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UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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E 000	Initial Comments The survey team entered the facility on 4/3/2023 to conduct a recertification and complaint investigation survey. The survey team was onsite from 4/3/2023 to 4/6/2023 and on 4/10/2023. Additional information was obtained offsite on 4/11/2023. Therefore, the exit date was 4/11/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #UBVG11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 4/3/2023 to conduct a recertification and complaint investigation survey. The survey team was onsite 4/3/2023 to 4/6/2023 and 4/10/2023. Additional information was obtained offsite on 4/11/2023. Therefore, the exit date was 4/11/2023. Event ID #UBVG11. The following intakes were investigated: NC00192222, NC00192416, NC00193912, NC00194565, NC00196593, NC00199735, NC00199980 and NC00200365. 2 of the 13 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.12 at tag F-600 at a scope and severity (J) CFR 483.25 at tag F-684 at a scope and severity (J) The tags F600 and F684 constituted Substandard Quality of Care.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/02/2023

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 000	Continued From page 1 An extended survey was conducted.	F 000		
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- §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, Nurse Practitioner, Medical Director, and Radiologist interviews, the facility failed to protect a severely cognitively impaired resident from injury of unknown origin. On 3/18/23 nurse aide #1 observed bruising on Resident #22's left thigh and right fourth toe. On 3/20/23 Resident #22 was assessed by a nurse and found to have a bruise to her left thigh described as the "size of a salad plate saucer" and swollen knee. X-ray results revealed Resident #22 had a grossly displaced complex fracture of the left distal femur with angulation at the fracture site (the femur was broken in more than one place and the bone fragments were at an angle to each other). This was for one of one resident reviewed for an injury of unknown origin.	F 600	Past noncompliance: no plan of correction required.	

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The findings included:

Resident #22 was admitted to the facility on 10/10/2018 with diagnoses that included Tourette's disease (a nervous system disorder involving repetitive movements or unwanted sounds) cognitive communication deficit, abnormal posture, vascular dementia with behavioral disturbances, convulsions, and osteoporosis.

The annual Minimum Data Set (MDS) assessment dated 1/4/23 showed Resident #22 was severely cognitively impaired, had unclear speech, and sometimes was able to understand others. The MDS showed Resident #22 required extensive assistance from two staff members for transfers and total assistance from one staff member for bathing. The MDS showed Resident #22 had not taken any anticoagulants, did not have any behaviors of refusing care, and did not have any physical/verbal behaviors directed at others. The MDS showed at the time of assessment, Resident #22 had not fallen in the previous six months.

The care plan dated 1/8/23 showed Resident #22 had a focused area of socially inappropriate/disruptive
behaviors of screaming out at times related to Tourette's disorder, a difficulty communicating, and at risk for falls with previous actual falls. Interventions included attempt to redirect as needed, use simple communications, assist with mobility at level resident requires, two persons assist with bathing, toileting, bed mobility, and transfers.

A shower log and skin assessment sheet dated

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3/18/23 (Saturday) showed Resident #22 had bruising on her left thigh and bruising on her right fourth toe. The shower sheet was signed by Nurse Aide #1 on 3/18/23 and the Unit Manager on 3/20/23.

A nursing progress note written by Nurse #2 dated 3/20/23 read "nurse aide was giving bath notice left knee was swollen. Physician was notified, order for left leg to be x-ray, writer called mobile x-ray mobile imagining."

An x-ray dated 3/20/23 of Resident #22's left femur (thigh bone) showed osseous mineralization was decreased. This could reflect osteopenia (reduced bone mass lesser severity than osteoporosis) or osteoporosis (condition in which bones become brittle and fragile from a loss of tissue). The report also read Resident #22 had a grossly displaced complex fracture of the distal femur with angulation at the fracture site and soft tissue swelling. (the femur was broken in more than one place and the bone fragments were at an angle to each other).

A Physician orders dated 3/20/23 showed an order to send Resident #22 to the emergency room for evaluation of a possible femur fracture.

A nursing progress note written by the Unit Manager dated 3/20/23 read "Resident sent to ER for further evaluation and treatment per MD for possible leg femur fracture."

The emergency room physical assessment dated 3/20/23 read "Left leg has obvious deformity. There is moderate swelling to left thigh with bruising. No additional obvious trauma on exam."

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Resident #22's vital signs were stable, and she was not in any distress. No known injury. Resident #22 showed signs of dementia, was alert, and moved her extremities spontaneously. The x-ray taken at the emergency room on 3/20/23 showed Resident #22 had a comminuted fracture (a fracture where the bone is broken in at least two places) that was reduced (a procedure used to set broken bones without cutting the skin open) in the emergency room and splinted after orthopedic surgery consultation. The facility was unable to provide the emergency room with information related to the cause of Resident #22's injuries. Resident #22 was admitted to the hospital on 3/20/23 with a diagnosis that included a closed fracture of the distal end of her left femur. (a fracture of the thigh bone above the knee). The resident was readmitted to the facility on 3/24/23.

An interview was conducted on 4/4/23 at 1:29 P.M. with Nurse Aide #2 who was assigned to Resident #22 on 3/20/23 for the 7 A.M. to the 7 P.M. shift. NA #2 indicated she was familiar with Resident #22. Resident #22 was unable to communicate with staff and rarely made her needs known. During the interview, NA #2 indicated Resident #22 was able to move her legs to hanging off the bed and sit up in the bed without assistance from staff. During the interview, NA #2 indicated she was assigned to work with Resident #22 on 3/17/23 during the 7 A.M. to 7 P.M. shift and had not observed Resident #22 to have any bruising. NA #2 indicated when she went to work on 3/20/23, she had not received a report that stated Resident #22 had a fall or any injury and Resident #22 behaved at her baseline with no indication she was in pain. NA#2 indicated when she went to

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Resident #22's room to provide her with a bed bath she noticed bruising that was light in color on her left thigh approximately the size of a "salad plate saucer." NA #2 indicated when she reached over the side of the bed, NA #2 observed Resident #22 to have a swollen knee. NA #2 reported the bruising to the assigned nurse.

An interview was conducted on 4/4/23 at 2:02 P.M. with Nurse #2 who was assigned to Resident #22 on 3/20/23 for the 7 A.M. to the 7 P.M. shift. Nurse #2 indicated she had not received a report Resident #22 had a fall or another incident with injury. Nurse #2 indicated Resident #22 was sleeping when she arrived for her shift on 3/20/23 with no signs of she was in pain. During the interview, Nurse #2 indicated NA #2 reported Resident #22 had a bruise on her thigh, a bruise under her left leg by her knee, and an indentation above the left knee. Nurse #2 assessed Resident #22 and described the bruise under her leg at the knee as being "about the size of a softball". The bruise was dark purple, red, with a "little bit of tint on her thigh." Nurse #2 indicated the indentation at the left knee was only observed when the leg was looked at from the side. During the interview, Nurse #2 indicated she felt Resident #22 had a broken leg and reported the injury to the Unit Manager. Nurse #2 further indicated the x-ray technician reported to her, when Resident #2's left thigh was x-rayed, Resident #22 did not call out when her leg was repositioned.

An interview was conducted on 4/4/23 at 1:16 P.M. with the Unit Manager. The Unit Manager indicated she was unaware Resident #22 had any bruising on her left thigh until 3/20/23 when Nurse #2 made her aware. The Unit Manager indicated

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herself and Nurse #2 went and assessed Resident #22. During the interview, the Unit Manager indicated Resident #22 was unable to verbalize what caused the bruise, so a head-to-toe assessment was completed with the following results: a bruise the size of a softball on the top of Resident #22's left thigh that appeared to be a newer bruise because it was not yellow, a bruise behind Resident #22's left knee, and a bruise on a toe. The Unit Manager indicated she does not recall which toe had a bruise. During the interview, the Unit Manager indicated Resident #22 was unable to verbalize pain but did not show any nonverbal signs of being in pain when she assessed her on 3/20/23. The Physician was notified, and a mobile x-ray was ordered. The Physician gave orders to send Resident #22 to the emergency room when the x-ray results showed a fracture. The Unit Manager indicated after Resident #22 went to the emergency room an investigation was started by the Administrator.

An interview was conducted on 4/4/23 at 3:42 P.M. with the Director of Nursing (DON). During the interview, the DON indicated the morning Resident #22 went to the emergency room, the Unit Manager reported a bruise of unknown origin to herself and the Administrator.

