Aide (NA) #4 revealed she was new to day shift, she had only been working this shift for about 1 week and she had not trimmed any nails. NA #4 stated she had not noticed Resident #30's toenails being long. An interview was conducted on 12/13/22 at 3:11 PM where the Director of Nursing (DON revealed the NA's could trim fingernails but not toenails, they should report concerns to the nurse or Unit Manager (UM). The UM assessed the resident's nails. She further revealed podiatry came to the facility to trim toenails. She was unsure of how often podiatry came to the facility. The DON revealed she and the former Social Worker use to make the list of residents to be seen be podiatry, but she had recently taken over this responsibility. During an interview on 12/13/22 at 3:20 PM the Unit Manager (UM) revealed she completed ADL audits daily and she assessed nails during those audits. She audited 3 random residents per day.	F 687	results of these audits during the¿QAPI meeting and the committee will evaluate the process monthly for 12 weeks. Date of Completion 2/9/23	

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If nails needed to be trimmed, she let the NA know. If the resident was a diabetic, the UM trimmed their nails.

Review of the list of Residents that were seen during the most recent podiatry visit on 10/25/22 revealed Resident #30 was not on that list.

An observation of Resident #30 on 12/15/22 at 9:51 AM revealed his toenails were long, thick, and extended approximately ½ inch past the tips of his toes.

On 12/15/22 at 12:25 PM an observation and interview were conducted with the UM. The UM stated she could not remember how Resident #30's toenails looked. Upon observation the UM stated the resident's toenails were long and thick. She further stated his toenails needed to be trimmed by podiatry. She was not sure why Resident #30 was not seen on 10/25/22 when podiatry was in the facility.

During an interview on 12/15/22 at 3:09 PM the care coordinator for podiatry services revealed residents at the facility could receive podiatry services every 62 days but they typically saw residents every 90 days. All residents needed to be referred to podiatry. Residents were referred by the facility, when podiatry received the referral, they faxed an order form to the facility to be signed and returned to podiatry. The Care Coordinator stated they had they ability to view the facility census from their office. They periodically reviewed the census and sent order forms for residents that had not been referred and have certain diagnoses. Those diagnoses included diabetes. The facility needed to return the signed order; residents could only receive

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services if they had a signed order by the physician. She further stated the facility could request an extra visit for any concerns that needed to be addressed before the next scheduled visit, using the same referral process. The Care Coordinator revealed Resident #30 had not been seen by podiatry. She stated that meant he either had not been referred or his signed order had not been returned.

An interview with the DON on 12/15/22 at 5:26 PM revealed she was unsure why Resident #30's toenails were not trimmed on 10/25/22 when podiatry services were in the building. She stated the former social worker oversaw podiatry appointments at that time. She indicated Resident #30 should have received a podiatry referral and services. She stated she was currently gathering resident names to refer to podiatry.

During an interview with the Administrator on 12/15/22 at 7:00 PM revealed if a resident required podiatry services, she expected them to be referred so they could be provided those services.

2. Resident #50 was admitted to the facility on 09/01/22 with diagnosis which included diabetes.

Resident #50's quarterly MDS dated 09/22/22 revealed he was cognitively intact and required limited assistance of 2 staff with personal hygiene and extensive assistance of 1 staff with bathing.

Review of the resident's care plan dated 10/2/22 revealed a focus area for the resident having diabetes mellitus type II. The interventions

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included refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails.

Observation and interview on 12/12/22 at 3:07 PM revealed Resident #50 sitting in his wheelchair in his room with his feet bare. Observation of both feet revealed his nails on both big toes were ½ to ¾ inch beyond the end of both toes. There were other toes on both feet that were ¼ to ½ inches beyond the end of his toes. The resident stated he had asked staff (could not remember names) about seeing the podiatrist when he was there last (on 10/25/22) but had not been seen by him.

Interview on 12/13/22 at 3:03 PM with Nurse Aide (NA) #4 revealed she was assigned to care for Resident #50 on the day shift. NA #4 stated she had not clipped Resident #50's nails and stated nails were usually done by the nurses if they were diabetic and their toenails by the podiatrist. NA #4 further stated she had not noticed his toenails or that they needed to be trimmed and had not reported to the nurse they needed to be trimmed.

Interview on 12/13/22 at 3:30 PM with the Unit Manager (UM) revealed she or one of the nurses were responsible for auditing residents' nails and when they needed to be trimmed it was done by the Unit Manager or a designated nurse. The UM further stated she had not noticed Resident #50's toenails and was not aware they needed to be trimmed.

Interview on 12/15/22 at 3:35 PM with Nurse #5 who was assigned to care for Resident #50 from 7:00 AM to 7:00 PM revealed she had not noticed the resident's toenails needing trimmed. She

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F 687	Continued From page 25 stated he was diabetic and should have been seen by the podiatrist on his last visit to the facility on 10/25/22. Interview on 12/15/22 at 5:42 PM with the Director of Nursing (DON) revealed in the absence of a social worker she had asked the Unit Manager and Assistant Director of Nursing to compile a list of residents that needed to be seen by the podiatrist the week of December 5th. The DON stated they were unable to find the list of residents referred for podiatry services in the social worker office, so they had compiled a list themselves last week. The DON further stated Resident #50 was on the list to be seen at the next scheduled podiatry visit but couldn't remember who had told her to add him to the list. She indicated they emailed a list to the podiatry office of residents that needed to be seen and then the podiatry office confirms insurance approval and diagnosis for them to be seen. The DON further indicated she did not know why Resident #50 was not seen on the last podiatry visit on 10/25/22. Interview on 12/15/22 at 6:55 PM with the Administrator revealed she was not sure why the resident had not been seen on 10/25/22 when the podiatrist had last been at the facility but said she expected all residents in need of services to be referred to the podiatrist for foot dare.	F 687		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		2/9/23

