STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING ______ B. WING ______	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF PLYMOUTH	**1084 US 64 EAST PLYMOUTH, NC 27962**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/13/23 through 02/16/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 5DI911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 02/13/23 through 02/16/23. Intake NC00195327 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.12 at tag F607 at a scope and severity (J) The tags F600 and F607 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/2/22 and was removed on 2/16/23. An extended survey was conducted. The following intakes were investigated NC00188464, NC00189456, NC00191115, NC00195327, NC00195882, NC00196226, NC00196220, and NC00198340. Four of the 11 complaint allegations resulted in deficiency. The Statement of Deficiencies was amended on 4/19/23. Tag F610 was moved to tag F607.	F 000		
F 583	Personal Privacy/Confidentiality of Records	F 583		3/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/09/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 583 SS=D	Continued From page 1 CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, and staff interviews the facility failed to maintain a	F 583	On 2/21/2023 the DON educated CNA #3 regarding resident dignity to include not	

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F 583	Continued From page 2 resident's privacy during incontinence care by leaving the resident exposed while the Nursing Assistant (NA) #3 left the room to gather incontinent supplies. This occurred for 1 of 2 resident (Resident #24) reviewed for privacy. Findings included: Resident #24 was admitted to the facility on 12-26-17. The quarterly Minimum Data Set (MDS) dated 1-13-23 revealed Resident #24 was cognitively intact and required total assistance with one person for toileting. An observation of incontinence care occurred on 2-15-23 at 5:20am. NA #3 was observed to be standing outside Resident #24's room holding a bag of briefs. Upon entering the resident's room, the resident's privacy curtain was not pulled allowing the resident to be observed laying on the bed with her gown pulled up to her breast with no brief exposing her vaginal area. Resident #24 was noted to start pulling down her gown when she saw writer. Observation of Incontinence care revealed NA #3 repeatedly left the resident exposed as she went into the bathroom to wet/rinse her washcloth and each time Resident #24 was observed to try and pull her gown down to cover herself. NA #3 also left the resident room again to retrieve a towel and left the resident exposed. During an interview with NA #3 on 2-15-23 at 5:30am, the NA stated she usually tried to cover the resident if she had to leave during incontinence care. The NA explained she had been running behind and did not realize she did	F 583	exposing a resident during care, pulling the privacy curtain and closing the blinds. ADON/designee initiated an in service with all staff to include nursing, therapy, dietary, housekeeping, maintenance, social work, activity, business office, laundry, administrator and agency contract staff regarding dignity, not exposing a resident during care, pulling the privacy curtain and closing the blinds. The in service will be completed by 3/09/2023. All employees will receive the dignity in-service during orientation. The Unit Manager and/or designee will observe personal care, 2 resident per hall 3 times per week x 4 weeks, then 1 resident per hall weekly x 4 weeks using a dignity audit tool. The Unit Manager and/or designee will immediately address the deficient practice identified to include reeducation of staff. The Administrator will forward the results of the Dignity Audit Tool to the Executive QA committee in a daily huddle and issues or concerns will be addressed immediately. The Executive QA committee will meet monthly x 2 month and review the Dignity Audit tool to determine trends and/or issues that may need further interventions and/or changes to the plan.	

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F 583	Continued From page 3 not have briefs and thought she would be gone for a moment, but it took longer than she expected. NA #3 stated she did not pull the privacy curtain because the resident was in the room by herself and did not know why she had not covered the resident but said she should have covered the resident and had the privacy curtain pulled. Resident #24 was interviewed on 2-15-23 at 8:34am. The resident stated the Director of Nursing had come and spoken with her regarding being exposed during incontinence care. Resident #24 stated she was not upset or embarrassed. The resident stated, "I just felt cold because the fan was blowing on me." An interview with the Director of Nursing (DON) occurred on 2-16-23 at 11:57am. The DON stated the correct procedure was for NA #3 to uncover the part of the body being washed and keep the rest of the resident's body covered. The DON also said if the NA had to walk away, the NA should have covered the resident while she was gathering her supplies. The Administrator was interviewed on 12-16-23 at 12:16pm. The Administrator stated residents should be always covered to protect their privacy.	F 583		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		3/15/23

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F 585	Continued From page 4	F 585		

respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

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

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman

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F 585	Continued From page 5 program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement	F 585		

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F 585	Continued From page 6 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family, and staff interviews the facility failed to resolve a grievance (Resident #1) and failed to provide a written response to a grievance (Resident #288) for 2 of 2 residents reviewed for grievances. Findings included: A review of the facility policy dated 10/1/20 titled "Resident and Family Grievances" revealed in part, "10. Procedure: g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation." It further revealed in part, "12. The facility will make prompt effort to resolve grievances." 1. Resident #1 was admitted to the facility on 8/31/2018 with a diagnosis including rheumatoid arthritis (a chronic inflammatory disorder affecting the joints) and diabetes mellitus. A review of her annual Minimum Data Set (MDS) assessment dated 5/10/2022 revealed she was cognitively intact. She required the total assistance of 1 person to eat. A dietician progress note for Resident #1 dated	F 585	1. Resident #288 concerns on the issue of untimely incontinence care was provided a verbal response to her grievance on 2/17/2023 by the DON and a written response was provided to the resident on 2/17/2023 by DON. Resident #1 has a dental consultant on 4/12/2023 with Southern Smiles for removal of existing dental roots and preparation of full set of dentures. Resident and Resident Representative made aware of appointment. 2. 100% audit of all resident concerns for the last 12 months, to include any for resident # 288 and resident # 1, will be reviewed by the Social Worker to ensure all resident concerns were completed and resolved timely using a Grievance Resolution QI tool by 3/09/2023. No concerns were identified in the 100% audit. Director of Nursing was in-serviced by the Chief Clinical Officer on 2/15/2023 to include the grievance process, written responses, and proper follow-up. 100% in-service will be conducted by the DON with all staff, dietary, housekeeping, maintenance, social worker, activities, business office, laundry, administrator and contract agency staff, regarding the facility	

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F 585	Continued From page 7 2/10/23 revealed her weight was stable for 30, 60, and 90 days. It further revealed she was revealed she was receiving a mechanical soft carbohydrate-controlled diet. Resident #1 was meeting her nutritional needs with supplements in place. On 2/13/23 at 1:51 PM an interview with Resident #1 indicated she did not have any natural teeth. She stated she had been waiting on dentures since the last time she saw the dentist at the facility. She stated she was not having any trouble chewing her food without dentures and she was not having any mouth pain. She further indicated the last time she saw the dentist he told her she needed to have her tooth roots out before she could get dentures, but these had still not been removed. On 2/15/23 at 5:47 PM a telephone interview with Resident #1's family member indicated she spoke with the resident by telephone daily and her family member had been telling her repeatedly she had not gotten her dentures. She stated she filed a grievance with the facility in March or April of 2022 regarding her family member waiting for dentures for two years. She went on to say she had scheduled an outside appointment for Resident #1 at one time and the facility called her to let her know it was better for her to let the facility schedule appointments because that way they could coordinate the transportation. She further indicated it was her understanding the facility would coordinate any dental appointments. Resident #1's family member stated she had called the facility multiple times to speak with the Administrator but was frequently told she was in a meeting and would call her back. She stated she never received a call back from anyone. She	F 585	Grievance process to include ensuring all Resident Concerns are completed on the appropriate sheets and appropriate department managers are notified immediately of the concern by the DON. Also the facility Grievance process will be reviewed with all staff regarding ensuring the grievance procedure is being followed appropriately per policy and procedure on 3/09/2023 by DON. All newly hired license nurses, CNAs, maintenance, dietary, housekeeping, therapy, bookkeeping or activities will be inserviced on the Grievance process during orientation by DON. 3. All residents□ concerns, to include resident # 288 and resident # 1, will be reviewed to ensure all concerns were completed timely and resolved with follow up documentation using a Grievance Resolution QI tool and any issues will be addressed at that time by the Social Worker. Each will be audited utilizing the Grievance Resolution tool for 4 weeks. The Administrator will review and initial the Grievance Resolution QI form weekly X 4 weeks to ensure all concerns were resolved timely and with follow up documentation completed, and any areas of concerns were addressed. 4.Social worker will take Grievance audit tool to monthly QI meeting. The Executive QI committee will meet monthly and review the Grievances Resolution tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of	

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F 585	Continued From page 8 went on to say she would have expected Resident #1 to be seen by a dentist and to have gotten dentures by now. A review of the grievance dated 4/13/22 filed by Resident #1's family member revealed in part the detail of the grievance was Resident #1 had been waiting for new dentures for 2 years. The person investigating the grievance was the Director of Nursing (DON). The written response to the grievance from the Administrator dated 4/19/22 revealed the dental provider had seen Resident #1 on 2/18/20 and Resident #1 would be placed on the next dental clinic list. The resolved date of the grievance was 4/19/22. On 2/16/23 at 11:55 AM an interview with the Administrator indicated Resident #1 should have received a resolution to the grievance dated 4/13/22. 2. Resident #288 was admitted to the facility on 2/1/23 with a diagnosis of right lower leg fracture. A review of Resident #288's medical record revealed she was her own Responsible Party (RP). On 2/14/23 at 4:10 PM an interview with Resident #288 indicated she had a concern about a delay in care that was provided to her when she first came to the facility. She stated she verbalized this concern to a facility staff member. She went on to say since that time she felt the issue was resolved. Resident #288 stated no one had spoken to her about any grievance and she had not received a written response to her concern. She stated she had not even realized a grievance was filed. She went on to say it would have been	F 585	monitoring x 2 months.	

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F 585	Continued From page 9 nice to receive a follow up to her grievance so she could have been aware of what was done. A review of a grievance filed by Resident #288 dated 2/3/23 revealed she had a concern about a delay in the care provided to her. The facility staff member listed as investigating the grievance was the Director of Nursing (DON). The date the grievance was resolved was listed as 2/3/23. No written grievance response was attached or documented. The DON's signature was listed on the form as the grievance official. On 2/14/23 at 3:53 PM an interview with the DON indicated she received Resident #288's grievance when the Administrator was out of the facility. She stated she completed the investigation for the grievance. She went on to say she did not follow up with Resident #288 verbally or in writing regarding the outcome. The DON stated she usually passed grievances along to the Administrator when she completed her investigation and was not aware a written response was needed.	F 585		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		3/15/23

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F 600	Continued From page 10 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interviews the facility failed to protect a cognitively impaired resident (Resident #82) from physical abuse from an employee when a Nursing Assistant (NA) #2 was witnessed by another employee (Restorative Aide) "grab" Resident #82 forcibly by the arm once when assisting the resident out of her wheelchair and another time when Resident #82 began walking away from the bathroom and then NA #2 pushed Resident #82 into the resident bathroom. Resident #82 did not have the cognitive capacity to express an adverse outcome. A reasonable person would have been traumatized by being physically abused by their caregiver in their home environment. The facility failed to protect Resident #28 from mistreatment by NA # 1. This occurred for 2 of 3 residents reviewed for abuse. Immediate Jeopardy began on 11-2-23 when the facility failed to protect Resident #82's right to be free from abuse. The immediate Jeopardy was removed on 2-16-23 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity D (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure the education and monitoring systems put in place are effective and to address deficient practice cited at scope and severity D for Resident #28.	F 600	1. Immediate action(s) taken for the resident(s) found to have been affected include: November 2, 2022, an investigation was immediately started by the administrator upon notification of an abuse allegation. 24-hour initial abuse allegation report was submitted to the Health Care Personnel Registry (HCPR) and the alleged employee (NA #2) was suspended on November 2, 2022, pending the outcome of the investigation and subsequently terminated on November 4, 2022. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of the residents have the potential to be affected. November 2, 20022 □ November 3, 2022: " 100% of alert & oriented residents (BIMs 13 and above) questioning about abuse by the facility social worker. No concerns were identified during the interviews. " The Social Worker attempted to conduct an interview with resident #82 but the resident was unable to complete it. " 100% Head to toe assessments were completed on all residents with BIMs scores below 13, including resident #82. No evidence of physical or mental harm was noted.	