An interview was conducted on 4/5/23 at 10:09 A.M. with the Administrator. During the interview, the Administrator indicated he was made aware Resident #22 had a bruise on 3/20/23. The Administrator stated he went to Resident #22's room and observed a bruise that was a significant size of approximately 10-15 centimeters. The Administrator indicated the doctor was contacted, an x-ray was taken that showed a fracture, and the resident was sent to the emergency room.

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A telephone interview was conducted on 4/6/23 at 3:25 P.M. with the Nurse Practitioner (NP). The NP
indicated she was in the building on 3/20/23 when she was alerted by nursing staff Resident #22 needed to be assessed for a bruise. The NP observed a large bruise on Resident #22's top to the side of her left thigh that appeared to be under 24 hours old based on the coloration and her leg was a little swollen. During the interview the NP indicated she felt Resident #22 had a possible fracture. The NP indicated the facility completed an investigation and it was determined the injury occurred due to a mechanical lift, Resident #22's combativeness, and Resident #22's weak bones.

A telephone interview was conducted on 4/5/23 at 8:22 A.M. with the Medical Director. During the interview, the Medical Director indicated he was familiar with Resident #22 and had given orders to send her to the emergency room for evaluation for a femur fracture. The Medical Director indicated Resident #22 had advanced dementia, seizure activity, contractures, and was unable to straighten her legs. The Medical Director further indicated when staff used a mechanical lift to transfer Resident #22, the pressure points on her body were in different locations compared to a person who was not contracted. The Medical Director further indicated with Resident #22's weakened bones, the movement with the mechanical lift, and rolling back and forth during a shower, the bone may have become grossly displaced. During the interview, the Medical Director indicated he was unaware of Resident #22 having a fall prior to being taken to the emergency room on 3/20/23 for an evaluation.

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A telephone interview was conducted on 4/11/23 at 9:24 A.M. with Radiologist #1. During the interview, Radiologist #1 accessed Resident #22's electronic medical record and reviewed the x-rays of Resident #22's left femur (thigh bone) taken while she was in the emergency room. Radiologist #1 indicated the left thigh fracture was a recent fracture and had occurred approximately within a day or less from her hospitalization. The radiologist indicated Resident #22 had diminished bone mineralization which made her more prone to fractures. During the interview, Radiologist #1 indicated based off the severity of the break on the femur (thigh bone), the multiple fractures on the femur, the location of the break above the knee, he would guess the resident had a fall. The radiologist further stated an aggressive amount of force from a fall, or a car accident was required for this type of fracture, and it was an unusual fracture to have occurred in a mechanical lift.

The Administrator was notified of the Immediate Jeopardy on 4/6/23 at 5:00 P.M.

The facility provided a corrective action plan on 4/8/23 which alleged a date of completion of 3/25/23. The corrective action plan indicated:

The root cause analysis identified that the alleged noncompliance resulted from the failure of the facility to ensure each resident is free from injury of unknown origin for one resident #22. The RCA identified that an employee failed to use the mechanical lift properly per facility mechanical lift policy and procedures. Resident #22 have fragile bones resulting from decreased osseous mineralization that reflect osteopenia and

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osteoporosis. The RCA concluded that due to Resident #22 condition of osteopenia it is most likely that the sustained fractures resulted from an improper use of the mechanical lift by nursing aide #1 on 3/18/2023. The RCA concluded that the extent of resident #22 injuries is related to resident #22 medical condition and improper use of the mechanical lift.

On 3/25/2023, Nursing assistant #1 was immediately suspended to allow further investigation of the allegation of abuse/neglect of Resident #22.

Nurse #1 assessed Resident #22 on 03/20/2023 and notified the attending physician who ordered an X ray of the Resident #22 leg. Unit Coordinator #1 spoke to Xray technician who completed the Xray and received a preliminary result that resident had a fracture. Unit Coordinator contacted the Attending Physician who ordered resident to be sent to emergency room for evaluation and treatment. The Unit Coordinator #1 notified the resident's responsible party of the change in condition as well as transfer to the emergency room on 3/20/2023.

On 03/25/2023, Director of Nursing completed a one-on-one re-education for Nursing Aide #1 on the importance of having assistance when using mechanical lift. The Director of Nursing also re-educated Nurse Aide #1 on 3/25/2023 on the abuse prohibition policy and procedures to include, but not limited to, ensuring each resident remains free from injuries of unknown sources.

Resident #22 was readmitted on 3/24/2023. Resident #22 was reassessed by MDS Coordinator #1, and the care plan was revised to

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include measures for pain management and two person's assistance with ADLs, and the use of two persons assistance with mechanical lift.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

100% interview of all residents in the facility who are alert and oriented completed by assistant Director of Nursing, Staff Development Coordinator, Unit Coordinator #1 and/or MDS Coordinator on 3/25/23 to identify any other resident with an allegation of abuse/neglect. No other resident voiced any allegation of abuse/neglect. Findings of this audit are documented on a "resident abuse interview tool" located in the facility compliance binder.

100% audit of current resident's medical diagnosis completed by assistant director of Nursing, Staff Development Coordinator, MDS Coordinator #1, Unit Coordinator #1, and/or MDS Coordinator #2 on 03/25/2023, to identify any other resident with diagnosis of osteopenia and or osteoporosis and assure each resident has a care plan with intervention such as use two persons for transfer, to minimize risk for pathological and/or spontaneous fractures. Findings of this audit are documented on a "care plan ADL audit tool" located in the facility compliance binder.

MDS Coordinator #1 and/or MDS Coordinator #2 on 03/25/2025, assure each resident has an Assistance of Daily Living (ADL) care plan that indicates the amount of assistance required during ADL care to include the use of mechanical

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lifts. Findings of this audit are documented on a care plan "ADL audit tool" located in the facility compliance binder.

100% audit of all incident reports written in the last 30 days completed on March 25, 2023, by Director of Nursing, Unit coordinator #1, and/or Unit manager #2 to identify any other incident of injury of unknown source. No other injuries of unknown sources identified. Findings of this audit are documented on an Incident report audit tool located in the facility compliance binder.

100% audit of all current resident's shower sheets for the last 30 days was completed on 03/25/2023 by Director of Nursing, MDS Coordinator #1, MDS coordinator #2, Unit coordinator #1, and/or Unit Manager #2 to identify any other documentation of an injury of unknown source further investigation. No other injuries of unknown sources were identified. Findings of this audit are documented on "shower sheets audit tool" located in the facility compliance binder.

Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 03/25/2023, facility will ensure all remains free from abuse, neglect, misappropriation of resident property, and exploitation, to include be free from injuries of unknown source.

Effective 03/25/2023 facility employees follow the company abuse prohibition policy and procedures, and policy and procedures when using mechanical lift to ensure each resident

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remains free from abuse to include injuries of unknown source. At least two employees are present when using a mechanical lift from 3/25/2023.

Effective 03/25/2023, all new residents have a bed mobility assessment completed on admission, quarterly, and with any changes in their bed mobility status, by the nurse on duty. This is reviewed in the daily clinical meeting and be documented on the facility medical records under the comprehensive care plan. Any resident who requires mechanical lift has a care plan for two persons assistance with the mechanical lift.

Effective 03/25/2023, the facility clinical team to include the Director of Nursing, Assistant Director of Nursing, Unit Coordinator #1 and/or Unit Coordinator #2 revised the process of reviewing all new admits/readmits in a daily clinical meeting and include the provision for bed mobility assessment to ensure it is completed and documented in electronic medical records, presence of osteopenia and/or osteoporosis, and ensure appropriate care plan is in place. Any discrepancies identified are corrected promptly. Finding of this systemic change is documented on the daily clinical meeting report form located on the daily clinical meeting binder.

100% education of all current staff to include full-time, part-time, employees from contracted staffing agencies company, and as needed employees completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to, the importance of completing bed mobility assessment on admission, quarterly and with

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changes of bed mobility status. Staff education also focused on facility abuse prohibition policy and procedures. and the requirements to use two persons assistance when using mechanical lifts at all times. This education was completed by 03/25/2023. Any staff members not educated 03/25/2023 is not allowed to work until educated. This education is now provided annually and has been added to the new hire orientation for all new employees including agency employees effective 03/25/2023.

How the facility plans to monitor its performance to make sure that solutions are sustained:

Effective 03/25/2023, the Director of Nursing, Assistant Director of Nursing, MDS Coordinators (#1, #2), Unit Coordinators (#1, #2), and/or Weekend Supervisor complete abuse prohibition monitoring process. This monitoring process is accomplished by observing residents to ensure employees are providing services in the facility that assure each resident is free from abuse and neglect, and to provide an environment that is free from accidents and hazards. The monitoring process is accomplished by observing five randomly selected staff when using the mechanical lift to ensure two people are present when using the lift. This monitoring process will be completed daily for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings are addressed promptly. This monitoring process is documented on a "Mechanical lift use" monitoring tool located in the facility compliance binder.

