STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345223	A. BUILDING _____ B. WING _____	C 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HILL HEALTH & REHAB CENTER	1510 HEBRON STREET HENDERSONVILLE, NC 28739

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E 000	Initial Comments An unannounced complaint investigation and recertification survey were conducted from 01/17/23 through 01/20/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# L5ON11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted on 01/17/23 through 01/20/23. Event ID #L5ON11. The following intakes were investigated: NC00192627, NC00192821, NC00194771, NC00196632. One of the six complaint allegations was substantiated and resulted in citation F684.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR), parenteral (nutrition administered by a route other than the mouth)/intravenous (through a vein) feeding, hospice and prognosis for 3 of 22 sampled residents reviewed for MDS accuracy (Resident #24, #59, and #178). Findings included: 1. Resident #24 was admitted to the facility on 12/16/14. Her diagnosis included dementia,	F 641	F641 Accuracy of Assessment 1. Facility was indicated to not have complete assessments on 3 of its Residents. On 1/19/2023 the Minimum Data Set nurse modified assessment for resident #24 dated 8/25/2022. Section A, pre admission screening for diagnosis of serious mental illness was updated. Resident #59 assessment dated 12/5/2022 was updated for two sections. Section K, no identified order for parental/IV feeding, and section O, did not reflect resident's election of hospice care	2/15/23

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

Electronically Signed | 02/13/2023

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F 641	Continued From page 1 bipolar disorder, schizophrenia, anxiety, and unspecified intellectual disabilities. Resident #24's PASRR Level II Determination Notification letter dated 12/16/14 indicated no end date. The significant change in status MDS assessment dated 08/25/22 indicated Resident #24 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability. During an interview on 01/19/23 at 3:06 PM, the Social Worker (SW) revealed she was responsible for completing the PASRR section on MDS assessments. The SW confirmed Resident #24 had a Level II PASRR determination. The SW explained it was an oversight and the MDS assessment dated 08/25/22 should have reflected Resident #24 had a Level II PASRR determination. A joint interview was conducted with the Administrator and Director of Nursing (DON) on 01/20/23 at 5:08 PM. The Administrator and DON both stated they would expect for MDS assessments to be completed accurately. 2. Resident #59 was admitted to the facility on 12/02/22. Her diagnoses included chronic obstructive pulmonary disease (trouble breathing), acute and chronic respiratory failure, and dementia. The admission Minimum Data Set (MDS) dated 12/05/22 revealed Resident #59 received Parental/Intravenous (IV) feeding while a resident at the facility.	F 641	while resident was receiving hospice. Resident #178 assessment dated 10/3/2022 was updated for one section. Section O, did not reflect resident's election of hospice care while resident was receiving hospice. All residents had the potential to be affected. 2. All assessments that were completed after January 1, 2023 were audited on 2/15/2023 by the director of nursing or designee to ensure accuracy of sections A, K, and O. No additional modifications were necessary. 3. The Director of Nursing provided education to the MDS nurse, the facility social worker and the registered dietician on accurate MDS assessment and documentation as it relates to resident cognition, diet and hospice services on 2/06/2023. All new staff in these roles will receive education upon hire. 4. The Director of Nursing will be responsible for the plan of correction. The Director of nursing will be responsible for a weekly audit to ensure each resident MDS assessment is accurate for sections A, K, O prior to submission. The audit will be completed weekly for 8 weeks. Audits will be reviewed in QA monthly and POC may be modified or audits extended to ensure ongoing compliance. 5. Completion date 2/15/2023	

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F 641	Continued From page 2	F 641		

Review of Resident #59's medical record revealed no physician order for Parental/IV feeding.

During an interview on 01/18/23 at 4:12 PM, the Registered Dietician (RD) stated since Resident #59's admission, she was not aware of her receiving Parental/IV feedings and there was no physician order. The RD confirmed Parental/IV feeding was marked received while a resident in error on Resident #59's MDS assessment dated 12/05/22.

During an interview on 01/19/23 at 2:46 PM, the MDS Nurse explained the RD completed the nutrition section of MDS assessments. The MDS Nurse reviewed Resident #59's physician orders and confirmed there was no order for Parental/IV feeding. She explained Parental/IV feeding was marked received while a resident in error on Resident #59's MDS assessment dated 12/05/22.

A joint interview was conducted with the Administrator and Director of Nursing (DON) on 01/20/23 at 5:08 PM. The Administrator and DON both stated they would expect for MDS assessments to be completed accurately.

3. Resident #178 was admitted to the facility on 09/27/22. Her diagnoses included hypertensive heart disease with heart failure and chronic obstructive pulmonary disease (trouble breathing).

The Hospice Care Agreement dated 09/23/22 revealed Resident #178 elected to receive hospice services effective 09/27/22.

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F 641	Continued From page 3 The admission Minimum Data Set (MDS) assessment dated 10/03/22 revealed Resident #178 did not have a life expectancy of less than six months and was not receiving hospice care. During an interview on 01/19/23 at 2:46 PM, the MDS Nurse reviewed Resident #59's medical record and confirmed she received hospice care effective 09/27/22. The MDS nurse stated hospice care and prognosis of life expectancy of less than 6 months should have been marked on the MDS assessment dated 12/05/22. A joint interview was conducted with the Administrator and Director of Nursing (DON) on 01/20/23 at 5:08 PM. The Administrator and DON both stated they would expect for MDS assessments to be completed accurately.	F 641		
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655		2/15/23

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F 655	Continued From page 4 (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete baseline care plans within 48 hours of admission to address the immediate needs for 2 of 22 sampled residents reviewed (Resident #4 and #59). Findings included: 1. Resident #4 was admitted to the facility on 12/23/22 with diagnoses that included chronic pain, dysphagia (difficulty swallowing), and history of falls.	F 655	F655- Baseline Care Plan 1. Facility failed to complete baseline care plans within 48 hours of admission to address immediate needs for resident #4 and #59. Care plans for resident□s #4 and #59 were reviewed and updated to appropriately reflect needs. All residents had the potential to be affected. 2. On 2/13/2023 the Regional Director of	

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F 655	Continued From page 5 Review of Resident #4's medical record revealed a comprehensive care plan was initiated on 12/23/22 in lieu of a baseline care plan. Care plans related to Nursing and Therapy were documented as completed on 01/05/23. Care plans related to Dietary needs were documented as completed on 01/11/23. Care plans related to Activities and Social Services had no documented completion date. During an interview on 01/19/23 at 2:46 PM, the Minimum Data Set (MDS) Nurse stated usually when a resident was admitted, a baseline assessment was initiated and then she completed the comprehensive care plan. The MDS Nurse explained she was out of work approximately 2 weeks the end of December 2022 and was not sure why a baseline care plan was not initiated for Resident #4. A joint interview was conducted with the Interim Director of Nursing and Administrator on 01/20/23 at 5:08 PM. The Administrator stated the MDS Nurse was responsible for completing baseline care plans and she expected them to be completed within 48 hours of the resident's admission. 2. Resident #59 admitted to the facility on 12/02/22 with diagnoses that included chronic obstructive pulmonary disease (trouble breathing), heart disease, acute and chronic respiratory failure. Review of Resident #59's medical record revealed a care plan was initiated on 12/02/22 in lieu of a baseline care plan. Care plans related to Social Services were documented as completed	F 655	Clinical Services audited baseline care plans for each admission after January 1, 2023. There were three residents admitted during the look back period that had base line care plans that were initiated after the 48 hour time requirement. The three additional residents care plans were reviewed and updated as appropriate. All other residents baseline care plans were initiated timely. 3. All nurses were educated by the Director of Nursing or designee by 2/10/2023 on initiating a baseline care plan within 48 hours of admission for each resident. The admitting nurse will be responsible for initiating the base line care plan for each new resident. Newly hired licensed nurses will be educated on initiating a baseline care plan within 48 hours of admission. 4. The Director of Nursing will be responsible for this plan of correction. The Director of Nursing or designee will be responsible to ensure compliance with baseline care plans, the director of nursing or designee will complete audits on all new admissions to ensure that a 48 hour baseline care plan is in place. Audits will be completed 5 times per week for 2 weeks, 3 times per week for 2 weeks and weekly for 8 weeks. Audits will be reviewed in the Quality Assurance Performance Improvement meeting monthly. The plan of correction may be changed or audits extended to ensure ongoing compliance.	

