STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345340	A. BUILDING _____ B. WING _____	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT MAPLE LEAF	1101 MAPLE CARE LANE STATESVILLE, NC 28625

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 02/26/23 through 03/01/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID BQR511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted on 02/26/23 thorugh 03/01/23. Event ID: BQR511. The following intakes were investigated: NC00187963, NC00190150, NC00193415, NC00193442, NC00193979, NC00194123, NC00194241, NC00196279, NC00198085, NC00198132, NC00198318, NC00198446, NC00198605, NC00198728. 22 of 37 complaint allegations resulted in deficiency.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		3/24/23

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

Electronically Signed 03/24/2023

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, Resident, and Staff interview the facility failed to treat a resident in a dignified manner by not providing incontinent care when requested (Resident #22) and for not providing showers as the resident preferred (Resident #15) for 2 of 3 residents reviewed for dignity. The Finding included: 1. Resident #22 was admitted to the facility on 08/31/22 with diagnoses of heart disease, diabetes, and weakness.	F 550	F550 - Regarding the alleged deficient practice of failure to treat a resident in a dignified manner as evidenced by: a. not providing incontinent care when requested (Resident #22) and b. not providing showers as the resident preferred (Resident #15) On 03/16/2023, Resident #22 was interviewed and assessed by Director of Nursing to ensure incontinence care had been provided per staff. Resident #15□s Kardex was updated on	

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F 550	Continued From page 2 The quarterly Minimum Data Set (MDS) assessment dated 01/17/23 revealed that Resident #22 was cognitively intact for daily decision making, required extensive assistance with toileting, and was frequently incontinent of bladder and occasionally incontinent of bowel. No refusal of care was noted during the assessment reference period. Resident #22 was interviewed in her room on 02/28/23 at 1:33 PM. Resident #22 stated that on 02/04/23 in the early evening hours she turned her call light on and when Nurse Aide (NA) #1 responded she made her aware she needed incontinent care and needed to be changed. NA #1 stated that she would be back, but she did not return to change her. Resident #22 stated that after the change of shift Medication Aide (MA) #1 came in and provided care to her, she stated she was saturated with urine, and MA #1 had to take her to the shower to get her cleaned up. Resident #22 further stated that on 02/05/23 at approximately 4:30 PM she began turning her call light on because the brief she had on was wet. Resident #22 stated that NA #1 kept coming in (at least twice) and turning her call light off and would say she would be back to change her, but she never returned to change her. Resident #22 stated that at change of shift another NA who she could not recall her name came into her room to provide care to her sometime after 7:00 PM. Resident #22 explained on 02/04/23 and 02/05/23 by the time the oncoming shift provided care to her she was saturated with urine that required an entire bed change. Resident #22 stated she did not like the fact that she sat soiled for so long, "it doesn't make me feel good, but what else can I do?" I have no choice but to sit and wait for the staff to come and help me.	F 550	03/13/2023 with her preferred bathing method noted as shower. All residents who have incontinence and require assistance with toileting have the potential to be affected. Interview and/or assessments were conducted by the Director of Nursing and Nurse Unit Coordinators on 03/17/2023 of all incontinent residents dependent on staff to identify any additional concerns related to provision of incontinence care, with no additional concerns noted. Resident need for staff assistance with incontinence care will be determined at time of admission and noted on Kardex. All residents requiring staff assistance with bathing have the potential to be affected by this practice. On 03/13/2023 an audit was conducted of all residents requiring assistance with bathing by Nurse Unit Coordinator to determine their preferred method, day(s) and shift for bathing with this preference added to the CNA plan of care as needed, per audit findings by 03/17/2023. Resident bathing method preferences will be added to the CNA plan of care upon admission. On 03/16/2023, DON and Infection Preventionist initiated in service education to nursing staff regarding provision of incontinence care for dependent residents. Education of nursing staff to continue upon to return to work, to be completed by 03/24/2023. Education for newly hired or contracted nursing staff will be provided by DON, Unit Coordinator,	

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F 550	Continued From page 3 NA #2 was interviewed via phone on 02/28/23 at 2:43 PM and confirmed that she worked the weekend of 02/04/23 and 02/05/23. She stated that on 02/05/23 she reported to work at 7:00 PM. NA #2 stated that she responded to Resident #22's call bell at approximately 7:00 PM to 7:15 PM and was made aware that she was wet and needed to be changed. NA #2 stated that she told Resident #22 she had just arrived to work and was gathering supplies and she would be right back to get her cleaned up. NA #2 stated that she went and gathered her supplies and immediately returned to Resident #22's room at around 7:30 PM room to provide care to her. She stated Resident #22 was in the bed and was soaking wet with urine. She stated that she was so wet, Resident #22 required an entire bed linen change. NA #1 was interviewed via phone on 02/28/23 at 5:21 PM. NA #1 stated that she had just started working at the facility one month ago (01/25/23). NA #1 stated that she was familiar with Resident #22 and had provided care to her both days the weekend of 02/04/23 and 02/05/23. She stated that Resident #22 turned on her call light anytime she needed something including when she needed incontinent care. If Resident #22 was up in her wheelchair NA #1 stated that she would take her to the bathroom and provide care but if Resident #22 was in bed she would provide care to her in the bed. NA #1 did not recall the times that she provided care to Resident #22 on either 02/04/23 or 02/05/23 because she would just do so at the time Resident #22 turned her call light on and requested care. NA #1 denied that she had turned Resident #22's call light off and denied that she had not provided care when	F 550	Infection Preventionist, or charge nurse upon hire, prior to receiving assignment. Education for nursing staff regarding residents□ rights to choose their method of bathing by Administrator, Director of Nursing (DON), Nurse Unit Coordinator, or Infection Preventionist initiated on 03/16/2023. Education to continue for nursing staff upon to return to work, to be completed by 03/24/2023. Education will be provided to newly hired or contracted nursing staff by Administrator, Director of Nursing, or other member of nurse management team upon hire prior to receiving an assignment. DON or Unit Coordinator will conduct random interviews or assessments of residents who are incontinent and require staff assistance per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks to ensure incontinent care is being provided to residents dependent on staff for assistance. Audit will be conducted by DON or Unit Coordinator of 5 residents requiring assistance with bathing per week to ensure they are bathed per their preferred method for 4 weeks, then 3 residents for 4 weeks. Administrator and DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Administrator and DON will review the	

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F 550	Continued From page 4 requested. MA #1 was interviewed via phone on 03/01/23 at 9:21 AM. MA #1 confirmed that she had worked the weekend of 02/04/23 and 02/05/23. She further explained that on 02/04/23 she took over Resident #22's unit at 11:00 PM. MA #1 recalled on 02/04/23 after shift change around 11:30 PM, she responded to Resident #22's call light. Resident #22 stated she was soiled and needed to be changed. MA #1 stated that when she pulled back the covers to provide care, she found that Resident #22 was soaking wet with a dried brown ring of urine on her bottom sheet. She stated that she told Resident #22 that she was going to get her up and take her to the shower so she could wipe down her mattress and let it air dry while they were in the shower. MA #1 stated she asked Resident #22 what happened and why she was so wet, she stated that NA #1 had left without providing care to her. MA #1 stated she assisted Resident #22 to her wheelchair stripped her bed of the soiled linens, wiped her mattress with Clorox wipes and let it air dry while she took Resident #22 to the shower. The Administrator and Director of Nursing (DON) were interview on 03/01/23 at 11:41 AM. The Administrator and DON confirmed that they were not aware of the incidents with Resident #22 that occurred on 02/04/23 and 02/05/23. She added that incontinent care should be completed when requested by Resident #22 before her call light was turned off. The DON added that she had a conversation with Resident #22 in the past about her wearing briefs when in the bed, she stated that Resident #22 toileted during the day while up and she did not think there was any reason why she could not toilet during the night to avoid	F 550	plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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F 550	Continued From page 5	F 550		

wearing a brief. The DON stated she offered Resident #22 a bedside commode which she declined because she was afraid it would not get empty and would smell bad in her room. The DON stated she believed Resident #22 was being untruthful and exaggerating the time she was left soiled and about the staff turning her call light off. The DON further stated, "I believe in treating everyone with the upmost respect and dignity and I have tired to promote her dignity and she refused."

2. Resident # 15 was readmitted to the facility on 01/09/23.

The admission Minimum Data Set (MDS) dated 01/14/23 indicated Resident #15 was cognitively intact.

Review of Resident #15's Activities of Daily Living (ADL) sheet revealed the last documented bed bath was on 02/18/23. There was no documentation of Resident #15 receiving a shower. Resident #15 was scheduled to receive a shower on Tuesdays and Fridays on first shift.

An interview and observation were conducted on 02/26/23 at 5:07 PM with Resident #15. She stated has not had a shower since she returned from the hospital on 01/09/23. She stated she had her face and hands washed a few times and a few bed baths but would like a shower so she could feel clean. Resident #15 stated she wanted a shower or at least a tub bath so she could just feel clean. She stated she just didn't know why the staff didn't want to clean her. Observations revealed Resident #15 did not look dirty, had no

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F 550	Continued From page 6	F 550		

body odor, and her hair was pulled back and did not appear greasy. The highlighted sentences contradict each other.

During a follow up interview on 03/01/23 at 8:31 AM with Resident #15, she stated she told the staff several times that she would like to have a shower but had still not received a shower or a tub bath since she was re-admitted to the facility. Resident #15 stated she felt nasty and "just wanted to feel clean".

In an interview on 03/01/23 09:26 AM with Nurse Aide (NA) #3, she stated she cared for Resident #15 regularly on second shift and had not assisted Resident #15 with a shower because she was a 2-person assistance, and they did not have the staff to give Resident #15 a shower.

