STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/24/23 through 04/27/23. The facility was found in compliance with requirement CFR 483.73, Emergency Preparedness. Event ID # Z2CF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint invesigation survey were conducted from 04/24/23 through 04/27/23. Event ID #Z2CF11. The following intakes were investigated NC00201071 and NC00201170. One of the six complaint allegations resulted in a deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		5/19/23

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

Electronically Signed | 05/13/2023

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F 585	Continued From page 1	F 585		

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident

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F 585	Continued From page 2 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff interviews, the facility failed to complete a grievance form, investigate, and provide a resident with a written grievance decision for 1 of 3 residents reviewed for grievances, (Resident #96).	F 585	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s	

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F 585	Continued From page 3 The findings included: Resident #96 was admitted to the facility on 1/26/2023. The admission Minimum Data Set assessment dated 2/1/2023 assessed Resident #96 to be cognitively intact. A review of the facility grievance log for 2023 did not include a grievance filed by Resident #96 or on her behalf. A review of the nursing notes for Resident #96 did not have any documentation of any complaints or incidents. Resident #96 was interviewed on 4/24/2023 at 10:45 AM. Resident #96 shared an incident that occurred soon after she arrived at the facility in January 2023. Resident #96 was not certain of the date but explained that she had requested to use the bedpan, and when she finished, no one came to remove her from the bedpan for a long time. Resident #96 explained she had wounds on her buttocks and upper back, and this made sitting on the bedpan for an extended period very painful. Resident #96 said that the morning after the incident, she reported to an unknown nurse what happened, and the patient advocate came to talk to her. During the conversation, Resident #96 was told by the patient advocate that a grievance would be filed on her behalf. Resident #96 explained that she understood the grievance process and she expected to receive a written summary of the grievance and how it was resolved, but she had not received anything regarding the investigation or the resolution. Unit Manager (UM) #1was interviewed on 4/26/2023 at 3:16 PM and she reported she was	F 585	allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F585 On 4/26/23 a Service Concern was generated for resident #96 regarding her concern regarding being left on the bedpan for an extended period. The form included sections: What other action was taken to resolve concern section. Results of action taken, grievance resolved, steps taken to investigate, summary of findings, name, date, grievance received, summary of grievance, confirmation of grievance, corrective actions, grievance official and signature. The resident was given verbal confirmation of the resolution and written confirmation provided to resident to demonstrated that the grievance was resolved. An audit of the current Service concern forms for the last 30 days was completed by the Resident Advocate on 5/9/23 to determine if they were completed in their entirety and the resolution present to the named resident or the resident responsible party and a copy given to the resident per his/her wishes. On 4/26/23 Regional Director of Clinical Services educated 100% administrative staff on the Grievance Policy and Procedure and F585. This education included the Service Concern Policy and the importance of completing the Service Concern forms correctly, resolving the concern,	

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F 585	Continued From page 4	F 585		

not aware of any incident or grievance filed on behalf of Resident #96.

The Admissions Director (AD) was interviewed on 4/26/2023 at 4:06 PM. The AD reported for a short period of time, the facility was unable to accept new admissions, and so the facility put her into the position of patient advocate and the grievance officer for the facility. The AD reported that she recalled an incident when Resident #96 reported she was left on the bedpan for an extended period, and she was upset about the way the staff treated her. The AD explained that after she talked to Resident #96, she talked to UM #1. The AD was not certain if she completed the grievance form for Resident #96 or if UM #1 completed the form. The AD explained that typically she would have completed a grievance and given a copy to the department manager for them to complete the investigation. The AD also mentioned that grievances were discussed during the morning meeting with all departments, but she could not recall if this incident was discussed because it happened several months ago.

A follow-up interview was conducted with UM #1 on 4/27/2023 at 11:20 AM. UM #1 explained she did not recall the incident with Resident #96 and was certain she had not completed a grievance on her behalf.