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F 689	Continued From page 26 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews with resident, family member, staff, Nurse Practitioner and Medical Director, the facility failed to provide care in a safe manner for 2 of 6 residents reviewed for supervision to prevent accidents (Resident #114 and Resident #25). On 11/17/22, Resident #114's lower half of her body went off the other side of the bed during incontinence care resulting in a non-displaced, comminuted (bone that is broken in at least two places) proximal tibia-fibula (explain) fracture of the right leg. The facility failed to investigate the injury and complete a root cause analysis and as a result no plan was in place to prevent further injury to residents. On 11/25/22, Resident #25 who required two staff member assistance with bed mobility, fell out of a raised bed onto the floor during incontinence care which resulted in a closed fracture of the left tibial plateau, a closed fracture of the right femur, and a closed traumatic fracture of the left tibial plafond (end of the shin bone and involves the ankle joint). She complained of severe pain to both knees which was worsened by movement and alleviated by nothing. In addition, the facility failed to complete accurate smoking assessments to provide a safe smoking environment for 2 of 2 residents reviewed for smoking (Resident #16 and Resident #36). Immediate jeopardy began on 11/17/22 when Resident #114 suffered an injury during incontinence care by one staff member that	F 689	1.Facility failed to provide an environment free of accident Hazards/Supervision /Devices to resident #114, #25, #16, and #36 by failing to provide care in a safe manner and by not completing resident safe smoking assessment timely and accurately.A current smoking assessment was completed on 12/14/22 for resident #16 and 12/19/22 for resident #36. Residents #114 received evaluation at treatment at the hospital on 11/18/22. Resident #25 received evaluation of treatment at the hospital on 11/26/22. 2.All dependent residents have the potential to be affected by the alleged deficient practice. An audit was completed to ensure that all residents were coded for the appropriate amount of assistance required for ADL care/bed mobility on 11/29/22. Assignment sheets were initiated to provide staff with information on the appropriate amount of assistance that each resident requires for ADLS. All staff were educated on new assignment sheet and providing care in a safe manner by DNS or Designee on 12/20/22. An audit was completed to ensure that all resident safe smoking assessments were up to date and accurate on 12/14/22. All that were late or incorrect were completed at that time. All staff educated on smoking assessments on 2/9/2023 by	

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F 689	Continued From page 27 resulted in a non-displaced, comminuted proximal tibia-fibula fracture of the right leg and continued when Resident #25 fell out of a raised bed onto the floor during incontinence care by one staff member. Immediate jeopardy was removed on 12/21/22 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of "D" (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure education and monitoring systems put into place are effective. Examples #3 (Resident #16) and #4 (Resident #36) were cited at a scope and severity level of D where a plan of correction is required. 1. Resident #114 was admitted to the facility on 11/09/22 and discharged to the hospital on 11/18/22. Her admission diagnoses included diabetes, osteopenia, and osteoporosis. Resident #114's admission Minimum Data Set (MDS) dated 11/14/22 revealed she was moderately cognitively impaired and was able to make all needs known. The MDS also revealed the resident required extensive assistance of 1 staff member for bed mobility and toileting (incontinence care) and extensive assistance of 2 staff members for personal hygiene. Review of Resident #114's baseline care plan dated 11/10/22 revealed a focus area for being at risk of falls. The interventions included anticipate and meet the resident's needs, be sure the resident's call light is within reach and encourage her to use it for assistance as needed, and resident needs prompt response to all requests for assistance.	F 689	DNS or Designee. 3.DON/ADON or Designee will continue ADL care/bed mobility audits 4x weekly for 12 weeks. MDS/DON or designee will audit smoking assessments weekly for 12 weeks to ensure timeliness and accuracy. 4. To monitor the effectiveness of the above action plan, the DON will report the results to the QAPI committee and will evaluate the process monthly for 12 weeks. Date of Completion 2/9/23	

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Review of Resident #114's chart revealed no progress notes regarding an injury to the resident or an assessment of the resident on 11/17/22.

Review of a fall report completed by the Director of Nursing (DON) on 11/17/22 at 8:51 PM revealed the "resident was being changed by 1 staff member and the lower half of her body went off the other side of the bed." An initial assessment was completed by Nurse #3 with no apparent injury.

Phone interview on 12/13/22 at 4:48 PM with NA #3 who had been assigned to care for Resident #114 on 11/16/22 at 11:00 PM through 11/17/22 at 7:00 AM revealed the resident had not fallen out of the bed but had slid to the edge of the bed and her feet were dangling off the bed. NA #3 stated he was able to grab her at her midsection so she would not fall off the bed and flagged her nurse (Nurse #3) for assistance in getting her legs back on the bed. NA #3 further stated he had no idea how the resident could have broken her bones and was not sure if her leg had hit the wall or anything else while dangling off the bed. He indicated he yelled for help from the nurse while holding the resident's upper body to prevent her from falling from the bed.

Phone interview on 12/13/22 at 3:03 PM with Nurse #3 who was assigned to Resident #114 on 11/16/22 at 7:00 PM through 11/17/22 at 7:00 AM revealed Nurse #3 had not witnessed what had happened on 11/17/22 around 5:30 AM but when she walked into her room the resident's upper body was on the bed and her legs were dangling off the bed. Nurse #3 further stated she went into

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the room and "scooped the resident's legs and threw them back on the bed." She indicated NA #3 who was assigned to the resident was at the doorway to her room waving his arms and asking for assistance, so she had gone into the room to assist with her care. Nurse #3 further indicated she stayed in the room at her bedside until Resident #114's care was completed. She explained she could not remember if she assessed the resident because she had not actually fallen but her legs had slid off the bed. Nurse #3 further explained she had not notified the family because she had been told by NA #3 the resident had not fallen out of bed and said the resident was not complaining of pain at the time of the incident.

Interview on 12/13/22 at 11:30 AM with Resident #114's family member revealed she met the resident at her appointment with the orthopedic surgeon on 11/17/22. The family member stated Resident #114 told her she had fallen out of bed around 5:30 AM and her right leg was hurting her when she moved it. The family member further stated she had to hold her mother's right leg up using a towel when she pushed her in the wheelchair because there was no footrest on her wheelchair. She indicated Resident #114 told the orthopedic surgeon that she had fallen out of bed around 5:30 AM on 11/17/22 and her leg was hurting so the orthopedic surgeon sent her back to the facility with an order for mobile x-ray to the right leg and hip.