In an interview on 03/01/23 at 3:10 PM with NA # 5, he stated he cared for Resident #15 regularly was not surprised that Resident #15 had not received a bath or shower since her re-admission because they did not have enough help to give showers. He stated he had not ever given her a shower.

An interview was conducted on 03/01/23 at 3:12 PM with Nurse #1, she stated the reason that Resident #15 didn't get her showers was because there were not enough staff members to give showers.

In an interview on 03/01/23 at 12:02 PM with NA #6 she stated she had never given Resident #15 a shower, only a bed bath. She stated Resident #15 was a 2-person assist and they didn't have enough staff to give her a shower.

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F 550	Continued From page 7 The Director of Nursing (DON) was interviewed on 03/01/23 at 11:41 AM and stated that she believed in treating everyone with the upmost respect and dignity and care should be provided as requested.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 561		3/24/23

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F 561	Continued From page 8 Based on observations, record review, resident and staff interviews the facility failed to honor a resident's bathing preference for 1 of 6 residents reviewed for choices (Resident #15). The findings included: Resident #15 was readmitted to the facility on 01/09/23 with diagnoses that included a heart failure, pneumonia, and diabetes. The admission Minimum Data Set (MDS) assessment dated 01/14/23 indicated Resident #15 was cognitively intact and displayed no rejection of care. The MDS further revealed Resident #15 required extensive assistance with activities of daily living and bathing was coded as did not occur. Further review of the MDS revealed it was very important to Resident #15 to be able to choose between a tub bath, shower, bed bath, or sponge bath. Review of the undated facility shower book revealed Resident #15 was to receive a shower on Tuesdays and Friday on first shift. Review of Resident #15's ADL sheet documented she last received a bed bath on 02/18/23. There was no documentation of Resident #15 receiving a shower. An observation of Resident #15 on 02/26/23 at 05:07 PM revealed she did not look dirty and had no body odor. Her hair was pulled back and did not appear greasy. In an interview on 02/26/23 at 5:07 PM with Resident #15, she stated has not had a shower since she returned from the hospital on 01/09/23.	F 561	Regarding the alleged deficient practice of failure to honor a resident□s bathing preference for 1 out of 6 residents as evidenced by: a. Resident #15 with documentation of bathing provided via bed bath and not per her preference of a shower. Resident #15□s Kardex was updated on 03/13/2023 with her preferred bathing method noted as shower. Resident #15□s Kardex was updated on 03/20/2023 with her preference of a female to bathe her. All residents requiring staff assistance with bathing have the potential to be affected by this practice. On 03/13/2023 an audit was conducted of all residents requiring assistance with bathing by Nurse Unit Coordinator to determine their preferred method, day(s) and shift for bathing with this preference added to the CNA plan of care as needed, per audit findings by 03/17/2023. Resident bathing method preferences will be added to the CNA plan of care upon admission. Education for nursing staff regarding residents□ rights to choose their method of bathing by Administrator, Director of Nursing (DON), Nurse Unit Coordinator, or Infection Preventionist initiated on 03/16/2023. Education to continue for nursing staff upon return to work, to be completed by 03/24/2023. Education will be provided to newly hired or contracted nursing staff by Administrator, Director of Nursing, or other member of nurse management team upon hire prior to	

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F 561	Continued From page 9 She stated she had her face and hands washed a few times and a few bed baths but would like a shower so she could feel clean. During a follow up interview on 03/01/23 at 8:31 AM with Resident #15, she stated she told the staff several times that she would like to have a shower but had not received a shower or a bath since she was re-admitted to the facility. She stated she refused a bed bath one time because she did not feel comfortable with a male bathing her. In an interview on 03/01/23 09:26 AM with Nurse Aide (NA) #3, she stated she cared for Resident #15 regularly on second shift and had not assisted Resident #15 with a shower because she was a 2-person assistance, and they did not have the staff to give Resident #15 a shower. An interview on 03/01/23 at 11:37 AM with NA #4, revealed he attempted to give Resident #15 a bed bath on 01/25/23, but she refused because he was a male. He stated he was not aware of Resident #15's preference for a shower. In an interview on 03/01/23 at 3:10 PM with NA #5, he stated he cared for Resident #15 regularly was not surprised that Resident #15 had not received a bath or shower since her re-admission because they did not have enough help to give showers. He stated he had not ever given her a shower. He stated in the shower book, Resident #15 was scheduled for a shower on Tuesdays and Fridays during the day shift. An interview was conducted on 03/01/23 at 3:12 PM with Nurse #1, she stated the reason that Resident #15 didn't get her showers was because	F 561	receiving an assignment. Audit will be conducted by DON or designee of 5 residents requiring assistance with bathing per week to ensure they are bathed per their preferred method for 4 weeks, then 3 residents for 4 weeks. Administrator and DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Administrator, DON or designee will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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F 561	Continued From page 10 there were not enough staff members to give showers. She stated they had to prioritize resident safety and with limited staff, they couldn't send the NAs to the shower room and not have them on the floor caring for the residents and keeping them safe. She stated the NAs knew who was supposed to receive a shower by looking in the shower book. She further stated, if their name was in the shower book, that meant they were supposed to get a shower and not a bath. In an interview on 03/01/23 at 12:02 PM with NA #6 she stated she had never given Resident #15 a shower, only a bed bath. She stated Resident #15 was a 2-person assist and they didn't have enough staff to give her a shower. In an Interview on 03/01/23 at 3:53 with the Administrator, she stated if residents are scheduled and they want a shower then staff should give the shower as scheduled. If the resident does not to receive shower, then washing their face and hands would be appropriate. The lack of shower should be reported to the nurses to document.	F 561		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		3/24/23

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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 578	Continued From page 11 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to ensure code status information was available for use for Resident #68 and Resident #14 and failed to ensure the code status information was accurate throughout the medical record for Resident #35. This affected 3 of 3 residents (Resident #68, #35 and #14) reviewed	F 578	F578 □ Regarding the alleged deficient practice of failure to ensure code status information was available for use for Resident #68 and Resident #14 and failed to ensure the code status information was accurate throughout the medical record for Resident #35. This affected 3 of 3	

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F 578	Continued From page 12 for advanced directives. The findings include 1. Resident #68 was admitted to the facility on 02/22/22. A review of Resident #68's electronic medical record revealed a physician order for a Full Code dated 11/06/22. A review of the Code Status notebook kept at the nursing station revealed there was no advanced directive in the notebook for Resident #68. An interview was conducted with the Admissions Director (AD) on 02/28/23 at 11:08 AM. The AD explained that she addressed the residents' advanced directive, do not resuscitate or full code while in the admission meeting with the resident and or responsible party and put the paperwork in the big red code status notebook at the nursing station. The AD continued to explain that she had only been responsible for doing it for about 2 weeks, so she did not know anything about why Resident #68's code status was not in the notebook. During an interview with the Unit Manager (UM) #1 on 02/28/23 at 12:20 PM the UM explained that the Admission Director (AD) informed her of the residents' code status, and she was responsible for writing the order for it and the AD was responsible for putting the proper paperwork in the code status notebook. The UM indicated she did not know why Resident #68 did not have a designated advanced directive in the notebook. An interview was conducted with the Director of	F 578	residents (Resident #68, #35 and #14) reviewed for advanced directives. Resident #14, #35, and #68 were corrected to assure that residents wishes are being honored, order in electronic medical record/code status book at nurses station/care plan are all reflective of residents wishes. Corrected 02/28/2023. All residents have potential to be affected. Audit of all residents initiated by Unit Coordinator on 03/15/2023 with completion of 03/17/2023. Order in electronic medical record/code status book at nurse□s station/care plan reflective of residents wishes. Regional Director of Operations educated department head/managers on 03/17/2023 through 03/20/2023 regarding process to ensure upon admission the residents advanced directives wish are honored/order in electronic medical record/code status book at nurse□s station/care plan are reflective of residents wishes. Admissions Director will ensure understanding of residents advanced directive day of admission with resident and responsible party. Unit Coordinator and/or Director of Nursing to assure completed order/Code Status Binder updated and care plan reflective of residents wishes. Clinical morning meeting the day after admission IDT will review resident□s code status, order in electronic medical	

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Nursing (DON) on 02/28/23 at 11:28 AM who stated that it was her expectation that the residents' advanced directives be in the code status notebook at the nursing station, and they should match the residents' electronic medical record.

2. Resident #35 was admitted to the facility on 12/09/22.

Review of Resident #35's electronic health record revealed a physician order dated 12/09/22 for Do Not Resuscitate (DNR).

A review of Resident #35's care plan dated 12/21/22 revealed the Resident was a Full Code status with the goal to initiate all life sustaining technology as agreed upon.

An interview was conducted with the Minimum Data Set (MDS) Nurse #1 on 02/28/23 at 11:19 AM who explained that she was responsible for care planning Resident #35's advanced directive and remembered the day of the care plan meeting with the Resident and her family. The Nurse continued to explain that when she reviewed her advanced directive with the Resident, she voiced that she did not want to be a DNR but that she wanted to be a Full Code, so she wrote the care plan for a Full Code status. She stated she sent a message to Unit Manager #2 about the change in the advanced directive.

An interview was conducted with Unit Manager (UM) #2 on 02/28/23 at 12:20 PM. The UM explained that she was responsible for the residents on the hall that Resident #35 resided and stated she was not aware of being notified of the Resident's advanced directive needing to be

records/code status book updated/care plan updated. DON and/or Unit Coordinator will audit new admissions code status order/code status binder/care plan 3 times weekly for 8 weeks and review during Quality Assurance Committee meetings and continue audits at discretion of the committee.

