STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 06/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT GASTONIA	969 COX ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 06/06/23 through 06/09/23. Based on the Quality Assurance review the office determined idenification of Immediate Jeopardy which extended the survey, therefore the exit date was changed to 06/26/23. Event ID: 6QGX11. The following intakes were investigated: NC00202201, NC00201576, NC00201467, NC01381, NC00201224, NC00201158, NC00201160, NC00200894, NC00200269, NC00200244, NC00197601, and NC00196676. 18 of the 38 complaint allegations resulted in deficiency. Immediate Jeopady was identified at: CF483.25 at F697 at scope and severity J. F697 constitued Substandard Quality of care. Immediate Jeopardy began on 03/31/23 and was removed on 06/09/23. An partial extended survey was conducted.	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	F 550		6/27/23

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

Electronically Signed | 07/14/2023

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

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F 550	Continued From page 1 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 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, record reviews and staff interviews the facility failed to treat dependent residents in a dignified manner by not providing incontinent care (Resident #13) and for placing two incontinent products on Resident #12 for 2 of 4 residents (Resident #13 and #12) reviewed for dignity. The findings included:	F 550	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's	

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F 550	Continued From page 2 1. Resident #13 was admitted to the facility on 05/17/22. The quarterly Minimum Data Set (MDS) assessment dated 03/31/23 revealed Resident #13 had severe cognitive impairment and could make himself understood as well as being able to understand others. On 06/07/23 at 7:50 AM an observation was made of Nurse Aide (NA) #5 who went in to provide incontinent care to Resident #13 and upon entering the room a strong urine odor was immediately noted. The Resident was noted to be wearing two briefs layered on top of each other which were both soaked with urine and the turn sheet which was made from a flat sheet folded three times and the fitted sheet that were both soaked with urine as well. The briefs were so full of urine that they made a loud thud sound when the NA tossed the briefs into the trash can. An interview was conducted with Nurse Aide (NA) #5 on 06/07/23 at 7:50 AM who stated that it was not uncommon to find some of the residents wearing two briefs when she came on shift. The NA explained that when she asked why the residents were double briefed, she was told because it made the incontinent rounds easier for the third shift staff. The NA continued to explain that she was unable to get report from the third shift staff because when she came on shift around 7:00 AM the third shift was already gone off the hall. She also indicated that Resident #13 was a heavy wetter and needed to be checked and changed often. During an interview with Nurse Aide (NA) #3 on	F 550	policies and procedures should be considered to be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the Facility, or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 6/26/23. F550 - Regarding the alleged deficient practice of failure to treat a resident in a dignified manner as evidenced by: a. not providing incontinent care for Resident #13 b. placing two incontinent products on Resident #12 On 06/07/2023, Residents #12 & #13 were provided incontinent care. All residents who have incontinence and require assistance with toileting have the potential to be affected. Observations were conducted by the Director of Nursing (DON) and Nurse Unit Coordinators on 06/08/2023 of all residents who require assistance with the toileting and incontinence care to identify any additional concerns related to provision of incontinence care, with no additional concerns noted.	