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F 655	Continued From page 6 on 12/23/22. Care plans related to Activities, Dietary, Nursing, and Therapy were documented as completed on 12/28/22. During an interview on 01/19/23 at 2:46 PM, the Minimum Data Set (MDS) Nurse stated usually when a resident was admitted, a baseline assessment was initiated and then she completed the comprehensive care plan off of the baseline assessment. The MDS Nurse explained she was out of work approximately 2 weeks the end of December 2022 and was not sure why a baseline care plan was not initiated for Resident #59. A joint interview was conducted with the Interim Director of Nursing and Administrator on 01/20/23 at 5:08 PM. The Administrator stated the MDS Nurse was responsible for completing baseline care plans and she expected them to be completed within 48 hours of the resident's admission.	F 655	5. Completion date 2/15/2023	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Medical Director #1 interviews the facility	F 684	F684 Quality of Care	2/15/23

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F 684	Continued From page 7 failed to obtain treatment orders for 2 skin tears for 1 of 3 residents reviewed for skin conditions (Resident #68). Findings included: Resident #68 was admitted to the facility 12/21/22 with diagnoses including non-Alzheimer's dementia. Review of the admission Minimum Data Set (MDS) dated 12/27/22 revealed Resident #68 was severely cognitively impaired. An observation of Resident #68 on 01/17/23 at 03:24 PM revealed he had a dressing to his left elbow and a dressing to his right ring finger. An observation of Resident #68 on 01/19/23 at 08:36 AM revealed he had a dressing to his left elbow and a dressing to his right ring finger. Review of the facility's standing orders for skin tears read as follows: "Clean wound with wound cleanser. Approximate edges with steri-strips as possible. Apply a non-adherent pad and cover with occlusive dressing. Change dressing every 3-5 days and as needed for dislodgement or soiling." During an interview with Nurse #1 on 01/19/23 at 08:44 AM she confirmed she cared for Resident #68 on 01/18/23 and 01/19/23 on the 07:00 AM to 07:00 PM shift. She stated she was not aware of Resident #68 having dressings to his left elbow or right ring finger. During the interview Nurse #1 removed the dressing to Resident #68's right ring finger and an approximately half-inch linear skin tear was noted to the inner part of his finger.	F 684	1. Facility failed to have an appropriately obtained and transcribed order related skin issues. Nurse practitioner was notified on 1/19/2023 and an order was obtained for resident #68 to cleanse the area, pat dry and apply bacitracin and cover with dressing. All residents had the potential to be affected. 2. The director of nursing or designee conducted a skin audit on each resident in the facility by 2/6/2023 to ensure each resident with impaired skin integrity had an appropriate treatment order. No other skin areas that were without treatment orders were identified during the skin audit. 3. All licensed nurses will be educated by the director of nursing or designee by 2/6/2023 on obtaining and transcribing treatment orders for any new skin area identified. All newly hired licensed nurses will be educated on obtaining and transcribing treatment orders for any new skin areas identified. 4. The director of nursing or designee is responsible for this plan of correction. The director of nursing or designee will conduct a skin assessment on 5 randomly selected residents weekly for 12 weeks to ensure any impaired skin issues have appropriate treatment orders. The audits will be reviewed weekly in resident review and monthly in Quality Assurance Performance Improvement. The Quality Assurance Performance Improvement team may alter the plan of correction or	

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F 684	Continued From page 8 On 01/19/23 at 08:49 AM Nurse #1 removed the dressing from Resident #68's left elbow. A large round skin tear was noted to the outer part of Resident #68's elbow. Review of Resident #68's January 2023 Treatment Administration Record (TAR) revealed no treatment orders for dressing changes to the skin tears to his left elbow and right ring finger. An interview with Nurse #2 on 01/20/23 at 09:17 AM revealed she cared for Resident #68 on 01/17/23 on the 07:00 AM to 07:00 PM shift. She stated she was notified during report on 01/17/23 that Resident #68 had a skin tear to his left elbow and the dressing was changed by Nurse #3 at 06:00 AM on 01/17/23. Nurse #2 stated Resident #68 obtained a skin tear to his right ring finger on 01/17/23 and she put a dressing on his finger. Nurse #2 stated she should have contacted the Physician or Nurse Practitioner (NP) and obtained treatment orders for Resident #68's skin tears, but she got distracted by behaviors occurring on the unit and forgot to obtain treatment orders. A telephone interview with Nurse #3 on 01/20/23 at 01:17 PM revealed she cared for Resident #68 on 01/16/23 on the 07:00 PM to 07:00 AM shift. She stated near the end of her shift the morning of 01/17/23 a Nurse Aide (NA) told her the dressing to Resident #68's left elbow skin tear had come off and she replaced the dressing. Nurse #3 stated she told Nurse #2 about replacing the dressing to Resident #68's left elbow skin tear and Nurse #2 told her she would contact the Physician or NP to obtain a treatment order. She stated she did not know when or how Resident #68 received the skin tear to his left	F 684	extend the audits to ensure ongoing compliance. 5. Completion date 2/15/2023	

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F 684	Continued From page 9 elbow. An interview with Medical Director #1 on 01/20/23 at 03:01 PM revealed he had no concerns if nursing staff put an initial dressing on skin tears using standing orders but he expected nursing staff to put the orders in the computer so they could be signed by himself or a Nurse Practitioner (NP) and would appear on the resident's TAR. A joint interview with the interim Director of Nursing (DON) and Administrator on 01/20/23 at 05:17 PM revealed if nursing staff implemented standing orders for skin tears the orders should be placed in the computer so the orders could be signed by the Physician or NP and would appear on the resident's TAR to ensure the dressings were changed.	F 684		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician	F 712		2/15/23

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F 712	Continued From page 10 and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure physician visits were performed every 30 days for the first 90 days of admission and/or alternated with the Nurse Practitioner's visits every 60 days thereafter for 7 of 10 sampled residents reviewed for physician visits (Residents #3, #42, #58, #60, #177, #71, and #7). Findings included: 1. Resident #3 was admitted to the facility on 05/20/20. His diagnoses included heart failure, hyperlipidemia, and seizure disorder. The quarterly Minimum Data Set (MDS) dated 10/18/22 indicated Resident #3 had intact cognition. Review of Resident #3's Electronic Medical Record (EMR) revealed he was seen by Physician #2 on 01/28/22. There were no other progress notes of visits with Physician #2. Review of Resident #3's EMR revealed he was seen by Nurse Practitioner #1 01/18/22, 02/08/22, 03/01/22, 04/28/22, 05/19/22, 06/16/22, 07/21/22, 08/16/22, 10/25/22, and 12/08/22. During an interview on 01/20/23 at 11:54 AM, the Interim Director of Nursing (DON) revealed she spoke with Physician #2 on 01/19/23 and asked him if he had a list of the dates he had seen residents at the facility and Physician #2 told her	F 712	F712 Physician Visits-Frequency/Timeliness 1. Facility was indicated to have missed scheduled physician visits for seven residents. The Medical Director was scheduled and visited each of the residents affected. Resident #3 was seen on 1/19/2023, resident #43 was seen on 1/26/2023, resident #58 was seen on 2/1/2023, resident #60 was seen on 1/27/2023 and resident #7 was seen on 2/2/2023. Resident #177 expired 10/30/2022, and resident #71 expired 10/22/2022. All residents had the potential to be affected. 2. The Director of Nursing or designee reviewed each resident's medical record by 2/10/2023 to determine the last time each resident was assessed by the Medical Director. A schedule will be made to ensure any resident that has not been assessed by the Medical Director. 8 residents were scheduled to be seen by 2/15/2023. 3. Education will be provided to the Director of Nursing, Assistant Director of Nursing, unit manager and the Director of Medical Records by the Regional Director of Clinical Services by 1/31/2023. The Director of Medical Records will be responsible for maintaining a physician	

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F 712	Continued From page 11 he did not have a list. During a telephone interview on 01/20/23 at 12:30 PM, Physician #2 stated the only progress notes of his visits to the facility were the ones in the resident's EMR. Physician #2 stated he was aware of the regulation regarding frequency of visits. He explained the previous corporation did not have a medical record clerk that tracked when residents needed to be seen for regulatory visits in order to remind him. Physician #2 stated if his progress notes were not documented in the resident's EMR, then there were none and the resident had not been seen. During an interview on 01/20/23 at 5:15 PM, the Administrator stated she expected Physician #2 to follow the regulatory guidelines to ensure residents were seen as required and needed. 2. Resident #43 was admitted to the facility on 07/12/21. Her diagnoses included pneumonia due to COVID-19, congestive heart failure, diabetes, and vascular dementia. The significant change Minimum Data Set (MDS) dated 12/19/22 indicated Resident #43 had severe impairment in cognition. Review of Resident #43's Electronic Medical Record (EMR) revealed she was seen by Physician #2 on 01/07/22, 06/24/22, and 09/23/22. Review of Resident #43's EMR revealed she was seen by Nurse Practitioner #1 on 11/08/22, 11/29/22, 12/13/22, and 01/23/23. During an interview on 01/20/23 at 11:54 AM, the	F 712	visit schedule. Education will include physician assessment every 30 days for the first 90 days post admission and every 60 days thereafter. Any new hires in the above listed positions will be in serviced on maintaining physician visit schedules. 4. The Director of Nursing is responsible for this POC. The physician visit schedules will be audited weekly for 12 weeks by the Director of nursing or designee to ensure each resident is assessed by the physician no later than 10 days following the due date. Any issues will be reviewed by the Medical Director for follow up. The audits will be reviewed monthly in Quality Assurance Performance Improvement for the duration of the audits. The Quality Assurance team may alter the plan of correction or extend the audits to ensure ongoing compliance. 5. Completion Date 2/15/2023	

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Interim Director of Nursing (DON) revealed she spoke with Physician #2 on 01/19/23 and asked him if he had a list of the dates he had seen residents at the facility and Physician #2 told her he did not have a list.

During a telephone interview on 01/20/23 at 12:30 PM, Physician #2 stated the only progress notes of his visits to the facility were the ones in the resident's EMR. Physician #2 stated he was aware of the regulation regarding frequency of visits. He explained the previous corporation did not have a medical record clerk that tracked when residents needed to be seen for regulatory visits in order to remind him. Physician #2 stated if his progress notes were not documented in the resident's EMR, then there were none and the resident had not been seen.