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F 600

Continued From page 11

Findings included:

1. Resident #82 was admitted to the facility on 9-19-22 with multiple diagnoses that included dementia.

The quarterly Minimum Data Set (MDS) dated 1-23-23 revealed Resident #82 was severely cognitively impaired and did not have any behaviors. Resident #82 was also documented as needing supervision with two people for transfers and total assistance with one person for toileting and ambulation. The MDS also documented Resident #82 was on Hospice services.

Review of Resident #82's roommate (Resident #24) statement dated 11-2-22 taken by the facility's Social Worker revealed the roommate reported NA #2 was upset with Resident #82 because Resident #82 would not get out of her wheelchair to be changed. The roommate reported NA #2 walked Resident #82 to the bathroom, but Resident #82 held onto the bathroom doorknob, so NA #2 "snatched" Resident #82's hand off the doorknob and pushed the resident into the bathroom.

Resident #82's roommate (Resident #24) was interviewed on 2-13-23 at 9:38am. The roommate was cognitively intact per the quarterly MDS dated 1-13-23 and stated she did not remember any incident involving Resident #82 and NA #2 in November 2022.

An interview with the Social Worker (SW) occurred on 2-14-23 at 9:29am. The SW stated she was informed by the Administrator that NA #2 was walking Resident #82 to the bathroom and NA #2 told Resident #82 "I'm not your sister get

F 600

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
November 2, 2022 November 4, 2022, a series of mandatory in-services were conducted for all staff (direct care staff, administrative staff, and contractors) by the Director of Nursing (DON) on the Carrolton Facility Policy for Abuse, Neglect, and Exploitation.

February 14, 2023 February 15, 2023, a series of mandatory in-services were again conducted for all staff (direct care staff, administrative staff, and contractors). Staff were required to complete this training prior to working.

Education included the abuse policy and procedure to ensure compliance with resident rights and applicable state and federal law emphasizing:
" Residents rights to be free of abuse, neglect, misappropriation of resident property and exploitation,
" Identification of abuse, neglect, misappropriation of resident property and exploitation,
" Resident protection (including immediate suspension of the alleged employee pending the outcome of the investigation),
" Immediate reporting of abuse (noting state and federal guidelines)
" Abuse investigation
" Zero abuse tolerance (including employee termination)

While abuse has always been a part of

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THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

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Continued From page 12

into the bathroom" then pushed Resident #82 into the bathroom on 11-2-22 at 1:45pm. The SW said she was unable to interview Resident #82 related to the resident's cognitive status, but she had interviewed the resident's roommate. She stated Resident #82's roommate had told her she saw Resident #82 holding onto the doorknob of the bathroom, the NA "snatching" Resident #82's hand off the doorknob and then push Resident #82 into the bathroom.

A telephone interview occurred with the Restorative Aide on 2-14-23 at 10:08am. The Restorative Aide explained she had entered Resident #82's room on 11-2-22 at approximately 1:35pm to provide therapy but realized Resident #82 was soiled. She stated she left the room and requested NA #2 to the resident room to assist her in changing Resident #82. The Restorative Aide stated when NA #2 entered the room, the NA declined any assistance. She went on to explain when the NA tried to get Resident #82 out of her wheelchair, the resident tried to get back in bed and the NA became upset "grabbing" forcefully Resident #82's arm and telling the resident to "get into the bathroom." The Restorative Aide stated the NA walked Resident #82 to the bathroom door and told the resident to stand there while the NA went out to retrieve more supplies. The Restorative Aide stated when the NA left the room the resident started walking back to her bed. She said when the NA returned, the NA "grabbed" forcefully Resident #82's arm again and forcefully started pulling the resident back towards the bathroom. The Restorative Aide stated once the NA and resident were at the bathroom door, the NA "pushed" Resident #82 into the bathroom, and she heard Resident #82's body hit the sink. The Restorative Aide stated NA

F 600

our initial orientation program as well as a requirement for annual training, the initial orientation program and annual in-services were revamped on February 15, 2023, to emphasize a zero tolerance for abuse.

4. How the corrective action(s) will be monitored to ensure the practice will not recur:

Beginning the week of March 12, 2023, the facility Social Worker or designee will:

" Interview alert & oriented residents for abuse signs of physical or mental abuse.
" Observe non-alert and oriented residents to include resident # 82, for behavioral changes that may indicate mistreatment or treatment abuse.
" Interview employees regarding abuse identification, resident protection, and timely reporting
" Interviews and observations will occur with the following schedule:
o 2 residents and 3 employees weekly x 4 weeks
o 2 residents and 3 employees every month x 2 months

Any concerns identified during interviews will be immediately addressed by the DON/Administrator to include investigation and staff retraining.

The DON will review the resident interview summaries provided by the social worker and concerns identified will be immediately addressed.

The Administrator will present the findings to the Quality Assurance and

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F 600	Continued From page 13 #2 then "slammed" the bathroom door shut. She said it was then she left the room to tell her supervisor. She explained she heard a "thud" and assumed it was the sink the resident hit because the toilet was to far away for the resident to hit. She stated she did not hear the resident cry out or make any sounds that would indicate she was hurt. The Restorative Aide also stated she did not intervene because she did not want to have a confrontation with NA #2, and she did not leave to retrieve help sooner because she wanted to make sure the resident was ok. A further telephone interview occurred with the Restorative Aide on 2-14-23 at 2:49pm. The Restorative Aide explained she had gone back and checked on Resident #82 while she was waiting to report the incident. She stated Resident #82 was in her room and after speaking with the resident she felt the resident was ok, so she escorted the resident to activities. The Therapy Director was interviewed on 2-14-23 at 3:47pm. The Therapy Director explained she was the Restorative Aide supervisor. She stated the Restorative Aide had informed her that there had been an altercation between NA #2 and Resident #82. The Therapy Director stated she could not remember the details but said she took the Restorative Aide to the Administrator as soon as she was informed of the allegation. The prior Administrator on 11-2-22 was interviewed by telephone on 2-14-23 at 1:51pm. The prior Administrator stated the Restorative Aide had come to her office and told her NA #2 had pushed Resident #82 into the bathroom. She stated she could not remember what time she was informed of the incident but stated she	F 600	Performance Improvement (QAPI) Committee monthly for 3 months. Audit records will be reviewed by the QAPI Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: March 15, 2023	

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immediately suspended NA #2 and ultimately had terminated NA #2. The prior Administrator stated she had also immediately informed the DON of the allegation.

A telephone interview occurred with NA #2 on 2-14-23 at 2:01pm. The NA explained she had entered Resident #82's room on 11-2-22 at approximately 1:40pm to provide incontinence care. She stated she walked Resident #82 to the bathroom and realized she needed more supplies, so she stated she left the resident in the bathroom while she left the room to gather more supplies. NA #2 stated when she returned to the room Resident #82 had left the bathroom, so she said she "grabbed" Resident #82's arm and "guided" her back into the bathroom. She said the Restorative Aide had offered to help but she declined. The NA also said she never pushed Resident #82 or forcibly grabbed the resident's arm.

Review of the facility's 5-day investigation report dated 11-4-22 revealed the incident occurred at 1:45pm on 11-2-22 when the Restorative Aide witnessed NA #2 push Resident #82 into the bathroom and state to the resident "come on let me clean you up because I'm not your sister." The report also stated Resident #82's roommate had also witnessed the incident and was interviewed. The investigation report revealed the facility had found the allegation to be true and had terminated NA #2's employment.

The Director of Nursing (DON) was interviewed on 2-14-23 at 1:28pm. The DON explained the Administrator had called her in her office on 11-2-22 "a little" after 3:00pm and had told her there had been an allegation of abuse. She

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stated the Administrator told her that the Restorative Aide had witnessed Resident #82 being pushed into the bathroom by NA #2. The DON said she first interviewed the Restorative Aide on 11-2-22 at approximately 3:10pm who had told her NA #2 had pushed Resident #82. She explained she then had to call the NA because the NA had finished her shift at 3:00pm so she was no longer in the building. The DON stated NA #2 told her she had walked Resident #82 into the bathroom and left the resident at the sink in the bathroom while she retrieved more supplies. She stated the NA told her when she returned to the room, the resident had walked out of the bathroom so the NA "took the resident's arm" and "guided" the resident back into the bathroom. The DON stated she told NA #2 that she would be suspended during the investigation. She stated the NA was terminated and had not returned to the building. The DON clarified NA #2 had been allowed to finish her shift on 11-2-22.

During a telephone interview with the facility's Medical Director on 2-16-23 at 12:35pm, the Medical Director stated he had been informed of the allegation of abuse with Resident #82 and that he would have expected the facility to do their due diligence in making sure residents are safe.

The Administrator was notified of the immediate Jeopardy on 2-14-23 at 6:43pm.

Date of alleged IJ removal 2-16-23.

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

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Resident #82 is the resident that was most likely to suffer because of the incident that occurred on November 2, 2022.

Witness statements (completed by the restorative aide and the roommate of resident #82) both state that nursing assistant, #2, stated to resident #82 "come on and be changed because I'm not like your sister" while simultaneously pushing resident #82 into the bathroom.
The restorative aide did not intervene.
Witness statements were both dated 11/2/22.

The Restorative Aide watched Resident #82 be pushed into the bathroom and did not protect the resident from potential further abuse. She left the resident in the care of NA #2. The abuse was not reported immediately as she waited to tell her supervisor. As a result, the NA worked the remainder of her shift and provided care to residents.

The resident had a BIMS score of 3 and therefore the social worker did not interview her.
The roommate of the resident was interviewed by the social worker on 11/2/22 in the presence of the resident #82.
On February 15, 2023, the Chief Clinical Officer visited Resident #82. She was not capable of providing any information about the incident.

Resident # 82 was assessed at the time of the incident and there was no evidence of physical or mental harm having occurred. A staff nurse assessed Resident #82 (head to toe) on 11/2/22 and her skin was noted to be clean, dry, and intact.
The resident had another assessment completed on third shift (11/3/23) which revealed "no skin

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F 600	Continued From page 17 issues". The initial documented allegation of abuse stated the incident occurred at 1:45 pm on 11/2/22. The DON stated that it was approximately 3:15 pm on 11/2/22 when the Administrator made her aware of the allegation of abuse. On Friday, November 4, 2022, the Administrator and DON met to review the findings of the investigation. NA #2 was terminated the same day via phone. All residents residing in the facility were considered at risk based on the deficient practice. All allegations of abuse reported in the last year were reviewed by the Chief Clinical Officer on 2/15/23. Review of other allegations of abuse did not reveal areas of concern. No other concerns regarding substantiated abuse, issues with reporting, or follow up identified. Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On Tuesday evening, February 14, 2023, the Director of Nursing, and a staff RN began educating direct care staff members (there were no other employees in the facility on second and third shift) on the definition of abuse; signs and symptoms of abuse. Education focused on abuse identification with emphasis on no tolerance for abuse. Inservice's continued with all employees on shift through the night and morning.	F 600		

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On Wednesday, February 15, 2023, a mandatory meeting for all staff members including nursing staff and contracted staff (dietary staff, therapy staff, and housekeeping staff, was conducted in the dining room at 3:00 pm.
The corporate clinical team, Chief Clinical Officer, Managing Director, and Administrator led the staff meeting and training.
Training topics included the following:

" Abuse policy and procedure to ensure full compliance with resident rights consistent with applicable state and federal law.
" Instruction was provided via handout, verbal instruction, and role play.