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F 550	Continued From page 3 06/07/23 at 2:45 PM the NA confirmed that she worked Resident #13's hall often and she frequently found the residents double briefed because it reduced the times the third shift staff had to provide incontinent care and turn and reposition the residents. The NA continued to explain that she did not know who was responsible for double briefing because she was not able to receive shift report from the third shift staff because they left the hall before she arrived. She stated that she has reported the double briefing to the day shift nurse when she found it, but it continued to happen. On 06/07/23 at 3:10 PM an interview was conducted with Nurse Aide (NA) #4 who explained that she often worked with Resident #13, and she often found the Resident wearing two briefs when she made the first round on first shift and thought it was for convenience. She stated because third shift did not provide a shift report she could not report which nurse aide was responsible for doing it. On 06/07/23 at 4:15 PM an interview was conducted with Nurse #1 who confirmed she often worked on Resident #13's hall and informed that no one had explained that third shift was double briefing the residents. The Nurse stated she thought it would be okay especially if the resident was a heavy wetter. Multiple attempts were made to interview Nurse Aide #6 who worked on 06/06/23 third shift but the attempts were unsuccessful. During an interview with the interim Director of Nursing (DON) on 06/07/23 at 5:10 PM the DON explained that she was not aware of any resident	F 550	On 06/09/2023, DON initiated inservice education to nursing staff regarding proper provision of incontinence care to dependent residents. Education of nursing staff to continue upon to return to work, to be completed by 06/24/2023. Education for newly hired or contracted nursing staff will be provided by DON or charge nurse upon hire, prior to receiving assignment. DON or nurse managers will conduct random observations of residents who are incontinent and require staff assistance per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks to ensure incontinent care is being provided per protocol (timely and without use of double incontinent products). Administrator or DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Administrator or DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Completion Date: 06/27/23	

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F 550	Continued From page 4	F 550		

wearing two briefs and that it was not acceptable for it to be done. She stated she felt that allowing double briefing would give the nursing staff the false impression that they did not have to check and change the residents as often as they needed, especially if they were heavy wetter's.

2. Resident #12 was admitted to the facility on 01/20/23.

Resident #12's quarterly Minimum Data Set (MDS) assessment dated 04/28/23 revealed her cognition was severely impaired and she required extensive assistance of 2 staff for bed mobility, toileting and hygiene.

During an observation on 06/07/23 at 7:40 AM Nurse Aide (NA) #5 provided incontinent care to Resident #12. During the procedure it was noted that the Resident had on 2 briefs layered on top of each other with the inner brief being wet with urine. The NA provided incontinence care and applied a fresh brief.

An interview was conducted with Nurse Aide (NA) #5 on 06/07/23 at 7:50 AM who stated that it was not uncommon to find some of the residents wearing two briefs when she came on shift. The NA explained that when she asked why the residents were double briefed, she was told because it made the incontinent rounds easier for the third shift staff. The NA continued to explain that she was unable to get report from the third shift staff because when she came on shift around 7:00 AM the third shift was already gone off the hall.

During an interview with Nurse Aide (NA) #3 on 06/07/23 at 2:45 PM the NA confirmed that she

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F 550	Continued From page 5	F 550		

worked Resident #12's hall often and she frequently found the residents double briefed because it reduced the times the third shift staff had to provide incontinent care and turn and reposition the residents. The NA continued to explain that she did not know who was responsible for double briefing because she was not able to receive shift report from the third shift staff because they left the hall before she arrived. She stated that she has reported the double briefing to the day shift nurse when she found it, but it continues to happen.

On 06/07/23 at 3:10 PM an interview was conducted with Nurse Aide (NA) #4 who explained that she often worked with Resident #12, and she often found the Resident wearing two briefs when she made the first round on first shift and thought it was for convenience. She stated because third shift does not provide a shift report she could not report which nurse aide was responsible for doing it.

On 06/07/23 at 4:15 PM an interview was conducted with Nurse #1 who confirmed she often worked on Resident #12's hall and informed that no one had explained that third shift was double briefing the residents. The Nurse stated she thought it would be okay especially if the resident was a heavy wetter.

Multiple attempts were made to interview Nurse Aide #6 who worked on 06/06/23 third shift but the attempts were unsuccessful.