Review of a mobile x-ray report completed on 11/17/22 revealed the resident had an acute transverse fracture of the proximal tibia and fibula.

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Review of Resident #114's progress notes dated 11/18/22 revealed she was transferred to the local hospital for evaluation and treatment of her fractured tibia and fibula on the right leg.

Review of the hospital Emergency Department (ED) notes dated 11/18/22 revealed the ED physician noted the resident's chief complaint was "fall and leg injury (fell out of bed, placed back in bed), complained of leg pain at a level of 7 out of 10." The notes further revealed the resident was sent for a CT scan which showed the following:
There is mild medial compartment knee osteoarthritis with posttraumatic soft tissue edema seen about the knee.
The visualized osseous structures are diffusely decreased in mineralization consistent with osteopenia/osteoporosis.
Impression:
1. Acute nondisplaced proximal tibial metaphysis (the neck portion of a long bone) fracture without evidence of articular surface (surface of the joint where ends of bones meet) involvement.
2. Acute nondisplaced proximal fibula fracture
3. Imaging findings suspicious for mild osteochondral (an injury that damages the cartilage and underlying bone) impaction fracture of the lateral femoral condyle. There is no overlying articular surface depression or fragmentation.
4. Small joint effusion (when too much fluid builds up around a joint).

Review of a note written on 11/17/22 by the admitting physician at the hospital revealed Resident #114 informed him she had fallen out of bed on 11/17/22 around 5:30 AM and had pain in

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her right leg when manipulated but not at rest. Resident #114 also reported that she had not hit her head during the fall and had no loss of consciousness. An attempt was made to interview the physician via phone without success.

Interview on 12/13/22 at 12:39 PM with Nurse #2 who was assigned to care for Resident #114 on 11/17/22 revealed she had heard the resident had fallen out of bed around 5:30 AM on 11/17/22 while NA #3 was providing incontinence care. Nurse #2 stated the Therapy Manager and the Transporter had told her about the fall and said the Transporter told her that Resident #114 had told several people that she had fallen out of bed on 11/17/22.

Phone interview on 12/21/22 at 12:40 PM with the Therapy Manager revealed she had been told on 11/17/22 by the Physical Therapy Assistant (PTA) that Resident #114 had fallen out of the bed around 5:30 AM on 11/17/22.

Phone interview on 12/21/22 at 12:42 PM with the PTA revealed he saw Resident #114 on 11/17/22 and was doing exercises to her leg with her when she told him she had fallen out of the bed around 5:30 AM on 11/17/22 and felt like her leg was broken. The PTA stated he immediately stopped treatment and reported what the resident had told him to Nurse #3 and to the Therapy Manager.

Phone interview on 12/21/22 at 4:00 PM with the Transporter revealed she had transported Resident #114 to her specialist appointment on 11/17/22 and her family member had met them at the office. The Transporter stated she overheard Resident #114 telling her family member that she

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had fallen out of the bed around 5:30 AM on 11/17/22. The Transporter further stated she had called the facility to inform the resident's nurse what she had overheard the resident telling her family member. She indicated when she talked with Nurse #3, she had not received any information in report about the resident having a fall out of the bed. The Transporter further indicated she could not recall if Resident #114 had complained of leg pain during the transport.

Interview on 12/15/22 at 11:27 AM with the Unit Manager (UM) revealed she had heard that Resident #114's legs had gone off the side of the bed during resident care and said she was not sure how she had fractured her bones. The UM stated Resident #114 had told several staff (could not remember who) that she had fallen out of bed around 5:30 AM on 11/17/22. The UM further stated she didn't necessarily think the resident was confused if she had told 3 different physicians that she had fallen out of bed but stated she had confusion at times. The UM indicated she had not found out about the resident's incident until after she returned to the facility from her appointment with the orthopedic surgeon on 11/17/22.

Interview on 12/15/22 at 12:53 PM with the Nurse Practitioner (NP) revealed she had been notified on 11/17/22 that Resident #114 had a fall around 5:30 AM on 11/17/22 but had not had any visible injuries. The NP stated she had been notified that the orthopedic surgeon Resident #114 had seen on 11/17/22 had ordered a mobile x-ray of the resident's right hip and leg. She further stated she had been notified on 11/18/22 that the x-ray was positive for comminuted right fibula/tibia fracture. The NP indicated she did not believe

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legs dangling off the bed would have caused a fracture and said there had to be some type of trauma to cause a fracture.

Interview on 12/15/22 at 2:31 PM with the Medical Director (MD) revealed he didn't see how she could have suffered a fracture of the tibia and fibula just from her legs dangling off the bed even though she had osteopenia. The MD stated there had to be some type of trauma to cause the fractures such as a fall. He further stated even though it wouldn't take much to cause a fracture in the presence of osteopenia there would have to have been some reason for the tibial and fibula fracture at the proximal end.

Follow up phone interview on 12/20/22 at 4:03 PM with the Medical Director revealed he did not want to change anything he had previously stated but said he wanted to clarify that he and the facility staff felt strongly Resident #114 had not had a fall out of bed. He stated her injury could have resulted from a twisting incident in the bed while moving, it could have been caused by the way she turned, or it could have been caused by something that was in her bed. The Medical Director stated he could not say for sure what had caused the injury to Resident #114.

Interview on 12/15/22 at 5:33 PM with the Director of Nursing (DON) revealed she had been informed by Resident #114 that she had fallen out of bed on 11/17/22 but she nor Nurse #3 had called and reported the incident to the family member because they had not considered it a fall. The DON stated she had filled out a fall report before she had spoken with Nurse #3 and NA #3 and after speaking with them had not considered her legs dangling off the bed a fall.

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She further stated she could not explain how Resident #114 had fractured her tibia and fibula and indicated it could be related to her osteopenia and osteoporosis as identified in her x-ray.