Staff members will not be allowed to provide care to residents or otherwise resume their normal job roles until they complete the training. Ongoing training will be conducted at the beginning of each shift by management nurses, Administrator, and Social Worker.

A staff roster was compiled today to include name, position, and signature. The roster will be passed shift to shift to the training coordinator to ensure all staff members have been trined. Direct supervisors of contracted services will ensure that their employees receive the training prior to working.

Abuse training has always been a part of our initial orientation program and a requirement for annual training. The program was revamped on 2/15/23 to emphasize zero tolerance for abuse.

Date of alleged IJ removal: February 16, 2023.

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F 600	Continued From page 19 The credible allegation of Immediate Jeopardy removal was validated by on-site verification on 2-16-23. Interviews conducted with staff (Nursing Assistants, Activity Director, Medical Assistant, Restorative Aide, Dietary, Therapy, and Nursing) revealed they had recent training on resident abuse that included how to identify types of abuse, intervening when they see abuse, assessing the resident and assessing other abuse allegations. The facility's Immediate Jeopardy removal date of 2-16-23 was validated. 2. Resident #28 was admitted to the facility on 11/08/13 with diagnoses which included hypertension and anxiety. The quarterly Minimum Data Set dated 12/16/22 revealed Resident #28 was cognitively intact and had severely impaired vision. For activities of daily living (ADL) he required supervision for bed mobility, walking in room, and locomotion on the unit; limited assistance for transfers; extensive assistance for dressing, toileting, and personal hygiene; and total dependence on staff for bathing. He was coded for no physical or verbal behaviors or rejection of care. Resident #28's balance during transition and walking was coded as not steady but able to stabilize without staff assistance. A review of Resident #28's care plan last revised 12/23/22 revealed a focus area of ADL with interventions which included that resident toilets without assistance but requires staff to guide due to blindness. His care plan also had a focus for the problematic manner in which the resident acts characterized by ineffective coping, verbal/physical aggression or combativeness. This focus area had interventions which included	F 600		

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to be sure to have the resident's attention before speaking or touching and do no argue or condemn resident.

The facility initiated an initial 24-hour report dated 2/11/23 which revealed Nursing Assistant (NA #1) had assisted Resident #28 to the bathroom and was assisting him back to bed after toileting at 1:00 AM on 2/11/23.

A written statement dated 2/11/23 by NA #1 read in part that she helped the resident to the bathroom and after the resident was finished, she got up to help him. The resident started fussing and grabbed her arm, trying to break it and he wanted to fight her so she told him to get to the bed the best way he could and left the room to avoid any other mishap.

A written statement dated 2/11/23 by Nurse #1 read in part that Resident #28 had his call light on. She entered his room and observed the resident was lying on the bed in his normal position with his shoes on and his feet were hanging off the side of the bed. He reported that the NA (NA #1) had 'slammed him into the bed'. When asked what happened he said that the NA was assisting him back from the bathroom and 'slammed him into the bed.' Nurse #1 spoke with NA #1 who stated when she was assisting resident back to bed, he started fussing with her and grabbed her arm and he was backing up to the bed. He then squeezed her arm hard and refused to release her. She said she snatched her arm out of his grip and told him he could get in bed himself. Then she exited the room. Nurse #1 advised NA #1 not to return to his room and Nurse #1 would answer his call light.

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F 600	Continued From page 21 An interview on 2/13/23 at 11:57 AM with the Director of Nursing (DON) revealed she was in the process of an investigation about this alleged abuse. She confirmed that NA #1 had been suspended during this investigation. An interview on 2/13/23 at 2:25 PM with Resident #28 revealed a Nursing Assistant (NA) (he did not know her name) had pushed him down and hurt his knee. He stated he did not go to the bathroom by himself and had asked the NA to help him to the bathroom. She took him to the bathroom and waited in his room. Resident #28 stated that when he said he was ready, she told him to 'come on then' and he told her he couldn't see. He stated she 'grabbed his left arm' and pushed him toward the bed. He stated he fell with his right knee on the floor and his left knee on the bed. Resident #28 stated the nurse (he did not know her name) came and got him out of the floor, took his shoes off, and helped him into bed. He said it took a long time for the nurse to come and get him out of the floor and he had one leg on the bed and his other knee was on the floor. He stated he did not tell the nurse his knee was hurting as both his knees hurt all the time anyway and there was nothing new with his knee. He stated he called his sister to tell her what happened. Resident #28 stated when the NA pushed him, he felt 'little and helpless." An interview on 2/13/23 at 3:39 PM with NA #1 confirmed she had taken Resident #28 to the bathroom and back towards his bed on 2/11/23 around 1:00 AM. She stated she could not remember what time Resident #28 had rung his call light to go to the bathroom. She stated she assisted him to the bathroom and remained in his room to assist him back to the bed. NA #1 stated	F 600		

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when he was done, she said for him to 'come on' and he told her he was blind. She stated she knew that. She stated he tried to break her arm as she directed him to the bed. She stated she did not hold his arm and had the flat of her hand on his back. She stated she did not remember what he said or what she said. When she left the room, he was not on the bed and was not in the floor. She stated he walked independently and needed guidance to the bed due to his blindness. She stated he was by his bed, and she felt he was safe to get in the bed by himself when she left the room. NA #1 also stated that Resident #28 gets on her nerves, and she did not go into his room unless he rang his call light.

An interview on 2/13/23 at 8:31 PM with Nurse #1 confirmed she had worked the night of 2/11/23 and had assisted Resident #28. She stated the resident's call light was on, so she went to answer it. She stated the resident was lying in his normal position which was flat on his back in the center of his bed, except his shoes were on and his feet were off the side of the bed. When she asked him what was wrong or how could she help him, he stated that the NA had 'slammed him in the bed.' She stated she let him verbalize his feelings and told him she would find out what was going on. She took his shoes off, helped him put his legs in the bed, and covered him up before exiting the room. She stated that Resident #28 was not lying in the floor and his knee was not on the floor. Nurse #1 went to talk with NA #1 and then told her not to go back into his room the rest of that night and that she would answer his call light the rest of the night. She stated she notified the oncoming shift about the incident during the morning shift change report around 7:00 AM.

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F 600	Continued From page 23 An interview on 2/15/23 at 9:18 AM with the Administrator revealed she was aware of the allegation of abuse and the ongoing investigation. An interview on 2/16/23 at 1:17 PM with the DON revealed she had not completed the 5-day investigation yet but stated that she thought the abuse allegation would be substantiated and that NA #1 would be terminated. She stated she was unaware of any other abuse allegations related to NA #1.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of	F 607		3/15/23

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F 607	Continued From page 24 employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect Resident #82 when the Restorative Aide had not intervened when she witnessed Nursing Assistant (NA) #2 forcibly grab Resident #82's arm twice and push the resident into the bathroom, the Restorative Aide left Resident #82 in the care of NA #2 and did not report the abuse immediately. The facility also failed to protect all residents from further potential physical abuse following allegations of staff to resident abuse (Resident #82 and Resident #28) by allowing NA #2 and NA #1 to continue to provide resident care for the remainder of their shifts. This occurred for 2 of 3 residents reviewed for abuse. Immediate Jeopardy began on 11-2-22 when the Restorative Aide did not intervene when NA #2 "grabbed" and "pushed" Resident #82 into the resident's bathroom. The immediate Jeopardy was removed on 2-16-23 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity D (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure the education and monitoring systems put in place are effective and to address deficient practice cited at scope and severity D for Resident #28.	F 607	1. Immediate action(s) taken for the resident(s) found to have been affected include: November 2, 2022, an investigation was immediately started by the administrator upon notification of an abuse allegation. 24-hour initial abuse allegation report was submitted to the Health Care Personnel Registry (HCPR) and the alleged employee (NA #2) was suspended on November 2, 2022, pending the outcome of the investigation and subsequently terminated on November 4, 2022. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of the residents have the potential to be affected. November 2, 20022 – November 3, 2022: • 100% of alert & oriented residents (BIMs 13 and above) questioning about abuse by the facility social worker. No concerns were identified during the interviews. • The Social Worker attempted to conduct an interview with resident #82 but the resident was unable to complete it. • 100% Head to toe assessments were completed on all residents with BIMs scores below 13, including resident #82.	

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Findings included:

1. Resident #82 was admitted to the facility on 9-19-22.

Review of the facility's "Abuse, neglect and Exploitation" policy dated 10-1-22 revealed in part that the facility will Identify, correct and intervene in situations in which abuse, neglect, exploitation and/or misappropriation of resident property was more likely to occur. Respond immediately to protect the alleged victim.

Review of the facility's 5-day investigation report dated 11-4-22 revealed the incident occurred at 1:45pm on 11-2-22 when the Restorative Aide witnessed NA #2 push Resident #82 into the bathroom and state to the resident "come on let me clean you up because I'm not your sister." The report also stated Resident #82's roommate had also witnessed the incident and was interviewed. The investigation report revealed the facility had found the allegation to be true and had terminated NA #2's employment.

A telephone interview occurred with the Restorative Aide on 2-14-23 at 10:08am. The Restorative Aide explained she had entered Resident #82's room on 11-2-22 to provide therapy but realized Resident #82 was soiled. She stated she left the room and requested NA #2 to the resident room to assist her in changing Resident #82. The Restorative Aide stated when NA #2 entered the room, the NA declined any assistance. She went on to explain when the NA tried to get Resident #82 out of her wheelchair, the resident tried to get back in bed and the NA became upset "grabbing" forcefully Resident #82's arm and telling the resident to "get into the

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No evidence of physical or mental harm was noted.
February 15, 2023, the Carrollton Facility Management corporate compliance team audited all reportable events occurring January 2022 through December 2022.
The audit consisted of a thorough review of the following items:

- Initial Reporting (including timely reporting to DHHR, Carrolton Facility Management, DSS and the police department, as applicable)
- Investigative file (Including witness statements, Interviews and/or Physical Assessments of all residents at risk)
- Evidence of immediate resident protection (including employee suspension/termination)
- Staff Education
- Final Reporting (including a Summary of Findings)
- Evidence of QAPI oversight

3. Actions taken/systems put into place to reduce the risk of future occurrence include:
November 2, 2022 – November 4, 2022, a series of mandatory in-services were conducted for all staff (direct care staff, administrative staff, and contractors) by the Director of Nursing (DON) on the Carrolton Facility Policy for Abuse, Neglect, and Exploitation.

February 14, 2023 – February 15, 2023, a series of mandatory in-services were again conducted for all staff (direct care staff, administrative staff, and contractors). Staff were required to

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F 607	Continued From page 26 bathroom." The Restorative Aide stated the NA walked Resident #82 to the bathroom door and told the resident to stand there while the NA went out to retrieve more supplies. The Restorative Aide stated when the NA left the room the resident started walking back to her bed. She said when the NA returned, the NA "grabbed" Resident #82's arm again and forcefully started pulling the resident back towards the bathroom. The Restorative Aide stated once the NA and resident were at the bathroom door, the NA "pushed" Resident #82 into the bathroom, and she heard Resident #82's body hit the sink. The Restorative Aide stated NA #2 then "slammed" the bathroom door shut. She said it was then she left the room to tell her supervisor. The Restorative Aide stated she did not intervene because she did not want to have a confrontation with NA #2, and she did not leave to retrieve help sooner because she wanted to make sure the resident was ok. She also said she was not comfortable leaving the resident with NA #2 but stated she knew she had to report what she saw. The Restorative Aide explained she could not find her supervisor for approximately an hour, so she was not able to report the incident immediately. She also explained she did not think she could go directly to the Administrator to report what she saw without speaking to her supervisor first. A telephone interview occurred with NA #2 on 2-14-23 at 2:01pm. The NA explained she had entered Resident #82's room on 11-2-22 at approximately 1:40pm to provide incontinence care. She stated she walked Resident #82 to the bathroom and realized she needed more supplies, so she stated she left the resident in the bathroom while she left the room to gather more supplies. NA #2 stated when she returned to the	F 607	complete this training prior to working. Education included the abuse policy and procedure to ensure compliance with resident rights and applicable state and federal law emphasizing: • Residents' rights to be free of abuse, neglect, misappropriation of resident property and exploitation, • Identification of abuse, neglect, misappropriation of resident property and exploitation, • Resident protection (including immediate suspension of the alleged employee pending the outcome of the investigation), • Immediate reporting of abuse (noting state and federal guidelines) • Abuse investigation • Zero abuse tolerance (including employee termination) While abuse has always been a part of our initial orientation program as well as a requirement for annual training, the initial orientation program and annual in-services were revamped on February 15, 2023, to emphasize a zero tolerance for abuse. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning the week of March 12, 2023, the facility Social Worker or designee will: • Interview alert & oriented residents for abuse signs of physical or mental abuse. • Observe non-alert and oriented residents to include resident # 82, for behavioral changes that may indicate	

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room Resident #82 had left the bathroom, so she "grabbed" Resident #82's arm and "guided" her back into the bathroom. She said she had continued to provide resident care until the end of her shift at 3:00pm. NA #2 stated she had heard there was an allegation she abused Resident #82 from the DON by telephone and stated she was informed then she would be suspended until the conclusion of an investigation.

