STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. BUILDING _____ B. WING _____	C 05/24/2023

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RIDGEWOOD LIVING & REHAB CENTER	1624 HIGHLAND DRIVE WASHINGTON, NC 27889

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/21/23 through 5/24/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FT2M11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/21/23 through 5/24/23. Event ID# FT2M11. The following intakes were investigated: NC00201833, and NC00194669. 1 of the 7 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		6/21/23

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

Electronically Signed | 06/15/2023

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents and staff and record review the facility failed to respond to a call bell for 1 of 4 residents review for dignity (Resident #11). The findings included: Resident #11 was admitted to the facility on 2/8/22 with diagnoses which included cerebral infarction, high blood pressure and cardiac arrhythmia. The quarterly Minimum Data Set (MDS) dated 3/31/23 documented Resident #11 was cognitively intact. She was coded as independent with bed mobility, walking in room and in corridors supervision for transfers. She needed limited assistance with toilet use. She had no range of	F 550	F 550 Regarding the alleged deficient practice of failure to respond to a call bell for Resident #11. The Director of Nursing (DON) , Assistant Director of Nursing , Staff Development Coordinator, LNHA, and Department Managers initiated in service education on 6-14-23, for all staff,(including RN/LPN, CNA, Hospitality aides, dietary, housekeeping , rehabilitation, maintenance, activities and administration),regarding Resident Rights: Dignity and Respect, to include ensuring call bells are within reach of the residents and the importance of answering the call bells timely.	

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F 550	Continued From page 2 motion limitations. She used a wheelchair. Resident #11"s care plan revised on 4/24/23 included a focus area of activities of daily living self-care performance deficit related to a history of stroke with hemiplegia and generalized weakness. The interventions included supervision to limited assistance with toileting and transfers. She also had a focus area of increased risk for falls related to gait/balance problems. Resident #97 was admitted to the facility on 2/9/23. The Admission MDS dated 2/15/23 documented Resident #97 was cognitively intact. A review of Resident #11's electronic medical record revealed a note written by Nurse #2 on 4/20/23 at 10:43 PM. The note documented Resident #11's call light was on, she "went into the room, noted the bed was to the lowest position and the resident was sitting on the floor in front of the bed ....No apparent injuries at the time. Minutes later called me back to the room, stated right hip hurting. [name brand acetaminophen] given effective .....Resident sleeping." On 5/21/23 at 3:10 PM Resident #97 stated about 4 weeks ago her roommate fell and no one came to help her. She said Resident #11 was calling out for help for almost an hour. On 5/22/23 at 10:25 AM Resident #11 stated she slipped off her bed during the night when she was trying to go to the bathroom. She said she was on the floor for an hour hollering for help. She said she remained on the floor until her roommate got someone to help.	F 550	Current facility residents are at risk of the alleged deficient practice of failure to answer call bell timely. The Director of Nursing (DON), Assistant Director of Nursing , Staff Development Coordinator, LNHA, and Department Managers initiated in service education on 6-14-23, for all staff,(including RN/LPN, CNA, Hospitality aides, dietary, housekeeping , rehabilitation, maintenance, activities and administration) regarding Resident Rights: Dignity and Respect, to include ensuring call bells are within reach of the residents and the importance of answering the call bells timely. New employees will be educated during new hire orientation. Department managers, unit coordinators and Administrator will audit call bell response time by activating call bells and timing the response. The audits will occur in 5 residents rooms x 5 days/week x 4 weeks, 5 resident rooms x 3 days /week x 4 weeks. 5 resident rooms 1x week x 4 weeks. Audits will occur on all shifts, all days of the week. SW and/or administrator will interview 5 residents per week x 12 weeks to ensure call bells are answered timely. The Administrator and/or the SW will review audits to identify patterns and/or trends and will adjust plan to maintain compliance and review plan during the monthly QAPI meeting for at least 6 months or until compliance is maintained. Completion 6-21-23	

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On 5/22/23 at 1:50 PM Resident #11 said she was laying on her bed and had dozed off then woke up and needed to go to the bathroom. She said she sat up on the edge of the bed and then slid off the bed onto the floor. She said she was on the floor for an hour hollering out for help. Resident #11 reported her roommate (Resident #97) called a family member and the family member called the facility telephone to tell them she had fallen. Resident #11 said that when they came into her room to get her up off the floor 3 staff members came into her room.

On 5/22/23 at 3:40 PM Nurse Aide (NA) #11 said she was in another resident's room when Resident #11 fell. She said she heard Resident #11 had fallen and she went to help due to the fall.

On 5/22/23 at 3:48 PM Nurse #2 reported she saw the call light on and when she went into the room Resident #11 was sitting on the floor in front of her bed. Nurse #2 said she assessed Resident #11 and found no injuries and no pain. She said she went to get help. Nurse #2 added NA #11 and Nurse #1 were working when the fall occurred. She added she had just provided medications for Resident #97 and after that was when she saw the call light.

On 5/23/23 at 9:43 AM Resident #97's family member said she remembered she received a telephone call from Resident #97, but she did not remember exactly what day or if the call came on her home telephone or her cellular telephone. She stated Resident #97 asked her to call the facility to get help for Resident #11 because she was on the floor. She said Resident #97 told her

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F 550	Continued From page 4	F 550		

she had activated the call light, but no one was responding, and it had been a long time. The family member said she called the facility's main phone number and told the person who answered the telephone that Resident #11 had fallen. The family member did not know who she talked to when she called the facility that evening.