Interview on 12/15/22 at 7:02 PM with the Administrator revealed she would expect care to be given in a safe manner and residents not injured while receiving incontinence care.

The Administrator was notified of immediate jeopardy on 12/20/22 at 3:00 PM.

2. Resident #25 was admitted to the facility on 3/13/19 with diagnoses that included hepatic failure, right foot drop, osteoarthritis, contracture of the left hand and right hand, and muscle weakness.

The significant change in status Minimum Data Set assessment dated 10/11/22 indicated Resident #25 was moderately cognitively impaired and required extensive assistance of 2 staff to accomplish activities of daily living (ADL) including bed mobility and toileting. Resident #25 had impairment to both sides of her upper extremities, weighed 258 pounds and received hospice care at the time of this assessment. The Care Area Assessment summary indicated Resident #25 was at risk for falls due to muscle weakness, medication use, impaired mobility, and incontinence.

Resident #25's care plan revised on 11/5/22 indicated Resident #25 had ADL self-care performance deficit related to activity intolerance, fatigue, impaired balance, limited mobility, and right foot drop. Interventions included Resident

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#25 required extensive assistance by 2 staff to turn and reposition in bed on care rounds and as necessary.

Resident #25's care guide revised on 11/5/22 indicated she required extensive assistance by 2 staff to turn and reposition in bed on care rounds.

An incident report dated 11/26/22 at 1:09 AM indicated Nurse #1 was called to Resident #25's room by Nurse Aide (NA) #1. Upon arrival, Resident #25 was witnessed kneeling on the fall mat with her upper body resting on the bed. Resident #25 was alert and complained of pain to bilateral knees. NA #1 was present during incident that occurred while providing care to Resident #25. NA #1 stated that Resident #25 was lying on left side in bed when the right leg slid, and Resident #25 landed on her knees on the fall mat. Full body assessment done. Vital signs as follows: blood pressure of 105/65, pulse of 82, respiratory rate of 20, temperature of 97.9, oxygen saturation of 96% on oxygen at 2 liters/minute via nasal cannula. Redness noted on the left thigh with no active bleeding. Pain medication administered. Resident #25 was sent out to the ER (emergency room) for further evaluation.

Nurse Aide (NA) #1's statement dated 12/1/22 indicated that on Friday, 11/25/22, NA #1 assisted Resident #25 with changing her brief. NA #1 cleaned her up, turned her on her side and made sure she was holding on to the bed rails. After that she placed a brief under her and at the same time Resident #25 rolled onto the floor on the fall mat on her knees while still holding onto the bed rails. NA #1 immediately stepped out of the room, motioned for Nurse #1 to let her know that

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Resident #25 was on the floor. Nurse #1 came in, saw Resident #25 on her knees on the fall mat and went to get NA #2. NA #2 came in and they laid Resident #25 flat on the fall mat. NA #1 went and got the total mechanical lift so they could get Resident #25 in her bed. After that NA #2 and NA #1 put Resident #25's brief on while Nurse #1 asked her if she was in pain. Resident #25 said yes, and Nurse #1 went to get her some pain medication. About 30 minutes later, Resident #25 said she was still hurting, and Nurse #1 said she gave Resident #25 all the pain medicine she could give her. Nurse #1 asked Resident #25 if she wanted to be sent out, if she wanted to call a doctor or call her family but Resident #25 said no, she was okay but was still in pain.

A phone interview with Nurse Aide (NA) #1 on 12/14/22 at 10:57 AM revealed the fall incident that involved Resident #25 happened on 11/25/22 around 9:30 PM when she went in by herself to Resident #25's room to change her brief and provide incontinence care to her. NA #1 stated when she walked into the room, Resident #25's bed was already at her waist level, so she didn't need to raise it up. Resident #25 had an air mattress on her bed. NA #1 stated she cleaned Resident #25's front perineal area and then turned her to her left side, facing the door. NA #1 stated she made sure Resident #25 was holding on to the bed rail after she turned her. NA #1 cleaned Resident #25's back side and got a brief ready to place on her. When NA #1 placed the brief underneath Resident #25's buttocks, Resident #25 rolled onto the fall mat with her knees first. While Resident #25 was on her knees on the fall mat but still holding on to the side rail with her hands, NA #1 stepped over to the door and motioned for Nurse #1 who was

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standing in the hallway by her medication cart to come into the room. When Nurse #1 walked into the room, Resident #25 was still holding on to the side rail with her hands, but she was on her knees on the fall mat. Nurse #1 went to get NA #2 while NA #1 continued to stay with Resident #25. They laid her flat on the fall mat on the floor. Resident #25 complained of pain to her knees and legs. Nurse #1 continued her assessment and gave Resident #25 her pain medication. NA #1 then obtained the total mechanical lift, and they transferred Resident #25 back to her bed. NA #1 further stated that after 15-20 minutes she checked on Resident #25 again and she was still in pain but at that time she refused to be sent out to the hospital. NA #1 stated that this was her first time working with Resident #25 and she did not know that she was supposed to have two staff member assistance. NA #1 also stated that NA #2 gave her report when she started her shift, but he did not mention about Resident #25 needing the assistance of two staff members for incontinence care.