Effective 03/25/2023, the Director of Nursing,

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Assistant Director of Nursing, Unit Coordinators (#1, #2), and/or Weekend Supervisor review all new admissions for the last 24 hours or from last clinical meeting to ensure that a bed mobility assessment has been completed, a diagnosis or osteopenia/osteoporosis has been identified (if any) and plan or care developed to include intervention such as two people assistance with transfers when to minimize risk if injuries. Any negative findings are corrected promptly. This monitoring process is completed daily for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the "bed mobility assessment tool for new residents" located in the facility compliance binder.

Effective 03/25/2023, the Director of Nursing, Assistant Director of Nursing, Unit Coordinators (#1, #2), and/or Weekend Supervisor complete incident/accident monitoring process. This monitoring process will be accomplished by reviewing all skin assessments and shower sheets completed for the last 24 hours or from last clinical meeting to ensure that any identified injuries of unknown source has been assessed by a nurse and being addressed promptly. Any negative findings are corrected promptly. This monitoring process is completed daily for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process are documented on the "Skin assessments audit tool" located in the facility compliance binder.

Effective 03/25/2023, the Director of Nursing and/or Assistant Director of Nursing report

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F 600	Continued From page 15 findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived. Date of Completion: 3/25/23 The facility provided a corrective action plan for the incident that happened on 3/18/23 with a completion date of 3/25/23. The onsite validation was conducted on 4/10/23. Staff from different departments and who worked different shifts were interviewed and verified they had received training in using two people when transferring residents in a mechanical lift. Alert and oriented residents were interviewed who indicated they had been asked if they had been abused by staff and the residents had no concerns. A review was completed of the audit logs that included the educational information provided to staff during the in-service and a review of in-service staff sign-in logs. The in-service logs were reviewed, staff names were randomly selected and verified to have received training. The audit of resident medical diagnoses, care plan to include two staff for transfer with a mechanical lift, the shower sheets and incident reports were verified to have been completed and no additional unreported injuries were identified. A review of the monitoring tool revealed staff had completed daily monitoring of shower sheets and incident reports. The QAPI plans to include this monitoring in their next meeting. The facility's compliance date was validated as 3/26/23.	F 600		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)	F 641		5/8/23

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F 641	Continued From page 16 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the MDS assessment in the areas of wound care (Resident #62), antipsychotic medication use (Residents #373, #20 and #57), and anticoagulant medication use (Residents #57 and #111), for 5 of 28 residents whose Minimum Data Set (MDS) assessments were reviewed. Findings included: 1. Resident #62 was most recently re-admitted to the facility on 02/16/23. Diagnoses included, in part: (1) Stage 4 sacral pressure ulcer and (1) deep tissue injury (DTI) to his left heel. A significant change MDS assessment dated 02/22/23 documented in Section M on Line M0300B1 that Resident #62 had (1) Stage 2 pressure ulcer. Review of the admission documentation dated 02/16/23 revealed Resident #62 had (1) Stage 4 pressure wound on his sacrum and (1) DTI to his left heel on admission. In an interview with MDS Nurse #2 on 04/05/23 at 12:50 PM she stated she did not know why she coded a Stage 2 pressure ulcer on the MDS assessment for Resident #62. She noted she could not find any supporting documentation that indicated he had a Stage 2 wound. She acknowledged he had (1) Stage 4 pressure ulcer on his sacrum and (1) DTI to his left heel at the	F 641	F641 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Minimum Data Set (MDS) coordinator #1 completed a review of the medical record for resident #62 and completed a modification of the 4/5/2023 MDS to reflect correct coding of section M, under the current number of unhealed pressure ulcers/injury at each stage section. The corrected MDS assessment was transmitted on 4/5/2023. Minimum Data Set (MDS) coordinator # 1 completed a review of the medical record for resident #373 and completed a modification of the 4/4/2023 MDS to reflect correct coding of section N, under the antipsychotic medication review section. The corrected MDS assessment was transmitted on 4/5/2023. Minimum Data Set (MDS) coordinator # 1 completed a review of the medical record for resident #20 and completed a modification of the 4/6/2023 MDS to reflect correct coding of section N, under the antipsychotic medication review section. The corrected MDS assessment was transmitted on 4/6/2023. Minimum Data Set (MDS) coordinator # 1	

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F 641	Continued From page 17 time of the assessment. She contributed the coding error to: (1) clicking the wrong box within the assessment, (2) being new to the MDS position, and (3) being new to the computer application used at the facility. 2. Resident #373 was admitted to the facility on 02/06/23 and discharged to the hospital on 02/08/23. Diagnoses included, in part: senile degeneration of the brain, dementia, and visual hallucinations. Review of an admission MDS assessment dated 02/08/23 documented in Section N on Line NO410A that Resident #373 received antipsychotic medication on 2 days (her length of stay at the facility). Also documented in Section N on Line N0450A was that Resident #373 had not received antipsychotic medication on a routine basis. Review of the February physician orders for Resident #373 revealed the following order: Seroquel 25 MG (Milligrams) twice a day by mouth for a mood disorder (an antipsychotic medication). In an interview with MDS Nurse #1 on 04/04/23 at 2:00 PM she stated the MDS assessment should have been marked as the resident did receive antipsychotic medication on a routine basis. She concluded she had mistakenly interpreted the question to read, "did she receive antipsychotic medication on a previous assessment", and since this was her first assessment, she marked the answer as "no." She stated she now understood the question asked if the resident had received antipsychotic medication on a routine basis, not	F 641	completed a review of the medical record for resident #57 and completed a modification of the 4/6/2023 MDS to reflect correct coding of section N, under the medication received section. The correction included coding of seven days of antipsychotic medication use (N0410A), and zero days of anticoagulant use (N0410E) during the look back period. The corrected MDS assessment was transmitted on 4/6/2023. Minimum Data Set (MDS) coordinator # 1 completed a review of the medical record for resident #111 and completed a modification of the 4/5/2023 MDS to reflect correct coding of section N, under the medication received section. The correction included coding zero days of anticoagulant use during the look back period (N0410E). The corrected MDS assessment was transmitted on 4/6/2023. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: MDS coordinator #1 and/or MDS coordinator #2 completed 100% review of active residents with pressure ulcers/pressure injuries to ensure current MDS reflects coding of pressure ulcers/injuries in section M appropriately to include current stagging or each wound. This audit was completed on 05/01/2023. The audit results did not reflect any other discrepancies in MDS coding of pressure ulcers/injuries. MDS coordinator #1 and/or MDS	

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F 641	Continued From page 18 on a previous assessment. She indicated she would modify the assessment to document that Resident #373 had received antipsychotic medication on a routine basis. 3. Resident #20 was admitted to the facility on 10/14/22 with diagnoses that included post-traumatic stress disorder and anxiety. Per the physician orders dated 10/14/22 Resident #20 was prescribed aripiprazole (an antipsychotic medication)10 milligrams twice daily. Resident #20's medication administration record for January 2023 revealed he received an antipsychotic daily during the 7-day lookback period. Resident #20's quarterly MDS assessment dated 1/17/23 revealed he did not receive antipsychotic medication. During an interview on 4/6/23 at 11:10 AM MDS Nurse #1 reported Resident #20 received antipsychotics during the 7-day lookback period of the 1/17/23 MDS, and she made a coding error. She reported she would make a correction on the assessment. 4. Resident #57 was admitted to the facility on 4/3/20 with diagnoses that included hypertension and heart failure. Per the physician orders, Resident #57 was prescribed Risperdal (an antipsychotic medication used to improve thinking, mood and behavior) 5 milligrams (mg) twice daily on 2/15/23 and was prescribed Clopidogrel (an antiplatelet medication used to prevent blood clots) 75 milligrams daily	F 641	coordinator #2 completed 100% review of active residents on an antipsychotic, antiplatelet, anticoagulant medications to ensure current MDS reflects coding of medication use in section N appropriately to include antipsychotic and anticoagulant. This audit was completed on 4/30/2023. The audit results did not reflect any other discrepancies in MDS coding medication use. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Regional MDS consultant re-educated facility MDS coordinate #1 and MDS coordinator #2 on proper coding of MDS, per RAI Manual, Chapter 3. The emphasis of this education includes, but not limited to, section N regarding coding medications, including antipsychotic medication, and anticoagulant, and section M related to proper coding of pressure ulcers. This education was completed on 5/1/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 05/02/23, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete MDS accuracy monitoring process. This monitoring process will be accomplished by reviewing 5 random residents to ensure MDS is coded	