On 5/23/23 at 3:25 PM Nurse # 1 stated she received a telephone call while she was at station 1. She said the call was from Resident #97 who stated her roommate (Resident #11) had fallen and needed help getting up. She said she received the call between 9:45 and 10:15 PM. Nurse #1 said she walked to Resident #11's room and 2 other staff members joined her as she walked from Station 1 to Resident #11's room. She said the staff who joined her were Nurse #2 and NA #11. She said Resident #11 was seated on the floor with her back towards her bed with her feet facing outward toward the door. Nurse #1 said Resident #11 reported she was trying to get to her wheelchair to go to the bathroom when she slid off the bed. Nurse #1 stated she assessed Resident #11 who had no injuries. She said she and NA #11 assisted the Resident to sit on the side of the bed. She said Nurse #2 obtained vital signs and she went to call the doctor. She added the call light for Resident #11's room alarms at Station 2 and can not be heard at Station 1.

On 5/24/23 at 10:24 AM NA #1 stated she was assigned all the rooms on the hall where Residents #11 and #97 were assigned during the 3:00 PM to 11:00 PM shift. She reported she was in another room on 4/20/23 and would not have been able to see or respond to a call light while she was in another room.

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F 550	Continued From page 5 On 5/24/232 at 11:44 AM Resident #97 stated she was in her bed and could see the clock on the wall from her bed. She said her roommate fell just before 9:00 PM and it was around 10:00 PM before anyone came to help her. Resident #97 said she currently had a new cellular telephone and did not have the call history from the day Resident #11 fell. She said she had activated the call light and not one came. She said Resident #11 was calling out "help, help" but no one came. She said she could not get out of bed without assistance so she could not help. Resident #97 said she called her family member and asked her to call the facility because no one was responding to the call light or Resident #11's calls for help. Resident #97 said she did not know what else to do and did not know the phone number for the facility, so she called her family member and asked her to call the facility phone to get help. During an additional interview with Resident #11 on 5/24/23 at 4:15 PM she said she felt scared when she was on the floor for such a long time calling out for help. She said her gown was above her knees, so she was not comfortable just sitting there for so long. She said she wondered if anyone was ever going to help her and she was glad she had a roommate who could get her help. She felt she may have to just get a pillow and sleep on the floor while waiting for help to arrive.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		6/21/23

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F 561	Continued From page 6 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews the facility failed to honor a residents bathing preference for 2 of 9 residents (Resident #55 and Resident #67) reviewed for choices. Findings included: 1. Resident #55 was admitted to the facility on 8-3-21 with multiple diagnoses that included hemiplegia affecting the left nondominant side. The annual Minimum Data Set (MDS) dated 5-6-23 revealed Resident #55 was cognitively	F 561	F 561 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #55 was scheduled for showers on Monday and Thursday AM shift. He has since requested his shower day be changed to Friday am shift only. Resident #55 has received showers on 5-22-23,5-25-23,5-29-23,6-12-23. Residents #67 is scheduled for showers	

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F 561	Continued From page 7 intact and required total assistance with one person for bathing. The MDS also documented the resident did not have any behaviors. Resident #55's care plan dated 5-17-23 revealed the resident had an ADL (activites of daily living) self-care deficit due to left sided hemiplegia. The goal for Resident #55 was to maintain the current level of functioning in ADL's. The interventions for the goal included bathing/showering required total assistance with one person explaining all steps of bathing during showers. A review of Resident #55's shower documentation from March 2023 through May 2023 revealed the resident was to receive showers on Mondays and Thursdays. Upon review there was no documentation of Resident #55 receiving a shower on the following days: March 2023, 9, 13, 20, 23, 27, and 30. April 2023, 6, 10, 13, 17, 24, and 27. May 2023, 4, 8, 15, and 18. Review of nursing documentation from March 2023 through May 2023 revealed no documentation of Resident #55 refusing his showers on the days listed. Resident #55 was interviewed on 5-21-23 at 10:55am. The resident discussed not having a shower in three weeks. He stated the staff tell him there are not enough staff to provide him with a shower. Resident #55 explained he was scheduled for a shower on Mondays and Thursdays but did not receive showers as he was scheduled and stated he would like to have his showers. An interview with a Nursing Assistant (NA) #1	F 561	on Monday and Thursday AM shift. He has since requested his shower day be changed to Friday am shift only. Resident #67 has received showers on 5-22-23,5-25-23,5-29-23,6-12-23. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All facility residents have the potential to be affected by the alleged deficient practice. The Unit managers completed a shower/bath audit for all current residents on 5-30-23, to validate that residents were scheduled for showers/baths per resident preference. Upon completion of audit changes in shower schedules were made upon request. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Shower/bath schedules are assigned to each resident and the licensed nurse will discuss the schedule with the resident and/or the resident representative to assure choice of shower/bath and scheduled time are according to their wishes. The certified nursing assistant (CNA) will be made aware of scheduled shower/bath day and time using the resident shower list and/or resident Kardex. If the resident refuses the shower/bath, the C NA will document refusal and notify the licensed nurse regarding the refusal. The licensed nurse	