The Social Worker (SW) was interviewed on 4/27/2023 at 11:40 AM. The SW reported he remembered the incident with Resident #96, and he had started a grievance form for her, and had given the uncompleted form to UM #1 for completion and her investigation. The SW reported Resident #96 should have received a written summary of the investigation and the

communicating to the resident and/or complainant and giving them a written resolution of the concern/grievance.

On 5/9/23 the Director of Nursing and Staff development coordinator began education for all staff on the Grievance policy and procedure and the importance of reporting, documenting, and resolving grievances. Any staff that have not completed the required training by 5/19/23 will not be allowed to work until re-education has been received. Newly hired staff will receive education regarding the Grievance policy and procedure at the time of new hire orientation.

The Resident Advocate or designee will ensure that all Service concerns will be logged, the resolution is accomplished, and the resolution is communicated to the resident/complainant. The Administrator is the Grievance Officer will review all grievances/concerns and validate that the form is completed in its entirety and the results have been communicated to the complainant. Upon validating the completion and resolution, the Administrator will sign the form.

The Administrator/designee will complete an audit of Service Concern forms 5x/week x 4 weeks, then bi-weekly x 4 weeks, to ensure that the form is completed in its entirety and the results have been communicated to the complainant in the method of their preference.
Results of the audits will be reported to

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F 585	Continued From page 5 resolution of the grievance once the investigation was completed. An interview was conducted with the Director of Nursing (DON) on 4/27/2023 at 1:40 PM. The DON reported that there had been miscommunication between departments, and some confusion about who would complete the grievance form. The DON reported they were unable to find the original grievance form started by the SW in January 2023, but they had written up a new grievance form dated 4/27/2023. The DON reported that education had been provided by UM #1 to the nursing staff after the incident, but she had not completed the form and turned it in for review and resolution. The DON explained she had gone to talk to Resident #96 and completed a grievance form dated 4/27/2023 with the details of the investigation and provided Resident #96 with a written summary of the grievance on 4/27/2023. The Administrator was interviewed on 4/27/2023 at 2:31 PM and he agreed with the DON there had been a breakdown in communication regarding who was responsible for completing the grievance for Resident #96. The Administrator reported that the grievance had been addressed by UM #1, education had been completed for nursing staff after the incident, but a written summary had not been provided to Resident #96 and a record of the grievance was not located.	F 585	the QAPI monthly committee. The Administrator will compile a report of the findings of these audits monthly and report to the Quality Assurance and Performance committee monthly. The Quality Assurance and Performance Improvement committee will make changes to the plan as necessary. The facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this plan of correction to ensure the facility attains and maintains substantial compliance. Date of compliance : 5/19/2023	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited	F 688		5/19/23

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F 688	Continued From page 6 range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview with the resident and staff, the facility failed to provide the splint as recommended by the therapist to prevent further decrease in range of motion (ROM) for 1 of 2 sampled residents reviewed for limitation in ROM (Resident #2). Findings included: Resident # 2 was admitted to the facility on 9/27/21 with multiple diagnoses including traumatic brain injury, hemiplegia affecting left nondominant side and left-hand contracture. Review of the therapy notes revealed Resident #2 had been on Occupational Therapy (OT) case load from 1/9/23 through 2/7/23 for contracture management. The OT note dated 2/7/23 indicated "patient tolerating passive ROM exercises with prolong stretch and manual muscle manipulation of left upper extremity (LUE) into extension for increased ROM and	F 688	F688 Resident #2 was rescreened by OT to assess for appropriate splinting needs related to contracture management. A 100% audit of all residents with splints/braces was completed by Director of Rehab Services on 5/3/23 to assure that all devices were available. Any residents identified with splints that were ill fitting or missing will be rescreened by OT for proper splint and contracture management. On 4/30/23 the Director of Rehab developed an internal tracking of ordering of splints and receipt, and communication system to communicate with therapy staff the status of ordered, new or changed splints. 100% of the therapy staff were provided	