During an interview on 01/20/23 at 5:15 PM, the Administrator stated she expected Physician #2 to follow the regulatory guidelines to ensure residents were seen as required and needed.

3. Resident #58 was admitted to the facility on 07/18/22. His diagnoses included diabetes, chronic kidney disease, and heart disease.

The quarterly Minimum Data Set (MDS) dated 12/09/22 indicated Resident #58 had severe impairment in cognition.

Review of Resident #58's Electronic Medical Record (EMR) revealed no evidence he was seen by Physician #2 or the Nurse Practitioner since his admission in July 2022.

During an interview on 01/20/23 at 11:54 AM, the Interim Director of Nursing (DON) revealed she

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spoke with Physician #2 on 01/19/23 and asked him if he had a list of the dates he had seen residents at the facility and Physician #2 told her he did not have a list.

During a telephone interview on 01/20/23 at 12:30 PM, Physician #2 stated the only progress notes of his visits to the facility were the ones in the resident's EMR. Physician #2 stated he was aware of the regulation regarding frequency of visits. He explained the previous corporation did not have a medical record clerk that tracked when residents needed to be seen for regulatory visits in order to remind him. Physician #2 stated if his progress notes were not documented in the resident's EMR, then there were none and the resident had not been seen.

During an interview on 01/20/23 at 5:15 PM, the Administrator stated she expected Physician #2 to follow the regulatory guidelines to ensure residents were seen as required and needed.

4. Resident #60 was admitted to the facility on 06/30/22. His diagnoses included mild protein-calorie malnutrition, and depression.

The quarterly Minimum Data Set (MDS) dated 12/03/22 indicated Resident #60 had moderate impairment in cognition.

Review of Resident #60's Electronic Medical Record (EMR) revealed he was seen by Physician #2 on 09/23/22. There were no other progress notes of visits with Physician #2.

Review the Nurse Practitioner #2's progress notes revealed Resident #60 was seen on 08/15/22, 08/29/22, 09/21/22, 10/10/22, 10/26/22,

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11/10/22, 11/28/22, and 12/08/22.

During an interview on 01/20/23 at 11:54 AM, the Interim Director of Nursing (DON) revealed she spoke with Physician #2 on 01/19/23 and asked him if he had a list of the dates he had seen residents at the facility and Physician #2 told her he did not have a list.

During a telephone interview on 01/20/23 at 12:30 PM, Physician #2 stated the only progress notes of his visits to the facility were the ones in the resident's EMR. Physician #2 stated he was aware of the regulation regarding frequency of visits. He explained the previous corporation did not have a medical record clerk that tracked when residents needed to be seen for regulatory visits in order to remind him. Physician #2 stated if his progress notes were not documented in the resident's EMR, then there were none and the resident had not been seen.

During an interview on 01/20/23 at 5:15 PM, the Administrator stated she expected Physician #2 to follow the regulatory guidelines to ensure residents were seen as required and needed.

5. Resident #177 was admitted to the facility on 01/07/22. Her diagnoses included congestive heart failure, diabetes, chronic kidney disease, anxiety disorder, and dementia.

The quarterly Minimum Data Set (MDS) dated 08/03/22 indicated Resident #177 had severe impairment in cognition.

Review of Resident #177's Electronic Medical Record (EMR) revealed she was seen by Physician #2 on 10/21/22. There were no other

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progress notes of visits with Physician #2.

Review of the Nurse Practitioner #2's progress notes revealed Resident #177 was seen on 08/31/22, 09/19/22, 10/03/22, and 10/17/22.

During an interview on 01/20/23 at 11:54 AM, the Interim Director of Nursing (DON) revealed she spoke with Physician #2 on 01/19/23 and asked him if he had a list of the dates he had seen residents at the facility and Physician #2 told her he did not have a list.

During a telephone interview on 01/20/23 at 12:30 PM, Physician #2 stated the only progress notes of his visits to the facility were the ones in the resident's EMR. Physician #2 stated he was aware of the regulation regarding frequency of visits. He explained the previous corporation did not have a medical record clerk that tracked when residents needed to be seen for regulatory visits in order to remind him. Physician #2 stated if his progress notes were not documented in the resident's EMR, then there were none and the resident had not been seen.

During an interview on 01/20/23 at 5:15 PM, the Administrator stated she expected Physician #2 to follow the regulatory guidelines to ensure residents were seen as required and needed.

6. Resident #71 was admitted to the facility 07/29/22 with diagnoses including diabetes and non-Alzheimer's dementia.

The admission Minimum Data Set (MDS) dated 08/08/22 revealed Resident #71 was severely cognitively impaired.

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Review of the Electronic Medical Record (EMR) revealed Resident #71 was seen by the Physician on 07/29/22 and had not seen by the Physician since that date.

Review of Resident #71's EMR revealed no documentation that he was seen by a Nurse Practitioner (NP) during his stay at the facility.

A telephone interview with NP #2 on 01/19/23 at 05:07 PM revealed she began coming to the facility around the end of July 2022 or the first of August 2022. She checked her notes and stated if she had seen Resident #71, she would have written a note and she had no documentation that she evaluated Resident #68 during his stay in the facility.

During an interview on 01/20/23 at 11:54 AM the interim Director of Nursing (DON) revealed she spoke with Medical Director #2 on 01/19/23 and asked him if he had a list of the dates he had seen residents at the facility and Medical Director #2 told her he did not have a list.

A telephone interview with Medical Director #2 on 01/20/23 at 12:30 PM revealed the only notes of his visits to the facility were contained in the EMR and if there were no notes in the EMR the resident had not been seen. Medical Director #2 stated he was aware of the regulatory frequency of Physician visits, but the previous corporation did not have a medical records clerk that tracked when residents needed to be seen to remind him to see residents.

A joint interview with the interim DON and Administrator on 01/20/23 at 05:17 PM revealed they expected physicians to follow the regulation

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for frequency of visits to assure all residents were seen in a timely manner.

7. Resident #7 was admitted to the facility on 11/5/21 with diagnoses that included chronic obstructive pulmonary disease (COPD), hypertension, protein - calorie malnutrition, and dementia.

A Quarterly Minimum Data Set (MDS) dated 12/2/22 indicated Resident #7 was severely cognitively impaired.

A review of the Electronic Medical Record (EMR) revealed Resident #7 was seen by the physician on 11/12/21 and had not been seen by the physician since that date.

A review of the EMR revealed Resident #7 was seen by the nurse practitioner for 2021 on 11/8/21, 11/11/21, 11/16/21, 11/24/21, 11/29/21, 12/1/21, and 12/8/21.

Interview with the Interim Director of Nursing (DON) on 1/20/23 at 11:54 AM revealed she had spoken to the physician 1/19/23 and asked him if he had a list of dates that residents at the facility had been seen, but the physician told her he did not have a list.

Interview with the Medical Director (MD) #2 on 1/20/23 at 12:30 PM revealed the only notes of his visits to the facility were the ones in the EMR. MD #2 stated that the previous corporation did not have a medical record clerk that tracked when residents needed to be seen for regulatory visits so he could be reminded of who needed to be seen. MD #2 revealed he was aware of the regulatory frequency of visits. MD #2 stated if his

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F 712	Continued From page 18 notes were not documented in the EMR, then there were no notes and the resident had not been seen. Interview with the Administrator on 1/20/23 at 5:15 PM revealed she expected the MD would see residents per the guidelines from day #1 to assure they were seen in a timely manner.	F 712		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		2/15/23

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F 732	Continued From page 19 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain daily nurse staffing sheets for 68 of 122 days during the period reviewed of 09/01/22 to 12/31/22. The facility also failed to ensure the daily nurse staffing sheets were maintained for a minimum of 18 months. Findings included: Review of the daily nurse staffing sheets for September 2022 revealed no information was available for the days of 09/01/22 through 09/25/22. Review of the daily nurse staffing sheets for October 2022 revealed no information was available for the days of 10/21/22 through 10/31/22. Review of the daily nurse staffing sheets for November 2022 revealed no information was available for the days of 11/01/22 through 11/06/22, 11/19/22, 11/20/22, 11/22/22 through 11/27/22, and 11/29/22. Review of the daily nurse staffing sheets for December 2022 revealed no information was	F 732	F732 Posted Nurse Staffing Information 1. Facility failed to produce appropriate daily staffing posting records. The daily staff postings were reviewed for November 2022, December 2022 and January 2023 by the facility administrator on 1/31/2023. Any missing staff postings were completed using the facility payroll and staff schedule on 1/31/2023 2. On 2/10/2023 the facility administrator reviewed each daily staff posting since 1/20/2023 to ensure it had been completed and was accurate. There were no missing staff postings during the audit. 3. The administrator was educated by the Regional on 1/31/2023 on ensuring the daily staff postings are accurate, posted daily and maintained for 18 months. Any potential new hires in this position will be educated on daily posting and maintaining postings for 18 months. 4. The Administrator will be responsible for this POC. An audit starting January 13,	