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changed.

During an interview with the Director of Nursing (DON) on 02/28/23 at 11:28 AM she explained that the MDS Nurse should have care planned Resident #35's advanced directive for what it was at the time of the care plan meeting (DNR) and notified the UM about the Resident's wishes for the advanced directive to be changed to a Full Code. The DON stated when the order for the Full Code was obtained then the MDS Nurse should have updated the care plan to reflect a Full Code.

3. Resident #14 was readmitted on 01/16/23.

Review of Resident #14's electronic medical record revealed a physician order dated 01/31/23 that read, Full Code.

A review of the Code Status notebook kept at the nursing station where all residents in the faciltiy code status inforamtion was kept revealed there was no advanced directive in the notebook for Resident #14.

An interview was conducted with the Admissions Director (AD) on 02/28/23 at 11:08 AM. The AD explained that she addressed the residents' advanced directive, do not resuscitate or full code while in the admission meeting with the resident and or responsible party and put the paperwork in the big red code status notebook at the nursing station. The AD continued to explain that she had

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F 578	Continued From page 15 only been responsible for doing it for about 2 weeks, so she did not know anything about why Resident #14's code status was not in the notebook. During an interview with the Unit Manager (UM) #1 on 02/28/23 at 12:20 PM the UM explained that the Admission Director (AD) informed her of the residents' code status, and she was responsible for writing the order for it and the AD was responsible for putting the proper paperwork in the code status notebook. The UM indicated she did not know why Resident #14 did not have a designated advanced directive in the notebook. An interview was conducted with the Director of Nursing (DON) on 02/28/23 at 11:28 AM who stated that it was her expectation that the residents' advanced directives be in the code status notebook at the nursing station. The DON stated that they implemented the notebook at the nursing station for the nursing staff to have a quick reference of code status during an emergency and a place to keep the original document so they could make copies if the resident was transferred to the hospital.	F 578		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, Resident and staff interviews the facility failed to provide incontinent care when requested by the resident for 1 of 6	F 677	F677 □ Regarding the alleged deficient practice of failure to provide incontinent care for a resident who was dependent for	3/24/23

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F 677	Continued From page 16 residents reviewed for activities of daily living (Resident #22). The finding included: Resident #22 was admitted to the facility on 08/31/22 with diagnoses of heart disease, diabetes, and weakness. The quarterly Minimum Data Set (MDS) assessment dated 01/17/23 revealed that Resident #22 was cognitively intact for daily decision making, required extensive assistance with toileting, and was frequently incontinent of bladder and occasionally incontinent of bowel. No refusal of care was noted during the assessment reference period. A care plan created on 01/27/23 read in part, Resident #22 had a history of urinary tract infections. The interventions included: check with care rounds and as needed for incontinence. Wash, rinse, and dry soiled area. Resident #22 was interviewed in her room on 02/28/23 at 1:33 PM. Resident #22 stated on 02/04/23 in the early evening hours (could not recall the exact time) she turned her call light on and when Nurse Aide (NA) #1 responded she made her aware she needed incontinent care and needed to be changed. NA #1 stated that she would be back, but she did not return. Resident #22 stated that after the change of shift Medication Aide (MA) #1 came in and provided care to her, she stated she was saturated with urine, and MA #1 had to take her to the shower to get her cleaned up. Resident #22 further stated that on 02/05/23 at approximately 4:30 PM she began turning her call light on because the brief	F 677	toileting as evidenced by: a. Residents #22 did not receive incontinent care when requested on 02/04/23 and/or 02/05/2023. On 03/16/2023, Resident #22 was interviewed and assessed by Director of Nursing to ensure incontinence care had been provided per staff. All residents who have incontinence and require assistance with toileting have the potential to be affected. Interview and/or assessments were conducted by the Director of Nursing and Nurse Unit Coordinators on 03/17/2023 of all incontinent residents dependent on staff to identify any additional concerns related to provision of incontinence care, with no additional concerns noted. Resident need for staff assistance with incontinence care will be determined at time of admission and noted on Kardex. On 03/16/2023, DON and Infection Preventionist initiated in-service education to nursing staff regarding provision of incontinence care for dependent residents. Education of nursing staff to continue upon to return to work, to be completed by 03/24/2023. Education for newly hired or contracted nursing staff will be provided by DON, Unit Coordinator, or Infection Preventionist upon hire, prior to receiving assignment. DON or Unit Coordinator will conduct random interviews or assessments of residents who are incontinent and require	

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F 677	Continued From page 17 she had on was wet. She stated that NA #1 was working again that day and had been providing care to her throughout the day. Resident #22 stated that NA #1 kept coming in (at least twice) and turning her call light off and would say she would be back to change her, but she never returned to change her. Resident #22 stated that at change of shift another NA who she could not recall her name came into her room to provide care to her sometime after 7:00 PM. Resident #22 explained that she took Lasix (diuretic) every day and she urinated a lot, she explained on 02/04/23 and 02/05/23 by the time the oncoming shift provided care to her she was saturated with urine that required an entire bed change. NA #2 was interviewed via phone on 02/28/23 at 2:43 PM and confirmed that she worked the weekend of 02/04/23 and 02/05/23. She stated that on 02/05/23 she reported to work at 7:00 PM and was preparing to complete a walking round with NA #1 who had worked the previous shift. NA #2 stated NA #1 disappeared from the unit by the time she had sat her belongings down and was gathering her assignment information, she stated, "she just disappeared" and NA #2 did not receive any report that day. NA #2 stated she responded to Resident #22's call bell at approximately 7:00 PM to 7:15 PM and was made aware that she was wet and needed to be changed. NA #2 stated that she told Resident #22 she had just arrived to work and was gathering supplies and she would be right back to get her cleaned up. NA #2 stated that she went and gathered her supplies and immediately returned to Resident #22's room at around 7:30 PM room to provide care to her. She stated Resident #22 was in the bed and was soaking wet with urine. She stated that she was so wet, Resident #22 required an entire bed	F 677	staff assistance per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks to ensure incontinent care is being provided to residents dependent on staff for assistance. DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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change. She confirmed that she had removed the soiled brief and sheets, washed Resident #22's peri area and applied a clean brief and clean bed linens. She stated that Resident #22's buttocks were not red, and she had no "sores" on her buttock. NA #2 further stated that Resident #22 was able to turn from side to side and she was able to provide care to her by herself.

The Weekend Supervisor was interviewed via phone on 02/28/23 at 3:55 PM. She confirmed that she was working on the weekend of 02/04/23 and 02/05/23. She stated she was not aware of the specific incident with Resident #22 but stated she had performance issues with NA #1 and had reports of residents being left wet. She stated that NA #1 was a new NA and she had requested additional orientation for her and had asked the staff to perform walking rounds with NA #1 so that any issues could be brought to her attention before she left after her shift.

NA #1 was interviewed via phone on 02/28/23 at 5:21 PM. NA #1 stated she had just started working at the facility one month ago (01/25/23). She confirmed that she was working the weekend of 02/04/23 and 02/05/23. She added that she was still in orientation but was working by herself that day due to staff call outs. NA #1 stated she was familiar with Resident #22 and had provided care to her both days that weekend. She stated that Resident #22 turned on her call light anytime she needed something including when she needed incontinent care. If Resident #22 was up in her wheelchair NA #1 stated that she would take her to the bathroom and provide care but if Resident #22 was in bed she would provide care to her in the bed. NA #1 did not recall the times that she provided care to Resident #22 on either

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02/04/23 or 02/05/23 because she would just do so at the time Resident #22 turned her call light on and requested care. NA #1 denied that she had turned Resident #22's call light off and denied that she had not provided care when requested. NA #1 stated that she did not do a round or report with NA #2 when she came on shift but could not recall why she had not done so. NA #1 stated no had one spoken to her about the weekend of 02/04/23 and 02/05/23 and was unaware of any issues that occurred during that time.

MA #1 was interviewed via phone on 03/01/23 at 9:21 AM. MA #1 confirmed she had worked the weekend of 02/04/23 and 02/05/23. She further explained that on 02/04/23 she took over Resident #22's unit at 11:00 PM, she indicated that she was not sure who had worked the previous shift as she did not get any report when she arrived for her shift. MA #1 explained that Resident #22 wore a pull up during the day or anytime she was out of bed but if she was in bed, she preferred to wear a brief due to how much she urinated because of her medications that she took. MA #1 recalled on 02/04/23 after shift change around 11:30 PM, she responded to Resident #22's call light. Resident #22 stated she was soiled and needed to be changed. MA #1 stated that when she pulled back the covers to provide care she found that Resident #22 was soaking wet with a dried brown ring of urine on her bottom sheet. She stated that she told Resident #22 that she was going to get her up and take her to the shower so she could wipe down her mattress and let it air dry while they were in the shower. MA #1 stated she asked Resident #22 what happened and why she was so wet, she stated that NA #1 had left without

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F 677	Continued From page 20 providing care to her. MA #1 stated she assisted Resident #22 to her wheelchair stripped her bed of the soiled linens, wiped her mattress with Clorox wipes and let it air dry while she took Resident #22 to the shower. After the shower she remade Resident #22's bed and then assisted her back to bed. MA #1 stated that Resident #22 peri area was not red and was intact during that shower. The Administrator and Director of Nursing (DON) were interviewed on 03/01/23 at 11:41 AM. The Administrator stated that NA #1 was a new employee and had been going through a lot of orientation. She stated NA #1 had requested additional orientation and the staff had come to her with performance issues. The staff had reported to the Administrator that NA #1 lacked the confidence to jump in and get things done, she required a lot of prompting and someone to help NA #1 stay on task. She further explained they were trying to foster NA #1 as much as possible. The Administrator and DON confirmed they were not aware of the incidents with Resident #22 that occurred on 02/04/23 and 02/05/23. The DON stated the staff should be rounding for incontinent care every two to three hours. She added that incontinent care should be completed when requested by Resident #22 before her call light was turned off.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 679		3/24/23