A phone interview with Nurse #1 on 12/13/22 at 12:10 PM revealed she was doing her medication pass around 9:30 PM on 11/25/22 when NA #1 came to the door and motioned to her to come to Resident #25. When Nurse #1 entered Resident #25's room, she observed Resident #25 kneeling in front of her bed with her upper body still on the bed and her knees on the fall mat beside her bed. NA #1 told her that she was providing incontinence care to Resident #25 and had her turned towards her left side with her right leg crossed over her left leg as she was cleaning her. And then Resident #25 started sliding off the bed with her knees first. Resident #25 told Nurse #1, "I can't be in this position. My knees are killing

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me," with her knees bent on the fall mat. Nurse #1 exited Resident #25's room to get NA #2. After assessing Resident #25, they transferred her back to bed using a total mechanical lift. Nurse #1 stated she observed some redness on Resident #25's left thigh but she did not notice any bruising or swelling. Resident #25 complained of pain to both knees, and she gave her prn (as needed) pain medication. Nurse #1 also obtained an order for x-ray after she notified the provider on-call about Resident #25's fall and pain to both knees. Resident #25 kept on calling staff to her room over and over because of pain to her knees so Nurse #1 offered to send her to the hospital if the pain was unbearable. At first, Resident #25 refused to go to the hospital and stated to her that she felt some relief but after a few minutes, Nurse #1 learned that Resident #25 had called EMS (emergency medical services) herself and that she had changed her mind and wanted to go to the hospital instead. Resident #25 told Nurse #1 that the pain was unbearable and that she had decided to go to the hospital. Nurse #1 stated that Resident #25 required 2 staff assist with ADL in bed and that NA #1 should have called another staff member to help her while providing care to Resident #25. Nurse #1 stated that Resident #25 was able to move her arms some but couldn't move her legs. Resident #25 had been bed bound and had never been on her knees before.

Attempts were made to contact NA #2 on 12/14/22 at 10:04 AM, 12/15/22 at 9:51 AM and 12/15/22 at 4:31 PM but they were unsuccessful.

An interview with the Therapy Manager on 12/13/22 at 3:10 PM revealed she was familiar with Resident #25, and they had provided

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occupational therapy treatment to her due to her hand contractures. Resident #25 was barely able to bend both legs with the right leg worse than the left leg. She couldn't bear any weight on her legs and required a total mechanical lift for transfers. Resident #25 was dependent on staff assistance with mobility which meant she couldn't do anything by herself. She stated they had recommended for nursing to have at least 2 staff members present during care in the bed mainly because of her weight and her impaired mobility.

A review of the hospital discharge summary revealed Resident #25 was admitted to the hospital on 11/26/22 and discharged to another facility on 12/6/22. Her admitting diagnoses included a closed fracture of the left tibial plateau (top surface of the tibia or shin bone), a closed fracture of the right femur (thigh bone), and a closed traumatic fracture of the left tibial plafond (end of the shin bone and involves the ankle joint). Orthopedics was consulted and they opted for non-surgical management. Resident #25 complained of severe pain to both knees which was worsened by movement and alleviated by nothing. Resident #25 was discharged from the hospital on 12/6/22 to another skilled nursing facility with hospice (which she had prior to hospital admission).

An interview with Nurse Practitioner #2 on 12/15/22 at 12:48 PM revealed she was familiar with Resident #25 and knew she needed total assistance with bed mobility. Resident #25 was not able to move herself in bed and required two staff members with incontinence care and with any care in the bed.

An interview with the Medical Director on

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12/15/22 at 2:32 PM revealed Resident #25 required assistance from 2 staff members with incontinence and ADL care. He stated he found out that Resident #25 fell after the incident had occurred, but he wasn't aware that her fall was caused by one staff member taking care of her. He further stated there should have been two staff members providing care to her while she was in bed due to her impaired mobility.

An interview with the Director of Nursing (DON) on 12/14/22 at 10:41 AM revealed she became aware of Resident #25's fall on 11/28/22 when Resident #25's family member called her. The DON stated she talked to Nurse #1, NA #1 and NA #2 and she found out that NA #1 had gone in to provide incontinence care to Resident #25 by herself. The DON stated there should have been 2 staff members to provide care to Resident #25. They had enough staff that day for them to pair up and provide care to the residents for each hall. She further stated NA #1 was an agency nurse aide, but NA #2 had oriented her about her assigned residents at the start of her shift. NA #2 was supposed to have shared with NA #1 information about the residents such as how they ate, if they required assistance with eating, what size of brief they wore, how they transferred and whether they required one or two persons for turning and repositioning in bed. The DON stated the facility used care guides and NA #1 should have looked at it prior to providing care to Resident #25.

The Administrator was notified of immediate jeopardy on 12/14/22 at 2:50 PM.

The facility provided an acceptable removal action plan on 12/21/22 that read:

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*Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

Resident #114 with history of left below the knee amputation was having ADL (Activity of Daily Living) care provided related to an incontinent episode on 11/17/22. When the resident was rolled over to the left, her legs continued to roll off over the side of the bed. Nurse Aide #3 yelled for help and Nurse #3 came to assist him. The Nurse was able to hold the resident's leg and assist her back onto the bed. As a result of this event, Resident #114 received a non-displaced, comminuted, proximal tibia-fibula fracture of the right leg.

Resident #25 had a fall from the bed on 11/25/22. Resident #25 was receiving ADL care while in bed. While being turned and repositioned, her legs rolled off the bed and landed on the floor mat at the bedside. She was assessed for injury then assisted back to bed. At that time, she was given as needed medication and stated that she had some relief. Shortly thereafter, she called 911 and stated that she now wanted to go to the hospital but had refused to go when asked by the nurse earlier.

On 11/21/22 the DON (Director of Nursing) and ADON (Assistant Director of Nursing) initiated education to current nursing staff regarding safe turning and repositioning. Education was not completed by all nursing staff prior to the next event occurring on 11/25/22.

Root cause analysis for Resident #25 was conducted by the DON, NHA (Nursing Home

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Administrator) and RDCS (Regional Director of Clinical Services) on 11/29/22 and it was determined the Nurse Aide failed to have 2 staff members present while providing care for a dependent resident resulting in a fall out of bed.

Root cause analysis for Resident #114 was conducted by the DON, Medical Director, NHA and RDCS on 12/20/22 and it was determined the Nurse Aide failed to have another staff member present while providing care for a dependent resident resulting in an awkward sliding of the lower extremities off the side of the mattress.

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

On 11/29/22 a review of the Resident #25's current mobility assessment was completed and verified that she required two persons to assist with bed mobility and ADL care. The DON created a new assignment sheet to include the amount of assistance each resident requires for bed mobility and ADLs. This assignment sheet will be accessible to Nurses and Nurse Aides, in a notebook labeled Assignment Sheets, at the Nurses station. This assignment sheet will be updated daily to include new admissions and readmissions by the DON and ADON during the morning clinical meeting. The DON and ADON were educated by the RDCS on this new process on 11/29/22.