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F 732	Continued From page 20 available for the days of 12/01/22, 12/3/22 through 12/07/22 and 12/21/22 through 12/31/22. During an interview on 01/20/23 at 3:10 PM, the Administrator revealed she was new to the facility as of November 2022 and currently responsible for the scheduling of staff until a permanent Director of Nursing was hired. The Administrator confirmed she was aware of the regulatory requirement to maintain 18 months of daily nurse staffing sheets. She explained a change in ownership occurred in November 2022 and she had only been able to locate the nurse staffing information from the previous ownership for the days of the months provided for September 2022 and October 2022. During a joint interview with the Director of Nursing (DON) on 01/20/23 at 5:08 PM, the Administrator explained ultimately, both she and the DON were responsible for ensuring the daily nurse staffing sheets were posted, accurate and maintained per regulation; however, once the Scheduler position was filled, they would be responsible for the daily posting and maintaining of nurse staffing sheets per regulation.	F 732	2023 will be completed by the Director of Nursing or designee and the daily staff postings will be reviewed 5 times a week for 12 weeks. Audit will be reviewed monthly in Quality Assurance Performance Improvement. The team may change the Plan of Correction or extend the audit to ensure ongoing compliance. 5. Date of completion 2/15/2023	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		2/15/23

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F 756	Continued From page 21 irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the Consultant Pharmacist, and Medical Doctor (MD), the Consultant Pharmacist failed to identify drug irregularities and provide recommendations for 1 of 1 resident reviewed for mood/behavior (Resident #60). The findings included:	F 756	F756 Drug Regimen Review, Report Irregular, Act On 1. Facility did not obtain appropriate labs related lithium levels for one resident. Pharmacy recommendation for resident #60 was provided to the Medical Director on 2/7/2023 by the Director of Nursing. A	

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F 756	Continued From page 22 Resident #60 was admitted to the facility on 06/30/22. His diagnoses included paranoid schizophrenia, and bipolar disorder. An active physician's order for Resident #60 dated 06/30/22 read, Lithium Carbonate (mood stabilizer) 300 milligrams (mg) two times a day related to bipolar disorder. The quarterly Minimum Data Set (MDS) dated 12/03/22 indicated Resident #60 had moderate impairment in cognition. The Medication Administration Records (MAR) for October 2022, November 2022, December 2022, and January 2023 revealed Resident #60 received Lithium Carbonate twice daily as ordered except when refused. Review of Resident #60's medical record revealed there were no lab results for lithium level since his admission in June 2022. Review of Resident #60's medical record revealed monthly Medication Regimen Reviews (MMR) were completed by the Consultant Pharmacist on the following dates: 07/31/22 with recommendations, 08/31/22 with no recommendations, 09/30/22 with recommendations, 10/30/22 with no recommendations, 11/30/22 with no recommendations and 12/30/22 with no recommendations. During a phone interview on 01/20/23 at 2:32 PM, the Consultant Pharmacist revealed for residents who were 65 years of age and older and taking Lithium, the recommendation would be to monitor lithium levels every 2 months. The Consultant	F 756	lithium level was obtained on 2/7/2023 and the results were presented to the Medical Director. There were no new orders for resident #60. All residents had the potential to be affected. 2. All pharmacy recommendations for the month of December 2022 and January 2023 were audited by the Director of Nursing by 2/14/2023 to ensure each recommendation has been acknowledged by the Medical Director or Nurse Practitioner. No additional recommendations were necessary. 3. Education was provided to the Director of Nursing and the Administrator on 1/31/2023 by the Regional Director of Clinical Services on Monthly Pharmacy Recommendations, timely follow up and use of Omniview to access monthly reports when necessary. The Director of Nursing will be responsible for ensuring the pharmacy recommendations are completed monthly. Any newly hired Director of Nursing or Administrator will be in serviced on monthly pharmacy recommendations, timely follow up and use of Omniview to access monthly reports when necessary. 4. The Director of Nursing is responsible for this plan of correction. The director of nursing or designee will audit the pharmacy recommendations for three months using the report provided to the facility by Omnicare. The audits will be reviewed monthly in the facility Quality Assurance Performance Improvement	

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F 756	Continued From page 23 Pharmacist explained the previous corporation had a lot of turnover in staff and for awhile when he resubmitted recommendations in follow-up, it created a lot of duplication so he started following up verbally with the Director of Nursing (DON). The Consultant Pharmacist recalled he submitted a recommendation in July 2022 to obtain a lithium level for Resident #60 and remembered being told by the DON the lab was obtained; however, the lab results had not been scanned into Resident #60's medical record. He added the recommendation for Resident #60 from July 2022 was still open. The Consultant Pharmacist explained the recommendation made in September 2022 for Resident #60 was for clarification of a Tylenol medication order that was addressed. During a phone interview on 01/20/23 at 12:30 PM, the MD stated for residents who were taking lithium, levels for monitoring were typically done every 3 to 6 months. The MD was unaware lithium levels had not been obtained on Resident #60 since his admission in June 2022. The MD stated he relied on the Consultant Pharmacist to remind him when lab work needed to be obtained and did not recall receiving any recommendations from the Consultant Pharmacist for Resident #60. During a joint interview with the Administrator on 01/20/23 at 5:08 PM, the Interim DON stated she expected for pharmacy recommendations to be reviewed, addressed and sent back to the Consultant Pharmacist prior to the next monthly MRR. During a joint interview with the Interim DON on 01/20/23 at 5:08 PM, the Administrator stated she would have expected for there to have been	F 756	meeting. The plan of correction may be modified or extended by the Quality Assurance team if necessary to ensure ongoing compliance. 5. Date of Completion 2/15/2023	

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F 756	Continued From page 24 physician orders to monitor Resident #60's lithium levels and labs obtained per the manufacturer's guidelines and/or physician's order.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Consultant Pharmacist, and Medical Doctor (MD), the facility failed to monitor lithium levels for 1 of 1 resident reviewed for mood/behavior (Resident #60). Findings included:	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1. Facility did not obtain appropriate labs related lithium levels for one resident. Pharmacy recommendation for resident #60 was provided to the Medical Director	2/15/23

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F 757	Continued From page 25	F 757		

Resident #60 was admitted to the facility on 06/30/22. His diagnoses included paranoid schizophrenia, and bipolar disorder.

An active physician's order for Resident #60 dated 06/30/22 read, Lithium Carbonate (mood stabilizer) 300 milligrams (mg) two times a day related to bipolar disorder.

The Medication Administration Records (MAR) for October 2022, November 2022, December 2022, and January 2023 revealed Resident #60 received Lithium Carbonate twice daily as ordered except when refused.

The quarterly Minimum Data Set (MDS) dated 12/03/22 indicated Resident #60 had moderate impairment in cognition.

Review of Resident #60's medical record revealed there were no lab results for lithium level since his admission in June 2022.

During a phone interview on 01/20/23 at 2:32 PM, the Consultant Pharmacist revealed for residents who were 65 years of age and older and taking Lithium, the recommendation would be to monitor lithium levels every 2 months.

During a phone interview on 01/20/23 at 12:30 PM, the Medical Doctor (MD) stated for residents who were taking lithium, levels for monitoring were typically done every 3 to 6 months. The MD was unaware lithium levels had not been obtained on Resident #60 since his admission in June 2022. The MD stated he relied on the Consultant Pharmacist to remind him when lab work needed to be obtained and did not recall receiving any recommendations from the Consultant

on 2/7/2023 by the Director of Nursing. A lithium level was obtained on 2/7/2023 and the results were presented to the Medical Director. There were no new orders for the resident #60. All residents had the potential to be affected.

2. All pharmacy recommendations for the month of December 2022 and January 2023 were audited by the Director of Nursing by 2/14/2023 to ensure each recommendation has been acknowledged by the Medical Director or Nurse Practitioner. No new recommendations necessary.

3. Education was provided to the Director of Nursing and the Administrator on 1/31/2023 by the Regional Director of Clinical Services on Monthly Pharmacy Recommendations, timely follow up and use of Omniview to access monthly reports when necessary. The Director of Nursing will be responsible for ensuring the pharmacy recommendations are completed monthly. Any new Director of Nursing or Administrator will be in serviced on monthly pharmacy recommendations.

4. The Director of Nursing is responsible for this plan of correction. The Director of Nursing or designee will audit the pharmacy recommendations for three months using the report provided to the facility by OmniCare. The audits will be reviewed monthly in the facility Quality Assurance Performance Improvement meeting. The plan of correction may be

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F 757	Continued From page 26 Pharmacist for Resident #60. During a joint interview with the Administrator on 01/20/23 at 5:08 PM, the Interim Director of Nursing (DON) stated she expected for pharmacy recommendations to be reviewed, addressed and sent back to the Consultant Pharmacist prior to the next monthly Medication Regimen Review (MRR). During a joint interview with the Interim DON on 01/20/23 at 5:08 PM, the Administrator stated she would have expected for there to have been physician orders to monitor Resident #60's lithium levels and labs obtained per the manufacturer's guidelines and/or physician's order.	F 757	modified or extended by the Quality Assurance team if necessary to ensure ongoing compliance. 5. Completion date of 2/15/2023	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		2/15/23

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F 758	Continued From page 27 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Medical Director #2 interview, and facility Pharmacy Consultant interview the facility failed to ensure an as needed (PRN) psychotropic medication (medication that affects the brain and mental processes) was limited to 14 days or document the rationale (reason) and duration for continued use for 1 of 5 residents reviewed for unnecessary medications (Resident #33).	F 758	F758 Free from Unnecessary Psychotropic Meds/prn Use 1. Facility failed to obtain a stop date for a as needed psychotropic medication. The Director of Nursing notified the Medical Director for resident #33 on 2/7/2023 and the MD added a 14 day stop date to the Lorazepam 2mg/ml. All	