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F 679	Continued From page 21 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, facility activity calendar, resident and staff interviews, the facility failed to ensure group activities were planned in the evenings on weekdays and on weekends to meet the needs of residents who expressed that it was important to them to attend group activities for 4 of 4 residents reviewed for activities (Resident #65, Resident #14, Resident #22 and Resident #62). The findings included: A review of the February 2023 activity calendar revealed morning breakfast daily and dining with music Monday through Friday (lunch). An activity titled "Social Time" listed Monday through Friday at 4:30 PM, but was not listed on the weekends. There were no activities listed after 4:30 PM on the calendar on weekdays. On weekends, the following activities were listed: Saturday- 10:30 AM Snack social and 2:30 PM Bingo and Sunday- Spiritual in rooms (Channel 32) and at 2:30 Bible Chat. The calendar revealed there were no other activities available on the weekends. a. Resident #65 was admitted to the facility on 4/12/21. An Annual Minimum Data Set (MDS) dated 4/18/22 indicated Resident #65 felt that it was very important to have activities that included	F 679	F679 □ Regarding the alleged deficient practice of failure to meet the interests and needs of 4 of 4 residents as evidenced by: A. Ensuring group activities were planned in the evenings on weekdays and B. On the weekends to meet the needs of residents who expressed that it was important to them to attend group activities. Residents #14, #22, #62 and #65- were interviewed by Activities Director to assess their activities preferences, documented preferences & will have care plan updated by 03/24/2023. All residents have the potential to be affected. Activities Director and Activities Assistant conducted interviews of all residents and obtained their activity preferences and will have care plans updated by 03/24/2023. Regional Director of Operations educated Activities Director on 3/17/23 on the importance of honoring residents activities preferences as well as increasing evening activities and weekend activities per resident request/preference.	

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F 679	Continued From page 22 music, books, newspaper, going outside, and doing things in a group setting. The assessment further indicated Resident #65 was cognitively intact. A review of the comprehensive careplan for Resident #65 revealed no care plan for activity interest or involvement. An observation and interview with Resident #65 was conducted on 2/26/23 at 3:24 PM. Resident #65 was in her room lying in bed and indicated staff did not ask her if she wanted to go to the few activities offered because they were short staffed. Resident #65 also stated "life here is boring." Resident #65 had various art hangings in her room and she said she used to be able to participate in art activities, but the facility did not provide them anymore. b. Resident #14 was admitted to the facility on 9/8/22. An Admission Minimum Data Set (MDS) dated 9/13/22 indicated Resident #14 felt that it was very important to do activities that included receiving the newspaper, listening to music, and doing things in a group setting. The assessment further indicated Resident #14 was cognitively intact. An observation and interview with Resident #14 was conducted on 2/26/23 at 5:09 PM. Resident #14 was in her room sitting in her wheelchair with the roommate's television on; however, Resident #14 was not watching it. She indicated she got bored often due to the lack of activities in the evening and on the weekends.	F 679	Regional Director of Operations educated IDT on 03/20/2023 regarding importance of all staff ensuring residents have activities based on their preferences. Activities Director and MDS to assure preferences care planned as appropriate. Administrator will conduct interviews on 5 residents weekly for 8 weeks for their input as to Activities meeting their preferences and their suggestions. Administrator to share interviews with IDT during morning standup as well as Quality Assurance Committee and continue audits at discretion of committee.	

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F 679	Continued From page 23	F 679		

A review of the comprehensive care plan for Resident #14 revealed no care plan for activity interest or involvement.

c. Resident #22 was admitted to the facility on 8/31/22.

An Admission Minimum Data Set (MDS) dated 9/6/22 indicated Resident #22 felt that it was very important to do activities that included listening to music, pets, religious activities, and doing things in a group setting. The assessment further indicated Resident #22 was cognitively intact.

An observation and interview with Resident #22 was conducted on 2/26/23 at 3:51 PM. Resident #22 indicated the facility did not have a lot to do for activities and she stated, "we are so bored we cannot see straight. The activity calendar looks full, but it has our meals as three activities each day." Resident #22 was conversing with her roommate (Resident #62) during the interview, and Resident #22 stated the activity at 4:30 PM on weekdays titled "Social Time" was strictly where snacks were brought to each of their rooms and not an activity or a group activity to socialize.

A review of the comprehensive care plan for Resident #22 revealed no care plan for activity interest or involvement.

d. Resident #62 was admitted to the facility on 8/31/22.

An Admission Minimum Data Set (MDS) dated 9/6/22 indicated Resident #62 felt that it was important to do activities that included watching the news, listening to music, playing with pets,

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F 679	Continued From page 24	F 679		

attending religious activities, and doing things in a group setting. The assessment further indicated Resident #62 was cognitively intact.

An observation and interview with Resident #62 was conducted on 2/26/23 at 3:51 PM. Resident #62 indicated that the facility did not have many activities to do and indicated their activity calendar may look full, but it actually was very limited in structured activities and it included meals. Resident #62 explained "we simply get bored because there's nothing to do." Resident #62 was conversing with her roommate (Resident #22) during the interview. Resident #62 agreed with Resident #22 (her roommate) that the activity at 4:30 PM on weekdays titled "Social Time" was strictly where snacks are brought to each of our rooms and not an activity or a group activity to socialize.

A review of the comprehensive care plan for Resident #62 revealed no care plan for activity interest or involvement.

An interview with the Activity Director was conducted on 2/27/23 at 11:45 AM which revealed she was in charge of developing the activity calendar each month. She acknowledged that the meals were included in the activity calendar and she had been trying to provide activities for the facility alone until an assistant was recently hired to help. She stated that an activity that was scheduled every Monday only benefited one resident in the facility, but remained on the calendar. She explained that this was a spiritual activity entitled "Jehovah's Witness" and this was not applicable to most resident's in the facility. The Activity Director explained that she added an extra day of bingo to the calendar but

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F 679	Continued From page 25 was not aware meals could not be counted as an activity and would try to modify the calendar beginning in April. The activity director acknowledged there were no activities in the evenings and on the weekends there was bingo on Saturday and on Sunday there was a worship service, but this activity was where residents were able to watch church on television and not a live in person service. During an interview with the Administrator on 03/01/23 at 3:24 PM she revealed she was aware that the residents had requested more bingo activities and that an extra day of bingo was added to the calendar in recent months. The Administrator stated that she was not aware of ongoing concerns with the lack of activities in the evenings and on the weekends.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff	F 686	Regarding the alleged deficient practice	3/24/23

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F 686	Continued From page 26 and Wound Nurse Practitioner interviews, the facility failed to implement a new treatment order prescribed by the Wound Nurse Practitioner for a pressure ulcer for 1 of 1 resident (Resident #86) reviewed for pressure ulcers. The finding included: Resident #86 was admitted to the facility on 02/17/23 with diagnoses that included diabetes mellitus, chronic kidney disease, peripheral vascular disease, and neuropathy. Review of Resident #86's weekly skin assessment dated 02/18/23 revealed purplish/black areas on bilateral buttocks. The care plan dated 02/19/23 revealed Resident #86 had actual skin impairment with interventions to monitor the site for infection and to ensure the dressing was intact. A review of Resident #86's Wound Nurse Practitioner (NP) wound evaluation dated 02/22/23 revealed the Resident's right buttock was unstageable and the treatment would be cleansing with wound cleanser and applying a medical grade honey and cover with a gauze border dressing every day. A review of Resident #86's physician orders revealed an order dated 02/24/23 to cleanse right buttock with wound cleanser and apply medical grade honey and cover with a gauze border dressing every day. A review of Resident #86's Wound Nurse Practitioner wound evaluation dated 02/27/23 revealed the Wound NP utilized sharp	F 686	of failure to provide services to treat a pressure ulcer as evidenced by: a. the facility failed to failed to implement a new treatment order prescribed by the Wound Nurse Practitioner for a pressure ulcer for 1 of 1 resident (Resident#86) Dressing was applied per current physician order for resident #86 on 02/28/2023. All residents with pressure ulcers have the potential to be affected. An audit was conducted by Director of Nursing on 03/17/2023 of all residents with pressure ulcers to ensure treatments were in place per physician orders, with no additional deficiencies identified. On 02/28/2023, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Infection Preventionist began providing in-servicing regarding treatment of pressure ulcers per physician orders to licensed nurses, with education continuing upon return to work to be completed by 03/24/2023. All newly hired or contracted licensed nurses will be in-serviced by Director of Nursing, Infection Preventionist, or charge nurse upon hire. DON or Unit Coordinator will conduct random audits of all residents with pressure ulcers per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks to ensure all pressure ulcers have correct dressing applied per physician	

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F 686	Continued From page 27 debridement to the unstageable pressure ulcer and the treatment was changed to cleansing with wound cleanser and apply Santyl ointment (a debriding agent) and cover with a gauze border dressing every day. A review of the Wound Nurse Practitioner wound log dated 02/28/23 revealed the order for cleansing the pressure ulcer with wound cleanser and applying Santyl ointment and cover with a gauze border dressing every day. A review of Resident #86's Treatment Administration Record (TAR) for 02/2023 revealed the order to cleanse right buttock with wound cleanser and apply medical grade honey and cover with a gauze border every day was initiated on 02/24/23. Further review of the Treatment Administration Record (TAR) for 02/2023 revealed the order for cleansing the pressure ulcer with wound cleanser and applying Santyl ointment and cover with a gauze border dressing every day was not added to the TAR on 02/28/23. An observation of the pressure ulcer treatment was conducted on 02/28/23 at 1:35 PM by Nurse #2. The Nurse cleansed the pressure ulcer with a wound cleanser and applied medical grade honey ointment then covered the pressure ulcer with a gauze border dressing every day. Review of Resident #86's TAR for 03/2023 revealed an order to cleanse right buttock with wound cleanser and apply medical grade honey and cover with a gauze border every day. The treatment was signed off for 03/01/23 indicating the treatment had been completed.	F 686	order. DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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An interview was conducted with the Unit Manager (UM) #2 on 03/01/23 at 12:05 PM who explained that the Wound Nurse Practitioner sent her wound log to the facility via email and there was no one person responsible to look at the log and pick up on writing new orders that might need to be initiated. The UM stated she tried to look at the log for order changes for the residents she was responsible for, but she had not looked at it yet. The UM pulled up the wound log that was sent to the facility on 02/28/23 and located the order change of Santyl for Resident #86 and stated she had not had time to look at it yet. The UM stated in her opinion the Santyl ointment should have been obtained from the pharmacy by now and the new treatment should have been applied to the pressure ulcer.