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F 688	Continued From page 7 contracture management. Rolled wash cloth measuring 4 centimeters (cm) across placed in palm to maintain prolong stretch with therapist completing hourly checks. Patient tolerated washcloth for 3 hours and 20 minutes without signs and symptoms of redness, discomfort, pain and swelling. Patient left wrist cock-up splint (provides customized support for gradual extension of non-fixed contracture of the hand and wrist) was ordered - did not arrive to facility." The recommendation was "for the resident to safely wear a cock-up splint on left wrist and hand for up to 6 hours with minimal signs and symptoms of redness, swelling, discomfort or pain". The quarterly Minimum Data Set (MDS) assessment dated 3/1/23 indicated that Resident #2's cognition was intact, and she had limitation in ROM on both sides of upper and lower extremities. Review of Resident #2's care plan dated 3/1/23 was conducted. One of the care plan problems was "resident was at risk for complications secondary to contractures to left elbow/wrist, bilateral foot drop and curvature of thoracic/cervical spine." The goal was "the resident will not have complications related to the contractures." The approaches included "refer to therapy as needed." Resident #2 was observed on 4/24/23 at 9:57 AM. Her left hand was observed to be in a fist position and there was no splint nor washcloth noted. When interviewed, Resident #2 stated that she was not wearing any device on her left hand. Resident #2 was again observed on 4/25/23 at	F 688	education by the Director of Rehab Services that included: " Appropriate charting guidelines for splinting and bracing of clients. " Communicating change in splinting/brace of clients relating to tolerance, splint/brace ordering and availability or ineffectiveness " Noncompliance issues with splinting/bracing schedules and participation " Communicating education being provided to Nursing staff when transitioning splinting nursing department. All education will be completed by 5/19/2023. Any staff that has not received the education by 5/19/2023 will not be allowed to work until education is received. Any new staff will receive education upon hire as part of the onboarding process. The Director of Rehab will maintain a log of all newly ordered splints and audit weekly x4 weeks, biweekly x4 weeks, then weekly x 1 month to assure that ordered splints have been received. Any issues identified with the ordering process will be reported to the QAPI committee during the monthly QAPI meeting. Date of completion: 5/19/2023	

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F 688	Continued From page 8	F 688		

8:35 AM and on 4/26/23 at 9:10 AM. Her left hand was in fist like position and there was no splint nor washcloth noted.

The OT was interviewed on 4/26/23 at 9:50 AM. She reported that she had worked with Resident #2 for the management of her contractures from 1/9/23 through 2/7/23. Upon discharge, she recommended for the resident to wear a splint to her left upper extremity. She ordered the splint, but it never came. She added that she had used a washcloth to the resident's left hand, and she tolerated it well. The OT stated that she did not inform the staff to apply the washcloth thinking the splint will arrive soon.

The Nurse Aide (NA) #2, assigned to Resident #2, was interviewed on 4/26/23 at 11:05 AM. She stated that she had not seen a splint on Resident #2's left hand.

Nurse #2, assigned to Resident #2, was interviewed on 4/26/23 at 12:15 PM. She stated that she had not seen Resident #2 wearing a splint. She reported that when a resident had a splint ordered, the NA was responsible for applying the splint.

The Rehabilitation (Rehab) Director was interviewed on 4/27/23 at 9:38 AM. He stated the splint that was recommended for Resident #2 was ordered on 2/9/23. When he called, the company indicated that the splint had been sent out to the facility. He reported that he did not have any tracking system to see who and what splint was ordered for a specific resident. He stated that at times he would receive a box with splints in it, but he did not know to whom the splints belonged. He also stated that nobody had been

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F 688	Continued From page 9 following up if the ordered splints had arrived or not. The Director of Nursing (DON) was interviewed on 4/27/23 at 11:28 AM. The DON indicated that the Rehab Department was responsible for ordering, tracking, and following up for the splints that were ordered. She also stated that she expected the resident to receive the care to prevent further decrease in ROM.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to provide oxygen therapy per physician order for 1 of 3 residents reviewed for respiratory care (Resident #27). The findings included: Resident #27 was admitted to the facility on 05/10/2010. Resident #27 had diagnoses which included chronic respiratory failure with dependence on supplemental oxygen. Review of the electronic medical record revealed a physician order for Resident #27 dated	F 695	F695 On 4/26/23 resident #27 was assessed for any signs and symptom of respiratory complications and his oxygen concentrator was set at the ordered liters. On 4/26/23 a 100% audit was complete for all residents on continuous supplemental oxygen to assure that the oxygen concentrators were set to the ordered liters per the MD order. On 4/26/23 education was started for all licenses nurses that included:	5/19/23