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F 758	Continued From page 28 Findings included: Resident #33 was admitted to the facility 09/18/19 with diagnoses including seizure disorder. Review of Resident #33's Physician orders revealed an order dated 03/02/22 for lorazepam (a medication that can treat seizures) 2 milligrams (mg) per milliliter (ml) intramuscular (an injection in the muscle) every 5 minutes prn for seizure activity-do not exceed 2 doses. The order did not contain a stop date. Review of Resident #33's Medication Administration Record (MAR) from August 2022 through January 2023 revealed he had not received any doses of lorazepam. An interview with Medical Director #2 on 01/20/23 at 12:12 PM revealed he did not recall receiving a pharmacy recommendation prompting him to limit Resident #33's prn lorazepam order to 14 days or to provide a rationale and extend the duration of the order past 14 days. He stated it was important for Resident #33 to have a prn lorazepam order, but the order should have a stop date. During an interview with the Pharmacy Consultant on 01/20/23 at 04:02 PM he confirmed he performed monthly medication reviews for Resident #33. He stated he should have prompted Medical Director #2 to put a stop date on Resident #33's prn lorazepam. The Pharmacy Consultant stated since the prn lorazepam was ordered for seizures and the new regulations requiring either a 14 day stop date or a rationale for a longer duration did not come into effect until October 2022, it was an oversight that he did not	F 758	residents with as needed psychotropic medications had the potential to be affected. 2. An audit was completed of all current resident medication orders to ensure there were no current as needed psychotropic medication orders that were ordered beyond 14 days without a rational for continued use from the attending physician or prescribing practitioner. This audit was completed by the Director of Nursing or designee on 1/31/2023. All opportunities were corrected by the administrative nurses by 2/3/2023. 3. Licensed nurses will be re-educated on ensuring that any as needed order for psychotropic medication received from the attending physician or prescribing practitioner will be given an automatic 14 day stop date. It will be the responsibility of the nurse in charge to notify the attending Medical Director or Nurse Practitioner that a rational will be required to continue to as needed psychotropic medication beyond the 14 days. This training was completed by the Director of Nursing or designee by 2/6/2023. Any new licensed nurses will be in serviced on ensuring that any as needed order for psychotropic medication received will be given a 14 day stop date and will a rational will be required to continue as needed psychotropic medications beyond the 14 days. 4. The Director of Nursing or designee	

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F 758	Continued From page 29 request a stop date from Medical Director #2. During a joint interview with the interim Director of Nursing (DON) and Administrator on 01/20/23 at 05:17 PM they stated they expected the pharmacy to prompt the Physician to put a stop date on prn lorazepam orders or provide a rationale for extending prn use past 14 days.	F 758	will be responsible for this plan of correction. The clinical dashboard along with the order listing report will be audited 5 times a week for 12 weeks to ensure each new as needed psychotropic medication has a 14 day stop date. Any opportunities identified will be reported to the Medical Director or Nurse Practitioner for follow up. Audits will be reviewed weekly in resident review and monthly Quality Assurance Performance Improvement. The plan of correction may be altered, and the audits extended by the Quality Assurance team to endure ongoing compliance. 5. Date of compliance 2/15/23	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff the facility failed to ensure the snack provided was the correct texture for a resident with a physician's order for mechanical soft food for 1 of 4 residents reviewed for nutrition (Resident #54). The findings included: Resident #54 was admitted to the facility on 09/28/22 with diagnoses including	F 805	F805 Food in Form to meet individual needs 1. Resident #54 was indicated to have an altered diet. Resident #54 was given a pretzel during an activity. Pretzels were removed from resident #54 by the Activity Assistant on 1/17/2023. A respiratory assessment was completed on resident #54 by the unit manager on 2/10/2023 with no respiratory distress indicated. The	2/16/23

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F 805	Continued From page 30 cerebrovascular accident and debility. A review of the physician's order written on 11/12/22 revealed Resident #54 received a regular diet with directions to provide food of a mechanical soft texture and thin liquids. A review of the quarterly Minimum Data Set dated 01/04/23 assessed Resident #54 as having moderately impaired cognition and needed supervision with setup for eating. A review of the care plan revised on 01/04/23 revealed Resident #54 had the potential for problems with nutrition. Interventions included serve diet as ordered, observe for signs of pocketing, choking, coughing, and holding food in mouth. During an observation and interview on 01/17/23 at 4:22 PM Resident #54 was sitting in the activity room intermittently coughing. Resident #54 was not actively eating or holding a pretzel and her face and lip color were pink. When asked if Resident #54 was okay, the Activity Assistant stated she just gave her some pretzels and water to drink but thought she wasn't supposed to. The Activity Assistant removed a snack size bag of pretzels located on the table and within reach of Resident #54. During an interview on 01/17/23 at 4:23 PM the Activities Director revealed Resident #54 received a mechanical soft diet with thin liquids and not supposed to have the pretzels. Review of a nurse progress note written on 1/17/23 revealed Resident #54's skin tone was normal and respirations unlabored and normal.	F 805	activity assistant was educated by the Life Enrichment Director regarding altered diets on 1/25/2023. All residents with altered diets had the potential to be affected. 2. On 2/10/2023 the Unit Manager assessed each resident in the facility that was receiving an altered diet for signs of respiratory distress. No concerns identified during the assessments. 3. The speech therapist was educated by the Director of nursing or designee on 2/16/2023 on distributing an updated diet list weekly and keeping it updated when diets change. The list will be kept at each nursing station and the main dining room. All staff were educated by the Director of Nursing or designee on verifying a resident□s diet order prior to distributing snacks or other food items by 2/16/2023. All new staff will be in serviced on verifying a resident□s diet prior to offering food. 4. The Administrator is responsible for this plan of correction. Resident activities involving food will be audited by the administrator or designee 5 times per week for 2 weeks then 3 times per week for 2 weeks and weekly for 8 weeks to ensure diet orders are being followed. The audits will be reviewed by the Quality Assurance Performance Improvement team monthly. The plan of correction may be changed and or audits extended to ensure ongoing compliance.	

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F 805	Continued From page 31 Lung sounds were clear on inspiration and expiration. Review of a nurse progress note written on 01/18/23 revealed Resident #54's skin tone was normal and respirations unlabored and normal. Lung sounds were clear on inspiration and expiration. During an interview on 01/20/23 at 11:10 AM the Activity Assistant revealed Resident #54 said she was hungry and wanted a snack, so she gave the resident some pretzels to eat and some water to drink. The Activity Assistant revealed she was new to her position and didn't know Resident #54 and stated it was oversight and she should've asked about the resident's diet order before giving food. During an interview on 01/20/23 at 11:10 AM the Activities Director revealed the Activity Assistant started 3 days ago and was new to her position and hadn't received training on what to do when a resident asked for food. The Activities Director revealed there was training related to giving residents food during an activity, but she hadn't reviewed it with the Activity Assistant. An interview was conducted on 01/19/23 at 11:49 AM with Speech Therapist/Rehab Director. The Speech Therapist/Rehab Director stated the pretzel given to Resident #54 wasn't the texture of a mechanical soft food and shouldn't be given to the resident. The Speech Therapist/Rehab Director revealed giving pretzels to Resident #54 increased the risk of choking. The Speech Therapist/Rehab Director revealed she had received multiple reports from staff Resident #54 often coughed when eating.	F 805	5. Completion Date 2/16/2023	

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F 805	Continued From page 32 An interview was conducted on 01/20/23 at 5:07 PM with the Director of Nursing (DON) and Administrator. The DON and Administrator stated they would expect the Activities Assistant to ask before giving a resident she didn't know any type of food or drink.	F 805		
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 by: Based on observations and staff interviews the facility failed to discard expired food items available for resident use in 1 of 1 walk-in coolers; maintain a clean walk-in cooler floor by preventing accumulation of food debris and dried white material in 1 of 1 walk-in coolers; label and date food stored in 1 of 1 walk-in coolers;	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. Expired food items were identified and the walk in cooler and nourishment room refrigerators. Meat was observed to be thawing in a manner contrary to facility	2/15/23