During an interview with the interim Director of Nursing (DON) on 06/07/23 at 5:10 PM the DON explained that she was not aware of any resident wearing two briefs and that it was not acceptable

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F 550	Continued From page 6 for it to be done. She stated she felt that allowing double briefing would give the nursing staff the false impression that they did not have to check and change the residents as often as they needed to especially if they were heavy wetter's.	F 550		
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. §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	F 583		6/27/23

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F 583	Continued From page 7 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, record reviews and staff interviews, the facility failed to provide a privacy curtain to provide visual privacy during care for 1 of 1 resident (Resident #13) reviewed for privacy. As a result, a reasonable person would experience embarrassment. The finding included Resident #13 was admitted to the facility on 05/17/22. The quarterly Minimum Data Set (MDS) assessment dated 03/31/23 revealed Resident #13 had severe cognitive impairment. The Resident required extensive assistance of one staff for bed mobility and toileting. Resident #13 was frequently incontinent of bladder and always incontinent of bowel. During an observation on 06/07/23 at 7:50 AM it was noted that Nurse Aide (NA) #5 provided incontinent care for Resident #13 that included changing his brief, turn sheet and the bottom sheet of his bed. At the time of the incontinent care there was no privacy curtain in the semi-private room to provide full visual privacy for Resident #13. The Resident's roommate appeared to be sleeping. An interview was conducted with Nurse Aide (NA) #5 on 06/07/23 at 7:50 AM who stated she was aware that there was no privacy curtain for Resident #13 before she provided care to the	F 583	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the Facility, or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 6/27/23. F 583 Resident #13 provided with a privacy curtain on 6/7/23. All residents with privacy curtains have	

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F 583	Continued From page 8 Resident. The NA stated she did not know why a privacy curtain was not in the Resident's room. An interview was conducted with Housekeeper #1 on 06/07/23 at 1:55 PM who confirmed that she was the Housekeeper on Resident #13's hall for that day. The Housekeeper explained that she did not know how often the privacy curtains were washed and replaced in the residents' rooms and the Housekeeping Supervisor was responsible for that. She stated if she found a room without a privacy curtain, she would notify the Housekeeping Supervisor. The Surveyor accompanied Housekeeper #1 to Resident #13's room where she noticed that there was no privacy curtain in the room. She stated she had already cleaned the Resident's room that day but did not notice the room did not have a privacy curtain and she thought she needed to pay closer attention to that when she cleaned the rooms. During an interview with the Housekeeping Supervisor on 06/07/23 at 2:00 PM the Housekeeping Supervisor explained that the privacy curtains were taken down and washed once a month on a schedule and as needed. He stated there was also a periodic audit for privacy curtains and one was done that morning and found that a privacy curtain had to be replaced in a room at the end of the hall. The Housekeeping Supervisor was asked about the privacy curtain, and he explained that the last time the privacy curtain in room the Resident's room was replaced was on the second Friday of last month (05/12/23). The Surveyor accompanied the Housekeeping Supervisor to the Resident's room where he noticed there was no privacy curtain in the semi-private room. The Housekeeping Supervisor stated someone must have taken it	F 583	potential to be affected. The House Keeping Director initiated an audit on 6/7/23 with completion date of 6/7/23 to assure all residents that required a privacy curtain had one in place. On 6/7/23 the Regional Director of Operations provided education to the Housekeeping Director regarding the importance of changing privacy curtains as needed and assuring that each curtain was replaced while maintaining privacy. On 6/9/23, Infection prevention nurse/ staff development initiated in-service education to clinical staff regarding importance of providing privacy curtains during assistance with personal care and or treatments. Education of clinical staff to continue upon return to work and completed by 6/24/23. Education for newly hired or contracted staff will be provided by DON, ADON, or charge nurse upon hire, prior to receiving assignment. The Housekeeping Director completed audits of privacy curtains on 6/7/23 and continued audits for two weeks. The Housekeeping Director will continue audits following deep cleaning schedules. The Administrator, Regional Director of Housekeeping or Regional Director of Operations will review the audits monthly to identify patterns and trends and will adjust the plan to maintain compliance. The Administrator will review the plan during Quality Assurance committee	