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F 695	Continued From page 10 11/9/2022 which read in part: oxygen at 2 liters per minute via nasal cannula (NC) related to chronic respiratory failure with hypoxia. A review of Resident #27's quarterly Minimum Data Set (MDS) dated 03/27/2023 revealed Resident #27 was cognitively intact with no documented behaviors. Resident #27 was coded as receiving oxygen therapy. Review of the care plan dated 10/27/2022 revealed Resident #27 was at risk for respiratory complications secondary to chronic respiratory failure with hypoxia requiring supplementary oxygen. The interventions included administer oxygen as ordered and observed for signs and symptoms of respiratory complications. An interview was completed on 04/24/2023 at 9:45 AM with Resident #27. He was aware that he used oxygen but was uncertain about the ordered liters. Observations were completed of Resident #27 on 04/24/2023 at 9:47 AM, 04/24/2023 at 2:44 PM, 04/25/2023 at 10:14 AM, 04/25/2023 1:16 PM, and 04/26/2023 at 8:58 AM. During each of the observations Resident #27 was observed in bed watching television, with his nasal cannula in his nostrils, the oxygen concentrator set at 1 liter per minute, and was observed to not be in distress. An interview was completed on 04/26/2023 at 08:58 AM with (Nursing Assistant) NA #1. NA #1 stated she does not do anything with oxygen settings. NA #1 further stated she did make sure the nasal cannula was applied correctly for resident's receiving oxygen.	F 695	" Assuring the Oxygen concentrator setting matches the MD order for the resident. " Assuring that resident wear oxygen equipment appropriately. " Documenting supplemental oxygen usage " Monitoring for respiratory complications of supplemental oxygen therapy. This education will be completed by 5/19/23. Any nurse that has not completed this education by 5/19/23 will not be allowed to work until they have received the education. This education will become a part of the new hire orientation process for all new hired licensed nurses. The Director of Nursing will complete an audit of all residents on continuous oxygen weekly x 4 weeks, then 2x/week x 4 weeks, then weekly x 4 weeks, then monthly until substantial compliance is obtained. The results will be reported to the monthly Quality Assurance committee for review and discussion to ensure substantial compliance. Date of completion: 5/19/2023	

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F 695	Continued From page 11 An interview was completed on 04/26/2023 at 09:00 AM with Nurse #1. Nurse #1 stated she checked oxygen settings throughout the shift. Nurse #1 further stated when she provided medications, she also checked oxygen settings. Nurse #1 had not completed medication administration to Resident #27 at the time of this interview. Nurse #1 explained Resident #27 could not change his oxygen settings independently. Nurse #1 further explained she reviewed physician's orders and stated that Resident # 27 should be on 2 liters continuous oxygen via nasal cannula. An observation was completed on 04/26/2023 at 9:10 AM with Nurse #1. Nurse #1 stated Resident #27's oxygen concentrator setting was set at 1.5 liters per minute. Nurse #1 corrected the oxygen setting and placed the flow rate at 2 liters per minute. Nurse #1 stated when setting the correct liter, the ball on the concentrator gauge should have the line through it to indicate the ordered liter. An interview was completed on 04/26/2023 at 9:51 AM with the Director of Nursing (DON). The DON stated the nurses should review the physician's order, ensure the in-room concentrator was at the correct ordered liter, and make sure the ball was in the middle of the line for the correct ordered rate.	F 695		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service	F 730		5/19/23