DON and ADON completed an audit on 11/29/22 of all current residents to identify required staff assistance for bed mobility and ADLs. On 11/29/22 care plans were revised by the DON,

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ADON and MDS (Minimum Data Set) Nurse to include 1- or 2-person assistance when providing care for dependent residents. Residents #25 and #114 were no longer in the facility.

The DON, ADON and RDCS re-educated all current nursing staff (Nurses and CNAs) including agency staff on safe technique for assisting with bed mobility, turning, and repositioning with incontinent care and ADLs, utilizing the resident assignment sheet to determine assistance required prior to providing care and the location of the assignment sheets at the nurse's station, by 12/20/22. After 12/20/22, the DON and Nurse Managers will ensure no nursing staff will be allowed to work, including any new hired staff and agency staff, without receiving this education.

A QAPI (Quality Assurance and Performance Improvement) meeting was held on 12/20/22 to review this plan. The QAPI Committee will make recommendations as needed.

Date of IJ Removal: 12/21/22

On 12/30/22, the facility's credible allegation for immediate jeopardy removal effective 12/21/22 was validated by the following: Staff interviews revealed they had received education on safe technique for assisting with bed mobility, turning, and repositioning with incontinent care and activities of daily living (ADL). Audits were completed of all current residents to identify required staff assistance for bed mobility and ADLs. A new assignment sheet was created and included the amount of assistance each resident requires for bed mobility and ADLs.

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3. Review of facility smoking policy dated 10/22/20 revealed residents who smoke would be assessed using the resident safe smoking assessment during the admission process and during each quarterly or comprehensive Minimum Data Set (MDS) assessment process.

Resident #16 was admitted to the facility on 09/09/19 and readmitted on 07/11/22.

Review of resident safe smoking assessment dated 05/05/22 completed by Nurse #4 revealed Resident #16 met the criteria for a safe smoker but was checked as requiring supervision while smoking.

Nurse #4 was not available for interview.

The revised care plan dated 08/28/22 revealed Resident #16 was a smoker, and the goal was smoking without supervision or assistance out of the facility door and while smoking through next review date. Resident #16's interventions included, in part, required supervision while smoking, and required assistance entering and exiting smoking area door.

The quarterly Minimum Data Set (MDS) dated 09/23/22 revealed Resident #16 was cognitively intact.

There were no further smoking assessments completed for Resident #16 from 5/6/22 through 12/14/22.

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Observation and interview with Resident #16 on 12/13/22 at 10:30 AM revealed her outside smoking in the designated smoking area while being supervised by nursing staff. Resident #16 was able to smoke and extinguish her cigarettes with no issues or concerns observed. She stated she was only allowed to smoke during scheduled smoking times while staff were present, and they provided her with her cigarettes and lighter. She revealed she was not allowed to smoke outside by herself because she has trouble getting in and out of the door to the smoking area, so staff had to be with her to help her.

An interview conducted with Nurse #2 on 12/13/22 at 12:33 PM revealed she was familiar with Resident #16 and her being a supervised smoker. She stated Resident #16 required supervision while smoking due to her requiring assistance with entering and exiting the doors to the smoking area. She revealed she does not recall how she was made aware of Resident #16 requiring supervision while smoking but believed she has been a supervised smoker since her admission.

An interview conducted with Regional Director of Clinical Services (RDCS) and Director of Nursing (DON) on 12/15/22 at 6:08 PM revealed they were familiar with Resident #16 and her being a supervised smoker due to requiring assistance with entering and exiting the smoking area door. The RDCS and DON stated resident smoking assessments should be completed upon admission, quarterly, annually, and when any significant changes occur, and they were not aware Resident #16's smoking assessment had not been completed since May 2022. The RDCS and DON revealed the MDS nurse was

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responsible for notifying the DON when resident smoking assessments were due, and the DON would assign nursing staff to complete them and had no knowledge why a smoking assessment had not been completed for Resident #16 since May 2022. The RDCS and DON also revealed they were not aware there was no documentation made on Resident #16's smoking assessment (dated 05/05/22) explaining that she was deemed a supervised smoker due to requiring assistance with entering and exiting the door to the smoking area. They indicated this should be documented on the smoking assessment for nursing staff to be able to review. The RDCS and DON stated going forward all nursing staff and the MDS Nurse would be educated on completing smoking assessments for all residents accurately and timely.

An interview conducted with the MDS Nurse on 12/15/22 at 02:54 PM revealed she had only been working at the facility since September 2022 and was in the process of making sure all resident assessments were up to date. She stated resident smoking assessment reminders would be sent out to the DON prior to quarterly and annual MDS being due so they could be completed timely, and it would be the responsibility of the DON and nursing staff to notify of any changes with smoking status.

An interview was conducted with Administrator on 12/15/22 at 7:13 PM and revealed all resident smoking assessments should be completed accurately and timely.

4. Review of revised facility smoking policy dated 10/22/20 revealed if a resident who smoked

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experienced any decline in condition or cognition, he or she would be reassessed for ability to smoke independently and evaluate whether any additional safety measures were indicated.

Resident #36 was admitted to the facility on 10/14/19 and readmitted on 12/02/22.

The annual Minimum Data Set (MDS) dated 10/09/22 revealed Resident #36 was cognitively intact and was coded for tobacco use.

Review of a physician order dated 12/02/22 revealed Resident #36 to receive continuous supplemental oxygen at 4 liters via nasal cannulas every shift.

Review of a re-entry resident safe smoking assessment completed by Nurse #3 dated 12/02/22 revealed Resident #36 was deemed safe (unsupervised) smoker. Question C5 pertaining to resident use of supplemental oxygen was answered no although Resident #36 was readmitted to facility with an order for supplemental oxygen dated 12/02/22. Directions for completion of section C located on the resident safe smoking assessment revealed if question C5 was answered yes for use of supplemental oxygen then the resident must be at minimum a supervised smoker.