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F 583	Continued From page 9 down and not replaced it. An interview was conducted with Nurse Aide (NA) #4 on 06/07/23 at 3:10 PM who confirmed that she often worked Resident #13's hall on first shift and the last time was on 06/06/23. The NA explained that she worked the hall one day the previous week and noticed that Resident #13 did not have a privacy curtain and reported it to the nurse on the hall at the time but could not remember which day it was, or which nurse she reported it to. She stated that she noticed yesterday that there still was no privacy curtain in the Resident's room. During an interview with the interim Director of Nursing on 06/07/23 at 5:10 PM she reported she was not aware that Resident #13 did not have a privacy curtain and it was essential for him to have a privacy curtain to provide full visual privacy especially since he was in a semi-private room.	F 583	meetings and continue audits at the discretion of the committee. Date of Completion: 6/27/23	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		6/27/23

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F 584	Continued From page 10 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure a sanitary and orderly interior when there were observations of lingering incontinence smells on 2 of 4 halls (halls 1 &2). The findings included: An initial walk through of the facility on 06/06/23 starting at 10:31 AM and ending at 11:01 AM revealed the 100 and the 200 hall with an overwhelming, stale odor of ammonia lingering in	F 584	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial	

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F 584	Continued From page 11 the main hallway. Call lights were being answered and a housekeeper was observed cleaning a resident room. A follow up observation of the 100 hall and the 200 hall completed on 06/06/23 from 1:47 PM through 1:55 PM revealed the overwhelming stale odor of ammonia remained. Additional observations of the 100 and 200 halls were completed on 06/07/23 from 9:15 AM through 9:20 AM. The observations revealed a continued overwhelming stale odor of ammonia emanating from both halls. An interview with Housekeeper #1 on 06/07/23 at 2:02 PM revealed she was assigned to the 100 hall that day and had been assigned to the 100 hall the day before. She reported initially that she smelled incontinence smells often on the 100 hall and that facility staff working on the hall had complained to her about the smell of incontinence on the hall. She reported she did have access and utilized an odor eliminator and felt when she used the odor eliminator, the smell did not return. Housekeeper #1 could not remember if she had used the odor eliminator on 06/06/23 or 06/07/23. A walk through of halls 100 and 200 with the Regional Vice President of Operations on 06/07/223 at 2:14 PM revealed the ammonia smell remained. The Regional Vice President of Operations reported since she had been diagnosed with COVID-19, she had not been able to smell scents. She reported she had been informed by several staff that the 100 and 200 halls had a lingering odor of incontinence at times. She reported she had reached out to the Regional Director of Environmental Services and	F 584	measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the Facility, or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 6/27/23. F584 There was not one specific resident identified. All residents that reside on 100/200 have potential to be affected. On 6/7/23- Maintenance Director and House Keeping Director completed audit on 100/200 halls to identify mattresses that needed replaced as potential odor source and any other identifiable odors. The House Keeping Director identified rooms in need of stripping and wax and completed by 6/24/23. On 06/09/2023, DON, Infection Preventionist and nursing unit coordinators initiated in-service education to nursing staff regarding potential sources of odors (clean linens, storage of dirty linen and trash carts, proper disinfectant). Education of nursing staff to continue upon returning to work, to be completed by 6/24/23. Education for	

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	345169	A. BUILDING _____ B. WING _____	C 06/26/2023