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F 730	Continued From page 12 education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a performance review every 12 months for 3 of 5 nursing assistants (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (NA # 4, #5, and #6). The findings included: 1. A. Review of NA #4's employee file revealed a date of hire of 11/12/1996. The employee file for NA #4 did not include a performance review for November 2022. B. Review of NA #5's employee file revealed a date of hire of 3/29/1999. The employee file for NA #5 did not include a performance review for March 2023. C. Review of NA #6's employee file revealed a date of hire of 3/8/2022. The employee file for NA #6 did not include a performance review for March 2023. The Staff Development Coordinator (SDC) was interviewed on 4/26/2023 at 9:54 AM and she revealed she had been in the position for approximately 7 months. The SDC reported she had not completed performance evaluations for any NA staff and was not aware a performance evaluation was to be used to determine the training needs of NA staff. The SDC explained she provided nursing and NAs with continuing education, in-services for skills, and education	F 730	F730 On 5/7/23 employee #4, #5, #6, received their performance reviews as required. A 100% audit was completed on 5/12/23 by the Director of Human Resources to identify any Certified Nursing Assistant that had not had a performance evaluation within the last 12 months. The Director of Human Resources will identify all certified nurse aides that had not received and evaluation within the last 12 month and will assure that the evaluation will be completed by the Director of Nursing or designee by 5/19/23. The Director of Human Resources and the Staff Development Coordinator received education on 4/30/23 from the Vice President of Operations regarding the expectations of completion of competencies for Certified Nursing Assistants every 12 months as it relates to F730. The Director of Human Resources will ensure all Certified Nursing assistants are tracked every 12 months to receive and update clinical competencies and performance evaluations. The Director of Human Resources will complete audits bi-weekly x4 weeks, weekly x4, then monthly thereafter.	

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F 730	Continued From page 13 related to policies and procedures for the facility. The SDC reported she had based NA staff in-service education on observations of the staff, and not on the results of performance reviews. The SDC reported she was not aware annual performance reviews were required to be completed. The SDC explained she had staff complete an annual competency checklist to assess needs but had not reviewed all the NA staff. The Director of Nursing (DON) was interviewed on 4/27/2023 at 2:17 PM and she reported she was not aware performance reviews were required for NA staff. The DON explained the SDC was providing a wide range of education to NA staff. The Administrator was interviewed on 4/27/2023 at 2:31 PM. The Administrator reported he was not aware performance reviews were not being completed annually to address the educational needs of the staff.	F 730	Findings will be reported to the QAPI committee monthly and ongoing. Any issues identified will be reported to the Director of Nursing or the Administrator. The Administrator is responsible for this plan of correction. The results of tracking will be reported to the Quality Assurance Performance Committee monthly and ongoing. Date of completion: 5/19/2023	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		4/29/23

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F 732	Continued From page 14 vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to post accurate staffing information for licensed and unlicensed nursing staff for 4 of 5 posted daily staffing forms reviewed. The findings included: 1. Daily staffing forms dated 2/28/2023, 3/3/2023, 3/21/2023, 4/24/2023, and 4/25/2023 were reviewed and the following 4 posted daily staffing forms had errors related to the licensed and unlicensed nursing staff:	F 732	F732 On 4/27/23the facility Daily Staffing Posting for 4/25/23 and 4/27/23 were corrected to reflect the correct posting information: Facility name, current date, total number, and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. The categories included Registered Nurses, Licensed Practical Nurses, or Licensed Vocational Nurses, Certified Nursing Aides, and Resident Census. The	