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F 561	Continued From page 8 occurred on 5-23-23 at 10:05am. The NA discussed Resident #55 being scheduled for a shower on the 7:00am to 3:00pm shift on Mondays and Thursdays. She confirmed she had been assigned to Resident #55 on 3-20-23, 5-4-23, and 5-9-23. NA #1 explained when she provided a resident with a shower, she would fill out a shower sheet and turn it in to the charge nurse either at the end of the shower or the end of the day. She stated she had always filled out a shower sheet when she completed a shower. The NA said if there was not a shower sheet for the above dates then she did not complete a shower for Resident #55 and stated she could not remember why a shower was not provided. NA #4 was interviewed on 5-23-23 at 12:10pm. The NA confirmed she had been assigned to Resident #55 on 4-24-23. She stated she did not provide the resident with a shower. The NA began to explain there were not enough staff but then stated the resident had refused. NA #4 stated she had not documented the refusal. During an interview with NA #5 on 5-23-23 at 12:15pm, the NA confirmed she had been assigned to Resident #55 on 3-9-23. She explained she had not provided a shower to Resident #55 on that day because she stated she had 20 residents assigned to her and did not have time to complete showers. A telephone interview occurred on 5-23-23 at 3:40pm with NA #6. The NA confirmed she had been assigned to Resident #55 on 4-6-23. She stated she could not remember if she had provided the resident with a shower but said if she had there would be a shower sheet.	F 561	will validate the refusal and notify resident representative if appropriate and will document the refusal in the progress notes or medication administration record (MAR). The licensed nurse (LN) will review with the resident their shower/bath preferences upon admission, quarterly and significant change and will update the shower/bath schedule according to the resident and/or resident representatives wishes. The DON, ADON, SDC and Unit Managers initiated education for the nursing staff(Licensed nurses and Nursing assistants) on 6/15/23 regarding providing showers/baths according to the resident wishes and documentation of shower/bath or documentation of refusals and notification of resident representative when necessary. All newly hired licensed nurses and nursing assistants will be educated during new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Unit Managers will review shower/bath documentation daily 5 times/week for four weeks then 3 times a week for 2 months. The Director of Nursing (DON) and/or the Assistant Director of Nursing (ADON) will review admission assessment documentation and quarterly care plan documentation regarding shower/bath preference 5 times a week for 4 weeks then 3 times a week for 2 months to validate that shower/bath preferences are	

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F 561	Continued From page 9 During an interview with the Director of Nursing (DON) on 5-24-23 at 9:21am, the DON explained the charge nurse would assign the showers for the day and provide the NAs with the shower sheets. She stated once the shower sheets were completed by the NA, the NA would return the shower sheet to the charge nurse who would place the shower sheets into her box. The DON stated she would then file the shower sheets into her filing cabinet. She also explained the charge nurse was responsible for monitoring the showers. The DON stated she was not aware that Resident #55 had not been receiving his showers but said she would not expect a NA to provide a shower if they were assigned over 15 residents. She explained she would expect a bed bath and incontinence care to be completed. The Administrator was interviewed on 5-24-23 at 9:35am. The Administrator stated she was aware there had been issues with residents receiving showers but stated she thought the showers were improving. She explained she expected the NAs to ask for help if they were not able to complete their assignments. 2. Resident #67 was admitted to the facility on 5-26-21 with multiple diagnoses that included cerebrovascular disease. The quarterly Minimum Data Set (MDS) dated 3-23-23 revealed Resident #67 was cognitively intact and required total assistance with one person for bathing. The MDS did not document Resident #67 as having any behaviors. Resident #67's care plan dated 4-10-23 revealed the resident had an ADL self-care deficit due to spastic hemiplegia affecting the left nondominant	F 561	documented according to the resident and/or resident representative wishes. The DON and/or the ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON and/or the ADON will review the plan during the monthly QAPI meeting, and the audits will continue according to the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 6-21-23.	

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F 561	Continued From page 10	F 561		

side. The goal for Resident #67 was to maintain the current level of ADL function. The interventions for the goal included resident was totally dependent with one person for showering and was to receive showers two times a week and as needed.

A review of Resident #67's shower documentation from March 2023 through May 2023 revealed the resident was to receive showers on Mondays and Thursdays. Upon review there was no documentation of Resident #67 receiving a shower on the following days:

March 2023, 9, 13, 16, 20, 23, and 30.
April 2023, 6, 10, 13, 20, 24, and 27.
May 2023, 4, 8, 15, and 18.

Review of nursing documentation from March 2023 through May 2023 revealed no documentation of Resident #67 refusing his showers on the days listed.

Resident #67 was interviewed on 5-21-23 at 11:00am. The resident stated he was not being provided a shower on his shower days. Resident #67 explained his shower days were Monday and Thursday and stated he was not receiving showers consistently and wanted a shower twice a week.

An interview with a Nursing Assistant (NA) #1 occurred on 5-23-23 at 10:05am. The NA discussed Resident #55 being scheduled for a shower on the 7:00am to 3:00pm shift on Mondays and Thursdays. She confirmed she had been assigned to Resident #67 on 3-20-23, 5-4-23, and 5-9-23. NA #1 explained when she provided a resident with a shower, she would fill out a shower sheet and turn it in to the charge

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F 561	Continued From page 11	F 561		

nurse either at the end of the shower or the end of the day. She stated she had always filled out a shower sheet when she completed a shower. The NA said if there was not a shower sheet for the above dates then she did not complete a shower for Resident #67 and stated she could not remember why a shower was not provided.

NA #4 was interviewed on 5-23-23 at 12:10pm. The NA confirmed she had been assigned to Resident #67 on 4-24-23. She stated she did not provide the resident with a shower. The NA began to explain there were not enough staff that day and she was unable to complete the showers. She stated she had not asked for help.

During an interview with NA #5 on 5-23-23 at 12:15pm, the NA confirmed she had been assigned to Resident #67 on 3-9-23. She explained she had not provided a shower to Resident #55 on that day because she stated she had 20 residents assigned to her and did not have time to complete showers. The NA explained she had not asked for help.

A telephone interview occurred on 5-23-23 at 3:40pm with NA #6. The NA confirmed she had been assigned to Resident #67 on 4-6-23. She stated she could not remember if she had provided the resident with a shower but said if she had there would be a shower sheet.