The Director of Nursing (DON) was interviewed on 2-14-23 at 1:28pm. The DON stated she was made aware of the allegation of abuse by the Administrator "a little" after 3:00pm on 11-2-22. She explained since the allegation was not reported immediately by the Restorative Aide, NA #2 was able to continue working with residents until the end of her shift at 3:00pm. The DON stated it was her understanding that the Restorative Aide could not find her supervisor immediately causing a delay in reporting the allegation of abuse. She also said the Restorative Aide should have reported the allegation to the Administrator when she was not able to locate her supervisor. The DON explained the Restorative Aide also should have retrieved help as soon as she saw NA #2 "grab" Resident #82's arm and not left the resident alone with NA #2 if she felt the resident was being abused.

The prior Administrator on 11-2-22 was interviewed by telephone on 2-14-23 at 1:51pm. The prior Administrator stated the Restorative Aide had come to her office and told her NA #2 had pushed Resident #82 into the bathroom. She stated she could not remember what time she was informed of the incident but stated she immediately suspended NA #2 and ultimately had terminated NA #2. The prior Administrator stated

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mistreatment or treatment abuse.
- Interview employees regarding abuse identification, resident protection, and timely reporting
- Interviews and observations will occur with the following schedule:
  - o 2 residents and 3 employees weekly x 4 weeks
  - o 2 residents and 3 employees every month x 2 months

Any concerns identified during interviews will be immediately addressed by the DON/Administrator to include investigation and staff retraining.

The DON will review the resident interview summaries provided by the social worker and concerns identified will be immediately addressed.

The Administrator will present the findings to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for 3 months.

In addition, the Carrollton Facility Management corporate compliance team will audit all reportable events occurring in the facility for the next 3 months. The audit will include the following:
- Initial Reporting (including timely reporting to DHHR, Carrolton Facility Management, DSS and the police department, as applicable)
- Investigative file (Including witness statements, Interviews and/or Physical Assessments of all residents at risk)
- Evidence of immediate resident

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F 607	Continued From page 28 she had also immediately informed the DON of the allegation. The Therapy Director was interviewed on 2-14-23 at 3:47pm. The Therapy Director explained she was the Restorative Aides supervisor. She stated the Restorative Aide informed her that there had been an altercation between a NA and resident. The Therapy Director stated she could not remember the details but said she took the Restorative Aide to the Administrator as soon as she was informed of the allegation. She said there had been a 1-2-hour lapse between the incident and the Restorative Aide informing her of what she saw. The Therapy Director stated the Restorative Aide could not find her but said the Restorative Aide should have gone to the Administrator instead of waiting to report the incident. The Administrator was notified of Immediate jeopardy on 2-14-23 at 6:43pm. The facility provided the following Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the noncompliance; and Resident #82 is the resident that was most likely to suffer because of the incident that occurred on November 2, 2022. On 11/2/23 at 1:45 PM the Restorative Aide watched Resident #82 be pushed into the bathroom by Nursing Assistant (NA) #2 and did not intervene or protect the resident from potential further abuse. She left the resident in the care of NA #2. The abuse was not reported	F 607	protection (including employee suspension/termination) • Staff Education • Final Reporting (including a Summary of Findings) • Evidence of QAPI oversight Audit results will be reported to the facility QAPI team by the Facility Nurse Consultant or designee. QAPI Committee will review all audit results until such time consistent substantial compliance has been achieved as determined. Audit results will be shared with the Resident/Family Group Council for comment and suggestions. Corrective action completion date: March 15, 2023	

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immediately as she waited to tell her supervisor. As a result, the NA worked the remainder of her shift and provided care to residents.

The initial documented allegation of abuse stated the incident occurred at 1:45 pm on 11/2/22.
The DON stated that it was approximately 3:15 pm on 11/2/22 when the Administrator made her aware of the allegation of abuse.

At approximately 3:30 pm on 11/2/22, the DON and ADON called NA #2 via phone because she had completed her shift and made her aware of the incident and allegation.
NA#2 denied the allegation. The DON suspended her pending the outcome of the investigation.

On Friday, November 4, 2023, the Administrator and DON met together to review the findings of the investigation. NA #2 was terminated the same day via phone.

All residents residing in the facility were considered at risk based on the deficient practice.

A thorough review of all allegations of abuse within the last year was completed on 2/15/23 by the Chief Clinical Officer. There were no negative trends.

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

On Tuesday evening, February 14, 2023, the Director of Nursing, and a staff RN began educating direct care staff members (there were

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no other employees in the facility on second and third shift) on protecting residents from abuse. Staff members were told to notify their Supervisor and Administrator immediately. In the absence of the Administrator the Director of Nursing, and / or the Supervisor in charge should be always notified and - protect the resident from abuse or further abuse.

Inservice's continued with all employees on shift through the night and morning.

On Wednesday, February 15, 2023, a mandatory meeting for all staff members (including nursing staff, contracted nursing staff, dietary staff, therapy staff, contracted therapists, and housekeeping staff) was conducted in the dining room at 3:00 pm.

The corporate clinical team, Chief Clinical Officer, Managing Director, and Administrator led the staff meeting and training.
Training topics included the following:

" Abuse policy and procedure to ensure full compliance with resident rights consistent with applicable state and federal law.
" Proper abuse reporting (immediately to supervisor and Administrator). In the absence of the Administrator immediate reporting should be to the Director of Nursing and / or Supervisor in Charge.
" Protection of residents (the one affected and the remaining facility residents) by staying with resident; removing the alleged abuser; and sending persons home that have been accused of abuse.
" Examples of how to protect the affected resident

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as well as all other resident in the facility were provided via verbal instruction and role play.
" Instruction was provided via handout, verbal instruction, and role play.

Staff members will not be allowed to provide care to residents or otherwise resume their normal job roles until they complete the training. Ongoing training will be conducted at the beginning of each shift by management nurses, Administrator, and Social Worker.

A staff roster was compiled today to include name, position, and signature. The roster will be passed shift to shift to the training coordinator to ensure all staff members have been trained. Direct supervisors of contracted services will ensure that their employees receive the training prior to working. All contracted staff members will participate in our training (nursing staff, housekeeping staff, therapy staff, and dietary staff).

The corporate orientation program was revised on 2/15/23 to provide more detailed education on zero tolerance for abuse, resident protection, and appropriate reporting requirements.

Effective 2/15/22 and in addition to formal state reporting requirements, the following will occur:

1. All allegations of abuse will be phoned to the Administrator, Managing Director, and Chief Clinical Officer immediately upon receipt.

2. Within 24 hours of allegation receipt, the facility QAPI team will meet to review the allegation and to participate in the investigation outcome.
The Administrator and Director of Nursing will

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lead the investigation and the QAPI meeting. The Social Worker will assist in the QAPI meeting, and a corporate member of the compliance team will participate to ensure policy adherence.

3. Negative trends and outcomes will be recorded, tracked, and trended.

4. All allegations of abuse will be emailed to the corporate compliance line.

5. The corporate compliance team will review allegations, investigations, and reporting to ensure compliance to ensure thorough and timely investigation and appropriate reporting.

6. For the foreseeable future, all allegations of abuse will be routed to the Corporate Compliance Team for follow up and review to ensure that we have done everything possible to prevent and report abuse appropriately.

Date of alleged IJ removal: February 16, 2023.

The credible allegation of Immediate Jeopardy removal was validated by on-site verification on 2-16-23. Interviews conducted with staff (Nursing Assistants, Activity Director, Medical Assistant, Restorative Aide, Dietary, Therapy, and Nursing) revealed they had recent training on resident abuse and were able to verbalize how to identify types of abuse, intervening when they see abuse, and when to report abuse. The corporate personal was also interviewed regarding their procedures. The Chief Clinical Officer explained the Administrator was responsible for emailing allegations of abuse to the corporate compliance line which was directed to three members of their

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compliance team plus the Corporate President and Chief Operating Officer. The Chief Clinical Officer also explained the corporate orientation program was revised to reflect that the accused staff member would be removed from the building and suspended until the investigation was completed. The revised orientation program was dated 2-15-23. The facility's Immediate Jeopardy removal date of 2-16-23 was validated.
2. Resident #28 was admitted to the facility on 11/08/13.

The quarterly Minimum Data Set dated 12/16/22 revealed Resident #28 was cognitively intact.

Review of the 24-hour initial allegation report by the facility dated 2/11/23 with the incident date/time of 2/11/23 1:00 AM had an allegation type of resident abuse with a description which read that the resident stated CNA (Certified Nursing Assistant) pushed him onto the bed when assisting back to bed after toileting.

An interview on 2/13/23 at 8:31 PM with Nurse #1 revealed she was working on 2/11/23 and was assigned to Resident #28. She stated she observed his call light on around 2:00 AM, so went into his room. She stated the resident reported to her that the NA (NA #1) had 'slammed him in the bed'. She left his room and talked with NA #1 who was providing care in another resident's room. Nurse #1 stated NA #1 told her that Resident #28 grabbed her arm when she was assisting him back from the bathroom. She stated the NA reported she yanked her arm out of his grip, told him since he wanted to be ugly, he could find his own way to the bed and left the room. Nurse #1 told the NA not to return to Resident #28's room the rest of the shift. Nurse

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F 607	Continued From page 34 #1 reported this interaction to the oncoming Nurse who was the ADON during shift change report around 7:00 AM. NA #1 continued to work the remainder of the shift providing resident care. An interview on 2/13/23 at 3:39 PM with Nursing Assistant (NA) #1 revealed she had an incident with Resident #28 on 2/11/23. She stated she did not remember what time this occurred. She stated there had been other incidents with Resident #28 when he got agitated and cussed at her, so she did not go in his room unless he rang his call light. She stated she worked the rest of her shift and continued to provide resident care. An interview on 2/13/23 at 3:15 PM with the Assistant Director of Nursing (ADON) revealed she had received report on 2/11/23 around 7:00 AM during the morning shift change report of the incident between NA #1 and Resident #28. She also revealed she received a call from the resident's family member around lunch in which the allegation was reported. The ADON explained that Resident #28 was care planned for behaviors such as cursing and yelling at staff and that neither she nor Nurse #1 had recognized this as an allegation of abuse until after the family member called. An interview on 2/15/23 at 9:18 AM with the Administrator confirmed that the resident and employee incident should have been reported immediately to the Director of Nursing or herself. She additionally confirmed that NA #1 had worked providing resident care until the end of her shift and should have been removed from the work immediately. She did not know why this had not been reported by Nurse #1 in a timely manner or why NA #1 had been allowed to continue	F 607		