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F 732	Continued From page 15 a. The schedule for 2/28/2023 day shift (7:00 AM to 3:00 PM) was reviewed and indicated 17 nursing assistants (NAs) were scheduled to work. The daily posted staffing form documented 16 NA had provided 128 hours of care that shift. The afternoon shift (3:00 PM to 7:00 PM) schedule was reviewed and indicated 5.5 Licensed Practical Nurses (LPNs) and 11 NAs were scheduled to work. The daily posted staffing form documented 4 LPNs provided 32 hours of care, and 9 NAs provided 72 hours of care. The night shift (11:00 PM to 7:00 AM) schedule was reviewed and indicated 3 LPNs were scheduled to work, and the daily posted staffing form documented that 2 LPNs provided 16 hours of care on 2/28/2023. b. The schedule for 3/3/2023 was reviewed and indicated 6 LPNs and 19 NAs were scheduled to work the day shift. The daily posted staffing form documented 9 LPNs provided 72 hours of care, and 15 NAs provided 120 hours of care. The schedule for the afternoon shift was reviewed and indicated 6 LPNs and 10.5 NAs were scheduled to work. The daily posted staffing form documented 7.5 LPNs provided 60 hours of care, and 9.5 NAs provided 76 hours of care during that shift. The schedule for night shift was reviewed and indicated 3 LPNs were scheduled to work. The daily posted staffing form documented 4 LPNs provided 32 hours of care. c. The schedule for 3/21/2023 was reviewed and indicated 5.5 LPNs were scheduled to work the afternoon shift on that date. The daily posted staffing form documented 7 LPNs provided 56 hours of care. The schedule for the night shift was reviewed and indicated 5 LPNs and 9 NAs were scheduled to work. The daily posted staffing	F 732	posting was in a clear and readable format in a prominent place accessible to residents and visitors. 2. All residents who reside in the facility have the potential to be affected by the alleged deficient practice. 3. On 4/29/23 the Regional Director of Clinical Services in-serviced the Director of Nursing and Scheduler on the requirements of Nursing Information Posting. The Director of Nursing then in-serviced the Unit managers, the Evening Supervisor and Weekend Supervisor on the same requirements. 4. The Director of Nursing will audit the daily shift posting daily x 8 weeks to assure compliance with the posting requirements. Results of each audit will be reviewed in monthly QA committee meeting. Date of completion : 4/29/2023	

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F 732	Continued From page 16 form documented 4 LPNs provided 32 hours of care, and 11 NAs provided 88 hours of care that shift. d. The schedule for 4/25/2023 was reviewed and indicated that 16 NAs were scheduled to work the day shift on that date. The daily posted staffing form documented 15 NAs had provided 120 hours of care that date. The schedule for afternoon shift on that date was reviewed and indicated 10.5 NAs were scheduled to work. The daily posted staffing form documented 9 NAs provided 72 hours of care. The Scheduler was interviewed on 4/27/2023 at 2:12 PM. The Scheduler reported she was filling out the daily posted staffing forms for the day, and she would correct the forms for any call outs or staff leaving early up until she left at 5:00 PM, and then she would come the next day and make final corrections. The Scheduler reported no other staff members were responsible for correcting the daily posted staffing forms during the afternoon or night shifts. An interview was conducted with the Director of Nursing (DON) on 4/27/2023 at 2:17 PM. The DON reported she understood the Scheduler corrected the staffing sheets the next morning, but she was not aware of the errors in reporting the staff who worked that shift. The DON reported she expected the staffing forms to accurately reflect the staffing of the facility.	F 732		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring.	F 867		5/17/23

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F 867	Continued From page 17	F 867		

A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such 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.

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F 867	Continued From page 18 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity 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	F 867		

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F 867	Continued From page 19 improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including 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 and staff interviews and observations, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions the committee put into place during the COVID-19 Infection Control survey and complaint investigation survey of 11/16/20, the complaint investigation survey of	F 867	F867 By May 10, 2023, the facility quality assurance (QA) Committee held two meetings to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) committee and review on-going compliance issues. The Director of	