During an interview with the Director of Nursing (DON) on 5-24-23 at 9:21am, the DON explained the charge nurse would assign the showers for the day and provide the NAs with the shower sheets. She stated once the shower sheets were completed by the NA, the NA would return the shower sheet to the charge nurse who would

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F 561	Continued From page 12 place the shower sheets into her box. The DON stated she would then file the shower sheets into her filing cabinet. She also explained the charge nurse was responsible for monitoring the showers. The DON stated she was not aware that Resident #67 had not been receiving his showers but said she would not expect a NA to provide a shower if they were assigned over 15 residents. She explained she would expect a bed bath and incontinence care to be completed. The Administrator was interviewed on 5-24-23 at 9:35am. The Administrator stated she was aware there had been issues with residents receiving showers but stated she thought the showers were improving. She explained she expected the NAs to ask for help if they were not able to complete their assignments.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon	F 565		6/21/23

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F 565	Continued From page 13 the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and review of the Resident Council meeting minutes the facility failed to resolve a repeat grievance related to call bell responses which was reported during the Resident Council meetings for 3 of 6 months of meeting minutes reviewed (December 2022, February 2023 and May 2023). The findings included: A review of the Resident Council meeting minutes dated 12/1/22 revealed one of the items listed in the section titled old business was residents voiced a grievance related to staff not responding to the call bells or responding and turning the call bell off without providing the care requested. The written response to the Resident Council dated 12/8/22 documented the corrective action was "12/2 in-service held for nursing department	F 565	F 565 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The administrator addressed Resident Council grievances from March through May 2023. The Activity Director presented the Resident Council President and the group a written letter of resolution on 6-19-23 regarding voiced concerns of call lights not answered timely. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents have the potential to be affected by the alleged deficient practice of the facility□s failure to	

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F 565	Continued From page 14 addressing answering call lights and not cutting the call light off until the care has been provided." One of the items listed as new business was "not getting changed from 11:00 PM-7:00 AM." Resident #3, Resident #2 and Resident #11 were among the residents present for the meeting. A review of the Resident Council meeting minutes dated 2/3/23 revealed one of the items listed under new business was "call lights are not being answered or they get turned off without any help." The written response addressed to the resident council dated 2/15/23 documented the corrective action taken as "Resident right in-service for all staff completed on 2/10/23." Resident #3 and Resident #2 were among the residents in attendance at the meeting. The Resident Council meeting minutes dated 5/3/23 revealed one of the items listed under new business was "staff are not answering call lights, or they will come in and cut the call light off without helping." Resident #3, Resident #2 and Resident #11 were among those who attended. The response dated 5/8/23 reported the corrective actions taken was "Staff educated on answering call bell timely." An interview was conducted with the Resident Council President, Resident #3 on 5/23/23 at 10:04 AM. Resident #3 was alert, oriented and interviewable. Resident #3 stated it did not do any good to report grievances during the Resident Council meetings because they were never resolved, and the corrective action shared with the Resident Council was always the same thing. She explained the corrective was always that an in-service was completed. Resident #3 said the in-service was not working because the	F 565	resolve concerns voiced by the Resident council members. The administrator addressed Resident Council grievances from March through May 2023. The Social Worker presented the Resident Council President and the group a written letter of resolution on 6-19-23 regarding voiced concerns of call lights not answered timely. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Administrator provided education on 6-15-23 to the Activity Director, Social Service director (SSD) regarding the facility grievance policy and procedure. The Activities Director (AD) will attend the Resident Council group during meetings and will document concerns voiced by the group on the facility Grievance form. The AD will give the Grievance form to the Social Worker to put on the grievance log. The SW will review with the Administrator who will assign the appropriate staff member to investigate and follow up regarding the concern within 5 days and present the investigation/resolution to the social worker. The social worker will complete the letter of resolution. The Activity Director will present the letter of resolution to the Resident Council President. The AD and Resident council president will present the resolution letter to the Resident Council Group at the next scheduled meeting. Indicate how the facility plans to monitor	

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F 565	Continued From page 15 complaints were always the same thing. The number one concern was always the call lights not being answered or if answered they only turned the call light off and did not provide the needed care. On 5/23/23 at 3:14 PM during a follow up interview with Resident #3 (the Resident Council President) she explained the process for responses to grievances discussed during the Resident Council meetings. She reported a grievance response letter was read in the next month's meeting to address any reported grievances. Resident #3 stated she received the grievance response letter indicated the facility investigated and conducted an in-service, but the next meeting was the same grievance was reported, so the grievance was not getting resolved. Resident #3 said she talked to the new Director of Nursing (DON) and told her the in-services were not solving the problem. Resident #3 said she did not remember when she talked to the new DON. An interview was conducted on 5/21/23 at 3:56 PM with Resident #2. Resident #2 was alert, oriented and interviewable She stated she had received the grievance response letters which said the facility investigated the concerns from Resident Council but there was not a true resolution because the problems continued. Staff were still not responding to call lights or were not providing the care requested but turned the call light off. Resident #2 said she was the Resident Council Vice President. An interview was conducted on 5/23/23 at 8:45 AM Resident #11. Resident # 11 was alert, oriented and interviewable. She stated the call	F 565	its performance to make sure that solutions are sustained; The Administrator and/or the Social Service Director (SSD) will review the Resident Council minutes and the Resident council grievance log monthly following the monthly resident council meeting to identify voiced concerns and validate that the concerns were documented on the facility Grievance form, the concerns were investigated and a resolution was obtained and presented to the Resident Council President in writing within 5 days of receiving the grievance and reviewed at the next scheduled Resident Council meeting for 3 months. During audit Administrator/Social worker will identify if there are any repeat concerns. If repeat concerns are identified administrator will conduct a root cause analysis and revise the plan for sustained compliance. The Administrator and/or the SSD will review the audit/monitors monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and/or the SSD will review the plan during the monthly QAPI meeting and the monitors will continue at the discretion of QAPI committee. Indicate dates when corrective action will be completed;6-21-23	

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F 565	Continued From page 16 lights were still not being answered although this problem was discussed in the Resident Council meeting. Resident #11 said she had to wait about an hour for staff to respond to assist her from the floor when she slid off her bed about 4 weeks ago. During an interview with the DON on 5/24/23 at 2:00 PM she reported grievances including those from the Resident Council were written up on a grievance form and based on the what the grievance was it was sent to the assigned department. She said within 5 days a response was written and a letter was sent back to the person or people who filed the grievance. She stated she just started working here in April 2023. On 5/24/23 at 2:42 PM the Administrator stated the facility tried to respond to the Resident Council grievances and had educated staff about responding to call bells in a timely manner and providing care in a timely manner, but she did not know the answer for why this continued to be a problem.	F 565		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		6/21/23