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F 607	Continued From page 35 providing resident care. An interview on 2/15/23 at 2:37 PM with the Director of Nursing confirmed the exchange between Resident #28 and NA #1 should have been reported immediately to her or the Administrator and that NA #1 should have been removed from the facility immediately. She did not know why Nurse #1 had not reported it to her immediately or why NA #1 had continued to provide resident care until the end of her shift.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		3/10/23

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	345266	A. BUILDING ______ B. WING ______	C 02/16/2023

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F 609	Continued From page 36 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to file a report with the state agency within 2 hours of an alleged abuse for 1 of 2 residents reviewed for abuse (Resident #28). Findings included: An interview on 2/13/23 at 3:15 PM with the Assistant Director of Nursing (ADON) confirmed she had received a verbal report about an interaction between Resident #28 and Nursing Assistant (NA) #1 during the morning shift report around 7:00 AM. She stated this was not reported to her as an abuse allegation. She stated she received a phone call from the resident's family member around lunch in which the allegation was reported. The ADON went to interview the resident and initiated the investigation. She stated she contacted the Director of Nursing (DON) to report the allegation, completed the 24-hour documentation and faxed it to state agency. She stated she was unaware of the 2-hour reporting requirement and acknowledged the fax journal report date/time for the fax was 2/11/23 6:46 PM. An interview on 2/13/23 at 8:31 PM with Nurse #1 confirmed she had worked the night of 2/11/23 and had assisted Resident #28. She stated she was unaware of the incident between NA #1 until it was reported to her by Resident #28 when she answered his call light around 2:00 AM. She stated that NA #1 was in another resident's room providing care when she located her. She stated	F 609	24 hour report was sent to DHSR on 2/11/2023. Investigation initiated as appropriate. Resident #28 refused skin check on 2/11/2023 by ADON. Full skin check completed on 2/14/2023 as resident allowed no injury noted. NA was suspending pending investigation on 2/11/2023. Statements were obtained from staff and the resident by DON/designee. Investigation concluded 2/17/2023. Employee terminated 2/17/2023. All residents has the potential to be affected by the deficient practice. All staff were inserviced by the DON to include contract staff and was completed on 2/21/2023 on abuse, neglect and timely reporting. DON/designee will audit 3 staff members weekly x 4 weeks on proper reporting and intervention of abuse, then 3 staff members monthly x 2 using an abuse audit tool. All results of the abuse audit tool will be forwarded to the Executive QI committee by the DON/Designee monthly x 3 months for trends and recommends and any changes.	

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F 609	Continued From page 37 she notified the oncoming shift about the interaction during the morning shift change report around 7:00 AM. An interview on 2/15/23 at 9:18 AM with the Administrator revealed she was aware of the requirement to report an abuse allegation within 2 hours and the facility should have reported this allegation in a timely manner. An interview on 2/15/23 at 2:37 PM with the DON revealed she was aware of the requirement to report the allegation within 2 hours.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		3/15/23

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F 655	Continued From page 38 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff and Representative (RP) interviews the facility failed to provide a written summary of the baseline care plan for 1 of 2 residents (Resident #43) whose baseline care plans were reviewed. Findings included: Resident #43 was admitted to the facility on 9/9/22 with a diagnosis of left femur (thigh bone) fracture. Resident #43's baseline care plan was dated 9/11/22. A review of the admission Minimum Data Set (MDS) assessment for Resident #43 dated	F 655	Resident #43 And RR received a copy of care plan on 3/6/23. All new admissions have the potential to be affected by the alleged deficient practice. Audit of last 30 days of admissions to ensure that a base line care plan or a copy of baseline care plan was given to resident and/or RR. No areas os concern identified. Any resident that was found to be affected will be provided with a copy of care plan as appropriate. Education was provided by the Corporate Staff Development Manager/ Consultant Social Worker on3/15/23 on providing a copy of	

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F 655	Continued From page 39 9/16/22 revealed he was moderately cognitively impaired. Resident #43's medical record did not reveal any evidence he or his RP ever received a written summary of his base line care plan. On 2/13/23 at 3:37 PM an interview with Resident #43 indicated he did not recall receiving a written summary of his baseline care plan since his admission to the facility. On 2/14/23 at 12:28 PM a telephone interview with Resident #43's RP indicated he did not recall receiving a written summary of Resident #43's base line care plan. On 2/16/23 at 8:40 AM an interview with the MDS Coordinator indicated the facility Social Worker (SW) provided residents and/or their RP's with a written summary of the baseline care plan. On 2/16/23 at 8:57 AM an interview with the SW indicated Resident #43's initial care plan meeting was conducted via telephone with his RP. She stated if the care plan meeting was conducted in person then a written summary of the baseline care plan was offered. She went on to say if the care plan meeting was conducted via telephone a written summary was not provided. On 2/16/23 at 11:55 PM an interview with the Administrator indicated resident's and/or their RP's should be receiving a written summary of their baseline care plan.	F 655	the baseline care plan to RR and resident. All new admissions to facility will be audited by Assistant Director of Nursing to ensure that their baseline care plan is completed timely, reviewed with resident and or RR and copy provided time of review utilizing a QI tool. The results of QI tool will be brought to the monthly QAPI meetings by the ADON monthly x 2 months to review for need for continuing monitoring.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		3/15/23

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F 656	Continued From page 40 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 41 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop comprehensive individualized care plans for 1 of 3 residents (Resident #239) reviewed for care plans. Findings included: Resident #239 was admitted to the facility on 10/14/21 with diagnoses which included non-Alzheimer's dementia and hypertension. He was sent to the hospital on 5/14/22 and did not return to the facility. Review of Resident #239's electronic medical record revealed an incident report of falls on 2/27/22 and 3/21/22. The quarterly Minimum Data Set (MDS) dated 4/13/22 revealed Resident #239 had moderately impaired cognition. He was coded for 2 falls with no injury since admission. Review of Resident #239's care plan last reviewed on 4/25/22 had no focus area for falls. Review of Resident #239's electronic medical record revealed an incident report of a fall on 5/14/22. An interview on 2/16/23 at 9:22 AM with the MDS Coordinator revealed Resident #239 had falls and	F 656	Resident # 239 no longer resides in the facility. All residents have the potential to be affected by the deficient practice. Education was provided to the MDS Coordinator by the Corporate Consultant on 3/08/2023 to include comprehensive and accurate care plan. Administrative Nursing team completed a 100% audit utilizing a Data Collection tool for care plan accuracy on all current residents by 3/09/2023. Any errors noted were corrected at time of audit. 100% education was provided to all licensed nurses on accuracy of care plans by 3/09/2023 the MDS (Minimum Data Set) nurse was educated that all residents should have a comprehensive and accurate care plan based on the needs of the resident identified in the Comprehensive Assessment. Using the MDS calendar, care plans will be audited 2 care plans per week x 3 months utilizing the Data Collection tool by the Administrator. The results of the Data Collection Audit Tool will be brought to QAPI by DON for review and recommendations monthly x 3	

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F 656	Continued From page 42 this should have been on his care plan. She stated it was an oversight on her part. An interview on 2/16/23 at 11:42 AM with the Administrator revealed the facility should accurately develop an individualized care plan for each resident.	F 656	months.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		3/15/23

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F 657	Continued From page 43 by: Based on record review and staff interviews, the facility failed to revise the care plan for 1 of 3 residents reviewed for Preadmission Screening and Resident Review (PASRR) (Resident #50). The findings included: Resident #50 was admitted to the facility on 5/23/18 with diagnoses which included Alzheimer's dementia and hypertension. Review of Resident #50's PASRR Level II Determination Notification dated 5/16/18 noted an expiration date of 7/15/18. The placement determination recommendations noted that nursing home placement was appropriate for a 60-day period. Review of Resident #50's PASRR Level I Determination Notification dated 1/30/19 had no expiration date for the Level I determination. Review of Resident #50's care plan last reviewed 12/23/22 had a focus area with a Level II PASRR with interventions for nursing needs for medical condition or needs requiring nursing for maintaining maximum functioning and rehabilitation services as ordered. The quarterly Minimum Data Set (MDS) dated 1/27/23 revealed Resident #50 had severe cognitive impairment. An interview on 2/14/23 at 4:17 PM with the Admissions Director revealed she was responsible for obtaining and updating the PASRR. She stated Resident's PASRR change from a Level II to a Level I occurred prior to her	F 657	1. Resident # 50 MDS was modified on 2/15/2023 to reflect the correct PASSAR level & care plan was updated by the MDS nurse. 2. 100% audit of all current residents care plans were audited by administrative nursing team with corrections and updates as needed 3. Corporate nurse consultant in-serviced MDS nurse on care plan accuracy. Administrator will review 2 care plans per week x 3 months utilizing an MDS accuracy QI tool. 4. Administrator will bring the results of the audits to the Executive QI committee will meet monthly and review audits of MDS Accuracy tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months	

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F 657	Continued From page 44 employment. An interview on 2/15/23 at 9:12 AM with the MDS Coordinator revealed she was responsible for revising the residents' care plans. She stated that Resident #50 was a Level I PASRR and his care plan should have been revised. An interview on 2/15/23 at 9:15 AM with the Administrator revealed she was unaware Resident #50's care plan was inaccurate and stated that resident care plans should accurately reflect the resident's status.	F 657		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to schedule an eye surgery referral consult for 1 of 1 resident (Resident #3) reviewed for vision. Findings included:	F 685	Resident #3 has an appointment scheduled on 3/22/2023 with Albermarle Eye Center. 100 % audit was conducted by Assistant Director of Nursing for vision consults on 2/20/2023. Any appropriate referral were	3/15/23

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F 685	Continued From page 45 Resident #3 was admitted to the facility on 9/9/20 with diagnoses which included unspecified glaucoma. The quarterly Minimum Data Set (MDS) dated 12/12/22 revealed Resident #3 had moderately impaired cognition and was coded for adequate vision. Review of an Optometrist eye care note dated 5/13/22 revealed a recommendation for cataract consult for Resident #3. Review of Resident #3's Psychiatry progress note dated 11/15/22 read in part "There is a note in her chart from ophthalmology that states she has cataracts and glaucoma. Provider then suggested she see an eye surgeon, but I do not see any other notes after that, and that note was dated May 2022. Suggest that facility follow up on whether or not the referral was done. Decreasing vision in a dementia patient can lead to increased confusion, leading to increased agitation." An interview on 2/15/23 at 8:43 AM with Nurse #3 revealed she was responsible for reviewing the eye care notes and psychiatry progress notes to ensure recommendations were completed. She stated that she had no explanation of why the eye referral appointment was not made. An interview on 2/15/23 at 9:17 AM with the Administrator revealed if a resident needed services, she expected them to receive them promptly and it had been an oversight. An interview on 2/15/23 at 10:45 AM with Resident #3 revealed she had "trouble with her vision and couldn't see that well."	F 685	made from results of audits. 100% nursing staff was in-service by DON through 3/15/23 on consults referrals and follow through to ensure they are completed s ordered. DON will audit all consultations for referrals to contract services weekly x 4 weeks then every 2 weeks x 4, then monthly x 2 utilizing a QI tool. The results of the QI tool will be brought to the QAPI meeting by the DON monthly x 3 months.	