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F 641	Continued From page 19 on 11/22/22. Resident #57 was not prescribed anticoagulant. Resident #57's medication administration record for February 2023 revealed, she received Risperdal, an antipsychotic medication 7 days during the 7-day lookback period and she had not received an anticoagulant. Resident #57's annual Minimum Data Set (MDS) assessment dated 2/22/23 revealed she received an anticoagulant 6 days of the 7-day lookback period. The MDS assessment revealed she did not receive antipsychotic medication during the lookback period. On 4/6/23 at 11:10 AM an interview was conducted with MDS Nurse #1 who stated she coded the Clopidogrel as an anticoagulant on the 2/22/23 MDS in error. She further stated it was an error that Resident #57 was not coded as receiving an antipsychotic on the MDS. MDS Nurse #1 stated she would make the corrections. 5. Resident #111 was admitted to the facility on 11/10/2022, and diagnoses included atherosclerotic heart disease (thickening or hardening of the arteries caused by buildup of plaque in the inner lining of an artery). Physician orders dated 11/10/2022 included Clopidogrel (an antiplatelet medicine) 75 milligram (mg) tablet daily for a blood thinner. A review of the January 2023 Medication Administration Record (MAR) indicated Resident #111 received Clopidogrel 75 mg daily. The MAR also indicated Resident #111 had not received any anticoagulant medication.	F 641	correctly per RAI guidelines. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a MDS accuracy monitoring tool located in the facility compliance binder. Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. Completion date: 05/08/2023	

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F 641	Continued From page 20 The quarterly Minimum Data Set (MDS) assessment dated 1/17/2023 indicated Resident #111 received anticoagulants for seven days during the 7-day look back period. In an interview with MDS Nurse #1 on 4/5/2023 at 7:46 a.m., she stated Resident #111's MDS was coded for receiving anticoagulants because Clopidogrel was listed as a blood thinner on the physician's order, and there was documentation of administration of Clopidogrel on the January 2023 Medication Administration Record for the 7-day look back period. After reviewing the MDS manual, she said Clopidogrel was not listed as a blood thinner in the MDS manual, and Resident #111's MDS should not have been coded for anticoagulants. She stated Clopidogrel was an antiplatelet medication, and the physician should have been called to change the reason for ordering Clopidogrel. In an interview with the Administrator on 4/5/2023 at 8:47 a.m., he stated Resident #111's MDS should not have been coded for anticoagulants, and MDS staff and nurses have been educated on conducting adequate MDS assessments.	F 641		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		

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F 684	Continued From page 21 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, nurse practitioner, and medical director interview, the facility failed to have a nurse assess a severely cognitively impaired resident (Resident #22) when an injury of unknown origin was discovered. On 3/18/23 nurse aide (NA) #1 did not report new bruising to Resident #22's left thigh and right fourth toe. On 3/20/23 Resident #22 was observed to have a bruise to her left thigh described as the "size of a salad plate saucer" and swollen knee. These findings were reported to Nurse #2 who assessed Resident #22. X-ray results revealed Resident #22 had a grossly displaced complex fracture of the left distal femur with angulation at the fracture site (the femur was broken in more than one place and the bone fragments were at an angle to each other). This was for 1 of 1 resident reviewed for an injury of unknown origin. The findings included: Resident #22 was admitted to the facility on 10/10/2018 with diagnoses that included Tourette's disease (a nervous system disorder involving repetitive movements or unwanted sounds) cognitive communication deficit, abnormal posture, vascular dementia with behavioral disturbances, convulsions, and osteoporosis. The annual Minimum Data Set (MDS) assessment dated 1/4/23 showed Resident #22 was severely cognitively impaired, had unclear speech, and sometimes was able to understand others. The MDS showed Resident #22 required	F 684	Past noncompliance: no plan of correction required.	

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extensive assistance from two staff members for transfers and total assistance from one staff member for bathing. The MDS showed Resident #22 had not taken any anticoagulants, did not have any behaviors of refusing care, and did not have any physical/verbal behaviors directed at others.

The care plan dated 1/8/23 showed Resident #22 had a focused area of socially inappropriate/disruptive behaviors of screaming out at times related to Tourette's disorder and a difficulty communicating. Interventions included attempt to redirect as needed and use simple communications.

A shower log and skin assessment sheet dated 3/15/23 showed Resident #22 had no documented bruises on her skin. The shower sheet was signed by Nurse Aide #1 on 3/15/23 and the Unit Manager on 3/16/23.

A shower log and skin assessment sheet dated 3/18/23 (Saturday) showed Resident #22 had bruising on her left thigh and bruising on her right fourth toe. The shower sheet was signed by Nurse Aide #1 on 3/18/23 and the Unit Manager on 3/20/23.

Review of facility records showed no shift report sheet dated 3/18/23 from the 7 P.M. to 7 A.M. shift. The shift report listed each resident on an assignment. The shift report was used by staff to document changes in a resident's care reported from previous shifts and that occurred during their shift, in addition the sheet showed resident's glucose blood sugar results for sliding scale insulin to be administered.

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Review of a nursing progress note written by Nurse #2 dated 3/20/23 read "nurse aide was giving bath notice left knee was swollen. Physician was notified, order for left leg to be x-ray, writer called mobile x-ray mobile imagining."

Review of an x-ray dated 3/20/23 of Resident #22's left femur (thigh bone) showed osseous mineralization was decreased. This could reflect osteopenia (reduced bone mass lesser severity than osteoporosis) or osteoporosis (condition in which bones become brittle and fragile from a loss of tissue). The report also read Resident #22 had a grossly displaced complex fracture of the distal femur with angulation at the fracture site and soft tissue swelling. (the femur was broken in more than one place and the bone fragments were at an angle to each other).

Review of physician orders dated 3/20/23 showed an order to send Resident #22 to the emergency department for evaluation of a possible femur fracture.

Review of a nursing progress note written by the Unit Manager dated 3/20/23 read "Resident sent to ER for further evaluation and treatment per MD for possible leg femur fracture."

Review of the hospital physical assessment dated 3/20/23 read "Left leg has obvious deformity. There is moderate swelling to left thigh with bruising. No additional obvious trauma on exam." Resident #22's vital signs were stable, and she was not in any distress. Resident #22 showed signs of dementia, was alert, and moved her extremities spontaneously. The x-ray taken at the hospital on 3/20/23 showed Resident #22 had a

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comminuted fracture (a fracture where the bone is broken in at least two places) that was reduced (a procedure used to set broken bones without cutting the skin open) in the emergency room and splinted after orthopedic surgery consultation. Resident #22 was admitted to the hospital on 3/20/23 with diagnosis that included closed fracture of distal end of left femur. (a fracture of the thigh bone above the knee). The resident was readmitted to the facility on 3/24/23.

A telephone interview was conducted on 4/4/23 at 2:32 P.M. with NA #1 who was assigned Resident #22 on 3/18/23 and 3/19/23 during the 7 P.M. to 7 A.M. shift. During the interview, NA #1 indicated when she gave Resident #22 a bed bath on 3/18/23, she observed bruising on Resident #22's left thigh, under her left knee, and on her fourth toe. NA #1 indicated Resident #22 did not appear to have a deformed leg. NA #1 stated she reported the bruising on Resident #22 to Medication Aide #2 and continued to provide Resident #22 with care throughout the rest of the shift. NA #1 indicated there was no change in Resident #22's behaviors from her baseline. During the interview, NA #1 indicated the previous shift had not reported any bruising on Resident #22.

A follow up telephone interview was conducted with NA #1 on 4/6/23 at 11:19 A.M. During the interview, NA #1 indicated the skin conditions she observed on Resident #22 were immediately reported to Medication Aide #2 when she observed them. NA #1 described the bruise she observed on Resident #22's knee as a yellow bruise in the middle of Resident #22's knee, about the width of "a number two pencil from the eraser to where it says two on the side of the

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pencil" that curved with the natural curve of the knee. During the interview, NA #1 was unable to describe the length of the bruise on Resident #22's left knee. NA #1 indicated she completed the shower sheet and put the sheet in the shower book at the nurses' station for review. NA #1 indicated Resident #22's bruising was not reported to the assigned nurse on duty. During the interview, NA #1 indicated she had been educated prior to this date to report changes to both the medication aide and the assigned nurse. NA #1 did not indicate the appearance of Resident #22's bruise on 3/19/23.