An interview was conducted with the Wound Nurse Practitioner on 03/01/23 at 11:26 AM who explained that Resident #86 was admitted with a deep tissue injury over his right buttock, and she initially started the medical grade honey ointment to get the debridement process started. When she evaluated the pressure ulcer on Monday 02/27/23 she debrided the pressure ulcer and changed the order from the medical grade honey to Santyl ointment because the pressure ulcer needed a more aggressive debriding agent to speed up the debridement process. The Wound NP continued to explain that she sent the wound log to the facility via email within 24 hours of her visit which was on 02/27/23 and her expectation was for the facility to initiate new orders as soon as they obtained the treatment from their pharmacy. The Wound NP stated Santyl should have been started before now (03/01/23 at 11:26 AM).

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F 686	Continued From page 29 On 03/01/23 at 12:24 PM during an interview with the Director of Nursing she stated it was the Unit Managers responsibility to follow up with writing the new treatment orders provided by the Wound Nurse Practitioner and it was her expectation that it should have been done when they received the new orders on 02/28/23. On 03/01/23 at 12:50 PM an interview was conducted with the Administrator who indicated her expectation was that the new treatment for Resident #86's pressure ulcer should have been started on 02/28/23.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide supervision to prevent a cognitively impaired resident (Resident #129) from attacking another cognitively impaired resident (Resident #130) in their shared bathroom which result in Resident #130 having a bloody right lower lip, left nare and left cheek. Her right wrist was swollen, bruised, and painful and required evaluation at the Emergency Room (ER). The Findings included:	F 689	Regarding the alleged deficient practice of failure provide adequate supervision to prevent accidents as evidenced by: a. a cognitively impaired resident (#129) from attacking another cognitively impaired resident (#130) Resident #130 was transferred to Emergency Department and received care for an abrasion and pain. Resident #129 was immediately placed with one on one staff supervision and transferred to	3/24/23

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F 689	Continued From page 30 Resident #129 was admitted to the facility on 11/20/20 and expired in the facility on 11/30/22. Resident #129's diagnoses included schizoaffective disorder, dementia, and bipolar disorder. A care plan created on 12/11/20 read, Resident #129 is/has the potential to be verbally aggressive, yelling, threatening staff, lying to staff about things related to ineffective coping skill, mental/emotional illness, and poor impulse control. The interventions included: administer medications as ordered, analyze key times, places, triggers and what de-escalates the behavior, assess, and anticipate resident needs, and give the resident as many choices as possible, Review of the quarterly Minimum Data Set (MDS) assessment dated 06/21/22 revealed that Resident #129 was moderately cognitively impaired for daily decision making, had no behaviors, and required limited assistance with walking in room and on corridor during the assessment reference period. An incident report dated 09/08/22 read in part, staff heard yelling down hallway, nurse ran down hallway with Nurse Aide (NA). Found another resident (Resident #130) sitting on toilet. Resident #129 was standing beside Resident #130 yelling and had a hold of Resident #130's right upper arm. She was being very verbally aggressive to Resident #130. Three staff members had to remove Resident #129 from the bathroom. The incident report was electronically signed by Nurse #6.	F 689	Emergency Department for mental health evaluation. Residents 129 & 130 have both since discharged from facility with no additional incidents. All residents have the potential to be affected. On 03/17/2023, Director of Nursing and nurse unit coordinators conducted a behavior assessment of all residents to ensure no newly identified aggressive behaviors. On 03/20/2023, Minimum Data Set Coordinators reviewed care plans to ensure any interventions are care planned for any identified behaviors. On 03/20/2023, education began to all staff on residents with aggressive behavior in nursing homes and appropriate de-escalation techniques by Director of Nursing, Administrator, and Unit Coordinator with education to continue upon return to work and completed by 03/24/2023. Education will be provided by a member of nurse management to all newly hired or contracted certified nursing assistants upon hire/contract prior to receiving assignment. DON, Unit Coordinator, or Infection Preventionist will conduct random audits of 5 residents□ behavior assessments per week for 4 weeks, then 3 behavior assessments per week for four weeks to ensure any newly identified behavior has been care planned with an appropriate intervention.	

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F 689	Continued From page 31 Review of a physician order dated 09/08/22 for Resident #129 read, Send to Emergency Room (ER) for evaluation. Resident #130 was admitted to the facility on 06/03/22 and expired in the facility on 01/10/23. Resident #130's diagnoses included dementia. The quarterly MDS assessment dated 09/08/22 indicated that Resident #130 had long/short term memory problems, was moderately impaired for daily decision making, and no behaviors were noted during the assessment reference period. Further review of the MDS revealed that Resident #130 was always continent of bowel and bladder. Review of a Nurse's note written by Nurse #6 dated 09/08/22 read, staff heard yelling down the hallway. Nurse ran down hallway with NA and found Resident #130 sitting on toilet with injury. Right lower lip was bleeding, left nare was bleeding, left cheek bleeding, right wrist was swollen, bruised, and painful. Resident #129 was standing beside Resident #130 yelling and had a hold of Resident #130's right upper arm. The two residents were separated immediately, and aide was provided to Resident #130's injuries. Review of a physician order dated 09/8/22 for Resident #130 read, Send to ER for evaluation. Review of Discharge Documentation for Resident #130 from the local ER dated 09/08/23 read in part, no fractures were identified on scan, your right Xray shows old fractures, no new fracture. Keep area clean and dry, change dressing daily. Apply ice to the wrist 20 minutes on, 20 minutes off at least 5 times a day.	F 689	DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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Nurse #6 was interviewed via phone on 02/27/23 at 11:56 AM. Nurse #6 confirmed that she recalled the incident between Resident #129 and Resident #130 on 09/08/22 at approximately 9:30 PM. She stated, "for starters we told management not to move them, they were on separate halls, and they moved them to the same hall to share a bathroom." Nurse #6 stated that both Resident #129 and Resident #130 were continent of bowel and bladder and went to the bathroom all the time. She stated she was working a double shift that day (09/08/22) and heard "screaming" down the hallway. Nurse #6 stated she ran down the hallway and opened the bathroom door and found Resident #130 sitting on the toilet with her lip, nose, and right nare bleeding and Resident #129 was standing in the other doorway screaming for Resident #130 to get out of the bathroom. Resident #130 stated "she attacked me" and Resident #129 stated "I did not." Nurse #6 stated that she and the NA's removed Resident #129 from the bathroom and returned her to her private room while she stayed with Resident #130 and assessed her injuries. She stated she cleaned the blood off Resident #130's face and found a small cut under her eye and her lip was split but she was worried about her arm because it was bruised and swollen (could not recall for sure which arm). Nurse #6 stated that both Resident #129 and Resident #130 were sent to the ER that night and had not returned when she left her shift at 11:00 PM. Nurse #6 stated that when Resident #129 returned to the facility she was provided a one-on-one sitter until a private room with a private bathroom was available.

NA #3 was interviewed via phone on 02/27/23 at 12:23 PM who confirmed that she recalled the

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incident with Resident #129 and Resident #130 that occurred on 09/08/22. She stated that Resident #129 "was always upset when someone was in her bathroom." NA #3 stated that on 09/08/22 Resident #130 had gone into the bathroom that the two residents shared and we heard Resident #130 yelling so we responded to her room. Resident #130 was sitting on the toilet and Resident #129 was standing in the doorway screaming at her to get out of the bathroom. She added that they immediately separated the two residents and Nurse #6 assessed Resident #130 lip, nose, and eye area that were bleeding. NA #3 stated that both residents went to the ER that night in separate ambulances and when they returned Resident #129 had one on one sitter until a private room with a private bathroom was available.

The Administrator was interviewed on 02/27/23 at 5:02 PM who stated that on 09/08/22 Nurse #6 called her at home to report the incident. She stated that NA #7 separated the two residents and stayed with Resident #129 until Emergency Medical Services (EMS) arrived. Nurse #6 also told the Administrator of Resident #130's injuries to her face and her arm. The Administrator stated she was unaware of any issues with the shared bathroom but was aware that Resident 129 had verbal aggression but had not had any physical aggression. The Administrator stated that when Resident #129 returned from the ER she was placed on one on one and then moved to a private room with private bathroom.