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F 685	Continued From page 46 An interview on 2/15/23 at 2:49 PM with the Director of Nursing revealed that consultant recommendations needed to be followed.	F 685		
F 689 SS=E	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, observation, staff, and resident interviews the facility failed to follow their policy and provide a hazard free environment when 1 of 1 resident (Resident #22) who was a supervised smoker was allowed to keep his cigarettes and lighter in his room and when the facility did not provide ashtrays and/or a litter free receptacle for hot ashes in their smoking area. The failure to provide a safe disposal source for hot ashes had the potential to affect all residents who smoked at the facility. Findings included: The facility's smoking policy dated 10-1-20 was reviewed and revealed in part the following: provision of ashtrays made of noncombustible material and safe design, and smoking materials of residents requiring supervision will be maintained by nursing staff.	F 689	Resident #22 cigarettes and lighter was removed from his person and placed on the locked medication cart by DON on 2/16/2023. Education was provided to resident on 2/16/2023 by DON on the smoking policy. Housekeeping cleaned smoking area on 2/16/2023 to ensure available ash trays and sanitary trash cans. All smoking residents were educated on the facility smoking policy on 2/16/2023 by Activity Assistant. All new residents will be educated on the facility smoking policy upon admission by the Admission Coordinator. 100% of all staff to include housekeeping, dietary, laundry, maintenance, business office, social worker, activities and agency contract staff were be in-service on the facility smoking policy to include safe smokers	3/15/23

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Review of the list of residents who smoked at the facility revealed there were five residents who smoked and utilized the smoking area.

Resident #22 was admitted to the facility on 7-26-22 with multiple diagnoses that included hemiplegia and hemiparesis.

The quarterly Minimum Data Set (MDS) dated 1-23-23 revealed Resident #22 was cognitively intact and was dependent on assistance for all movement. The MDS also documented Resident #22 as a smoker.

Resident #22's care plan dated 1-30-23 revealed the resident was a smoker and had a goal that he would not suffer any injury from unsafe smoking. The interventions for the goal were the resident required supervision while smoking.

Review of Resident #22's smoking assessment dated 2-13-23 revealed the resident required supervision during smoking.

Observation and interview occurred with Resident #22 on 2-13-23 at 10:24am. An observation of the resident's nightstand revealed a pack of cigarettes and a lighter laying on top of the nightstand. Resident #22 acknowledged that he smoked and stated the staff allowed him to keep his cigarettes and lighter in his room. The resident also acknowledged that other residents came into his room to visit.

Observation of the smoking area occurred on 2-13-23 at 2:15pm. The observation revealed no ash trays, several cigarette butts were laying on the concrete and grass/dirt area and a metal container with a lid that was full of paper trash.

F 689

and unsafe smokers, proper smoking areas, cleaning of the smoking area on 3/09/2023 by the DON. Any new staff hired will be in-serviced on the facility smoking policy and proper, cleanliness of or smoking area by DON/designee.

Residents who require supervised smoking staff will request to search the room for smoking materials weekly x 4 weeks using a safe smoking QI tool by the Activity Director. The residents smoking area will be audited weekly x 4 weeks using the safe smoking QI tool for cleanliness and ashtray availability by the housekeeping supervisor/designee.

The Activity Director and Housekeeping Supervisor will forward the finding of the safe smoking QI tool to the QAPI meetings monthly x 3 months and will be reviewed and recommend any changes needed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Continued From page 48

On 2-13-23 at 4:00pm, observation of Resident #22 smoking occurred in the smoking area. The observation revealed Resident #22 had on an apron, he had his cigarettes and lighter with him, there was no ashtray in the smoking area, and the metal receptacle contained paper trash. The Director of Nursing (DON) was observed placing a cigarette in the resident's mouth and lighting it for him. When Resident #22 was finished with his cigarette the DON was observed to place the cigarette on the ground and stamp it out.

The DON was interviewed on 2-13-23 at 4:05pm. The DON acknowledged there was not an ashtray present in the smoking area for the residents. She explained the residents threw their cigarettes in the yard that contained dirt and grass. The DON stated the metal container with the lid in the smoking area was a place the residents could have disposed of their cigarettes but acknowledged it was full of paper trash. She explained she did not know who was responsible for the smoking area to assure the proper equipment was present because the housekeeping staff would say it was maintenance and maintenance would say it was housekeeping's responsibility. The DON also explained per their smoking policy, residents were to keep their smoking material at the nursing station but stated the staff had allowed the residents to keep their cigarettes and lighter because it was a "fight" to retrieve their smoking materials. She added she was sure Resident #22 would not try to smoke in the building and did not think other residents would take the smoking materials.

Nurse #4 was interviewed on 2-14-23 at 1:25pm.

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F 689	Continued From page 49 The nurse stated the residents that smoke were supposed to return their smoking materials to the hall nurse when they were done smoking but stated most of the residents kept their smoking material. She said she did not see that as a hazard because the residents knew not to smoke in their rooms. During an interview with Nursing Assistant (NA) #4 on 2-14-23 at 3:43pm, the NA stated when she took residents out to smoke, she would retrieve their smoking materials once they were done smoking. She stated it was a fire hazard to allow the residents to keep their smoking materials. The Administrator was interviewed on 2-16-23 at 12:16pm. The Administrator discussed residents who smoked were to keep their smoking materials at the nursing station and the smoking area's metal bin should be clear of any trash to avoid fires. She stated she was not aware of the condition in the smoking area and that residents were being allowed to keep their smoking materials. The Medical Director was interviewed on 2-16-23 at 12:30pm. The Medical Director stated there was a potential hazard because there was nothing to keep a resident from lighting a cigarette in the middle of the night.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		3/15/23

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F 690	Continued From page 50 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to ensure a resident who entered the facility with an indwelling urinary catheter that was not medically justified was assessed for removal of the catheter as soon as possible. In addition, the facility failed to have a physician's order for the indwelling urinary catheter and for catheter care. This deficient	F 690	Resident #15 urinary catheter was removed on 2/15/23. Resident was able to void without difficulty. Urinary catheter audit was done on 2/22/23 by ADON. All residents with urinary catheters had appropriate orders and diagnoses for catheter use.	

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F 690 Continued From page 51
practice affected 1 of 2 residents (Resident #15) reviewed for a urinary catheter.

Findings included:

Resident #15 was admitted to the facility on 1/13/23 with diagnoses which included cerebrovascular accident and Diabetes Mellitus.

Review of the hospital discharge summary for Resident #15 dated 1/13/23 revealed no mention of a urinary catheter or catheter associated diagnosis.

Review of Resident #15's physician's orders revealed no order for a urinary catheter or associated catheter care except an order dated 1/13/23 to change the indwelling catheter every month and as needed for leakage, occlusion, encrustation, or removal.

Review of the discharge with return anticipated Minimum Data Set (MDS) dated 1/18/23 revealed Resident #15 was discharged to the hospital.

Review of the hospital discharge summary for Resident #15 dated 1/23/23 read in part 'She also has an indwelling [urinary catheter] and it sounds as though these were place for incontinence, not retention.' Further review of the hospital discharge summary revealed no catheter associated diagnosis such as neurogenic bladder or urinary retention.

Review of the entry MDS dated 1/23/23 revealed Resident #15 returned to the facility from the hospital.

The admission Minimum Data Set dated 1/30/23

F 690

In-service of all licensed nurses was conducted on 2/23/2023 to educate on use, trial voiding, documentation and orders.

ADON will perform audit of urinary catheters to include current residents weekly x 4 weeks then monthly x 1 month utilizing a census. All new admissions with urinary catheters will be assessed on admission for need for urinary catheter and removal for voiding trials unless clinically demonstrated that catheter is required.

The ADON will forward results of audits to the Executive Quality Assurance (QA) Committee monthly x3 months and review to determine that all residents with catheters continue to need the catheters.

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revealed Resident #15 had moderately impaired cognition and was coded as total dependence on staff for activities of daily living. She was coded to have an indwelling urinary catheter and no voiding trial.

Review of the physician's orders revealed an order dated 2/10/23 entered by Nurse #3 to add the diagnosis of neurogenic bladder with obstructive uropathy.

An interview on 2/15/23 at 1:27 PM with Nurse #3 revealed Resident #15 did not have an order for a urinary catheter on her admission to the facility. She stated the resident had a urinary catheter when she was admitted on 1/13/23. She stated that the resident should have an order for a urinary catheter, and she did not know why she did not. She stated she knew that the resident should have a medical diagnosis to have a urinary catheter which included a neurogenic bladder, urinary retention, or other bladder diagnosis. She stated she obtained an order from the physician on 2/10/23 for a medical diagnosis of neurogenic bladder for the resident to have a catheter. She also stated she did not know if attempts were made to discontinue the catheter or if she had a voiding trial.

An interview on 2/15/23 at 10:48 AM with Nursing Assistant (NA) #3 revealed she frequently provided care for Resident #15. She stated the resident had a urinary catheter since she was first admitted from the hospital and she always provided her catheter care during her shift.

An interview on 2/15/23 at 2:28 PM with the Director of Nursing revealed she expected Resident #15 to have a diagnosis for a urinary

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F 690	Continued From page 53 catheter, a voiding trial, and orders for a catheter and its care. She did not know why this was not done. An interview on 2/16/23 at 12:00 PM with the physician revealed the resident should have had a voiding trial to determine if she was retaining urine and orders for a urinary catheter if she needed to have a catheter. He stated he had no information to determine if the resident had urinary retention until a voiding trial was completed. An interview on 2/16/23 at 11:40 AM with the Administrator revealed that Resident #15 should have orders for a urinary catheter if she required one after a voiding trial and she did not know why this had not been done.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		3/15/23

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F 692 Continued From page 54

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, consulting Registered Dietitian (RD) interview and physician interview and record review the facility failed to obtain weekly weights for a new admission and ensure all weights were recorded in the medical record for a resident who had identified weight loss for 1 of 5 residents (Resident #23) reviewed for nutrition.

The findings included:

Resident #23 was admitted to the facility on 12/06/22 with diagnoses which included respiratory failure with tracheostomy tube, unstageable sacral pressure ulcer, abdominal feeding tube site wound and diabetes.

The admission Minimum Data Set (MDS) assessment dated 12/13/22 revealed Resident #23 was severely cognitively impaired. She required total assistance with activities of daily living except she required extensive assistance with eating. The MDS recorded her weight of 194 pounds and no or unknown significant weight loss.

A review of Resident #23's weights in the EMR revealed on 12/9/22 she weighed 194.3 pounds. On 12/22/22 she weighed 189.7 pounds and on 12/29/22 she weighed 184.0 pounds. There were no weights for January 2023 or February 2023 recorded in the EMR.

F 692

Resident # 23 weight was obtained on 2/17/2023 by Therapy Manager. Weight variance was noted with interventions put in place on 2/17/2023 by ADON. Medical Director and RR made aware on 2/17/2023 by ADON. Therapy Director and Restorative Aide now have access to directly input weights into Point Click Care when obtained.

On 2/22/2023, the Director of Nursing in-serviced the Therapy Manager and Restorative Aide on directly putting weights into Point Click Care.

The ADON will review all weights to ensure weekly and monthly weights are obtained weekly x 4 weeks in the weekly weight meeting then monthly x 2 month. This audit is to ensure all weights are obtained and placed in Point Click Care for review.

The ADON will forward the results of the weekly weight meeting to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet monthly review the Weekly Weights to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.

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The monthly note by the RD dated 12/30/22 documented in part "CBW (current body weight) of 184 lbs. (pounds) ... This results in a 10 lb. weight loss ... Recommend to add name brand nutritional supplement BID (two times per day) with lunch and dinner to help halt weight loss. Will continue to monitor."

An additional RD note dated 1/20/23 documented "Resident noted to have sacral wound and abdomen LUQ (left lower quadrant) wound. Recommend Vitamin C 500mg (milligrams) BID, Zinc 220mg QD (each day), and name brand protein supplement 60 ml (milliliters) BID. Will continue to monitor and follow PRN (as needed)."

The physician's follow-up note dated 1/25/23 read in part "Her weight is 184 pounds, but we do not have a recent weight on her, but I think her weight has been stable .... She looks elderly and cachectic (loss of body weight and muscle mass) as well .... She is on appropriate zinc, vitamin C, and name brand protein supplement to promote wound healing." "No signs of any new breakdown at this point..."