A telephone interview was conducted on 4/4/23 at 3:06 P.M. with Medication Aide #2 assigned Resident #22 on 3/18/23 and 3/19/23 during the 7 P.M. to 7 A.M. shift. During the interview, the Medication Aide indicated when nurse aide #1 went into Resident #22's room to provide incontinence care to Resident #22, she observed a bruise on Resident #22's fourth toe and the back of her left knee. Medication Aide #2 indicated NA #1 reported the bruises to her at that time. Medication Aide #2 indicated the bruising appeared purple and dark in color and she thought the bruises were old. During the interview, Medication Aide #2 stated she wrote down the location of the bruises on a piece of paper and gave the paper to Nurse #1. The Medication Aide #2 indicated she had not received a report Resident #22 had a fall or another incident and was unsure what had caused the bruising.

A follow up telephone interview was conducted on 4/6/23 at 11:37 A.M. with Medication Aide #2. During the interview, the Medication Aide indicated when she observed the bruises on

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Resident #22, she wrote the information down on a 24-hour shift report. The Medication Aide was unsure what time she handed the report to Nurse #1. The Medication Aide observed Resident #22 to have two bruises, a bruise on the top of the right fourth toe and a bruise on the back of the knee. During the interview, Medication Aide #2 indicated Resident #22 had to be turned onto her side to observe the bruise on her left knee. Medication Aide #2 was unable to describe the size and appearance of the bruise and stated she was "not sure how to measure bruises." Medication Adie #2 was unable to recall if she verbally told the nurse about Resident #22's bruising.

A telephone interview was conducted on 4/5/23 at 4:21 P.M. with Nurse #1 who was the nurse overseeing the Medication Aide on 3/18/23. During the interview, Nurse #1 indicated when a nurse aide completed a resident's shower, the nurse aide used the shower sheet paperwork to document any changes in the resident's skin. The shower sheet was then provided to the assigned nurse with any changes in the resident's skin for the nurse to complete an assessment of the resident. Nurse #1 indicated she did not receive a report on 3/18/23 about any changes in Resident #22's skin. Nurse #1 further indicated had she received a report, she would have assessed Resident #22's skin.

A follow up interview was conducted on 4/6/23 at 11:45 A.M. with Nurse #1. During the interview, Nurse #1 indicated at approximately 6:30 A.M. on 3/19/23, Medication Aide #2, assigned to Resident #22, gave her a scratch sheet of paper. The paper had the residents assigned to Medication Aide #2's blood glucose results, to

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include Resident #22's blood glucose results. Nurse #1 indicated she did not see any changes in Resident #22's skin written on the sheet. During the interview, Nurse #1 indicated no one during the shift verbally told her about any bruises on Resident #22's skin.

An interview was conducted on 4/5/23 at 4:29 P.M. with NA #3 who was assigned Resident #22 on 3/19/23 for the 7 A.M. to 7 P.M. shift. During the interview NA #3 indicated she had not worked with Resident #22 long and she does not recall Resident #22 to have a bruise. NA #3 indicated nothing about Resident #22 having a bruise was given during the shift report and had she observed a bruise on Resident #22, she would have immediately reported the mark to her assigned nurse.

An interview was conducted on 4/4/23 at 1:29 P.M. with Nurse Aide #2 who was assigned to Resident #22 on 3/20/23 for the 7 A.M. to the 7 P.M. shift. NA #2 indicated she had not received a report Resident #22 had a fall or any injury. When she went to Resident #22's room to provide her with a bed bath she noticed bruising that was light in color on her left thigh approximately the size of a "salad plate saucer." NA #2 indicated when she reached over the side of the bed, NA #2 observed Resident #22 to have a swollen knee. NA #2 reported the bruising to the assigned nurse.

An interview was conducted on 4/4/23 at 2:02 P.M. with Nurse #2 who was assigned to Resident #22 on 3/20/23 for the 7 A.M. to the 7 P.M. shift. Nurse #2 indicated she had not received a report Resident #22 had a fall or another incident with injury. Nurse #2 indicated

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Resident #22 was sleeping when she arrived for her shift on 3/20/23 with no calling out or moaning. During the interview, Nurse #2 indicated NA #2 reported Resident #22 had a bruise on her thigh, a bruise under her left leg by her knee, and an indentation above the left knee. Nurse #2 assessed Resident #22 and described the bruise under her leg at the knee as being "about the size of a softball". The bruise was dark purple, red, with a "little bit of tint on her thigh." Nurse #2 indicated the indentation at the left knee was only observed when the leg was looked at from the side. During the interview, Nurse #2 indicated she felt Resident #22 had a broken leg and reported the injury to the Unit Manager. Nurse #2 further indicated the x-ray technician reported to her, when Resident #2's left thigh was x-rayed, Resident #22 did not call out when her leg was repositioned.

An interview was conducted on 4/4/23 at 1:16 P.M. with the Unit Manager. The Unit Manager indicated she was unaware Resident #22 had any bruising on her left thigh until 3/20/23 when Nurse #2 made her aware. The Unit Manger indicated herself and Nurse #2 went and assessed Resident #22. During the interview, the Unit Manger indicated Resident #22 was unable to verbalize what caused the bruise, so a head-to-toe assessment was completed with the following results: a bruise the size of a softball on the top of Resident #22's left thigh that appeared to be a newer bruise because it was not yellow, a bruise behind Resident #22's left knee, and a bruise on a toe. The Unit Manager indicated she does not recall which toe had a bruise. During the interview, the Unit Manager indicated Resident #22 was unable to verbalize pain but did not show any nonverbal signs of being in pain when she

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assessed her on 3/20/23. The physician was notified, and a mobile x-ray was ordered. The Physician gave orders to send Resident #22 to the hospital when the x-ray results showed a fracture. The Unit Manager indicated on 3/18/22 staff should have reported the bruise on Resident #22's thigh to the nurse that worked that shift.

A telephone interview was conducted on 4/6/23 at 3:25 P.M. with the Nurse Practitioner (NP). The NP
indicated she was in the building on 3/20/23 when she was alerted by nursing staff Resident #22 needed to be assessed for a bruise. The NP observed a large bruise on Resident #22's top to the side of her left thigh that appeared to be under 24 hours old based on the coloration and her leg was a little swollen. During the interview the NP indicated she felt Resident #22 had a possible fracture. The NP indicated the facility completed an investigation and it was determined the injury occurred due to a mechanical lift, Resident #22's combativeness, and Resident #22's weak bones.

A telephone interview was conducted on 4/5/23 at 8:22 A.M. with the Medical Director. During the interview, the Medical Director indicated he was made aware Resident #22 had a bruise on her left thigh on 3/20/23. The Medical Director indicated an x-ray was ordered and it was discovered Resident #22 had a fracture. During the interview, the Medical Director indicated Resident #22 was severely demented and unable to express to staff the cause of her bruise. The facility completed an investigation and determined the improper use of a mechanical lift and the repositioning of the resident during her bath had caused the injury.

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An interview was conducted with the Director of Nursing (DON) on 4/4/23 at 3:42 P.M. During the interview, the DON indicated the Unit Manager reported the bruise on Resident #22's left thigh to herself and the Administrator. When the facility was made aware of the bruise, an investigation was immediately started. The DON indicated staff should have reported the bruise to herself or the Administrator when it was discovered over the weekend, and she is unsure why staff had not reported the injury when it was first discovered.

The Administrator was notified of the Immediate Jeopardy on 4/6/23 at 5:00 P.M.

The facility provided a corrective action plan on 4/8/23 which alleged a date of completion of 3/25/23. The corrective action plan indicated:

The root cause analysis identified that the alleged noncompliance resulted from the failure of the facility staff (nurse aide #1) to report an injury of unknown source to a nurse on 3/18/2023 for further assessment and plan of care. Resident #22 injury was assessed by a nurse on 3/20/2023.
How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 3/25/2023, Nursing assistant #1 was immediately suspended to allow further investigation of the allegation of abuse/neglect of Resident #22.

Nurse #1 assessed Resident #22 on 03/20/2023 and notified the attending physician who ordered an X ray of resident #22's leg. Unit coordinator #1

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spoke to Xray technician who completed the Xray and received a preliminary result that resident had a fracture. Unit coordinator #1 contacted the Attending physician who ordered resident #22 to be sent to hospital for evaluation and treatment. The unit coordinator notified resident #22 responsible party of the change in condition as well as transfer to the hospital on 3/20/2023.