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F 583	Continued From page 17 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents and staff and record review the facility failed to offer or provide privacy during a bed bath for 1 of 4 residents reviewed for dignity (Resident #7). Findings included: Resident #7 was admitted to the facility on 2/12/15. Resident #7's minimum data set assessment dated 4/10/23 revealed he was assessed as moderately cognitively impaired and had verbal behavioral symptoms directed towards others 1 to 3 days of the lookback period. He required	F 583	. F 583 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The LNHA and ADON provided education for NA #8 on 5-22-23, regarding providing privacy when providing care to residents, to include closing window shades, privacy curtain and door. The DON observed Resident #7 on 6-16-23, while NA was providing care. The window shade was closed, door	

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F 583	Continued From page 18 extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. Resident #7's care plan dated 4/4/23 revealed he was care planned for activities of daily living self-care performance deficit related to activity intolerance and impaired mobility. The interventions included to provide one aide to assist Resident #7 to perform bathing, dressing, personal hygiene. During observation on 5/22/23 at 10:51 AM Nurse Aide (NA) #8 was observed providing a bed bath to Resident #7. Upon arriving at the room, the door to Resident #7's room was observed to be all the way opened, and the privacy curtain was drawn ¼ of the run (the length of the track for the curtain.). Resident #7's head and shoulders were obscured by the curtain, but from his chest down to his feet he was visible from the hall. He had a t-shirt and socks on, and the rest of his body was uncovered. He was lying on his back and his sheets and blanket were underneath his feet and legs. He was not wearing a brief. NA #8 entered Resident #7's room and began to provide care without adjusting the curtain or door for privacy of Resident #7. On 5/22/23 at 10:54 AM another resident walked past the open door and could see all the resident except the area of his head and shoulders which were obscured by the curtain and the area covered by his socks and t-shirt.. The other resident spoke with NA #8 briefly at the doorway and the NA then closed the door and completed Resident #7's bath. During an interview on 5/22/23 at 11:02 AM Resident #7 stated being uncovered and exposed to the hall made him feel unimportant but he was used to it. He concluded it would be his	F 583	closed, and privacy was provided. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current facility residents that are dependent on staff to provide privacy during care is at risk for the alleged deficient practice of leaving window shade open during care. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The DON, SDC, ADON, Unit managers-initiated education on 6-15-23, for nursing staff (licensed nurses and nursing assistants) regarding providing privacy when providing care to residents, to include closing window shades, privacy curtain and door. Newly hired licensed nurses and nursing assistants will be educated during new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON and Unit managers will observe 10 residents that are dependent on staff for providing privacy during care, weekly for 4 weeks, then 20 monthly for 2 months. The DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the	

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F 583	Continued From page 19 preference that he was covered but had become accustomed to it. During an interview on 5/22/23 at 11:03 AM Nurse Aide #8 stated she had set Resident #7 up for his bath as he could clean his torso himself. She then was going to complete his bath with the surveyor. She stated she did not leave the door open. She concluded she did not notice the door was open when she returned to the room. During an interview on 5/22/23 at 11:22 AM the Administrator stated the nurse aide should have provided the resident privacy when she entered the room and the door was open, and the resident was visible from the hallway unclothed. During an interview on 5/22/23 at 12:05 PM the Director of Nursing stated the nurse aide should have provided or offered privacy to the resident when she entered the resident's room to complete his bath.	F 583	monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 6-21-23.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) Assessment in the areas of dental (Resident #102) and Pre-Admission Screening and Resident Review (PASRR) (Resident #2) for 2 of 18 resident assessments reviewed.	F 641	F 641 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The MDS nurse completed a modified MDS assessment for Resident #102 on	6/21/23

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F 641	Continued From page 20 Findings included: 1. Resident #102 was admitted to the facility on 4/20/23 A review of the Nursing Admission Assessment for Resident #102 dated 4/20/23 revealed she had broken or carious (decayed) teeth. A review of her admission MDS assessment dated 4/26/23 revealed she had no obvious or likely cavity or broken natural teeth. The Care Area Assessment (CAA) for dental care was not triggered. On 5/21/23 at 2:07 PM an observation of Resident #102 revealed she had multiple black and broken natural teeth. On 5/24/23 at 10:11 AM an interview with MDS Nurse #1 indicated she completed the dental section of Resident #102's MDS Assessment dated 4/20/23. She stated she normally went to the resident, had them open their mouth, and observed their dental status when she completed the section. She went on to say Resident #102 did have broken and decayed teeth and she coded the dental section of her MDS inaccurately. MDS Nurse #1 stated it was possible she had just gotten distracted when she was coding this MDS and had made a mistake. On 5/24/23 at 2:09 PM an interview with the Director of Nursing (DON) indicated the dental section of Resident #102's MDS assessment dated 4/20/23 should have accurately captured her dental status. 2. Resident # 2 was admitted to the facility on 5/28/21 with diagnoses including bipolar disorder	F 641	5-24-23, to include accurate coding of Section L “Dental” of the MDS. The MDS nurse submitted the modified MDS assessment to the CMS on 5-30-23. The MDS nurse completed a modified MDS assessment for Resident #2 on 5-26-23, to include coding of PASARR Level II. The MDS nurse submitted the modified MDS assessment to CMS on 5-26-23. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current facility residents with a PASARR Level II and dental concerns have the potential to be affected by the alleged deficient practice of the facility’s failure to accurately code on the MDS assessment. The MDS nurses completed an audit on 6-9-23, of current facility residents to identify residents with a PASARR Level II and residents with dental concerns, and validate that the MDS is coded accurately to reflect the PASARR Level II and dental concerns. There was a total of 24 residents with PASARR Level II, and 0 of those were coded inaccurate on the MDS assessment. The MDS nurses completed an audit of section L “dental” coding on 6-15-23. There was a total of 16 residents with dental concerns, and of those were coded inaccurate. The MDS nurses modified assessments for the 16 residents that were identified, on 6/9/23 , 6-15-23 and submitted to CMS by 6-15-23 to reflect accurate coding of the PASARR Level II and dental concerns on the MDS assessment.	