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F 867	Continued From page 20 12/31/21, the recertification and complaint investigation survey of 09/19/22, and the recertification and complaint investigation survey dated 04/27/23. F 641 was originally cited during the COVID-19 Infection Control survey of 11/16/20, re-cited during the complaint investigation survey dated 12/31/21. F695 was cited and F641was re-cited during the recertification and complaint investigation survey dated 09/19/22. Both F641 and F695 were re-cited during the recertification and complaint investigation survey dated 04/27/23. The continued failure of the facility during four federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. Findings included: This tag is cross-referenced to: 1.F 695: Based on observations, staff interviews, and record reviews the facility failed to provide oxygen therapy per physician order for 1 of 3 residents reviewed for respiratory care (Resident #27). During the recertification and complaint investigation survey of 09/19/22, the facility failed to provide necessary respiratory care and services that met the need for Resident #46 to maintain a clear airway from tracheal secretions and frequent coughing which resulted in five trips in a two- and one-half week period of time to the Emergency Department (ED) to clear her airway and treat hypoxia. The facility failed to seek medical attention for the resident when he complained of shortness of breath earlier in the	F 867	Nursing (DON) and Assessment Nurse (MDS) will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. At the next scheduled QAPI meeting the Director of Nursing and Assessment Nurse will provide updates regarding the POC specifically related to the repeat tag F695 and F641. On 5/17/2023, the Regional Director of Clinical Services educated the administrative team members including the Director of Nursing and Assessment Nurse related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related F695 and F641. As of 5/17/2023 after the Regional Director of Clinical Services in-serviced the Director of Nursing on the facility QAPI Committee will begin identifying other areas of quality concern through the quality improvement (QI) review process, for example: review of rounds tools, review of work orders, review of Point Click Care (PCC - electronic health record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, review of audits related to the plan of correction, and review of regional facility consultant recommendations. The QAPI committee will meet at a minimum of monthly and will meet to identify issues related to quality	

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F 867	Continued From page 21 night which resulted in low oxygen of 50% (out of 100%) by early morning. Emergency medical services were required, and a non-rebreather oxygen mask (high level oxygen flow) was needed and treatment at the Emergency Department. The resident was also sent to an outside cardiology appointment without oxygen and was in respiratory distress for 2 of 2 residents reviewed for respiratory care. 2.F 641: Based on observations, record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for 1 of 7 residents reviewed for MDS accuracy. Resident #54 was not coded for Level II Preadmission Screening and Resident Review (PASRR). During the COVID-19 Infection Control survey and complaint investigation survey of 11/16/20, the facility failed to conduct a skin assessment to accurately document a resident's skin condition on the Minimum Data Set (MDS) Assessment for 1 of 1 resident assessment reviewed. During the complaint investigation of 12/31/21 the facility failed to accurately code Activities of Daily Living (ADL) on the Minimum Data Set (MDS) assessment for 1 of 14 residents reviewed for ADL's. During the recertification and the complaint investigation survey dated 09/19/22, the facility failed to accurately code wandering behavior, a prognosis of less than six months, pain medication, and activities of daily living on the Minimum Data Set (MDS) assessments for 4 of 40 residents reviewed for MDS accuracy.	F 867	assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. The monitoring procedure to ensure that the plan of correction is effective, and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements The QAPI committee will meet monthly with oversight of corporate staff member. Date of completion 5/17/2023	

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F 867	Continued From page 22 On 04/27/23 at 2:44 PM an interview with the Administrator was conducted. The Administrator revealed he had only been at the facility for about six months when the facility conducted monthly QAPI meetings, and he believed the monitoring of previous survey citations had been resolved since January of 2023. The Administrator revealed he was not certain why the corrective actions for the repeated citations were not sustained and believed the corrective actions were resolved in January 2023.	F 867		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects	F 887		5/17/23

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F 887	Continued From page 23 associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and interview with the staff, resident and family, the facility failed to offer the COVID 19 vaccine to 2 of 5 sampled residents reviewed for COVID 19 vaccination (Residents # 113 & #68). Findings included:	F 887	F887 On 4/27/23 the Infection Preventionist obtained consent for the COVID 19 Vaccine for residents #113 and #68. Residents #113 and #68 will receive their COVID vaccine at the next scheduled	

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	345420	A. BUILDING _____ B. WING _____	C 04/27/2023