On 03/25/2023, Director of nursing completed a one-on-one education with nursing assistant #1 on the importance of reporting any incident, accident, or any injuries to a nurse on duty for further evaluation and treatment.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

100% audit of all incident reports written in the last 30 days completed on March 25, 2023, by Director of Nursing, Unit coordinator #1, and/or Unit manager #2 to identify any other incident or injury not reported to a nurse on time. No other injuries and/or incidents/accidents identified as not reported to a nurse for proper follow ups. Findings of this audit are documented on an "incident report audit tool" located in the facility compliance binder.

100% audit of all current resident's shower sheets for the last 30 days was completed on 03/25/2023 by Director of Nursing, MDS Coordinator #1, MDS coordinator #2, Unit coordinator #1, and/or Unit manager #2 to identify any other documentation of an injury that was not reported to a nurse for proper assessment. No other injuries were identified as not reported to a nurse

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for proper follow-up. Findings of this audit are documented on "shower sheets audit tool" located in the facility compliance binder.

Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Effective 03/25/2023, facility ensures each residents receives quality of care and treatment based on the comprehensive assessment of a resident and in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to ensuring any injury of a resident is reported to a nurse for proper assessment and follow ups.
Effective 03/25/2023 facility employees follow the company policy and procedures, when observing/identifying any injury to a resident, by notifying the nurse on duty for proper assessment and follow ups. Effective 3/25/2023 and moving forward nurse on duty assess any reported injury and document findings on each resident's medical records.

100% education of all current staff to include full time, part time, employees from contracted staffing agencies company, and as needed nursing employees were completed by the Director of Nursing, Assistant Director of Nursing, Staff development coordinator, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but is not limited to, the importance of reporting any incident/accident to a nurse on duty for proper assessment and follow-ups. This education was completed by 03/25/2023. Any staff members not educated on

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03/25/2023, was not allowed to work until educated. This education will be provided annually and is added to the new hire orientation for all new employees effective 03/25/2023.

How the facility plans to monitor its performance to make sure that solutions are sustained.

Effective 03/25/2023, the Director of Nursing, Assistant Director of Nursing, MDS coordinators (#1, #2) and/or Unit Coordinators (#1, #2) have been completing quality of care monitoring process. This monitoring process is accomplished by reviewing all skin assessments and shower sheets completed for the last 24 hours or from last clinical meeting to ensure that any identified injuries has been assessed by a nurse and being addressed promptly. Any negative findings are corrected promptly. This monitoring process has been completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process are documented on the "Skin assessments audit tool" located in the facility compliance binder.

Effective 03/25/2023, the weekend nurse supervisor completes quality of care monitoring process. This monitoring process is accomplished by reviewing all skin assessments and shower sheets completed for the last 24 hours to ensure that any identified injuries have been assessed by a nurse and addressed promptly. Any negative findings are corrected promptly. This monitoring process is completed every Saturday, and Sunday for two weeks, weekly for two more weeks, then monthly for

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F 684	Continued From page 34 three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the "Skin assessments audit tool" located in the facility compliance binder. Effective 03/25/2023, the Director of Nursing and/or Assistant Director of Nursing report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived. Date of Completion: 3/25/23 The facility provided a corrective action plan for the incident that happened on 3/18/23 with a completion date of 3/25/23. The onsite validation process was completed on 4/10/23. Staff from different departments and who worked different shifts were interviewed and verified they had received training to immediately report injuries to a nurse. A review was completed of the audit logs that included the educational information provided to staff during the in-service and a review of in-service staff sign in logs. The in-service logs were reviewed, staff names were randomly selected and verified to have received training. The audit of the shower sheets and incident reports were verified to have been completed and no additional unreported injuries were identified. A review of the monitoring tool revealed staff had completed daily monitoring of shower sheets and incident reports. The QAPI plans to include this monitoring in their next meeting. The facility's compliance date was validated as 3/26/23.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		5/8/23

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F 690	Continued From page 35 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 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, observations, resident	F 690	F690	

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F 690	Continued From page 36 and staff interviews, the facility failed to attach an indwelling urinary catheter tubing to a secure device to prevent tension and possible injury and failed to provide necessary care and services of the indwelling urinary catheter when Nurse Aide (NA) #3 failed to clean the urinary catheter tubing when providing incontinent care for 1 of 2 residents reviewed for urinary catheters. (Resident #111) Findings included: Resident #111 was admitted to the facility on 11/10/2022, and diagnoses included stage 3 chronic kidney disease. The care plan dated 11/10/2022 stated Resident #111 required the use of a urinary catheter due to a diagnosis of obstructive uropathy. Interventions included securing the urinary catheter tubing to Resident #111's thigh to prevent pulling, ensuring urinary catheter tubing was secured, free of kinks or twisting to avoid urethral tension or accidental removal, providing urinary catheter care every shift and providing peri-care away from meatus to minimize bacterial migration into urethra and bladder. The quarterly Minimum Data Set (MDS) assessment dated 1/17/2023 indicated Resident #111 was cognitively intact and used an indwelling urinary catheter for urination. Physician orders dated 2/2/2023 included using a urinary catheter for obstructive uropathy and providing catheter care daily and as needed. On 4/3/2023 at 7:49 a.m. in an interview with Resident #111, she stated she once had a secure	F 690	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 04/05/2023, the Assistant Director of Nursing re-attached an indwelling urinary catheter tubing to a secure device applied to resident #111 leg, to prevent tension and possible injury. On 04/04/2023, Nurse #3 cleaned Resident #111's urinary catheter tubing after being instructed by the director of nursing. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 100% audit of all active residents in the facility with an indwelling urinary catheter were completed on 04/06/23 by the Director of Nursing and/or Assistant Director of Nursing, unit coordinator (#1 or #2) to identify any other resident with an indwelling urinary catheter, without secure device in place to prevent tension and possible injury. No other resident with a foley catheter without a secure device identified. Findings of this audit is documented on the indwelling urinary catheter audit tool located in the facility compliance binder. Assistant director of nursing completed indwelling urinary catheter care for 100% of all active residents with urinary catheter on 4/6/2023.	

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F 690	Continued From page 37 strap for the urinary catheter tubing on her leg. The secure strap was removed, and the nursing staff did not reapply another secure strap. She said when she moved in the bed, she surely pulled the urinary catheter tubing but have not felt it pulling. On 4/3/2023 at 8:00 a.m., Resident #111 removed her linens to expose her thigh area. The indwelling urinary catheter tubing was observed exiting from underneath the adult brief and resting along the edge of the adult brief high on the left upper thigh area. There was no secure device observed on Resident #111's left or right thigh to attach the urinary catheter tubing. In a continuous observation on 4/4/2023 at 2:11 p.m., NA #3 was observed providing peri-care to Resident #111 for incontinence of stool. The urinary catheter tubing was not observed in a secure device and when Resident #111 was asked by the resident representative if the area where the urinary catheter entered her body hurt, Resident #111 answered "yes". A small dried light tan-brown area was observed on the urinary catheter tubing two inches from where the urinary catheter exited the folded skin around the meatus (opening of the urethra). NA #3 was observed not cleansing the urinary catheter tubing while performing peri-care and exiting Resident #111's room at 2:26 p.m. On 4/4/2023 at 2:30 p.m. in an interview with NA #3, she stated she had completed providing peri-care to Resident #111. When asked about washing the urinary catheter tubing, she said the nurses were responsible for cleaning the urinary catheter tubing. She also stated nothing was used to secure the urinary catheter tubing to	F 690	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 05/01/2023, each resident with an indwelling urinary catheter has a leg strap attached to each resident□s leg and secure an indwelling urinary catheter tubing to prevent tension and possible injury. Effective 05/01/2023, Licensed nurses will add an order to monitor leg strap for each resident with an indwelling urinary catheter on each resident□s medical records. The order to monitor leg strap will assure each resident□s leg strap remains in place to secure catheter tubing to prevent tension and possible injury. Effective 05/01/2023, each resident with an indwelling urinary catheter receives indwelling catheter care during assistance of daily living care daily by certified nursing aides and/or licensed nurses. Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff development coordinator will complete 100% education for all nursing staff, to include full-time, part-time, and as needed staff. The emphasis of this education will be the importance of ensuring each resident with an indwelling urinary catheter has a leg strap in place to prevent tension and possible injury, and the catheter care is provided during ADL care and as needed. This education also	