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F 584	Continued From page 12 requested he investigate the issue and come up with a plan to remedy the situation. She stated incontinence odors should not linger on halls. An interview with Housekeeper #2 on 06/07/23 at 2:46 PM revealed she had been at the facility for approximately 2 years. She also reported she was typically assigned to the 500 hall but was filling in on the 200 hall on 06/07/23. Housekeeper #2 stated she had not noticed an overwhelming odor of ammonia, but it could have been related to the 200 hall keeping a trash can in the hallway. She reported each housekeeping cart should have a spray bottle of odor eliminator on it and stated that the cart she utilized on the 200 hall did not have a spray bottle of odor eliminator. She indicated she had not used odor eliminator on 06/07/23. During an interview with the Environmental Services Director on 06/07/23 at 2:53 PM, he reported he had spoken with his regional director shortly before the interview and was informed that there needed to be a bed audit completed on the 100 and 200 halls to ensure the ammonia odor was not coming from the resident beds. He also reported he was instructed to make plans to strip and rewax the floor. He stated each housekeeping cart should have a spray bottle of odor eliminator which should be utilized to ensure that ammonia and other unpleasant smells do not linger. He reported ultimately, it fell to his staff to ensure that there were no unpleasant smells in the facility.	F 584	newly hired or contracted nursing staff will be provided by DON, ADON or charge nurse upon hire, prior to receiving assignment. On 6/8/23, Housekeeping Director and Regional Director of Environmental Services initiated in-service education to House Keeping staff regarding deep cleans, odor control and proper usage of odor eliminating sprays. Facility identified some mattresses on 100/200 hall that were replaced by 6/24/23. The House Keeping Director will have ongoing audits of rooms for odor control following deep clean schedule. House Keeping Director and Regional Director of Environmental will review the audits/deep clean/strip and wax monthly to identify patterns and trends and will adjust plan to maintain compliance. The Administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Date of completion: 6/27/23	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		6/27/23

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F 658	Continued From page 13 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Gastroenterology Medical Staff interviews the facility failed to prepare a resident for a medical procedure by administering medications when the resident was ordered to remain "nothing by mouth" for the procedure, which resulted in the medical procedure being canceled. This affected 1 of 3 residents reviewed for professional standards (Resident #6). The findings included: Resident #6 was admitted to the facility on 07/20/22 with diagnoses that included dysphagia, heart disease, and others. Review of a physician order dated 07/20/22 read, Plavix (antiplatelet) 75 milligrams (mg) by mouth every day for heart disease. Review of a physician order dated 01/24/23 read, Esophagogastroduodenoscopy (EGD) (a diagnostic procedure to visualize the esophagus and other structures) on 03/31/23, nothing by mouth (NPO) starting on 03/30/23 at 11:59 PM and end on 03/31/23 at 11:59 PM and hold Plavix for three days started on 03/28/23 for endoscopy procedure. The orders were entered by the Former Director of Nursing (DON) #2. Review of the quarterly Minimum Data Set (MDS) assessment dated 02/10/23 revealed that Resident #6 was cognitively intact and required	F 658	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the Facility, or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 6/27/23. F658 - Regarding the alleged deficient practice of failure to meet professional standards of quality as evidenced by: a. Failure to prepare Resident #6 for a medical procedure by administering medication when resident was ordered to	

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F 658	Continued From page 14 extensive to total assistance with activities of daily living. No anticoagulation medication were received during the assessment reference period. Review of the Medication Administration Record (MAR) dated 03/01/23 through 03/31/23 revealed Resident #6's Plavix was held on 03/28/23, 03/29/23, and 03/30/23. The MAR further revealed that Resident #6's Plavix was administered on 03/31/23 at 10:00 AM. On 03/31/23 the Plavix was administered by Medication Aide (MA) #1. Former DON #2 was interviewed via phone on 06/06/23 at 1:08 PM and again on 06/07/23 at 9:48 AM. She reported that in January 2023 Resident #6 had gone to the Gastroenterologist for a consult and they had scheduled a EGD procedure and had sent orders for Resident #6 to be NPO for the procedure and to hold her Plavix for three days prior to the procedure. She stated that she carried out those orders and entered them into the electronic health record. Former DON #2 stated that she was aware the procedure was scheduled for 03/31/23 so three days prior would have been 03/28/23, 03/29/23, and 03/30/23. She stated that in addition Resident #6 was to be NPO after midnight on the day of the procedure so none of her morning medications on 03/31/23 should have been given. She stated that she was aware that someone, but she could not recall who had given Resident #6 her morning medications on 03/31/23 and her EGD procedure had to be canceled because she had taken her medications that included Plavix that morning. The procedure was rescheduled but the family did not want to wait six weeks so they were going to find another doctor that could do the procedure sooner but before that could occur Resident #6	F 658	remain nothing by mouth for the procedure on 03/31/2023 On 03/31/2023, Resident #6, resident representative and resident responsible party were notified by licensed nurse of missed appointment due to medication being administered. On 03/31/2023, Resident Gastroenterologist provider notified by licensed nurse with procedure cancelled. All residents who are to remain with nothing by mouth (NPO) pending a procedure have the potential to be affected. Residents with NPO status in the past thirty days were audited on 06/09/2023 by the Director of Nursing (DON) or nursing unit coordinators to ensure no additional concerns noted. On 06/09/2023, DON initiated inservice education to nursing staff regarding proper implementation of NPO status. Education of nursing staff to continue upon return to work, to be completed by 06/24/2023. Education for newly hired or contracted nursing staff will be provided by DON or charge nurse upon hire, prior to receiving assignment. Effective 06/09/2023, residents with new NPO status orders are added to clinical meeting review and discussed with nurse management team 5 days per week. DON will audit all residents with NPO status 5 times per week for 4 weeks, then	