Observation of Resident #36 on 12/12/22 at 10:35 AM revealed her outside smoking unsupervised without her oxygen in the designated smoking area. There were no staff present while Resident #36 was smoking, and she was able to smoke with no issues or concerns observed.

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The revised care plan dated 12/13/22 revealed Resident #36 was a smoker, and the goal was practicing safe smoking through the review date. Interventions included, in part, educate Resident #36 on risk and benefit of smoking while on oxygen, smoking cessation and use of nicotine patch. Ensure Resident #36 does not wear oxygen outside to smoke and instruct about facility policy on smoking locations, times, and safety concerns. Resident #36 was reassessed as an independent smoker.

A telephone interview was conducted with Nurse #3 on 12/14/22 at 8:27 AM and revealed she was familiar with Resident #36 and her being assessed an independent safe smoker. She stated she did recall completing the resident safe smoking assessment when Resident #36 was readmitted from the hospital to the facility on 12/02/22 and assessed her as being a safe smoker. She revealed Resident #36 had been assessed a safe smoker at the facility prior to her hospital stay and to her knowledge there had been no changes to her ability to smoke safely. Nurse #3 stated she did not recall if she had been made aware Resident #36 was readmitted with an order for continuous oxygen before she completed the resident safe smoking assessment. She revealed she was not aware residents receiving supplemental oxygen were to be at a minimal a supervised smoker according to the resident safe smoking assessment and if she had known she would have assessed Resident #36 correctly.

An interview was conducted with Nurse Practitioner (NP) #1 on 12/14/22 at 4:02 PM revealed she was familiar with Resident #36. She stated Resident #36 had health issues where her

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F 689	Continued From page 49	F 689		

oxygen levels would drop and required her to be on continuous oxygen. She revealed Resident #36 had also been deemed an independent smoker and was allowed to smoke anytime of the day or night. NP #1 stated Resident #36 would refuse to wear her oxygen so she could stay outside and smoke which caused her oxygen levels to drop and her having to be sent out to the hospital for treatment. She stated she had safety concerns with Resident #36 being deemed an independent smoker due to her oxygen levels dropping. NP #1 reviewed the resident safe smoking assessment and stated she was not aware Resident #36 should have been a supervised smoker if receiving supplemental oxygen. She revealed Resident #36 would have benefiting from being a supervised smoker and having scheduled smoking times, it would have helped with her oxygen levels in general.

A follow up interview conducted with Nurse Practitioner (NP) #2 on 12/15/22 at 12:48 PM revealed Resident #36 would benefit from being a supervised smoker and having supervised smoking times would help with her being more compliant with her oxygen and her care. She stated she was not aware residents receiving supplemental oxygen should be deemed supervised smokers on the resident safe smoking assessment and all resident assessments should be completed correctly.

An interview was conducted with Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) on 12/15/22 at 6:18 PM revealed they were familiar with Resident #36 and her being assessed as an independent safe smoker. The DON and RDCS stated Resident #36 was ordered supplemental oxygen, but

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F 689	Continued From page 50 because she refused to wear her oxygen, they did not believe the question on the resident safe assessment pertaining to supplemental oxygen applied to her. The DON and RDCS revealed resident smoking assessments should be completed accurately and timely and according to Resident #36's continuous supplemental oxygen order, she should have been assessed as a supervised smoker. An interview was conducted with the Administrator on 12/15/22 at 7:10 PM revealed all resident smoking assessments should be completed accurately and reflect all current physician orders.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		2/9/23

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F 812	Continued From page 51 by: Based on observations and staff interview, the facility failed to label, date and seal open food items stored for use in 1 of 1 walk- in refrigerator and 1 of 1 reach in cooler. This practice had the potential to affect the food served to residents. The findings included: An initial tour of the kitchen was made on 12/12/22 at 9:58 AM with the Dietary Manager (DM). The following problems were observed with the walk-in refrigerator: - 1 unsealed container labeled turkey sausage with a date of 12/11/22. - 1 unsealed, undated container of brown substance. The following problems were observed with the reach in cooler: - 1 pack of hotdogs in an unmarked open clear plastic bag. No expiration date or best buy date was observed on the packaging. An interview with the DM on 12/12/22 at 10:05 AM revealed the brown substance in the walk in refrigerator was beef gravy. The DM stated the items identified were supposed to be covered and dated when placed in the refrigerator or cooler. A follow-up interview conducted with the DM on 12/13/22 at 3:00 PM revealed the turkey sausage was served the day prior and should have been covered that night before dietary staff left the facility. He stated he did not know when the beef gravy had last been served. The interview revealed the dietary staff often would place food items uncovered in the refrigerator to cool down and the staff had just forgotten to recover the	F 812	1.Facility failed to store, prepare/serve sanitary food in kitchen area by not labeling, dating and sealing open food items in refrigerator/cooler.¿¿ 2.All residents have the potential to be affected by the alleged deficient practice.¿ An audit was conducted on 12/12/22 to ensure that all unlabeled, dated and unsealed containers were removed from refrigerators/coolers. Dietary staff have been¿educated in food handling safe practices by Dietary Manager on 12/12/22..¿¿ 3.Administrator and Dietary Manager will monitor refrigerators/coolers in the kitchen for safe food storage 1x weekly for 12 weeks.¿ ¿4.To monitor the effectiveness of the above action plan, the Administrator will bring the results of these audits and the ¿QAPI committee will evaluate the process and monitor monthly for 12 weeks Date of Completion 2/9/23	

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F 812	Continued From page 52 items. An interview conducted with the Administrator on 12/14/22 at 11:23 AM revealed it was the facility policy to ensure all food items were stored properly and she expected the dietary staff to follow those guidelines.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		2/9/23

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F 867	Continued From page 53	F 867		

development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity

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of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including