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F 690	Continued From page 38 Resident #111's leg. On 4/4/2023 at 2:35 p.m., Nurse #4 reported Nurse #3, assigned to Resident #111 was not at the desk. When questioned about who was responsible for cleansing and securing Resident #111's urinary catheter tubing, Nurse #4 stated she would have a check before she could answer that question. On 4/4/2023 at 2:45 p.m., NA #3 was observed repositioning Resident #111 on her right side and the urinary catheter tubing becoming tight. NA #3 was observed repositioning the urinary catheter tubing toward the direction Resident #111 was turning. On 4/4/2023 at 2:47p.m., Nurse #3 was observed cleansing Resident #111's urinary catheter tubing. While cleansing the urinary catheter tubing, Nurse #3 was observed asking NA #3 to move the urinary catheter drainage bag from the center of the bed frame down to the foot of the bed to prevent the urinary catheter tubing from pulling against the resident. NA #3 and Nurse #3 repositioned Resident #111 up in the bed and the urinary catheter remained unattached into a secured device. On 4/4/2023 at 2:51p.m. in an interview with Nurse #3, she stated nurse aides cleansed the urinary catheter tubing with morning care and when soiled. She said she was instructed to come perform Resident #111's catheter care. She further stated a secure device was usually applied when the urinary catheter was changed to prevent pulling of the urinary catheter and did not know why Resident #111 did not have a secure device to attach the urinary catheter and would	F 690	emphasized the importance of writing an order to monitor leg strap every shift for each resident with an order for indwelling urinary catheter, and an order for catheter care every shift. This education will be completed by 05/08/2023. Any nursing staff not educated by 05/08/2023, will not be allowed to work until educated. This education is also be added to the new hires orientation process for all new nursing staff effective 05/01/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 05/01/2023, Director of Nursing, and/or Assistant Director of Health Nursing, will monitor compliance with securing indwelling urinary catheter tubes by randomly observing three residents with indwelling urinary catheter to ensure leg strap is in place to secure the catheter tubing from tension and/or possible injuries, and catheter care is rendered during ADL care and as needed. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 05/01/2023, Director of Nursing, and/or Assistant Director of Health Nursing, will review all new admissions, readmission, or any resident with a new order for an indwelling urinary catheter for	

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F 690	Continued From page 39 get a secure device for Resident #111. On 4/4/23 at 3:07 p.m. in an interview with the Director of Nursing (DON), she stated both NA #3 and Nurse #3 could perform urinary catheter care, and NA #3 should provide catheter care when performing incontinent care for stool. She further stated both NA #3 and Nurse #3 were responsible for ensuring the urinary catheter was attached on Resident #111 to prevent pulling and movement of urinary catheter.	F 690	the last 24 hours or from last clinical meeting to ensure that any resident with an indwelling urinary catheter had a monitoring of leg strap, and catheter care orders are included in resident's medical records. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the Urinary catheter monitoring tool for new residents located in the facility compliance binder. Effective 05/01/2023, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Completion date 05/08/2023	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		5/8/23

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F 757	Continued From page 40 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, physician interview and staff interviews, the facility failed to discontinue an antibiotic medication as ordered by the physician for 1 of 5 residents reviewed for antibiotic medication administration, Resident #62. Findings included: Resident #62 was admitted to the facility on 06/06/18 with diagnoses that included, in part: Urinary tract infection (UTI), traumatic brain injury, and dementia. Review of a significant change Minimum Data Set (MDS) assessment dated 02/22/23 documented Resident #62 had intact cognition. Review of the care plan for Resident #62 revised on 02/22/23 documented a focal area of: At risk for skin irritation and UTI related to incontinence.	F 757	F757D Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 04/11/2023, the licensed nurse practitioner assessed resident #62, and determined that no adverse reactions and no negative outcomes noted. No further actions needed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 100% audit of all active residents in the facility with orders for antibiotics were completed on 05/01/2023 by the Director of Nursing and/or Assistant Director of	

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F 757	Continued From page 41 The goal was for Resident #62 to be free from skin irritation and UTI ' s through the next review. Interventions included, in part: encourage adequate nutrition and hydration, observe for signs of a UTI, complete labs as orders, and administer medications as ordered. Review of a laboratory report for a urine culture dated 03/03/23 revealed Resident #62 had >100,000 Providencia Stuartii growth in his urine. This organism was sensitive to the antibiotic Bactrim (Trimeth/Sulfa). Review of the March 2023 physician orders revealed Resident #62 had an order for Bactrim DS Tablet, take one tablet by mouth twice a day (BID) for 7 days for UTI. The order was placed on 03/04/23 with a stop date of 03/11/23 (auto generated by the computer). Review of the March 2023 Medication Administration Record (MAR) revealed Resident #62 had received Bactrim DS twice a day on 03/04/23, 03/05/23, 03/06/23, 03/07/23, 03/08/23, 03/09/23, 03/10/23 and 03/11/23 for a total of 8 days. In an interview with the Infection Control Nurse on 04/06/23 at 10:00 AM she stated the Bactrim DS order for Resident #62 should have stopped on 03/10/23. She explained the computer automatically generated stop dates when orders were entered into the system and the time of day the orders were entered effected the stop date. She noted the staff were supposed to check the auto generated stop dates to ensure they were correct and if incorrect, staff were to manually correct the date.	F 757	Nursing, unit coordinator (#1 or #2) to identify any other resident with an order of antibiotics to ensure a correct stop date is in place to ensure resident receives medication per physician order. No other resident identified with an incorrect stop date. Findings of this audit is documented on the antibiotics medication audit tool located in the facility compliance binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 05/01/2023, each resident with an order for antibiotics has a correct stop date in place based on the physician order. Effective 05/01/2023, Licensed nurse who enters orders in electronic medical records will manually count number of doses ordered and enters stop date to each antibiotic ordered based on duration specified by the ordering physician. Director of Nursing (DON), Assistant Director of Nursing (ADON) and/or Staff development coordinator will complete 100% education for all licensed nurses and medication aides, to include full-time, part-time, and as needed staff. The emphasis of this education will be the importance of counting number of doses ordered and manually add correct stop date for each antibiotic ordered based on the duration specified by the ordering Physician. This education will be	

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F 757	Continued From page 42 In an interview with the facility Administrator on 4/6/23 at 3:30 PM he stated the medication problems were related to a computer glitch that auto generated stop dates for medications incorrectly. He noted the nursing staff were supposed to count the doses and manually adjust the stop dates if needed. He stated he knew this was a problem and the facility was in the process of transitioning to a new program he hoped would fix the problem with the incorrect auto generated stop dates. In a telephone interview with the facility Medical Director on 04/11/23 at 8:50 AM he stated he was not aware of the problem with the computer and the auto generated stop dates that were incorrect. He noted in the situation with Resident #62, who had received an extra day of Bactrim DS, there was some flexibility with the medication. He reported it could be given up to 10 days, so getting two extra doses would not be detrimental to the resident; however, if it were to go on for 3 weeks it could be harmful. He concluded the problem with the computer auto generating incorrect stop dates for medications had to be fixed, that it was a definite problem he would address with the facility.	F 757	completed by 05/08/2023. Any Licensed nurse and/or Medication aide not educated by 05/08/2023, will not be allowed to work until educated. This education is also be added to the new hires orientation process for all new Licensed nurse and/or Medication aide effective 05/01/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 05/01/2023, Director of Nursing, and/or Assistant Director of Health Nursing, will monitor compliance with stop dates for antibiotics by reviewing all new admissions or readmission for the last 24 hours or from last clinical meeting to ensure that any resident with an order for antibiotics is entered correctly in electronic medical records to include the correct stop date based on the duration specified by the ordering physician. This monitoring process will be conducted daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Findings of this monitoring process will be documented on the Antibiotic use monitoring tool located in the facility compliance binder. Effective 05/01/2023, Director of Nursing, and/or Assistant Director of Health Nursing, will review all new orders for the last 24 hours or from last clinical meeting to ensure that any resident with an order for antibiotics is entered correctly in	

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F 757	Continued From page 43	F 757	electronic medical records to include the correct stop date based on the duration specified by the ordering physician. Any negative findings will be corrected promptly by the DON/ADON. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the Antibiotic use monitoring tool located in the facility compliance binder. Effective 05/01/2023, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Completion date: 05/08/2023	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		5/8/23