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F 641	Continued From page 21 and major depressive disorder. A review of the PASRR (Preadmission Screening Resident Review) Level II Determination Notification dated 2/12/19 revealed nursing facility placement was appropriate. A review of the annual MDS dated 4/11/23 revealed it was coded that Resident #2 was not a level II PASRR. On 5/24/23 at 9:55 AM MDS Nurse #1 stated the annual MDS dated 4/11/23 had an error and the PASRR was coded wrong. On 5/24/23 at 2:30 PM the Administrator stated MDS Nurse #1 informed her of the coding error, and it was just a mistake.	F 641	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Vice President of Reimbursement provided education on 6-2-23 to the MDS nurses regarding accurate coding of the PASARR Level II and section L “dental” on the MDS assessment. The admission coordinator (AC) and/or the SSD will identify residents with PASARR Level II upon admission to the facility. The AC and/or the SSD will maintain a list of residents with PASARR Level II and the expiration dates. The SSD and/or the MDS coordinators will validate PASARR Level II prior to coding the MDS assessment. The MDS nurses will validate accurate coding of PASARR Level II prior to locking the MDS assessment. The MDS nurse will complete a dental assessment on each resident upon admission, quarterly, annually, and significant change and will code the MDS Section “L” dental, accurately according to the assessment completed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing (DON) or the Assistant Director of Nursing (ADON) will monitor coding of PASARR Level II on the MDS assessment for residents identified with PASARR Level II 5 x week for 4 weeks then weekly for 2 months, prior to	

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F 641	Continued From page 22	F 641	the MDS assessment being locked, to validate that the MDS assessment was coding accurately to reflect PASARR Level II for the identified residents. The DON or the ADON will review 5 completed MDS assessments Section “L” dental weekly for 4 weeks then 10 monthly for 2 months. The DON or the ADON will review the monitors monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or the ADON will review the plan during monthly QAPI, and the monitors will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed;6-21-23	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff, and resident interviews the facility failed to provide incontinence care (Resident #85) and mouth care (Resident #46) to residents who were dependent on staff for activities of daily living (ADL) care for 2 of 5 residents reviewed for ADL care. Findings included:	F 677	F 677 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 85 was discharged to home, on 6-9-23. Residents # 46 received oral care on 5/22	6/21/23

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	345228	A. BUILDING _____ B. WING _____	C 05/24/2023

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F 677	Continued From page 23 1. Resident #85 was admitted to the facility on 2-1-22 with multiple diagnoses that included congestive heart failure. The quarterly Minimum Data Set (MDS) dated 4-8-23 revealed Resident #85 was cognitively intact and required total assistance with one person for toileting. The MDS documented Resident #85 as always being incontinent of urine and bowel. The MDS did not have documentation of any behaviors. Resident #85's care plan dated 4-20-23 revealed the resident had an ADL self-care deficit related to generalized weakness. The goal for Resident #85 was to maintain the current level of function in ADLs. The intervention for the goal was toileting required total dependence with one person. Resident #85 was interviewed on 5-21-23 at 11:42am. The resident discussed having to sit in her urine and feces for up to six hours. She explained this happened every day and that she had informed the nurses on duty (she was unable to recall any names). Resident #85 stated she knew how long she had to wait because there was a clock on the wall that she could see the time. Resident #85 was interviewed on 5-22-23 at 1:35pm. Upon entering the resident's room there was a smell of urine and a pile of sheets and under pad laying on the floor between the resident's bed and her roommate's bed. The sheets and under pad were observed to be saturated with urine. The resident stated she was very upset and explained she had gone from 6:15am to 12:15pm without being provided	F 677	and 5/23/23 as observed by the surveyor. The Director of Nursing, Assistant Director of Nursing, SDC and unit managers-initiated education for the nursing staff (licensed nurses and nursing assistants)on 6-15-23 regarding providing oral care and incontinence care for dependent residents. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current facility residents have the potential to be affected by failing to provide oral care and incontinence care to dependent residents. The Director of Nursing, Assistant Director of Nursing, SDC and unit managers-initiated education for the nursing staff (licensed nurses and nursing assistants) on 6-15-23 regarding providing oral care and incontinence care for dependent residents. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing, Assistant Director of Nursing, SDC and unit managers-initiated education for the nursing staff (licensed nurses and nursing assistants) on 6-15-23 regarding providing oral care and incontinence care for dependent residents. Newly hired licensed nurses and nursing assistants will be educated during new hire orientation.	