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F 812	Continued From page 33 maintain a clean and sanitary kitchen floor; safely defrost frozen food to prevent the potential for bacterial growth; label and date food in 1 of 2 nourishment room refrigerators (East Wing nourishment room); and maintain a clean refrigerator by preventing accumulation of dried white material in 1 of 2 nourishment room refrigerators (Life Enrichment Unit nourishment room). This practice had the potential to affect food served to the residents. Findings included: 1. An initial observation of the walk-in cooler on 01/17/23 at 09:32 AM revealed pieces of lettuce and carrots on the floor and dried white material to the floor, an opened and undated 5-pound container of tuna salad with an expiration date of 01/11/23, an opened and undated 5-pound container of cottage cheese with an expiration date of 12/25/22, an opened gallon of buttermilk with an expiration date of 01/11/23, and 7 unlabeled and undated bowls of salad. 2. An initial observation of the kitchen floor on 01/17/23 at 09:40 AM revealed crumbs across the entire floor and a white powder-like substance to the floor near the steamer. 3. An observation of the 3-compartment sink on 01/17/23 at 09:42 AM revealed a 5-pound pack of hamburger meat sitting in lukewarm water in the middle section of the 3-compartment sink. There was no running water covering the thawed meat. 4. An observation of the 3-compartment sink on 01/17/23 at 09: 43 AM revealed a metal pan of water containing two 5-pound packs of hamburger meat and four 5-pound packs of beef	F 812	policy. Floor in the walk in cooler, kitchen floors and refrigerators in the pantries were observed to be soiled. On 1/17/23 the Dietary Manager discarded expired food items for resident use from the walk-in coolers and nourishment room refrigerators. Any inappropriately defrosted meat was discarded. The walk in cooler, nourishment room refrigerators and kitchen floors were cleaned. All residents had the potential to be affected. 2. Food in walk-in cooler and nourishment refrigerators was checked immediately by the dietary manager for appropriate dates on 1/17/2023. On 1/17/23 the dietary manager reviewed the cleaning schedule for kitchen floors, coolers, and refrigerators and the policy for thawing meat for use in the facility. All opportunities were corrected by the Dietary Manager by 1/17/2023. 3. Dietary staff were in serviced on 1/18/23 by the Dietary Manager on storage and dating of refrigerated food for resident use; Dietary staff were in serviced on 1/18/23 on policy for thawing frozen foods; Dietary staff were in serviced on the cooler/refrigerator and floor cleaning schedule. All new dietary staff will be in serviced on storage and dating of refrigerated food for resident use, policy for thawing frozen foods, cooler/refrigerator and floor cleaning schedule. 4. The Dietary Manager is responsible	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 34 tips sitting in the left compartment of the sink. There was no running water covering the partially thawed meat. An interview with the Dietary Manager (DM) on 01/17/23 at 10:20 AM revealed the floors of the kitchen and walk-in cooler were supposed to be swept and mopped each evening but she worked the night of 01/16/23 and did not have time to sweep and mop the floor that night. She stated she expected food to be dated when it was opened and used or discarded before expiration date. The DM stated the bowls of salad should have been labeled and dated when they were placed in the walk-in cooler and she did not know when the bowls of salad were placed in the cooler. The DM stated she placed the 5-pound pack of ground beef in the middle of the 3-compartment sink and the two 5-pound packs of ground beef and four 5-pound packs of beef tips in the left compartment of the sink the morning of 01/17/23 and turned on a stream cold water to thaw the meat. She stated a new employee must have come behind her and turned the water off. The DM discarded the ground beef that was thawed in the middle compartment of the sink. A follow-up interview with the DM on 01/19/23 at 10:57 AM revealed she became the DM on 12/24/22. She stated the DM was responsible for checking expiration dates daily, but she had been working double shifts for the past 7 days and was helping out as a cook or dietary aide on 01/17/23 because she had 2 staff members that were out due to illness. The DM stated not discarding or removing the expired food from the walk-in cooler on or before the expiration date was an oversight. The DM stated ideally the meat should have been	F 812	for this plan of correction. To monitor for compliance the Dietary Manager or designee will audit the nourishment room and kitchen refrigerators to assure all items are labelled and dated appropriately. Kitchen floors and walk-in refrigerator floors will be audited by the Dietary manager or designee to assure cleanliness. Meats that are in the process of thawing will be audited for appropriate thawing practices. All audits will be conducted 5 times per week for two weeks, then 3 times per week for 2 weeks, then 1 time per week for 8 weeks. The audits will be reviewed monthly in Quality Assurance Performance Improvement meeting. The plan of correction may be changed and or the audits may be extended to ensure ongoing compliance. 5. Completion date 2/15/23	

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	345223	A. BUILDING _____ B. WING _____	C 01/20/2023

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F 812	Continued From page 35	F 812		

placed in the cooler to thaw the evening of 01/16/23, but since it wasn't it should have been thawed by being placed under a continuous stream of cold water.

5. An observation of the refrigerator in Life Enrichment Unit nourishment room on 01/20/21 at 09:31 AM revealed a large amount of a dried white substance on the top shelf of the refrigerator.

6. An observation of the East Wind nourishment room freezer on 01/20/23 at 09:37 AM revealed an opened and unlabeled/undated bottle of tea and an opened and unlabeled/undated bottle of cranberry apple juice.

An additional interview with the DM on 01/20/23 at 09:43 AM revealed the nourishment room refrigerators should be cleaned daily and all food and drink in nourishment room refrigerators and freezers should have a label with the resident's name, room number, and date placed in refrigerator. She stated the nourishment room refrigerators and freezers should be checked for cleanliness and undated or unlabeled items by kitchen staff daily and she had not had a chance to clean the nourishment room refrigerator or check for unlabeled/undated items in the freezer on 01/20/23.

An interview with the Administrator on 01/20/23 at 05:17 PM revealed she expected all food to be used or discarded by the expiration date, kitchen and cooler floors should be cleaned after each meal and at the end of each day, food stored in the walk-in cooler should have a prep and use-by date, nourishment room refrigerators should be clean, all food and drinks in nourishment room

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F 812	Continued From page 36 refrigerators or freezers should be labeled and dated, and meat should be thawed properly to avoid potential contamination and foodborne illness.	F 812		
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff the facility failed to ensure the Activity Assistant was trained to review physician diet orders prior to giving a snack to a resident that received foods of a mechanical soft texture for 1 of 4 residents reviewed for nutrition (Resident #54). The findings included: A review of the physician's order written on 11/12/22 revealed Resident #54 received a regular diet with directions to provide food of a mechanical soft texture and thin liquids. During an observation and interview on 01/17/23 at 4:22 PM Resident #54 was sitting in the activity room intermittently coughing. Resident #54 was not actively eating or holding a pretzel and her face and lip color were pink. When asked if	F 839	F839- Staff Qualifications 1. Resident #54 was indicated to have an altered diet. Resident #54 was given a pretzel during an activity. Pretzels were removed from resident #54 by the Activity Assistant on 1/17/2023. A respiratory assessment was completed on resident #54 by the unit manager on 2/10/2023 with no respiratory distress indicated. The activity assistant was educated by the Life Enrichment Director regarding altered diets on 1/25/2023. All residents with altered diets had the potential to be affected. 2. On 2/10/2023 the Unit Manager assessed each resident in the facility that was receiving an altered diet for signs of respiratory distress. No concerns	2/16/23

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F 839	Continued From page 37 Resident #54 was okay, the Activity Assistant stated she just gave her some pretzels and water to drink but thought she wasn't supposed to. The Activity Assistant removed a snack size bag of pretzels located on the table and within reach of Resident #54. During an interview on 01/20/23 at 11:10 AM the Activities Director revealed the Activity Assistant just started and had worked 3 days at the facility. The Activities Director stated the training the Activity Assistant had received was based on activities and not related to food or what to do when a resident asked for food or drink. The Activities Director stated the training did include that information, but she hadn't reviewed it with the Activity Assistant. An interview was conducted on 01/20/23 at 5:07 PM with the Director of Nursing (DON) and Administrator. The DON and Administrator stated they would expect the Activities Assistant to ask before giving a resident she didn't know any type of food or drink.	F 839	identified during the assessments. 3. The speech therapist was educated by the Director of nursing or designee on 2/16/2023 on distributing an updated diet list weekly and keeping it updated when diets change. The list will be kept at each nursing station and the main dining room. All staff were educated by the Director of Nursing or designee on verifying a resident□s diet order prior to distributing snacks or other food items by 2/16/2023. This education will also be completed with all newly hired staff. 4. The Director of Nursing will be responsible for this plan of correction. Resident activities involving food will be audited by the administrator or designee 5 times per week for 2 weeks then 3 times per week for 2 weeks and weekly for 8 weeks to ensure diet orders are being followed. The audits will be reviewed by the Quality Assurance Performance Improvement team monthly. The plan of correction may be changed and or audits extended to ensure ongoing compliance. 5. Completion Date 2/16/2023	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		2/17/23

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F 842	Continued From page 38	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 39 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure Nurse Practitioner progress notes were maintained in residents' medical records for 2 of 10 sampled residents reviewed for physician visits (Residents #60 and #177). Findings included: 1. Resident #60 was admitted to the facility on 06/30/22. Review of Resident #60's Electronic Medical Record (EMR) for the period August 2022 to January 2023 revealed a physician progress note dated 09/23/22. There was no other evidence discovered in the EMR which documented Resident #60 was seen by the physician or Nurse	F 842	F842- Resident records- Failure to maintain records 1. Resident records for resident #177 and resident # 60 were incomplete in the electronic documents section of the patient record. The practitioner notes for Resident # 177 for 8/13/22, 9/19/22, 10/3/22 and 10/17/22 were located and uploaded into the Electronic Documents section of the Medical Record on 2/16/2023. The practitioner notes for resident #60 dated 8/15/22, 8/29/22, 9/21/22, 10/10/22, 10/26/22, 11/10/22, 11/28/22 and 12/8/22 were located and uploaded into the Electronic Documents section of the Medical Record on 2/16/2023. All residents had the potential	