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F 812	Continued From page 44 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label, date, and/or remove expired food items stored in 2 of 2 nourishment rooms (100 Hall Nourishment Room and 500 Hall Nourishment Room). The findings included: An observation of the 500 Hall nourishment room was conducted on 4/3/23 at 5:42 A.M. with the Dietary Manager. The following items were observed: - A bag on the counter beside the refrigerator with a small take-out box and a biscuit wrapped in paper. - Two biscuits with meat between the bread, wrapped in clear plastic wrap. - One opened 32-ounce container of fortified nutritional shake - One opened 11-ounce container of palmetto cheese - One opened 10-ounce package of cheese None of the food containers were labeled with a resident's name or the date of storage. An observation of the 100 Hall nourishment room	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 4/3/2023, A bag on the counter beside the refrigerator with a small take-out box and a biscuit wrapped in paper, two biscuits with meat between the bread, wrapped in clear plastic wrap, one opened 32-ounce container of fortified nutritional shake, One opened 11-ounce container of palmetto cheese, one opened 10-ounce package of cheese observed in 500 Hall nourishment room were discarded immediately by the dietary manager. On 4/3/2023, One opened 32-ounce container of fortified nutritional shake, one 15-ounce opened clear plastic container of watermelon with a use by date of 3/24/23, one opened 20-ounce bottle of general ale, one opened 20-ounce bottle of soda, one opened 28-ounce bottle of a sports drink, one opened 24-ounce bottle of chocolate syrup observed in 100 hall	

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F 812	Continued From page 45 was conducted on 4/3/23 at 5:50 A.M. with the Dietary Manager. The following items were observed: - One opened 32-ounce container of fortified nutritional shake - One 15-ounce opened clear plastic container of watermelon with a use by date of 3/24/23 - One opened 20-ounce bottle of general ale - One opened 20-ounce bottle of soda - One opened 28-ounce bottle of a sports drink - One opened 24-ounce bottle of chocolate syrup None of the food containers were labeled with a resident's name or the date of storage. An interview was conducted on 4/3/23 at 5:42 A.M. with the Dietary Manager. During the interview, the Dietary Manager indicated staff had been educated to label all food brought into the nourishment room with the current date and resident's room number. The Dietary Manager indicated all the food without a name and date needed to be discarded. The Dietary Manager indicated without a date on the food, she had no way to know how long the food had been in the refrigerator and she discarded the above listed items. An interview was conducted on 4/5/23 at 4:49 P.M. with the Director of Nursing (DON). During the interview, the DON indicated nursing staff were responsible to place a date and the resident's name on items when placed into the nourishment rooms refrigerators. The DON indicated dietary staff were responsible for cleaning out the nourishment rooms. Food items had to be discarded by their expiration date or three days after being opened.	F 812	nourishment room were discarded immediately by the dietary manager. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 4/6/2023, Certified Dietary Manager conducted an inspection on all food storing areas to include 100 & 500 halls nourishment rooms, and the entire kitchen to identify any other open food items not labelled appropriately or stored beyond the use by and/or expiration dates. No other food items identified not labelled appropriately or stored beyond the use by and/or expiration dates. Findings of this audit is documented on the food storage audit tool located in the facility compliance binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 05/01/2023, the facility Certified Dietary Manager re-established a cleaning assignment for dietary staff on duty to ensure the food storage locations, to include nourishment rooms, refrigerators, freezers, and dry storage areas, are cleaned and all open food items include labels, dates, and are not stored beyond the use by and/or expiration dates. The new cleaning assignment will be used affective 05/01/2023. 100% education of all active/current	

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F 812	Continued From page 46	F 812	facility Dietary employees to include full time, part time, and as needed employees will be completed by the Dietary Manager. The emphasis of this education includes, but not limited to the importance of ensuring the food storage locations, to include nourishment rooms are cleaned and all open food items include labels, dates, and are not stored beyond the use by, and/or expiration dates. This education will be completed by 05/08/2023, any dietary employee not educated by 05/08/2023, will not be allowed to work until educated. This education will be provided annually and will be added on new hire orientation for all new dietary employee employees effective 05/08/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 05/01/2023, the Dietary Manager will complete kitchen monitoring process to ensure food storage locations, to include nourishment rooms, are clean and all open food items include labels, dates, and are stored not to exceed a use-by, or expiration dates. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on Food storage monitoring tool located in the facility compliance binder.	

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	345213	A. BUILDING _____ B. WING _____	C 04/11/2023

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F 812	Continued From page 47	F 812	Effective 05/01/2023, the Dietary Manager and/or Kitchen manager will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved established. Completion date 05/08/2023	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		5/8/23

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F 867	Continued From page 48 §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.	F 867		

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F 867	Continued From page 49	F 867		

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data 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 50 (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 record review, observations, staff interviews, nurse practitioner and medical director interview, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint survey of 2/4/2022. This was for two recited deficiencies on the current recertification and complaint investigation survey of 4/11/2023. The deficiencies included Accuracy of Assessments (F641) in the areas of wound care, use of antipsychotic and anticoagulant medications and Food Procurement: Store, Prepare and Serve, Sanitary (F812). The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F-641 Based on record review and staff interviews, the facility failed to accurately assess wound care (Resident #62), antipsychotic medication use (Resident's #373, #20 and #57), and anticoagulant medication use (Resident's #57 and #111), for 5 of 28 residents whose Minimum	F 867	F867 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: As of 5/01/2023 facility Quality Assurance Performance Improvement (QAPI) process has put in place measures to address the repeated deficient practice for both F641 and F812. The plan implemented was approved by the QAPI committee on 5/1/2023 to be effective to prevent repeat citation. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/1/2023, the facility Administrator conducted a review annual and complaint surveys for the prior 3 years to review all areas of repeat deficient practice. The review focus on the action plans implemented to identify whether the repat citation resulted from the same component of regulatory requirements. No other repeat citation identified under the same component of regulatory requirements.	

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F 867	Continued From page 51 Data Set (MDS) assessments were reviewed. During the recertification and complaint survey of 2/4/2022, the facility was cited for failure to accurately code the MDS assessment. In an interview on 4/10/2023 at 4:58 p.m. with the Administrator, he explained there had been a change in personnel in the MDS department. Although the MDS staff had received MDS training, the MDS staff needed more MDS training to prevent inaccuracy of the MDS assessment. F-812 Based on observations and staff interviews, the facility failed to label, date, and/or remove expired food items stored in 2 of 2 nourishment rooms (100 Hall Nourishment Room and 500 Hall Nourishment Room). During the recertification and complaint survey of 2/4/2022, the facility was cited for failure to label, date and close open food items stored in the kitchen refrigerator and freezer. In an interview on 4/10/2023 at 4:58 p.m. with the Administrator, he stated the plan of correction (POC) of 2/4/2022 addressed only the area cited (kitchen), and the POC needed to cover all components of the regulation which would include the nourishment refrigerators. In an interview with the Administrator on 4/10/2023 at 4:58 p.m., he explained how the Quality Assurance Performance of Improvement (QAPI) process was functionable, and how the issues of 2/4/2022 were addressed in the plan of corrections. He stated although there were	F 867	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 5/1/2023, the facility Administrator will discuss all cited deficiencies from the last annual inspection survey and/or from complaint investigation sited in the previous 12 months to ensure the area remains in regulatory compliance. On 5/1/2023 Director of Operations has re-educated the Administrator on the facility QAPI procedures for monitoring areas of identified deficient practice and process of removing monitoring of areas due to patterns of compliance, to prevent repeat deficiencies. 100% education of all active/current facility members of QAPI committee to includes Director of nursing Assistant Director of nursing (ADON), business office manager, activities director, housekeeping manager, maintenance director, admissions director, staff development coordinator, medical records, Rehab Director, MDS Coordinators, and Central Supply Person), were completed by the facility Administrator. The emphasis of this education includes but is not limited to the contents of QAPI committee and the importance of developing and maintaining appropriate plans to correct identified quality deficiencies to prevent re-occurrences. This education will be completed by 05/08/2023, any department	

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F 867	Continued From page 52 reoccurrences of deficiencies, the issues identified were in different areas than in the survey 2/4/2022, and QAPI needed to broaden the plan of correction based on the regulation.	F 867	head not educated by 05/08/2023, will not be allowed to work until educated. This education will be provided annually and will be added on new hire orientation for all new Department heads effective 05/08/2023. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 5/2/2023 Facility Administrator will review the Plan of Corrections for MDS accuracy (F641}, and food procurement (F812) during weekly ad hoc QAPI meeting to ensure the monitoring process is effective to attain and maintain compliance and prevent no future repeat citation. This monitoring process will be completed weekly for eight weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on Quality Assurance monitoring tool located in the facility compliance binder. Effective 05/02/2023, the facility administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved established. Completion date: 05/08/2023	