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F 658	Continued From page 15 was discharged from the facility. Medication Aide #1 was interviewed via phone on 06/06/23 at 1:49 PM and again on 06/07/23 at 3:01 PM. MA #1 stated if a resident's medications were on hold it would be indicated on the MAR and would not show up for administration. MA #1 did not recall anything specific about Resident #6's Plavix but stated if it was on the MAR to be administered then she would have signed it off and administered the medication as ordered. MA #1 stated that she was not aware that Resident #6 was NPO on 03/31/23, and if she was aware she would have asked the nurse if any of her medications could be given. She stated each resident that was scheduled for procedures had different stipulations, like some take a few medications with a sip of water and some take nothing, so she would have had to clarify the situation but again stated she had no idea that Resident #6 was NPO on 03/31/23 and administered her medications as she was directed by the MAR. MA #1 could not say how she would be aware if a resident was to be NPO. She stated "I have asked that question several times" but cannot seem to get a definitive answer. The Gastroenterology Medical Assistant was interviewed via phone on 06/06/23 at 4:45 PM and again on 06/07/23 at 1:15 PM. The Medical Assistant stated that Resident #6 had been seen in the office on 01/24/23 and given instructions regarding her EGD procedure scheduled for 03/31/23. She stated that Resident #6 was having difficulty swallowing and had the EGD procedure in the past. The plan was to do the procedure and see if there were any areas of concern and if so, they would take a biopsy, they would also be looking for indications that Resident #6's	F 658	will audit 3 residents with NPO status weekly for four weeks to ensure proper implementation. Administrator or DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Administrator or DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Completion Date: 06/27/23	

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F 658	Continued From page 16 esophagus needed to be dilated again or not. On the morning of 03/31/23 Resident #6 had informed the hospital staff that she had taken her Plavix that morning, and per the protocols of the office they immediately canceled her EGD procedure because if the doctor performing the procedure needed to biopsy any area there would be chance that Resident #6 could bleed uncontrollably so as a precaution, they canceled the procedure and rescheduled for a later date. The interim DON was interviewed on 06/07/23 at 4:19 PM who stated that she had only been at the facility for one week and was not at all familiar with Resident #6. After reviewing the documentation and situation the interim DON stated that Former DON #2 "could have scheduled the hold order better. I am sure that it ended too early." She added that she would expect the Plavix to be held until after the procedure and for Resident #6 to have been NPO as instructed so that her procedure could have been completed on 03/31/23 as scheduled.	F 658		
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 observations, record review and staff interviews the facility failed to provide incontinent care on dependent residents that would prevent residents from soaking through their briefs, turn sheets and fitted sheets for 2 of 4 residents (Resident #11 and #13) reviewed for activities of	F 677	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a	6/27/23