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F 867	Continued From page 55 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 12/16/21. This was for 6 deficiencies that were cited in the areas of Resident Rights/Exercise of Rights (F550), Reasonable Accommodations of Needs/Preferences (F558), Care Plan Timing and Revision (F657), ADL (Activities of Daily Living) Care Provided for Dependent Residents (F677), Free of Accident Hazards/Supervision/Devices (F689) and Food Procurement, Storage/Preparation/Serve under Sanitary Conditions (F812) on 12/16/21 and recited on the current recertification and complaint survey of 12/15/22. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put in place following the complaint survey conducted on 4/8/22. This was evident for 1 deficiency in Safe/Clean/Comfortable/Homelike Environment (F584) originally cited on the complaint survey on 4/8/22 and recited on the current recertification and complaint survey of 12/15/22. The duplicate citations during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included:	F 867	1. The¿Quality Assurance Committee met on 1/1/31/23 and reviewed the purpose and function of the Quality Assurance Performance (QAPI) Committee as well as the on-going compliance issues regarding tag F867.¿ 2. All residents have the potential to be affected. On 01/17/23,¿the Regional Director of Operations educated the Nursing Home Administrator on the appropriate functioning of the QAPI Committee and the purpose of the Committee to include identifying and correcting repeat deficiencies related tag F867. Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review of concern logs, review of rounding tools, daily review of Point Click Care documentation, and observation during leadership rounds.¿ 3. On 01/20/23, the Administrator educated the QAPI committee members consisting of, the Medical Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Infection Preventionist, Unit Coordinators, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, and	

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F 867	Continued From page 56 This tag is cross referenced to: F550 - Based on observation, record review, resident, and staff interviews the facility failed to provide care in a manner that maintained the resident's dignity by not providing incontinence care when needed. This is evidenced by Resident #266 feeling "violated". This occurred for 1 of 4 residents reviewed for dignity. (Resident #266) During the recertification and complaint survey on 12/16/21, the facility failed to promote dignity by not providing colostomy care for 2 hours after leakage occurred, by not providing a privacy cover over a urinary drainage bag and by not ensuring a resident had a call bell in his room for 3 of 4 residents reviewed for dignity. In addition, the facility failed to promote a dignified dining experience by using styrofoam plates for 2 of 2 meals observed. F558 - Based on record reviews, and interviews with family member, and staff, the facility failed to provide foot pedal on a wheelchair for a resident transported by the facility to a specialist appointment for one of one resident reviewed for accommodation of needs (Resident #114). During the recertification and complaint survey on 12/16/21, the facility failed to ensure a resident had a call bell in his room and failed to keep a resident call bell within reach. This was for 2 of 2 residents reviewed for accommodation of needs. F584 - Based on observations and resident and staff interviews, the facility failed to maintain home like environment and wall integrity in the residents' rooms for 2 of 9 sampled residents for	F 867	Pharmacy Consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly.¿ 4. The monitoring procedure to ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff monthly for 12 weeks for the monitoring The administrator is responsible for overseeing this plan of correction.¿ Date of Completion 2/9/23	

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F 867	Continued From page 57 rooms 314 and 316 and 1 of 3 hallways. During the complaint survey on 4/8/22, the facility failed to maintain clean floors in 3 of 3 hallways and in 2 of 15 resident rooms, ensure 1 of 2 handrails was secured to the wall on 200 hall, repair 5 of 5 drain covers on 200 hall, repair light fixture covers in 2 of 15 rooms and replace missing or damaged electrical wall plates in 2 of 15 rooms. F657 - Based on record review and resident and staff interviews, the facility failed to invite a resident and/or her representative to participate and provide input in care planning for 1 of 3 sampled residents (Resident #18) and failed to update the care plan to reflect the current advance directive for 1 of 3 residents reviewed (Resident #13). During the recertification and complaint survey on 12/16/21, the facility failed to review and revise a care plan in the areas of smoking, accidents, and nutrition. This was for 3 of 20 residents' care plans reviewed. F677 - Based on observation, record review, resident, and staff interviews, the facility failed to provide incontinence care, which resulted in resident #266 feeling "violated" for 1 of 6 dependent residents reviewed for activities of daily living (ADL). (Resident #266) During the recertification and complaint survey on 12/16/21, the facility failed to provide nail care and facial grooming for residents who required staff assistance with their activities of daily living (ADL). This was for 3 of 5 residents reviewed for ADL.	F 867		

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F689 - Based on record reviews, and interviews with resident, family member, staff, Nurse Practitioner and Medical Director, the facility failed to provide care in a safe manner for 2 of 6 residents reviewed for supervision to prevent accidents (Resident #114 and Resident #25). On 11/17/22, Resident #114's lower half of her body went off the other side of the bed during incontinence care resulting in a non-displaced, comminuted (bone that is broken in at least two places) proximal tibia-fibula (explain) fracture of the right leg. The facility failed to investigate the injury and complete a root cause analysis and as a result no plan was in place to prevent further injury to residents. On 11/25/22, Resident #25 who required two staff member assistance with bed mobility, fell out of a raised bed onto the floor during incontinence care which resulted in a closed fracture of the left tibial plateau, a closed fracture of the right femur, and a closed traumatic fracture of the left tibial plafond (end of the shin bone and involves the ankle joint). She complained of severe pain to both knees which was worsened by movement and alleviated by nothing. In addition, the facility failed to complete accurate smoking assessments to provide a safe smoking environment for 2 of 2 residents reviewed for smoking (Resident #16 and Resident #36).

During the recertification and complaint survey on 12/16/21, the facility failed to secure bleach used by a resident for personal use for 1 of 4 residents reviewed for accidents.

F812 - Based on observations and staff interview, the facility failed to label, date and seal open food items stored for use in 1 of 1 walk- in refrigerator

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F 867	Continued From page 59 and 1 of 1 reach in cooler. This practice had the potential to affect the food served to residents. During the recertification and complaint survey on 12/16/21, the facility failed to label and date opened food items, failed to store food in closed containers, failed to remove dented cans, failed to keep floor in dry storage free of debris for 1 of 1 dry storage rooms reviewed for food storage. An interview with the Administrator on 12/15/22 at 7:20 PM revealed the facility hadn't been able to implement procedures and monitor interventions put in place by the QAA committee due to changes in staffing and turn-over across all departments.	F 867		