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F 677	Continued From page 24 incontinence care. Resident #85 stated she kept putting her call light on starting at 7:30am and "people" would come in turn off her light and tell her they would send someone in to change her, but she stated no one ever came. The resident said she saw NA #5 walk past her room, and she "hollered" for her to come in her room. She stated NA #5 provided her with incontinence care at 12:15pm. Resident #85 confirmed the sheets and under pad on the floor were from her bed when NA #5 had provided her care. NA #5 was interviewed on 5-22-23 at 1:45pm. NA #5 discussed being assigned to another hall and not being assigned to Resident #85 today (5-22-23) but stated the resident had asked her to provide incontinence care. The NA confirmed the sheets and under pad laying on the floor in Resident #85's room were the linens she had removed while providing incontinence care. She stated Resident #85 was soaked "all the way down to her feet" so she had to change the linen. NA #5 discussed seeing dark yellow/brown rings on the sheet while providing care. The NA explained she left the sheets and under pad because she thought NA #10 was going to provide the resident with a bath and that NA #10 would pick up all the linen at that time. An interview with NA #10 occurred on 5-22-23 at 1:52pm. NA #10 confirmed she was assigned to Resident #85 and indicated she had not entered Resident #85's room until 20-30 minutes ago (around 1:30pm) to offer the resident a bath but she stated the resident had refused. She stated she had not seen the resident's call light on but said she was informed the resident needed incontinence care. NA #10 then said, "I have too many residents to care for and was not able to	F 677	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. ADON, DON, SDC, licensed nurses will audit 10 residents per day x 5 days/week x 4 weeks. Then 10 residents 3x week x 4 weeks than 10 residents per week x 4 weeks to ensure mouth care and incontinence care has been provided. The DON or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or ADON will review the plan during the monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 6-21-23.	

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F 677	Continued From page 25	F 677		

get to Resident #85." The NA confirmed she had not asked for assistance, nor had she provided any care to Resident #85 since she started her shift at 7:00am. NA #10 did not recall what time or who had told her Resident #85 needed incontinence care.

The Director of Nursing (DON) was interviewed on 5-22-23 at 2:19pm. The DON discussed speaking with the NAs last week to do initial rounds on all their assigned residents at the start of their shift and assess for any immediate needs. She stated she expected the NAs to do their rounds together at the start of a shift and for any NA who was struggling to complete their assignment to request help. The DON discussed Resident #85 should have been assisted with incontinence care when she turned on her call light and she stated NA #10 was a new NA and was unaware she could have asked for assistance.

The Administrator was interviewed on 5-24-23 at 9:35am. The Administrator stated she expected the NAs to request assistance if needed and for the NAs to be providing incontinence care when needed. She explained NA #10 was a new NA and may not have known she could request help.
2. Resident #46 was admitted to the facility on 10/18/21. Her diagnoses included dementia, adult failure to thrive and Alzheimer's disease.

The quarterly Minimum Data Set (MDS) assessment dated 3/1/21 indicated she was severely cognitively impaired. She was totally dependent on staff for bed mobility, toileting and bathing. She required extensive assistance with eating and personal hygiene. She had range of motion limitations of both lower extremities.

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The care plan for Resident #46 revised 3/28/23 indicated she had ADL (activities of daily living) self-care performance deficit related to weakness and cognitive status. Resident required staff assistance to complete ADL tasks daily. The care plan also indicated she had potential for decline in condition and received hospice services.

An observation and attempted interview of Resident #46 was conducted on 5/21/23 at 11:25 AM. Resident #46 attempted to respond to questions, but her words were not understandable. She had a buildup of cream to tan colored debris on her teeth and she had tan colored liquid in and around her mouth. Her breath had a foul odor.

On 5/22/23 at 2:19 PM Nurse Aide (NA) #12 stated she observed Resident #46's teeth were dirty this morning when she was bathing her. She said Resident #46 was the first resident she bathed this morning. She said since Resident #46 had buildup on her teeth, she brushed the resident's teeth 2 times. NA #12 said because her mouth smelled bad, she went to the Charge Nurse to obtain sponge tipped mouth swabs. She said she also cleaned Resident #46's mouth with the sponge tipped mouth swabs dipped in mouthwash.

On 5/23/23 at 2:37 PM Resident #46 was sitting up in a reclined geriatric chair. The Hospice NA was observed in Resident #46's room. During the observation the Hospice NA reported she usually saw this resident on Mondays, Wednesdays and Fridays but she was not able to come on Monday this week (5/22/23), so she came today. She added she arrived today at 1:50

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F 677	Continued From page 27 PM and noted mouth care had not been provided today. She said she brought her own supplies to provide mouth care as she had noticed no toothbrush or sponged tipped mouth swabs in the resident's room on her last visit on Friday (5/19/23). On 5/24/23 at 2:00 PM the Director of Nursing (DON) reported the facility NAs assumed the Hospice NA was providing all the care of the residents who were on hospice services, so the staff were educated to provide care for all residents including those who received hospice services. On 5/24/23 at 2:22 PM the Administrator said the facility NAs should be doing oral care for all residents.	F 677		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 725		6/21/23

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F 725	Continued From page 28 resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff, and resident interviews the facility failed to provide sufficient nursing staff resulting in residents not having their choices honored for bathing for 2 of 9 residents (Resident #55 and Resident #67). Findings included: This tag is cross referenced to: F561: Based on record review, staff, and resident interviews the facility failed to honor a residents bathing preference for 2 of 9 residents (Resident #55 and Resident #67) reviewed for choices. During an interview with a Nursing Assistant (NA) #10 on 5-22-23 at 1:52pm, the NA discussed having too many residents assigned to her and was unable to complete all her assigned tasks. The NA discussed having 15 residents assigned to her and she was not able to complete shower tasks assigned but was able to complete bed baths. The NA discussed she was assigned 15 or more residents three to four times a week. The Scheduler was interviewed on 5-24-23 at 8:53am. The Scheduler stated she was responsible for scheduling the nurses and NAs	F 725	F 725 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Cross tag F561: Resident #55 was scheduled for showers on Monday and Thursday AM shift. He has since requested his shower day be changed to Friday am shift only. Resident #55 has received showers on 5-22-23, 5-25-23, 5-29-23, and 6-12-23. Residents #67 is scheduled for showers on Monday and Thursday AM shift. He has since requested his shower day be changed to Friday am shift only. Resident #67 has received showers on 5-22-23, 5-25-23, 5-29-23, and 6-12-23. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Cross tag F 561: All facility residents have the potential to be affected by the alleged deficient practice.	