Nurse #7 was interviewed via phone on 02/27/23 at 6:01 PM. Nurse #7 stated that he knew of the incident that occurred on 09/08/22 between Resident #129 and Resident #130. He also

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F 689	Continued From page 34	F 689		

confirmed that he was working when the two returned to the facility after being evaluated at the ER. He recalled that Resident #129 was placed on one on one until a new room was available. Nurse #7 stated "if you ask me what I recall most about that incident was that we had told the Administration numerous times that it was not a good idea" to put Resident #129 in a room with another resident or one that shared her bathroom because she was "very territorial" of her space.

Unit Manager (UM) #1 was interviewed on 02/28/23 at 9:48 AM who confirmed she was aware of the incident between Resident #129 and Resident #130 on 09/08/22. UM #1 stated "for the longest time we avoided having a roommate" with Resident #129 because we had tired a couple of other residents and it did not work out so well, so we knew we had to leave her alone in a room. UM #1 stated that when Resident #130 was moved into the room next to Resident #129 which shared a bathroom it was apparent rather quickly that it was not going to work but we decided to "wait and see" how the two residents would do. She confirmed that after the incident on 09/08/22, Resident #129 had one on one sitters until a private room with private bathroom was available. UM #1 stated that Resident #129 had history of behaviors in the facility, and she recalled one time that Resident #129 picked up a television and was going to throw it at her roommate until Nurse #6 intervened and removed the television from her hands.

NA #7 was interviewed on 02/28/23 at 10:46 AM who confirmed that she was working on 09/08/22. She stated she was down the hallway with another resident and she heard someone yelling. NA #7 stated she went down the hallway and

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F 689	Continued From page 35 found Resident #130 in her bathroom on the toilet and Resident #129 was laying on her bed screaming at her to "get out" of the bathroom. NA #7 stated she told Resident #129 to be patient that Resident #130 would be out in just a minute and to please not yell at her. NA #7 stated that she returned to the room she was in previously to finish what she was doing. About fifteen minutes later she heard screaming again and she again ran down the hallway. Resident #130 was sitting on the toilet and her face was bleeding and she stated, "she hit me." Resident #129 was immediately removed from the bathroom and closed and locked the bathroom door and Nurse #6 assessed Resident #130. NA #7 stated she stayed with Resident #129 until EMS arrived to transport her to the ER, she was very calm and cooperative during that time. She added that when Resident #129 returned to the facility from the ER she was placed with one-on-one sitters until a private room with private bathroom was available. A follow up interview was conducted with the Administrator on 03/01/23 at 11:29 AM. She stated that after Resident #129 was moved to private room with a private bathroom she appeared to settle down and was only discussed in clinical meeting as needed. She did not feel like there was anything else the facility could have done to prevent the incident that occurred on 09/08/22. The Administrator could not recall any staff members verbalizing hesitancy about moving the two residents on the same hallway to share a bathroom and was adamant she was not aware of any other physical behaviors Resident #129 had.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning	F 695		3/24/23

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F 695	Continued From page 36 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failing to clean oxygen filters for 2 of 3 residents (Resident #3 and Resident #13) reviewed for oxygen usage. 1. Resident #3 was re-admitted to the facility on 2/24/23 with diagnoses that included asthma. A care plan dated 1/3/23 indicated Resident #3 requires oxygen usage with interventions to include may titrate oxygen rate to ensure oxygen saturations are greater than 92% and position for body alignment to facilitate optimal breathing patterns. A hospital discharge summary dated 2/24/23 indicated Resident #3 was to receive oxygen via nasal cannula at 2L (liters) continuously. Review of the Treatment Administration Record (TAR) dated February 2023 revealed the following: Change oxygen tubing when visibly soiled every Sunday night. The TAR further revealed that Nurse #4 initialed the oxygen tubing change on 02/26/23.	F 695	Regarding the alleged deficient practice of failure provide adequate supervision to prevent accidents as evidenced by: - Failing to clean oxygen filters for 2 of 3 residents. Residents #3 and #13 had their filters checked/cleaned immediately upon notification from surveyor on 3/1/23. Central Supply Coordinator maintains inventory of oxygen concentrators and conducted an audit of all residents with oxygen concentrators to ensure all that required a filter had their filter cleaned. This audit was completed by 3/10/23 and reviewed again on 3/17/23. Regional Director of Operations educated Central Supply on 3/17/23 regarding weekly checks/cleaning of oxygen concentrators with documentation. Regional Director of Operations educated Maintenance Director regarding doing an additional weekly check of oxygen concentrators to ensure compliance with	

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F 695	Continued From page 37 Multiple attempts were made to contact Nurse #4 without success. An observation on 2/26/23 at 2:51 PM revealed Resident #3's oxygen concentrator contained a black filter which had a visible grayish-white fuzzy substance on the surface. An observation on 2/27/23 at 8:57 AM revealed Resident #3's oxygen concentrator contained a black filter which had a visible grayish white fuzzy substance on the surface. An interview with Nurse #3 on 3/1/23 at 2:24 PM revealed she is a night shift nurse (11 PM to 7 AM shift) and stated all residents who use concentrators should have their filter cleaned weekly on Sunday night when the nasal cannulas were replaced. An interview with the Director of Nursing and Administrator on 3/123 at 3:53 PM revealed the filters attached to the oxygen concentrator to be cleaned weekly on Sunday by the nursing staff on night shift. The DON indicated the nurses cleaned external filters and maintenance staff would clean internal filters. 2. Resident #13 was readmitted to the facility on 10/03/22 with diagnoses that included respiratory failure and asthma. A physician order dated 10/27/22 read Oxygen at 2 liters per minute via nasal canula. The quarterly Minimum Data Set (MDS) dated 01/06/23 revealed that Resident #13 was	F 695	process. Central Supply Coordinator and Maintenance Director to submit weekly audit of oxygen concentrators to Administrator for 8 weeks. Administrator to review at morning standup and Quality Assurance Committee for 8 weeks and continue audits at discretion of the committee.	

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F 695	Continued From page 38	F 695		

moderately impaired for daily decision making, had shortness of breath with exertion, and required the use of oxygen during the assessment reference period.

Review of the Treatment Administration Record (TAR) dated February 2023 revealed the following: Change oxygen tubing when visibly soiled every Sunday night. The TAR further revealed that Nurse #3 initialed the oxygen tubing change on 02/05/23 and 02/19/23 and Nurse #4 initialed the oxygen tubing change on 02/12/23 and 02/26/23.

An observation of Resident #13 was made on 02/26/23 at 4:13 PM. Resident #13 was sitting in her wheelchair at the foot of her bed. She was wearing oxygen via nasal canula that was connected to an oxygen concentrator sitting next to her. The concentrator was noted to have no external oxygen filter and the space where the filter was to be placed was full of grey/white dust particles.

An observation of Resident #13 was made on 02/27/23 at 10:18 AM. Resident #13 was resting in bed. She was wearing oxygen via nasal canula that was connected to an oxygen concentrator sitting next to her bed. The concentrator was noted to have no external oxygen filter and the space where the filter was to be placed was full of grey/white dust particles.

An observation of Resident #13 was made on 02/28/23 at 4:46 PM. Resident #13 was sitting in her wheelchair at the foot of her bed. She was wearing oxygen via nasal canula that was connected to an oxygen concentrator sitting next to her. The concentrator was noted to have no

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external oxygen filter and the space where the filter was to be placed was full of grey/white dust particles.

An observation of Resident #13 was made on 03/01/23 at 10:08 AM. Resident #13 was being assisted to her recliner by the Physical Therapist (PT). The PT was observed to replace Resident #13's portable oxygen with the oxygen concentrator that sat next to her bed. The oxygen concentrator was noted to have no external oxygen filter and the space where the filter was to be placed was full of grey/white dust particles.

Nurse #5 was interviewed on 03/01/23 at 10:21 AM who confirmed that she was caring for Resident #13. She stated that the third shift nurses were responsible for changing the oxygen tubing once a week. Nurse #5 was unsure of who was responsible for cleaning/replacing oxygen filters. She stated that in other facility's she had worked the maintenance department took care of them but could not say who was responsible in this facility. Nurse #5 stated she had not cleaned or checked the filter on Resident #13's oxygen concentrator because she did not know she needed to.

The Maintenance Director was interviewed on 03/01/23 at 10:31 AM who stated that he cleaned/replaced the oxygen concentrator filers as needed. He was asked to observe Resident #13's oxygen concentrator and confirmed that there was no filter where it should be and that the dust needed to be removed from the empty space in the back of the concentrator.