Resident #32's current diet order dated 2/13/23 read, 2-gram sodium, dysphagia advanced texture, Regular (thin) consistency.

On 2/16/22 at 9:07 AM the Rehabilitation Director stated she and the Restorative Aide were responsible for obtaining weights for the residents in the facility. She said the residents were weighed weekly for the first 4 weeks and afterwards were weighed monthly. She said she did not know why there were no weights recorded in the EMR since 12/29/22 for Resident #23.

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On 2/16/23 at 12:25 PM Resident #23's physician stated he expected the EMR to be updated with the information needed to make medical decisions including the need for interventions to prevent weight loss.

On 2/16/23 at 1:42 PM the Assistant Director of Nursing (ADON) stated she was responsible for entering the weights into the EMR. She said she had a piece of paper with Resident #23's name on it and she had marked off the name which indicated she had entered Resident #23's weight into the EMR. She said she remembered she entered the weight into the EMR but, the entry must not have been saved in the EMR.

On 2/16/23 at 1:45 PM the ADON provided a paper with a small yellow paper attached. The small yellow paper documented on the date of 1/16/23 Resident #23 had a weight of 179.3 pounds.
The weight of 189.7 pounds on 12/22/22 compared to the weight of 179.3 pounds on 1/16/23 represented a 10.4 pound decrease which equates to a 5.48% weight decrease in 25 days.

On 2/16/23 at 1:52 PM the Director of Nursing (DON) stated the facility conducted weekly weight meetings where they discussed residents with weight loss. She said if there was not weight in the EMR it would not have triggered for weight loss and would not have been reviewed in the weight loss meeting. The DON added if the EMR was updated with her current weight they would have known about the additional 10 pound weight loss. She then said the ADON obtains any interventions from the RD for weight loss and enters them into the EMR as orders.

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F 692	Continued From page 57 On 2/16/23 at 2:20 PM during a telephone interview the RD reported Resident #23 was ordered 120 milliliters of a name brand nutritional supplement with lunch and dinner because of her previous weight loss from 194.3 pounds to 184 pounds. She said she was not aware any additional weight loss. The RD said she received a list of the residents' weights each week and Resident #23 was not on the list. She added if she had the information earlier, she would have put in additional intervention at that time.	F 692		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for	F 791		3/15/23

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F 791	Continued From page 58 dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff, family and physician interviews the facility failed to provide or obtain from an outside resource routine dental care for greater than 1 year. This was for 1 of 2 residents (Resident #1) reviewed for dental services. Findings included: Resident #1 was admitted to the facility on 8/31/2018 with a diagnosis including rheumatoid arthritis (a chronic inflammatory disorder affecting the joints) and diabetes mellitus. A review of her annual Minimum Data Set (MDS) assessment dated 5/10/2022 revealed she was cognitively intact. She required the total assistance of 1 person to eat. She had no weight loss of 5 percent (%) or more in the last month or	F 791	Resident # 1 will be seen by an outside dental provider/contracted dental provider for dental services on 4/12/2023. A 100% audit of all current residents, including resident # 1 was completed by the Assistant Director of Nursing on 2/20/23 to ensure all residents have no dental issues and have been seen by the dentist for timely routine care using a facility census. Any services identified by the audit for care services were scheduled at the next available appointment. The Assistant Director of Nursing will audit to ensure all residents are scheduled for appropriate services using a facility census. Any residents that needed dental services based on the audit will be	

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F 791	Continued From page 59 10% or more in the past 6 months. She received a mechanically altered therapeutic diet. No dental issues were present. A review of the Care Area Assessment associated with this MDS revealed no dental/oral problems were triggered. A review of the current comprehensive care plan for Resident #1 revealed a focus area of therapeutic diet. A goal last revised on 12/27/22 was for Resident #1 to not experience significant weight loss through the next review. Interventions included diet as ordered and provide assistance with meal as indicated. A dietician progress note for Resident #1 dated 2/10/23 revealed her weight was stable for 30, 60, and 90 days. It further revealed she was revealed she was receiving a mechanical soft carbohydrate-controlled diet. Resident #1 was meeting her nutritional needs with supplements in place. On 2/13/23 at 1:51 PM an interview with Resident #1 indicated she did not have any natural teeth. She stated she had been waiting on dentures since the last time she saw the dentist. She stated she was not having any trouble chewing her food without dentures and she was not having any mouth pain. She further indicated the last time she saw the dentist he told her she needed to have her tooth roots out before she could get dentures, but these had still not been removed. On 2/15/23 at 11:56 AM an interview with Nurse #3 indicated she was the facility's Unit Manager. She stated the facility no longer used the dental provider who saw Resident #1 on 2/18/20. She went on to say the facility had a new dental provider beginning in July 2022. She further	F 791	scheduled as per MD order. 100% in servicing for all nursing staff to include Unit Manager, on reporting gum/mouth issues and identifying oral problems to the License Nurse and any identified residents will be referred to dental services as needed. Orders for all dental consults will be reviewed for external referrals by the Assistant Directo fo Nursing weekly x 4 weeks, then monthly x 2 months using a dental QI tools for all residents, to include resident # 1 for any recommended dental needs utilizing the Dental Services QI Tool weekly x 4 then monthly x 2 months. The Administrator will review the Dental Services QI tool weekly x 4 weeks then monthly x 2 months for completion and to ensure all areas of concern were addressed. The Quality Improvement Executive Committee will review all Dental Services QI tool results monthly x 3 for any recommendations.	

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indicated Resident #1 had not been on the list to see this dental provider when they last visited the facility on 2/8/23. Nurse #3 stated if Resident #1 had been seen by a dental provider since 2/18/20 the record of that should be in her medical record. She went on to say the current dental provider sent her a list of residents they planned to see prior to their visit to the facility and then she could add any residents that needed to see the dentist who were not on the list. She further indicated she did not know how the dental provider got the initial list of residents. In a follow-up interview on 2/15/23 at 12:32 AM Nurse #3 indicated she was responsible for obtaining the consents from residents or their RPs for residents to be seen by the dental provider, getting them signed by the physician and then forwarding these to the dental provider. She stated she had not done this for Resident #1. She went on to say the facility needed a better system.

On 12/15/23 at 12:10 PM an interview with the facility Social Worker (SW) indicated she did not arrange residents dental appointments. She stated the only thing she did was to arrange transportation once an appointment was made. She went on to say she spoke with Resident #1 weekly, and Resident #1 had never indicated to her she wanted to see a dentist.

On 2/15/23 at 12:18 PM a telephone interview with the Clinical Care Coordinator for the facility's dental provider indicated the dental provider relied on the facility to get a dental consent for a resident. She stated the facility would forward the consent to the dental provider and that resident would then be placed on the list for the dental provider to see. She went on to say once a

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F 791	Continued From page 61 resident had been seen by the dental provider, they would automatically be placed on the future list to be seen when it was next recommended. The Clinical Care Coordinator stated Resident #1 was not currently in their system and she had no record of Resident #1 being seen by the dental provider. On 3/15/23 at 3:45 PM an interview with the Director of Nursing (DON) indicated if neither the facility dental care provider nor Resident #1's medical record had any documentation of Resident #1 being seen by a dentist since 2/18/20 then she could not provide any additional information. On 2/15/23 at 5:47 PM a telephone interview with Resident #1's family member indicated she spoke with her family member by telephone daily and her family member had been telling her repeatedly she had not gotten her dentures. She stated she filed a grievance with the facility in March or April of 2022 regarding her family member having been waiting for dentures for two years. She went on to say she had scheduled an outside appointment for Resident #1 at one time and the facility called her to let her know it was better for her to let the facility schedule appointments because that way they could coordinate the transportation. She further indicated it was her understanding the facility would coordinate any dental appointments Resident #1 needed. Resident #1's family member stated she called the facility multiple times to speak with the Administrator but was frequently told she was in a meeting and would call her back. She stated she never received a call back. She went on to say she would have expected Resident #1 to be seen by a dentist and	F 791		

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F 791	Continued From page 62 to have gotten dentures by now. A review of the grievance dated 4/13/22 filed by Resident #1's family member revealed in part the detail of the grievance was Resident #1 had been waiting for new teeth for 2 years. The written response to the grievance dated 4/19/22 revealed the dental provider had seen Resident #1 on 2/18/20 and Resident #1 would be placed on the next dental clinic list. On 2/16/23 at 7:59 AM an observation of Resident #1 revealed she was being assisted to finish her breakfast meal in her room by a staff member. In a follow-up interview with Resident #1 at that time she stated she had not seen a dentist in 2 years. She went on to say at her last visit a dentist had come to the facility to see her, opened her mouth, and told her he did not know why the facility called him about her getting dentures when she still had root tips in. Resident #1 further indicated the dentist told her at that visit she could not get dentures until the root tips were removed. She stated the facility was supposed to get her root tips removed so she could have dentures but never did. She went on to say while she was getting enough to eat and not having any trouble chewing her food, there were things she liked to eat that she couldn't eat without teeth. She further indicated she had not asked about seeing the dentist because the facility knew what they were supposed to do. On 2/16/23 at 11:16 AM an interview with the Administrator indicated residents should have routine dental care annually. She stated Resident #1 should have received the follow-up dental care she needed after her dental appointment on 2/18/20 and should have received the dental care	F 791		

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F 791	Continued From page 63 as indicated in the facility response to her family member's grievance. On 2/16/23 at 12:15 PM an interview with Resident #1's Physician indicated Resident #1 should have had the dental care recommended after her appointment on 2/18/20. He stated if the facility said they were going to put Resident #1 on the list to see the dentist, they should have done that.	F 791		
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 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.	F 867		3/15/23

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§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 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

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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 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:

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F 867	Continued From page 66 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 7/28/2021 recertification/complaint survey. This was for one repeat deficiency in the area of F 656 Develop/Implement Comprehensive Care Plan that was cited on the 7/28/2021 recertification and complaint survey. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA. The findings included: This tag is cross referenced to: F656: Based on record review and staff interviews, the facility failed to develop comprehensive individualized care plans for 1 of 3 residents (Resident #239) reviewed for care plans. During the recertification survey completed 7/28/2021 the facility failed to develop a comprehensive care plan to address pain for 1 of 1 resident reviewed for pain. On 2/16/23 at 2:40 PM an interview was conducted with the Director of Nursing and the	F 867	WHAT WE DID FOR RESIDENT INVOLVED: Facility held an Ad-HOC QAPI on with the Regional Staff Development Director in attendance. All residents have the potential to be affected by the alleged deficient practice. The administrative nursing team completed a 100% audit for all resident's care plan for comprehensive and accurate. Any inaccuracies and concerns were corrected at the time of the audit. The Corporate Consultant will review the last 6 months of facility QAPI meetings for signs of Program feedback, data systems and monitoring per state regulation/guidelines. The Corporate Staff Development Director will provide education to the QAPI committee on the QAPI/QAA system on 3-1-23. The DON/designee will educate all staff through 3-9-23 on QAPI/QAA and what the performance improvement plans that the facility currently has in place. Care plans will be monitored 2 care plans per week x 3 months utilizing an MDS calanders.	