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F 725	Continued From page 29 but requested help from the Administrator if she was unable to find enough staff for one of the shifts. The Scheduler stated she scheduled the staff by census not acuity but clarified if the facility needed extra staff, the Administrator provided her with the information related to how many extra staff were needed. The Scheduler could not remember why there had not been enough staff scheduled to meet resident choices. During an interview with the Director of Nursing (DON) on 5-24-23 at 9:21am, the DON discussed any NA who had more than 15 residents assigned to them would not be able to complete all their tasks such as showers. She also discussed there had been days when the NAs were assigned 20 or more residents, but she expected the NA to ask for assistance from the nurse or management staff. She explained she had met with the NAs last week and discussed asking for help if needed and even though the NA was assigned 20 residents, the management staff was available to assist. The DON explained the facility had been hiring staff and that the facility had a hospitality aide program where the facility was providing educational opportunities for the hospitality aides to obtain their NA certificate. The Administrator was interviewed on 5-24-23 at 9:35am. The Administrator discussed the facility "struggling" with having enough staff but stated the facility had been hiring more staff and providing programs for staff to further their education. The Administrator stated she expected the NAs to request assistance from the nurse or management staff to ensure residents were receiving care.	F 725	The Unit managers completed a shower/bath audit for all current residents on 5-30-23, to validate that residents were scheduled for showers/baths per resident preference. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Shower/bath schedules are assigned to each resident and the licensed nurse will discuss the schedule with the resident and/or the resident representative to assure choice of shower/bath and scheduled time are according to their wishes. The certified nursing assistant (CNA) will be made aware of scheduled shower/bath day and time using the resident shower list and/or resident Kardex. If the resident refuses the shower/bath, the CNA will document refusal and notify the licensed nurse regarding the refusal. The licensed nurse will validate the refusal and notify resident representative if appropriate and will document the refusal in the progress notes or medication administration record (MAR). The licensed nurse (LN) will review with the resident their shower/bath preferences upon admission, quarterly and significant change and will update the shower/bath schedule according to the resident and/or resident representatives wishes. The DON, ADON, SDC and Unit Managers initiated education for the nursing staff(licensed nurses and nursing assistants) on 6/15/23 regarding	

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F 725	Continued From page 30	F 725	providing showers/baths according to the resident wishes and documentation of shower/bath or documentation of refusals and notification of resident representative when necessary. Newly hired hired Licensed nurses and nursing assistants will be educated during hire orientation. The Administrator and DON will monitor staffing daily to assure that there is sufficient staff to meet the needs of the residents as evidenced by provision of showers/bathing and nail care. The facility has hired 6 nursing assistants, 8 Hospitality aides and 1 RN since the last day of the survey. Facility continues to recruit staff by sponsoring job fairs, meetings with community colleges, and advertisement on popular job websites. The company hired a recruiter to assist with the recruiting of staff. The facility utilizes hospitality aides to assist with non-resident care duties. Other staff members that are certified or licensed, are assigned to resident care when necessary to provide care to the residents. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Cross F Tag561 The Unit Managers will review shower/bath documentation daily 5 times/week for four weeks then 3 times a week for 2 months. The Director of Nursing (DON) and/or the	

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F 725	Continued From page 31	F 725	Assistant Director of Nursing (ADON) will review admission assessment documentation and quarterly care plan documentation regarding shower/bath preference 5 times a week for 4 weeks then 3 times a week for 2 months to validate that shower/bath preferences are documented according to the resident and/or resident representative wishes. The Administrator and DON will review daily staffing ratios for 3 months to validate that there is sufficient staff to meet the needs of the residents as evidenced by residents receiving showers/baths and nail care. The DON or ADON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON or ADON will review the plan during the monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 6-21-23.	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management	F 947		6/21/23

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F 947	Continued From page 32 training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure Nurse Aide (NA) #9 received at least 12 hours of in-service training in one year. This was for 1 of 5 NA in-service training records reviewed. Findings included: On 5/24/23 at 1:25 PM a review of NA #9's in-service training record from 2/1/22 through 5/24/23 provided by the facility's Staff Development Coordinator (SDC) revealed NA #9 had a total of 7 hours and 45 minutes of in-service training which included dementia management and abuse prevention. On 5/24/23 at 2:03 PM an interview with the SDC indicated NA's received their in-service training in person at the facility. She stated because NA #9 was only an as needed (prn) staff member she was not always present in the facility when in-service training was provided. She stated as a result, NA #9 did not have the required 12 hours of annual in-service training. On 5/24/23 at 2:04 PM an interview with the	F 947	F 947 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Nurse Aide #9 needs 4 hours 15 minutes of education to meet the 12 hour/year requirement including abuse training and dementia management. Education will be completed by 6-21-23. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. SDC coordinator audited the Inservice records on all Nurse Aides to ensure they met the 12 hours/year requirement. This was completed on 6-15-23. 26 other staff members were found to have not met the 12 hour/year requirement. They will complete the education by 6-21-23 or be removed from the schedule until education is completed. Address what measures will be put into	

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F 947	Continued From page 33 Administrator indicated because NA #9 was a prn employee, she was not always present in the facility when in-service training was provided. She stated as a result, NA #9 did not have the required 12 hours of annual in-service training.	F 947	place or systemic changes made to ensure that the deficient practice will not recur. DON, ADON, SDC, and unit managers-initiated education on the 12-hour education requirement on 6-15-23. DON /Administrator will audit Inservice records for nurse aides each month with nurse aides' annual evaluation. If the Inservice requirement has not been met nurse aide will be taken out of work until requirement is fulfilled Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. DON /Administrator will audit Inservice records for nurse aides each month x3 months with nurse aides' annual evaluation. If the Inservice requirement has not been met nurse aide will be taken out of work until requirement is fulfilled The Administrator and/or the HR director will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The Administrator and/or the HR director will review the plan during the monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; 6-21-23.	