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F 887	Continued From page 24 1.Resident #113 was admitted to the facility on 2/15/22 with multiple diagnoses including dementia. The annual Minimum Data Set (MDS) assessment dated 2/9/23 indicated that Resident #113 had severe cognitive impairment. Review of the facility's COVID 19 immunization record revealed that Resident #113 was "unvaccinated." Resident #113's responsible party (RP) was interviewed on 4/26/23 at 11:59 AM. She reported nobody from the facility's staff had offered the COVID 19 vaccine since admission. She stated she had been asking the staff (unable to remember names) to administer the vaccine to Resident #113, but nobody did. The Infection Control (IC) Nurse was interviewed on 4/26/23 at 12:59 PM. He stated Resident #113 did not receive the COVID 19 vaccine since he was unable to contact the resident's responsible party (RP). He reported he tried to contact the RP in March 2023 and was unable to reach her. A follow up interview was conducted with the Infection Control Nurse on 4/27/23 at 10:15 AM. He stated when he first started as the IC Nurse, the facility did not have a policy when to offer the COVID 19 vaccine to the resident. He reported the facility did not have an IC Nurse before he came on board and the resident's vaccination was not up to date. The Director of Nursing (DON) was interviewed on 4/27/23 at 11:28 AM. The DON stated the	F 887	COVID vaccine clinic which is scheduled for 5/17/23. All residents have the potential to be affected by this alleged deficient practice. On 5/11/23, the Infection Preventionist and the Director of Nursing completed a 100% audit of all residents COVID vaccine status and identified any resident that have not received the COVID vaccine and or are not up to date with their vaccination status, to get consent and offer vaccinations to residents that wish to receive the vaccine. Upon admission into the facility the Infection obtain consent for vaccination from the resident or the responsible party within 7 days of admission into the facility. The consent will be documented into the residents record upon receipt. Once consent is received the vaccine will be ordered and scheduled for administration within 7 days. On 4/27/23 the Regional Director of Clinical Services in-serviced the Infection Preventionist and Director of Nursing. This in-service included the following topics: " Importance of ensure residents or Responsible party are given a written choice for the COVID 19 Vaccine and the entire Vaccination Policy. This information has been integrated into the standard orientation training for all Directors of Nursing and Infection Preventionist. Quality Assurance	

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F 887	Continued From page 25	F 887	The Infection Preventionist/Director of Nursing will audit all newly admitted not up to date and newly admitted residents vaccination status to assure that all residents are consent and offered the COVID vaccination. This will be done weekly x 4 weeks, then biweekly x 4, then monthly x. Results of the audit will be reported to the QAPI committee monthly. Date of completion: 5/17/2023	

facility's policy on COVID 19 immunization was to offer the vaccine on admission. She reported the admitting Nurse was responsible for offering the vaccine to the resident and or the responsible party (RP) and to have the consent signed on admission. She indicated that she was aware the facility's policy on COVID 19 immunizations had not been followed, and the administration had identified the resident's vaccination status was not up to date, and they were working on it.

2. Resident # 68 was admitted to the facility on 8/23/21 with multiple diagnoses including diabetes mellitus.

The significant change in status Minimum Data Set (MDS) dated 3/2/23 indicated that Resident #68's cognition was intact.

Review of the facility's COVID 19 immunization record revealed Resident #68 was "unvaccinated."

Resident #68 was interviewed on 4/26/23 at 12:10 PM. He stated he wanted to receive the COVID 19 vaccine but nobody at the facility had offered it to him.

The Infection Control (IC) Nurse was interviewed on 4/26/23 at 12:59 PM. He stated Resident #68 did not receive the COVID 19 vaccine since the resident's responsible party (RP) declined. He reported Resident #68's cognition was intact, but he did not offer it to him.

A follow up interview was conducted with the Infection Control Nurse on 4/27/23 at 10:15 AM. He stated when he first started as the IC Nurse,

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F 887	Continued From page 26 the facility did not have a policy when to offer the COVID 19 vaccine to the resident. He reported the facility did not have an IC Nurse before he came on board and the resident's vaccination was not up to date. The Director of Nursing (DON) was interviewed on 4/27/23 at 11:28 AM. The DON stated the facility's policy on COVID 19 immunization was to offer the vaccine on admission. She reported the admitting Nurse was responsible for offering the vaccine to the resident and or the responsible party (RP) and to have the consent signed on admission. She indicated she was aware that the facility's policy on immunizations had not been followed, and the administration had identified the resident's vaccination status was not up to date, and they were working on it.	F 887		