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F 867	Continued From page 67 Administrator. The Director of Nursing reported the facility had identified areas of concern and formulated a plan to monitor those concerns but had not talked about care plans specifically. The Administrator reported the facility should have care plans updated for residents who had falls.	F 867	The Nursing consultant/corporate designee will review the monthly QAPI/QAA meeting minutes monthly x 4 months to ensure ongoing compliance with state regulations for an effective QAPI system and careplan plan audit results will be taking it to QAPI monthly x 3 months. Next scheduled meeting 3/15/2023. The results of the audit will be brought through the facilities monthly QAPI meeting monthly x 3 months (March, April and May) to evaluate the need for resolution or need for continued monitoring.	
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	F 880		3/10/23

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and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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F 880	Continued From page 69 §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 observations, record review and staff interviews the facility failed to perform hand hygiene after the removal of soiled gloves prior to putting on clean gloves when providing wound care for 2 of 3 residents reviewed for pressure ulcers (Resident #43 and Resident #31). Findings included: A review of an undated document titled "Handwashing/Hand Hygiene" provided by the facility in response to a request for a hand hygiene policy did not reveal any information regarding staff performing hand hygiene after the removal of gloves. A review of an undated document titled "Dressing Change, Clean" provided by the facility in response to a request for a wound care policy did not reveal any information regarding staff performing hand hygiene after the removal of gloves. 1. On 2/15/23 at 9:45 AM an observation of wound care provided to Resident #43 by the Treatment Nurse revealed she performed hand hygiene, put on clean gloves, and removed Resident #43's soiled sacral (bottom of spine)	F 880	F 880 Plan of Correction: 1. Immediate action(s) taken for the resident(s) found to have been affected include: The Director of Nursing re-educated the Treatment Nurse on 3/09/2023, regarding the importance of hand hygiene. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Survey reminders were given by the DON on February 15, to include sanitizing hands. In accordance with the Directed Plan of Correction (DPOC), a facility management meeting was held in the facility on March 9th 2023, to complete the root cause	

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wound dressing using her gloved fingers. She then removed her soiled gloves and put on a pair of clean gloves to apply his clean wound dressing without performing hand hygiene.

An interview with the Treatment Nurse on 2/15/23 at 9:55 AM indicated she should have performed hand hygiene after the removal of her soiled gloves before she put clean gloves on. She stated she usually did this but had been nervous during the observation and had forgotten to perform hand hygiene.

On 2/15/23 at 10:05 AM an interview with the Director of Nursing (DON) indicated hand hygiene should be performed after the removal of soiled gloves before putting on clean gloves. She stated this was to help prevent the spread of infection.

On 2/15/23 at 11:04 AM an interview with the Assistant Director of Nursing (ADON) indicated she was the facility's Infection Preventionist (IP). She stated she was taught hand hygiene should be performed after the removal of soiled gloves before putting on clean gloves. She stated this was to prevent the possible transfer of contaminates from soiled hands to the clean gloves. She went on to say the facility's hand hygiene policy did not specify staff should perform hand hygiene after removing gloves.

On 2/16/23 at 11:55 AM an interview with the Administrator indicated hand hygiene should be performed after the removal of soiled gloves before putting on clean gloves.

2. On 2/15/23 at 9:55 AM an observation of wound care provided to Resident #31 by the Treatment Nurse revealed she performed hand

F 880

analysis (RCA) and discuss the corrective action needed. Meeting participants included:
" Administrator,
" Director of Nursing,
" Corporate Infection Preventionist,
" Chief Operating Officer,
" Chief Clinical Officer,
" VP of Building and Properties,
" Facility Nurse Consultant,

In-services were completed by the Director of Nursing on February 23, 2023 through February 25, 2022, for facility nurses, including (LPNs and RNs).

The in-service included the following topics:
" Hand Hygiene,
" Including the following facility policies:
o Carrolton Policy #IC 3.0 Hand Hygiene Policy

In-services were completed by the Director of Nursing February 25, 2023, for facility nurses, including (LPNs and RNs).

4. How the corrective action(s) will be monitored to ensure the practice will not recur:

" The Infection Preventionist/Director of Nursing (DON), or designee, will observe facility staff (including nursing and housekeeping staff) on hand hygiene.
o At least five (5) staff members per week will be observed over the next three (3) months to ensure staff are properly preforming hand hygiene.

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F 880	Continued From page 71 hygiene, put on clean gloves, placed her left gloved hand on Resident #31's back and cleaned Resident #31's open sacral wound using moist gauze held with the fingers of her right gloved hand. She then removed her soiled gloves and put on a pair of clean gloves to apply his clean wound dressing without performing hand hygiene. An interview with the Treatment Nurse at this time indicated she should have performed hand hygiene after the removal of her soiled gloves before putting clean gloves on. She stated she usually did this but had been nervous during the observation and had forgotten to perform hand hygiene. On 2/15/23 at 10:05 AM an interview with the Director of Nursing (DON) indicated hand hygiene should be performed after the removal of soiled gloves before putting on clean gloves. She stated this was to help prevent the spread of infection. On 2/15/23 at 11:04 AM an interview with the Assistant Director of Nursing (ADON) indicated she was the facility's Infection Preventionist (IP). She stated she was taught hand hygiene should be performed after the removal of soiled gloves before putting on clean gloves. She stated this was to prevent the possible transfer of contaminates from soiled hands to the clean gloves. She went on to say the facility's hand hygiene policy did not specify staff should perform hand hygiene after removing gloves. On 2/16/23 at 11:55 AM an interview with the Administrator indicated hand hygiene should be performed after the removal of soiled gloves before putting on clean gloves.	F 880	" Routine monitoring of proper hand hygiene, the selection has been added to the facility QAPI plan. " Observation reports and competencies will be reviewed by the Carrolton Facility Management (CFM) Compliance Team monthly until such time consistent and substantial compliance has been achieved as determined by CFM. " Audit records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: March 9, 2023.	
F 940 SS=E	Training Requirements	F 940		3/15/23

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	345266	A. BUILDING ______ B. WING ______	C 02/16/2023

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F 940	Continued From page 72 CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure staff received the required training for 5 of 5 Nursing Assistants (NA #3, NA #5, NA #6, NA #7, and NA #8). This practice had the potential to affect all residents. Findings included: Review of the facility assessment dated 11-29-22 revealed NAs should receive the following training annually: communication, resident rights, and cultural competency. a. NA #3's hire date was 10-1-20. The education folder that was provided by the Director of Nursing (DON) for the past year (January 2022 through Feb 2023) was reviewed. The review revealed NA #3 had no documentation that she received communication training, Quality Assurance and Performance Improvement (QAPI) training and ethics training within the last year. b. NA #5 was hired on 10-1-20. The education folder for NA #5 was provided by the DON. Upon	F 940	NA #8 is no longer employed with the company. NA #3, #5, #6 and #7 did receive education to include communication training, QAPI, ethics and resident□s rights on 3/07/2023 by the Regional Staff Development Manager/Nursing Consultant. All residents have the potential to be affected by the alleged deficient practice. Employee folders were reviewed for education requirements. Education requirements were formulated based on the review results to include needed training on compliance and ethics, effective communication, dementia, culturally competent care and resident's rights. DON/designee conducted 100% education to include housekeeping, dietary,maintence, social worker, activities, business office,laundry, adminstrative,and agency contract staff through 3/15/23. Regional Staff Development Manger/Consultant developed a monthly	

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F 940	Continued From page 73 review of NA #5's education folder, there was no education present within the last year (January 2022 through Feb. 2023) for communication, resident rights, QAPI and ethics training. c. NA #6 was hired on 9-30-20. A review of NA #6's education folder, provided by the DON, for the last year revealed NA #6 did not have documentation that she received communication training, resident rights education, QAPI and ethics training within the last year (January 2022 through Feb. 2023). d. NA #7's hire date was 10-1-20. The education file provided by the DON, was reviewed. The review of the education revealed no documentation of NA #7 receiving QAPI training and ethics training within the last year (January 2022 through Feb.2023). e. NA #8 was hired on 9-30-20. The education folder provided by the DON for NA #8 was reviewed. The review revealed NA #8 did not have any documentation of communication training, QAPI and ethics training within the last year (January 2022 through Feb. 2023). The DON was interviewed on 2-16-23 at 11:57am. The DON acknowledged she was the one responsible for staff education and that she had provided all the education for the past year. The DON explained she was not present in the facility for 3 months in 2022 and stated during the 3 months staff education had not been completed. She stated the facility conducted in person trainings with sign in sheets and she was made aware of what annual trainings were needed by the facility's corporate Chief Nursing Officer. The DON reviewed the sign in sheets and	F 940	training calendar to ensure completion of required annual training. ADON will complete required training per schedule and DON will verify completed training monthly x 3 months. DON will bring the results of the compliance with training calendar and the signature confirmation sheet to the monthly Executive QI meeting monthly x 3 months. Any changes or recommendations will be made at that time.	

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F 940	Continued From page 74 stated she was not aware the above staff had not completed all the required training. The Administrator was interviewed on 2-16-23 at 12:16pm. The Administrator stated the DON conducted annual training on abuse and dementia management. She explained the education was completed in person with a sign in sheet. The Administrator said she did not know why the above staff had not completed all the required training on because she had been out of the building for 3 months in 2022.	F 940		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 947	NA #8 is no longer employed with the	3/15/23

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F 947	Continued From page 75 facility failed to provide required dementia management training and/or abuse training for 5 of 5 Nursing Assistance (NA #3, NA #5, NA #6, NA #7, and NA #8) reviewed for annual education. Findings included: a. NA #3's hire date was 10-1-20. The education folder that was provided by the Director of Nursing (DON) for the past year (January 2022 through Feb 2023) was reviewed. The review revealed NA #3 had no documentation that she received abuse training within the last year. b. NA #5 was hired on 10-1-20. The education folder for NA #5 was provided by the DON. Upon review of NA #5's education folder, there was no education present within the last year (January 2022 through Feb. 2023) for dementia management training or abuse training. c. NA #6 was hired on 9-30-20. A review of NA #6's education folder, provided by the DON, for the last year revealed NA #6 did not have documentation that she received dementia management training or abuse training within the last year (January 2022 through Feb. 2023). d. NA #7s hire date was 10-1-20. The education file provided by the DON, was reviewed. The review of the education revealed no documentation of NA #7 receiving abuse education within the last year (January 2022 through Feb.2023). e. NA #8 was hired on 9-30-20. The education folder provided by the DON for NA #8 was reviewed. The review revealed NA #8 did not	F 947	facility. NA #3, #5, #6 and #7 did receive education to include QAPI, resident rights, compliance and ethics, effective communication, abuse and dementia by Corporate Staff Development Manager/Consultant on 3/7/23. All residents have the potential to be affected by the alleged deficient practice. Employee folders were reviewed for education requirements by Corporate Staff Development Manager/Consultant. Education requirements were formulated based on the review results to include needed training on compliance and ethics, effective communication, dementia, culturally competent care,abuse and resident's rights through 3/15/23. DON/designee conducted 100% education to include housekeeping, dietary,mainenanace, social worker, activities, business office, laundry, adminstrative, and agency contract staff. Regional Staff Development Manger/Consultant developed a monthly training calendar to ensure completion of required annual training. ADON will complete required training per schedule and DON will verify completed training monthly x 3 months. DON will bring the results of the compliance with training calendar and the signature confirmation sheet to the monthly Executive QI meeting monthly x 3 months. Any changes or recommendations will be made at that time.	

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F 947	Continued From page 76	F 947		

have any documentation of abuse training within the last year (January 2022 through Feb. 2023).

The DON was interviewed on 2-16-23 at 11:57am. The DON acknowledged she was the one responsible for staff education and that she had provided all the education for the past year. The DON explained she was not present in the facility for 3 months in 2022 and stated during the 3 months staff education had not been completed. She stated the facility conducted in person trainings with sign in sheets and she was made aware of what annual trainings were needed by the facility's corporate Chief Nursing Officer. The DON reviewed the sign in sheets and stated she was not aware the above staff had not completed the dementia management training and/or the abuse training.

The Administrator was interviewed on 2-16-23 at 12:16pm. The Administrator stated the DON conducted annual training on abuse and dementia management. She explained the education was completed in person with a sign in sheet. The Administrator said she did not know why the above staff had not completed their annual training on abuse and/or dementia management because she had been out of the building for 3 months in 2022.