The Central Supply Clerk was interviewed on 03/01/23 at 10:44 AM who stated the third shift

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F 695	Continued From page 40 nursing staff were responsible for cleaning/replacing the oxygen filters. Multiple attempts to speak to Nurse #4 were made on 03/01/23. The Director of Nursing (DON) was interviewed on 03/01/23 at 12:02 PM who stated that on Sunday nights the nurses were responsible for changing oxygen tubing as well and checking/cleaning and/or replacing the oxygen concentrator filters. She stated that the nurses would do the external filters and the Maintenance department would do the internal filters. Nurse #3 was interviewed via phone on 03/01/23 at 2:24 PM who confirmed that she worked night shift at the facility on Sunday nights and was responsible for changing oxygen tubing and cleaning or replacing oxygen filters. Nurse #3 stated that she did not recall specifically checking or cleaning Resident #13's oxygen filter because she did so many. She further stated that it was her general practice to check and clean each oxygen filters for the residents on her unit on Sunday nights and if she documented that she did it then that would indicate it had been done.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725		3/24/23

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F 725	Continued From page 41 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, and Resident interviews the facility failed to provide sufficient nursing staff resulting in residents not being treated in a dignified manner and missed showers for 2 of 6 sampled residents (Resident #22 and Resident #15). The findings include: This tag is crossed referenced to F 550: Based on record review, Resident, and Staff interview the facility failed to treat a resident in a dignified manner by not providing incontinent care when requested (Resident #22) and for not providing showers as the resident preferred (Resident #15) for 2 of 3 residents reviewed for dignity.	F 725	On 03/20/2023 Administrator met with Resident #15 and #22 to review the current plans for recruitment/retention to ensure sufficient nursing staff to meet resident□s needs. All residents have potential to be affected. On 03/23/2023 Administrator met with Residents at Resident Council to review recruitment/retention plans to ensure sufficient nursing staff to meet resident□s needs. Regional Director of Operations educated Administrator, DON, HR, and Scheduling coordinator on importance of a daily meeting to review current staffing to ensure sufficient staffing to meet the	

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F 725	Continued From page 42 This tag is crossed referenced to F 561: Based on observations, record review, resident and staff interviews the facility failed to honor a resident's bathing preference for 1 of 6 residents reviewed for choices (Resident #15). This tag is crossed referenced to F 677: Based on record review, Resident and staff interviews the facility failed to provide incontinent care when requested by the resident for 1 of 6 residents reviewed for activities of daily living (Resident #22). An interview was conducted with the Weekend Supervisor via phone on 02/28/23 at 3:55 PM who explained that she worked every weekend from 7:00 AM to 11:00 PM on the medication cart, helping the Nurse Aides (NAs), and navigating whatever other issues came her way. She stated that nine times out of ten on the weekend the facility was short staffed, and residents had to wait longer than use for care. The Weekend Supervisor stated that showers were not being provided because they were too short staffed, "these residents deserve better than what they get." She explained that on the weekends there were generally one NA on each floor then the Nurses were expected to help pass meal trays, answer call lights, and provide care as needed, no matter how much we asked for help we were just left to "deal with it." The Scheduling Coordinator was interviewed via phone on 03/01/23 at 9:46 AM who confirmed that she had been at the facility since December 2022 and at that time staffing was "terrible," they	F 725	resident□s needs. Administrator/DON/HR/Scheduler to continue to meet daily after morning meeting and review staffing trends to ensure sufficient staff to meet needs of the residents. Administrator to meet with 5 Residents weekly to ensure residents aware of recruitment/retention efforts, interviews to be documented and reviewed with IDT Quality Assurance Committee for 8 weeks and continue audits at discretion of the committee.	

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F 725	Continued From page 43 did not have a lot of staff, and the staff that they had were upset because they had to work every other weekend so a lot of employees quite or went as needed and then would not come in when we needed them. The Scheduling Coordinator stated that she asked and begged for the facility to allow agency staff to come in and help fill the staffing shortages and finally about two weeks they agreed. She stated that the agency staff has eased some of the burden but she still had openings on second shift and the weekends. She added she was very flexible with the facility staff that they had in regard to their hours, she stated some come in at 7, some come in at 8 but she remained flexible in attempt to retain the employees that they had. The Scheduling Coordinator stated that she liked to have 8 NA on first and second shift and 5 on the night shift and one nurse on each unit or 2 nurses and a medication aide this included the weekends. She stated with the help of agency they are able to do this more often then they were two weeks ago. The Director of Nursing (DON) was interviewed on 03/01/23 at 4:01 PM who stated that the last month she "has been hanging on by a fingernail" due to staffing shortages. She stated she was getting pulled to assist with the staffing shortages and everything that she needed to be monitoring was not getting monitored like it should because she was busy with other things.	F 725		
F 800 SS=D	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that	F 800		3/24/23

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F 800	Continued From page 44 meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and Resident interviews the facility failed to have ongoing communication to ensure a newly admitted resident received a meal tray during meal service for 1 of 13 residents (Resident #88) reviewed for dining. The finding included: Resident #88 was admitted to the facility on 02/24/23. Review of Resident #88's medical record dated 02/24/23 revealed she was on a regular diet with regular texture and consistency. Review of Resident #88's admission nursing assessment dated 02/24/23 revealed the Resident was alert and oriented to person, place, and time. On 02/26/23 at 6:00 PM an observation was made of multiple staff passing out supper trays from the meal cart on 400 hall. An observation and interview were conducted with Resident #88 on 02/26/23 at 6:04 PM. The Resident was lying in bed and explained that they had not brought her supper tray to her yet. On 02/26/23 at 6:31 PM an observation was made of the meal cart not being on the 400 hall. An interview and observation of Resident #88 on	F 800	Regarding the alleged deficient practice of failing to have ongoing communication to ensure a newly admitted resident received a meal tray during meal service for 1 of 13 residents as evidenced by: - Resident #88 did not receive her dinner tray was not sent at the time other trays were being passed out. Resident #88 immediately received her tray after dietary services was notified of missing tray. All residents have potential to be affected. On 03/09/2023 District Dietary Manager in-serviced full time cook on making resident active in MealTracker and printing off trays. All dietary staff was also in-serviced on making a tray ticket for new admissions that come in after hours and placing them in with the meal tickets until dietary manager or full-time cook can get the resident made active in MealTracker and print the tickets out for them. Dietary Manager will not print tickets for the weekend prior to 3:00 PM. Diet slips will be turned into dietary from nursing department for notification of new admission, readmission, and/or diet changes. Full-time cook will make active any new admissions to MealTracker that admits Friday evenings, Saturday, or Sunday. Full Time Cook will print tickets	

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F 800	Continued From page 45 02/26/23 at 6:32 revealed she still had not received a supper tray. The Resident explained that a man stopped by and asked her for her tray, and she told him that she didn't have a tray. On 02/26/23 at 6:32 PM an interview with the Weekend Supervisor revealed she did not know why Resident #88 did not receive her supper tray and she would speak with Nurse Aide (NA) #4 to find out why she did not receive her meal tray. On 02/26/23 at 6:40 PM during an observation and interview of Nurse Aide #4, the NA was coming out of Resident #88's room and explained that he stopped by the Resident's room earlier and asked her if she had her tray and she told him that she did not have a tray. The NA stated that he misunderstood her because she was telling him that she did not receive her supper tray at all. The NA stated he thought her tray had already been picked up from the Resident's room by one of the other people helping him pass out the meal trays. The NA continued to explain that he normally did not have help passing out the meal trays and that day he had other people helping him, so he did not realize Resident #88 did not receive her supper tray. The NA stated he would go to the kitchen and get Resident #88 something to eat. During an interview with Resident #88 on 02/26/23 at 6:46 PM the Resident still did not have a supper tray. The Resident explained that NA #4 apologized to her for not getting her supper tray and told her that he normally did not get help passing out the meal trays therefore, he did not realize she did not get her supper tray. The NA was going to get her a supper tray.	F 800	for new residents once added to MealTracker and place tray ticket in with all other trays tickets for remainder of meals for the weekend. Full-time cook will leave diet slip on Dietary Manager□s desk for manager to validate that the resident has been made active. District Manager to be added to email chain that notifies of new admission/readmissions. Dietary Manager will validate that the admissions, readmissions and/or diet changes have been made in MealTracker and residents noted to be active every Monday. The District Dietary Manager will validate that the residents were made active in MealTracker by reviewing admission notifications compared to what is entered into MealTracker via history. Dietary Manager to share at Quality Assurance Committee for 8 weeks and continue audits at discretion of the committee.	

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At 6:51 PM on 02/26/23 Nurse Aide #4 took Resident #88 her supper tray of chicken tenders, macaroni and cheese, green beans and a cookie for dessert which was what was served to the rest of the residents.

An interview was conducted with Resident #88 on 02/28/23 at 10:24 AM. The Resident explained that she was disappointed when she did not get her supper tray on Sunday night (02/26/23) and stated, "when you are sick already it just did not make me feel good being forgotten."

On 02/28/23 at 10:31 AM during an interview with the Marketing Director she explained that she only passed out one supper tray on 400 hall on 02/26/23 because she arrived at the facility late that evening. She stated she did ask if there were anymore trays to pass out and was told no.

On 02/28/23 at 10:42 AM during an interview with the Admissions Director (AD) she confirmed that she helped pass out the supper meal trays on 400 hall on 02/26/23. The AD explained that there were two supper trays left on the cart that were not passed out because she put them back on the cart because the residents refused the trays. The AD stated she was not aware that Resident #88 did not receive her supper tray until later Sunday night.