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F 842	Continued From page 40 Practitioner #2 during that time frame. During an interview on 01/19/23 at 9:08 AM, the Interim Director of Nursing (DON) revealed she had discovered yesterday (01/18/23) there had been an integration issue between the physician's office and facility computer system. The Interim DON explained when the physician's office changed computer systems, there had been an issue with electronically sending the physician and Nurse Practitioner #2's progress notes from their computer system to the facility's computer system which resulted in the facility not receiving the progress notes when residents were seen. The Interim DON stated she spoke with the physician's office and the Nurse Practitioner to request the missing documentation. Review of email correspondence from Nurse Practitioner #2 to the Interim DON was provided by the Interim DON on 01/19/23 at 12:02 PM. The review revealed detailed progress notes from Nurse Practitioner #2's visits with Resident #60 on 08/15/22, 08/29/22, 09/21/22, 10/10/22, 10/26/22, 11/10/22, 11/28/22, and 12/08/22. During an interview on 01/20/23 at 5:15 PM, the Administrator stated she expected information such as Nurse Practitioner progress notes to be maintained in the resident's medical record. 2. Resident #177 was admitted to the facility on 01/07/22. Review of Resident #177's Electronic Medical Record (EMR) for the period August 2022 to January 2023 revealed a physician progress note dated 10/21/22. There was no other evidence discovered in the EMR which documented	F 842	to be affected. 2. A physician visit list was obtained from the attending physician and checked against the resident record. Any identified missing notes were uploaded into the electronic record by 2/17/2023. 3. The Director of Medical Records was educated by the facility administrator on 2/16/2023 on timely uploading of resident records and maintaining a schedule of Medical Director visits to ensure the medical records are uploaded for each visit. This education will be provided to any new medical records staff. 4. The Administrator is responsible for this plan of correction. To ensure ongoing compliance the director of nursing or designee will use the weekly physician visit list to audit that the medical records have been uploaded into the electronic documents section of the medical record. The audits will be reviewed in the monthly Quality Assurance Performance Improvement meeting. The plan of correction may be changed and or the audits may be extended to ensure ongoing compliance. 5. Completion date of 2/17/2023	

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F 842	Continued From page 41 Resident #177 was seen by the physician or Nurse Practitioner #2 during that time frame. During an interview on 01/19/23 at 9:08 AM, the Interim Director of Nursing (DON) revealed she had discovered yesterday (01/18/23) there had been an integration issue between the physician's office and facility computer system. The Interim DON explained when the physician's office changed computer systems, there had been an issue with electronically sending the physician and Nurse Practitioner #2's progress notes from their computer system to the facility's computer system which resulted in the facility not receiving the progress notes when residents were seen. The Interim DON stated she spoke with the physician's office and the Nurse Practitioner to request the missing documentation. Review of email correspondence from Nurse Practitioner #2 to the Interim DON was provided by the Interim DON on 01/19/23 at 12:02 PM. The review revealed detailed progress notes from Nurse Practitioner #2's visits with Resident #177 on 08/31/22, 09/19/22, 10/03/22, and 10/17/22. During an interview on 01/20/23 at 5:15 PM, the Administrator stated she expected information such as Nurse Practitioner progress notes to be maintained in the resident's medical record.	F 842		
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	F 867		2/15/23

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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 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

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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 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

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F 867	Continued From page 44 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 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 interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification and complaint survey conducted on 07/01/21. This was for two deficiencies in the areas of Drug Regimen/Review/Report Irregular/Act on (F756) and Food Procurement, Storage/Preparation/Serve under Sanitary Conditions (F812) originally cited on 07/01/21 and	F 867	F867 Quality Improvement Activities 1. Facility failed to maintain an effective Quality Assurance Performance Improvement process to implement systemic changes to effect: Drug Regimen Review, Expired Food, kitchen sanitization, Legionella testing and record maintenance. 2. Immediate in service on (F756) Drug	

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F 867	Continued From page 45 again on the current recertification and complaint survey of 01/20/23. Additionally, the QAA committee failed to maintain implemented procedures and monitor interventions put in place following the focused infection control and complaint survey conducted on 11/30/20. This was for one deficiency in the area of Infection Prevention and Control (F880) that was recited on the follow-up survey on 01/04/21, the recertification and complaint survey on 07/01/21, and the current recertification and complaint survey on 01/20/23.The duplicate citations during four federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: 1. This tag was cross referenced to: F756 Based on record review and interviews with staff, Consultant Pharmacist (CP), and Medical Doctor (MD), the CP failed to identify drug irregularities and provide recommendations for 1 of 1 resident reviewed for mood/behavior (Resident #60). During the recertification and complaint survey conducted on 07/01/22, the facility failed to implement an ordered pharmacy recommendation for 1 of 5 residents reviewed for unnecessary medications. F812- Based on observations and staff interviews the facility failed to discard expired food items available for resident use in 1 of 1 walk-in coolers; maintain a clean walk-in cooler floor by preventing accumulation of food debris and dried white material in 1 of 1 walk-in coolers; label and	F 867	Regimen Review, (F812) Food Procurement- expired food, kitchen sanitization, kitchen floors and floor in the walk-in cooler. (F880) Infection Control-Legionella, was completed with the Administrator and DON by the Regional Director of Operations. 3. Administrator and Director of Nursing were educated by the Regional Director of Operations on the appropriate QAPI process. Dietary staff were in serviced on 1/18/23 by the Dietary Manager on storage and dating of refrigerated food for resident use; Dietary staff were in serviced on 1/18/23 on policy for thawing frozen foods; Dietary staff were in serviced on the cooler/refrigerator and floor cleaning schedule. All new dietary staff will be in serviced on storage and dating of refrigerated food for resident use, policy for thawing frozen foods, cooler/refrigerator and floor cleaning schedule. Education was provided to the Director of Nursing and the Administrator on 1/31/2023 by the Regional Director of Clinical Services on Monthly Pharmacy Recommendations, timely follow up and use of Omniview to access monthly reports when necessary. The Director of Nursing will be responsible for ensuring the pharmacy recommendations are completed monthly. Any newly hired Director of Nursing or Administrator will be in serviced on monthly pharmacy	

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F 867	Continued From page 46 date food stored in 1 of 1 walk-in coolers; maintain a clean and sanitary kitchen floor; safely defrost frozen food to prevent the potential for bacterial growth; label and date food in 1 of 2 nourishment room refrigerators (East Wing nourishment room); and maintain a clean refrigerator by preventing accumulation of dried white material in 1 of 2 nourishment room refrigerators (Life Enrichment Unit nourishment room). This practice had the potential to affect food served to the residents. During the recertification and complaint survey conducted on 07/01/21, the facility failed to maintain a clean vent cover from an accumulation of dust on 1 of 2 ice machines. F880- Based on record review and staff interviews the facility failed to implement their policy and procedure for the assessment and prevention program of Legionella. Not implementing their policy had the potential to affect 72 residents currently residing at the facility. During the focused infection control and complaint survey on 11/30/20, the facility failed to 1) follow work criteria outlined in their policy and procedure related to staff not working if experiencing symptoms consistent with suspected Covid-19 and 2) failed to review the screening log for staff who documented yes to symptoms of Covid-19 and yes to the use of fever reducing medication and 3) failed to ensure a staff member was screened upon entrance and/or at the beginning of the shift prior to working with residents for 2 of 3 staff reviewed for screening. From 11/09/20 to 11/12/20, a total of 6 residents out of 82 and 3 staff have tested	F 867	recommendations, timely follow up and use of Omniview to access monthly reports when necessary. The Infection Control Preventionist educated all staff by 2/14/2023 on Legionella and the facility testing policy. The facility Infection Control Preventionist provided one on one education with the maintenance director and the test was performed on 2/13/2023. This education will be provided to all new staff. 4. The Administrator is responsible for this plan of correction. To monitor ongoing Quality Assurance Performance Improvement, the Regional Director of Clinical Services or the Regional Director of Operations will review monthly Quality Assurance Performance Improvement meeting to assure pertinent items are included and worked on monthly for 3 months. 5. Completion date 2/15/2023	

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F 867	Continued From page 47 positive for Covid-19. During the follow-up survey on 01/04/21, the facility failed to ensure dietary staff implemented the facility's infection control measures when dietary staff failed to wear a facemask that covered their mouth and nose while working in the kitchen. This failure occurred during a Covid-19 pandemic. During the recertification survey and complaint investigation on 07/01/21, the facility failed to ensure 3 visitors wore N-95 masks, goggles, and gowns while interacting with a resident on the quarantine unit who was not fully vaccinated for 1 of 2 residents reviewed for infection control. This failure occurred during a Covid-19 pandemic. An interview was conducted on 01/20/23 at 5:58 PM with the Administrator. The Administrator revealed since obtaining her position in November 2022 and the facility now under new ownership and change in the Medical Director the scheduled QAPI meetings were cancelled for December and January. The Administrator stated she had reviewed the citations from the previous survey on 07/01/21 but was not aware of the current issues identified in the kitchen or with the pharmacy reviews, and infection control.	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		2/17/23

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F 880	Continued From page 48	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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F 880	Continued From page 49 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement their policy and procedure for the assessment and prevention program of Legionella. Not implementing their policy had the potential to affect 72 residents currently residing at the facility. The findings included: Review of the facility's policy titled, "Legionella Assessment and Prevention Program" revised on 05/04/22 revealed the facility would ensure a Legionella Assessment was conducted in accordance with state and federal requirements. The policy indicated the Administrator would assign the person(s) responsible for completing the required Legionella Assessment and responsible for maintaining documentation of the	F 880	F880 Infection Control- Legionella 1. Facility was found to be untimely with Legionella testing. Facility ordered the test kit on 1/20/23 and the facility administrator assigned the legionella testing and record maintenance to the facility Maintenance Director. Facility Maintenance Director conducted a Legionella Assessment and Control Form on 2/14/23. All residents had potential to be affected. 2. No residents were affected by the lack of legionella testing. As of 2/13/2023 no resident displayed signs or symptoms of legionella. Root cause analysis was completed by the Facility administrator and the Infection Control Preventionist on	