An interview with the Certified Dietary Manager (CDM) on 02/28/23 at 4:50 PM revealed she assisted with plating the food for the supper meal on 02/26/23 and was made aware that Resident #88 did not receive her supper tray after they had finished the serving line in the kitchen. The CDM explained that she investigated the situation and found that the Resident was admitted on Friday

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F 800	Continued From page 47 02/24/23 and all weekend her meal tickets had to be handwritten until her information could be entered into the system before the system could print out a meal ticket for her. She continued to explain that she interviewed the dietary aide that wrote Resident #88 meal ticket for the supper meal that day so she could not determine why the Resident did not get her tray other than it was possible that the meal ticket was stuck to another meal ticket, or it was even possible that Resident #88's supper meal was put on a different cart but she could not be 100 % sure that happened either. An interview was conducted with the Administrator with the Director of Nursing (DON) in attendance on 03/01/23 at 12:24 PM. The DON explained that she was not made aware that Resident #88 had not received her supper tray until it was brought to her attention on the night of 02/26/23. The DON indicated there should be a double check system to ensure the all the residents received their meal trays.	F 800		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and	F 867		3/24/23

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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 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

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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 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

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F 867	Continued From page 50 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 reviews, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint survey conducted on 07/27/20. This failure was for one deficiency that was originally cited in the areas of Infection Control (F880) and was subsequently recited on the current recertification and complaint survey of 03/02/23. The repeat deficiency during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This tag is cross referred to:	F 867	F867 QAPI Regarding the alleged deficient practice of failure to establish and maintain an infection prevention and control program, as evidenced by: a) Nurse #2 failed to perform hand hygiene and change gloves after removing a dirty dressing, after cleansing a wound and before applying a clean dressing to a wound. On 02/28/2023, Nurse #2 was educated regarding infection control principles, hand hygiene and appropriate glove change by Nurse unit coordinator. On 02/28/2023, contaminated dressing was removed and reapplied per	

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F 867	Continued From page 51 F880: Based on observation, record review, and staff interviews, Nurse #2 failed to perform hand hygiene and change gloves after removing a dirty dressing, after cleansing a wound and before applying a clean dressing to a wound for 1 of 1 staff member that completed wound care (Nurse #2). During the Covid-19 Focused Infection Control and complaint investigation survey completed on 7/27/20 the facility failed to implement protocols when staff did not don and doff Personal Protective Equipment (PPE) when they entered and exited the rooms of residents who were on Droplet Precautions for 2 of 2 nursing staff observed working on the facility's quarantine hallway. The facility failed develop a policy that addressed when laundry staff were to perform hand hygiene and what Personal Protective Equipment (PPE) they were to wear. Additionally, a laundry aide was observed not wearing any PPE while handling clean and dirty laundry nor perform hand hygiene after touching soiled linen laundry for 1 of 1 staff observed processing laundry. Staff disposed of isolation gowns, that were used on the facility's quarantine unit, in a bag that was attached to a blood pressure machine. Staff failed to disinfect a mattress that was removed from a resident's room who was on droplet precautions, and failed to wear PPE, to prevent contact with skin and clothing, when the mattress was removed from the quarantine unit. These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents and staff in the facility through the transmission of COVID-19.	F 867	appropriate infection control standards, by the Director of Nursing. Beginning on 03/17/2023, the Director of Nursing (DON) provided in-service education to all staff regarding General infection control, including Hand Hygiene and Donning and Doffing gloves during wound care, with education to continue upon return to work for all staff and completion by 03/24/2023. Education will be provided to newly hired or contracted nursing staff upon hire prior to receiving an assignment. QAPI committee members, including the Infection Preventionist and Regional Director of Operations met on 03/20/2023 to review concerns related to: " Hand hygiene " Donning and doffing of gloves during wound care Root cause was determined to be: " Why Did this Occur? o Nurse failed to perform hand hygiene/change gloves after removing a dirty dressing " Why Did this Occur? o Nurse claimed she was nervous with the surveyor. " Why Did this Occur? o Nurse had been doing treatments for some time and team discussed that nurse had become complacent with treatment process. " Why Did this Occur? o Lack of consistent education/skills/oversight regarding treatment process and hand hygiene	

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F 867	Continued From page 52 The Administrator was interviewed on 03/01/23 at 4:01 PM who stated that the facility Quality Assurance (QA) committee met monthly and included all the department heads and the Medical Director, and a smaller group met monthly to go over antibiotic stewardship, residents with weight loss, trends, grievances, etc. They had monthly staff meetings to share QAPI information with the floor staff. Some recent PIP (performance improvement projects) they were working on were around staff retention and Point of Care (POC - point in time when care is given) documentation. The Administrator stated that they would incorporate the current survey results into their meeting and discuss way to achieve substantial compliance.	F 867	during treatments " Why did this occur? o Facility lost long term care wound nurse and has hired wound nurse 3/21/23, has participated with hand hygiene education. The Regional Director of Operations provided in service education for the Management team consisting of the Administrator, Director of Nursing, Minimum Data Set coordinators, Social Worker, Activities Director, Unit Coordinators, Maintenance, HR, Admissions, Medical Records, Business Office, Scheduler, and Central Supply regarding QAPI, how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance on 03/20/2023. Beginning the week of 03/20/2023 Director of Nursing Unit Coordinator, or Infection Preventionist will audit hand hygiene by observing 5 staff per week for four weeks, and then 3 staff per week for 2 months to assure and validate substantial compliance. Beginning the week of 03/20/2023, The DON and/or unit coordinators will observe 3 wound care encounters per week for four weeks, and then 1 wound care encounter every week for 2 months to assure and validate substantial compliance with infection prevention and control standards, to include appropriate glove changes.	

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F 867	Continued From page 53	F 867	The DON will review audits for patterns/trends and will adjust plan to maintain compliance and will review plan during the monthly QAPI meeting for 6 months or until compliance is maintained.	
F 880 SS=D	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 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;	F 880		3/24/23

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F 880	Continued From page 54 (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 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 observation, record review, and staff interviews, Nurse #2 failed to perform hand hygiene and change gloves after removing a dirty dressing, after cleansing a wound and before	F 880	Regarding the alleged deficient practice of failure to establish and maintain an infection prevention and control program, as evidenced by:	

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F 880	Continued From page 55 applying a clean dressing to a wound for 1 of 1 staff member that completed wound care (Nurse #2). The finding included: Review of a facility policy titled "Infection Control Guidelines for all Nursing Procedures" dated 12/29/20 under General Guidelines the policy indicated: 3. Employees must wash their hands for a minimum of 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions, c. After contact with secretions or non-intact skin; e. After handling items potentially contaminated with blood, bodily fluids, or secretions. 4. e. Before handling clean dressing, gauze pads and etc; h. After handling used dressings. On 02/28/23 at 1:35 PM an observation was made of Nurse #2 performing a dressing change on Resident #86's pressure ulcers. The Nurse sanitized her hands and applied clean gloves then brought wound care supplies (gauze soaked with wound cleanser, ointment in a medicine cup, and 2 border dressings) into the Resident's room. Resident #86 was positioned on his left side with his buttocks exposed where he had an unstageable wound on his coccyx (without a dressing present) and an open wound on his right buttocks (with a dressing present). The Nurse proceeded to cleanse the coccyx wound with the soaked gauze then removed the dirty dressing from his right buttock and cleansed that wound. She then used her index finger to apply the medicated ointment to the two wounds then covered the two wounds with border dressings. After Nurse #2 applied the two border dressings she removed her gloves and sanitized her hands.	F 880	a) Nurse #2 failed to perform hand hygiene and change gloves after removing a dirty dressing, after cleansing a wound and before applying a clean dressing to a wound. On 02/28/2023, Nurse #2 was educated regarding infection control principles, hand hygiene and appropriate glove change by Nurse unit coordinator. On 02/28/2023, contaminated dressing was removed and reapplied per appropriate infection control standards, by the Director of Nursing. Beginning on 03/17/2023, the Director of Nursing (DON) provided in-service education to all staff regarding General infection control, including Hand Hygiene and Donning and Doffing gloves during wound care, with education to continue upon return to work for all staff and completion by 03/24/2023. Education will be provided to newly hired or contracted nursing staff upon hire prior to receiving an assignment. QAPI committee members, including the Infection Preventionist and Regional Director of Operations met on 03/20/2023 to review concerns related to: " Hand hygiene " Donning and doffing of gloves during wound care Root cause was determined to be: " Why Did this Occur? o Nurse failed to perform hand hygiene/change gloves after removing a	

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F 880	Continued From page 56 An interview was conducted with Nurse #2 on 02/28/23 at 1:45 PM who explained that she realized she did not change her gloves and wash her hands during the dressing change. The Nurse continued to explain that she should have removed the dirty dressing from the Resident's right buttock first then remove her gloves and sanitized her hands before she cleansed the wounds. She stated she also should have removed her gloves and sanitized her hands before she applied the medicated ointment and applied the clean border dressings. The Nurse verbalized that she clearly contaminated the Resident's wounds. An interview was conducted with Unit Manager (UM) #2 and the Administrator on 02/28/23 at 2:00 PM. The observation of Nurse #2's performance was explained in step-by-step detail to the UM and the Administrator. The UM verbalized the Nurse should have removed her gloves and sanitized her hands after she removed the dirty dressing and after she cleansed the dirty wounds to prevent recontamination of the wounds. The Administrator acknowledged the situation and agreed with the Unit Manager.	F 880	dirty dressing " Why Did this Occur? o Nurse claimed she was nervous with the surveyor. " Why Did this Occur? o Nurse had been doing treatments for some time and team discussed that nurse had become complacent with treatment process. " Why Did this Occur? o Lack of consistent education/skills/oversight regarding treatment process and hand hygiene during treatments " Why did this occur? o Facility lost long term care wound nurse and has hired wound nurse 3/21/23, has participated with hand hygiene education. The Regional Director of Operations provided in service education for the Management team consisting of the Administrator, Director of Nursing, Infection Preventionist Minimum Data Set coordinators, Social Worker, Activities Director, Unit Coordinators, Maintenance, HR, Admissions, Medical Records, Rehab Director, EVS Director, Business Office, Scheduler, and Central Supply regarding QAPI, how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance on 03/20/2023. Beginning the week of 03/20/2023 Director of Nursing Unit Coordinator, or Infection Preventionist will audit hand hygiene by observing 5 staff per week for	

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F 880	Continued From page 57	F 880	four weeks, and then 3 staff per week for 2 months to assure and validate substantial compliance. Beginning the week of 03/20/2023, The DON and/or unit coordinators will observe 3 wound care encounters per week for four weeks, and then 1 wound care encounter every week for 2 months to assure and validate substantial compliance with infection prevention and control standards, to include appropriate glove changes. The DON will review audits for patterns/trends and will adjust plan to maintain compliance and will review plan during the monthly QAPI meeting for 6 months or until compliance is maintained.	