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F 880	Continued From page 50 completed assessment. The policy included a form titled, "Legionella Assessment and Control." The form included information to identify the facility's water supply source either city or well and the type of disinfectant used to treat the water. Identify areas Legionella might grow such as any whirlpool spas or hydrotherapy tubs being used. Include a description or diagram of the facility's plumbing system and any ice machines used for consumption. An interview was conducted on 01/20/23 at 3:07 PM with the Maintenance Director. The Maintenance Director revealed he started his position with facility the middle of April 2022 and didn't have the Legionella Assessment and was unaware it was his responsibility to complete. The Maintenance Director revealed he didn't know what measures the facility had in place to identify areas Legionella might grow and spread or the measures to prevent the growth in the building. An interview was conducted on 01/20/23 at 05:49 PM with the Administrator. The Administrator revealed the Maintenance Director was assigned to complete the Legionella Assessment. The Administrator revealed the Maintenance Director was in his position when she started at the facility in November 2022 and assumed the assessment was done. The Administrator revealed she wasn't aware the Maintenance Director didn't know about the facility's policy and procedures for Legionella until it was brought to her attention during the survey.	F 880	1/31/23. It was determined that there was a lack of knowledge by the Facility Maintenance Director. The administrator was educated by the Regional Vice President of Operations on ensuring the maintenance director performs the test annually and results are discussed by the Quality Assurance Committee. Facility Maintenance Director conducted a Legionella Assessment and Control Form on 2/14/23. 3. The Infection Control Preventionist educated all staff by 2/14/2023 on Legionella and the facility testing policy. This education will be provided to all new staff. The facility Infection Control Preventionist provided one on one education with the maintenance director related to record maintenance and annual testing. Test was performed on 2/13/2023. This education will be provided to all new potential maintenance staff. 4. The Administrator is responsible for this plan of correction. The facility administrator will be responsible for ensuring the legionella testing is completed annually and records are maintained. The administrator will check weekly for the legionella results and present the results to the Quality Assurance Performance Improvement team for review once obtained. 5. Date of Compliance 2/17/2023	

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F 885	Continued From page 51	F 885		
F 885 SS=D	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed notify residents' representatives and family members by 5:00 PM the next calendar day when a confirmed case of Covid-19 was identified for 1 of 5 residents (Resident #224) reviewed for reporting. The findings included:	F 885	F885 COVID-19 notification 1. Facility failed to timely notify family and residents of any new outbreak of Covid-19 per Center for Medicare and Medicaid Services guidelines. Facility re-group electronic messaging system was re-activated on 1/31/2023 so the administrator would have the ability to	2/15/23

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F 885	Continued From page 52 Review of the facility's Covid-19 testing log revealed Resident #224 received a positive result on 01/09/23. Review of the system put in place to inform Family Members (FM) and residents' Responsible Parties (RP); a positive case of covid-19 was identified revealed a letter was mailed on 01/09/23 when Resident #224 tested positive. The letter was signed by the Administrator. Review of the system in place to inform residents, Family Members (FM), and their Responsible Parties (RP), a positive case of covid-19 was identified revealed a letter was mailed when Resident #224 tested positive on 01/09/23. The letter was dated 01/09/23 and identified one resident was diagnosed with covid-19 and signed by the Administrator. An interview was conducted on 01/18/23 at 4:58 PM with the Administrator. The Administrator revealed a letter was mailed to FMs and the residents RP to inform them a positive case of Covid-19 was identified in the facility on 01/09/23. The Administrator revealed the facility had an automated phone service in place for notification, but she was unable to get it to function when Resident #224 tested positive for Covid-19. The Administrator stated the letter probably didn't get to all FMs and RPs by 5:00 PM the next calendar day. An interview was conducted on 01/20/23 at 5:10 PM with the Director of Nursing (DON) and Administrator. The DON revealed the process used to inform FMs and the RPs on 01/09/23 was to send a letter when the automated phone system didn't work. The DON stated the facility	F 885	send mass notification for each new positive COVID-19 case and an electronic message was sent by 5:00 PM the following business day. All residents had the potential to be affected. 2. On 2/14/2023 the facility administrator communicated to each resident and responsible party via electronic message system and in person, informing them of all positive COVID-19 cases since January 20, 2023. 3. The Director of Nursing, Infection Control Preventionist and the Administrator were re-educated by the Regional Director of Clinical Services on 1/31/2023 on ensuring notification is sent with each new positive resident and staff member per company policy and that the administrator will maintain proof the notification. Both Director of Nursing and Infection preventionist were added to the electronic messaging system. Cognitively intact residents will be notified of each new Covid-19 case by facility leadership team. This education and access will be provided to any new hires in these roles. 4. The Administrator will be responsible for this plan of correction. The COVID-19 testing list will be audited 5x week in Clinical Morning Meeting for 12 weeks to ensure notification was made according to the regulatory requirement. Any COVID-19 case that is identified as not being reported will be reported immediately upon facility identification.	

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F 885	Continued From page 53 could've called the residents' FMs and RPs. The Administrator stated in retrospect team members should've been delegated to call and inform FMs and the RPs to ensure they were notified of an identified Covid-19 case by 5:00 PM the next calendar day instead of sending the letter.	F 885	Audits will be reviewed monthly in Quality Assurance Performance Improvement meeting. The plan of correction may be altered, or audits extended to ensure ongoing compliance. 5. Date of Completion is 2/15/2023.	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.	F 886		2/15/23

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F 886	Continued From page 54 §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to retain documentation in the resident's medical record to include the date covid-19 testing was completed and the results for 5 of 5 residents reviewed for covid-19 (Resident #3, #15, #33, #54, and #60).	F 886	F886- Covid Testing 1. Facility failed to accurately document Covid-19 testing in the electronic medical record. A nursing note was entered for residents #3, #15, #33, #54, and #60 on	

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F 886	Continued From page 55 The findings included: Review of the facility's Infection Prevention and Control Policy revised on 12/23/22 included guidance for tracking, reporting, and documentation. The facility's policy for documentation was to retain test results in the resident's medical record. Review of the facility's tracking of covid-19 positive results revealed on 11/06/22 a positive case was identified. From 11/06/22 through 11/15/22 fourteen residents and six staff members tested positive. Resident #3 was admitted to the facility on 05/12/20. Resident #3's medical records revealed no covid-19 test results from 11/06/22 through 11/15/22. Resident #15 was admitted to the facility on 01/10/20. Review of Resident #15's medical records revealed no covid-19 test results from 11/06/22 through 11/15/22. Resident #33 was admitted to the facility on 09/18/19. Review of Resident #33's medical records revealed no covid-19 test results from 11/06/22 through 11/15/22. Resident #54 was admitted to the facility on 09/28/22. Review of Resident #54's medical records revealed no covid-19 test results from 11/06/22 through 11/15/22. Resident #60 was admitted to the facility on 06/30/22. Review of Resident #60's medical records revealed no covid-19 test results from	F 886	2/15/2023 by the Director of Nursing for the date the COVID-19 test was performed as well as the test result. Covid-19 testing lists beginning November 1, 2022 was reviewed and appropriately documented in the electronic medical record, and validated by the Director of Nursing. All residents have the potential to be affected. 2. Facility is unable to produce a complete list of residents that have been tested for COVID prior to survey exit due to lack of records provided by prior ownership. Any COVID test that were performed after 1/20/2023 have been documented in the electronic Medical Record and validated by the Director of Nursing. 3. The Infection Control Preventionist educated all licensed nurses on ensuring COVID testing, and results are entered in to the electronic medical record by 2/15/2023. This education will provided to all newly hired licensed nurses. 4. The Director of Nursing will be responsible for this plan of correction. The Director of Nursing or designee will audit the COVID-19 test list and the contact tracing log 5x week for 12 weeks to ensure the test and results are accurately entered into the electronic medical record. Any test not documented will be corrected in the electronic medical record and reeducation will be provided to the nurse. The audits will be reviewed in Quality	

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F 886	Continued From page 56 11/06/22 through 11/15/22. A telephone interview was conducted on 01/19/23 at 3:28 PM with the previous Director of Nursing (DON) during the covid-19 outbreak on 11/2022. The DON revealed on 11/06/22 the facility identified a single positive case of covid-19 and conducted facility wide testing of all residents. The DON revealed she performed rapid test for residents on the east unit and gave the results to the Administrator. A telephone interview was conducted on 01/20/23 at 4:32 PM with the previous Administrator during the covid-19 outbreak on 11/2022. The Administrator revealed they conducted facility wide testing and used the daily census to ensure all residents were tested. The Administrator stated if a resident tested positive for covid-19 their care plan was updated and a progress note written in their medical record. The Administrator revealed he didn't know what the process was for residents who tested negative or if the results were kept in their medical records. An interview was conducted on 01/20/23 at 5:13 PM with the interim DON and current Administrator. The DON and Administrator stated it was their expectation the resident's medical records include documentation of covid-19 test results regardless if negative or positive.	F 886	Assurance Performance improvement meeting for 3 months. 5. Completion Date of 2/15/2023.	