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F 677	Continued From page 17 daily living (ADL). The findings included: 1. Resident #11 was admitted to the facility on 06/03/23 with diagnoses that included chronic urinary retention (requiring an indwelling urinary catheter). The admission nursing assessment dated 06/03/23 indicated Resident #11 was alert and oriented. The assessment indicated the Resident had an indwelling urinary catheter and was continent of bowel. Resident #11's care plan was incomplete. An interview was conducted with Nurse Aide (NA) #5 on 06/07/23 at 7:50 AM who confirmed that she was assigned to care for Resident #11 that shift. NA #5 explained that she was not able to obtain shift report from the third shift staff because they were already gone when she came on duty that morning around 7:00 AM which was the normal routine. The NA stated she did not know when Resident #11 was last provided incontinent care. On 06/07/23 at 8:15 AM an observation was made of Nurse Aide (NA) #3 and NA #5 providing incontinent care to Resident #11. The Resident had a urinary catheter and wore a brief. Upon removal of the brief, Resident #11 had a bowel movement that was dried to his skin, and he was soaked with urine because his urinary catheter was kinked preventing gravity urine drainage into his drainage bag. The Resident's brief and turn sheet (which was a flat sheet folded three times) was soaked with urine. Resident #11's fitted sheet	F 677	deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the Facility, or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 6/27/23. F677 □ Regarding the alleged deficient practice of failure to provide necessary services to maintain good nutrition, grooming and personal hygiene as evidenced by: a. Residents #11 & Resident # 13 did not receive incontinent care that would prevent residents from soaking through their briefs, turn sheets and fitted sheets on 06/07/23. On 06/07/2023, Residents #11 & #13 were provided incontinent care. All residents who have incontinence and require assistance with toileting have the potential to be affected. Observations	

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F 677	Continued From page 18 had a large brown dried ring twice the circumference of the Resident's buttocks on which he laid. The Resident was gotten out of bed and his bed had to be stripped of all linen and remade. On 06/07/23 at 8:35 AM an interview was attempted with Resident #11. Resident #11 could not voice whether or not he realized he was wet and soiled but was able to nod "no" when asked if his lower abdomen was painful. An interview was conducted with Nurse Aide (NA) #3 on 06/07/23 at 2:45 PM who explained that she did not know when Resident #11 was last provided incontinent care because she did not make rounds with the third shift nurse aide because the nurse aide had already left the hall. The NA stated she heard the resident hollering, and when she went into see what was wrong, she found that his urinary catheter was leaking, and his brief was soiled with urine and feces. The NA continued to explain that Resident #11's turn sheet was wet with urine and his fitted sheet had a large brown dried ring and she had to change his whole bed. Multiple attempts were made to interview Nurse Aide #6 who worked 06/06/23 third shift but the attempts were unsuccessful. An interview conducted with Nurse #3 on 06/09/23 at 2:30 PM who confirmed that he was the Nurse on duty on third shift 06/06/23 but was not made aware of anything wrong with Resident #11's urinary catheter. The Nurse stated the staff made rounds about every two to three hours on third shift and rendered care as needed. He continued to explain that Nurse Aide #6 should	F 677	were conducted by the Director of Nursing (DON) and Nurse Unit Coordinators on 06/08/2023 of all residents who require assistance with the toileting and incontinence care to identify any additional concerns related to provision of incontinence care, with no additional concerns noted. On 06/09/2023, DON initiated inservice education to nursing staff regarding proper provision of incontinence care to dependent residents. Education of nursing staff to continue upon to return to work, to be completed by 06/24/2023. Education for newly hired or contracted nursing staff will be provided by DON or charge nurse upon hire, prior to receiving assignment. DON or nurse managers will conduct random observations of residents who are incontinent and require staff assistance per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks to ensure incontinent care is being provided per protocol (timely and without use of double incontinent products). DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Completion Date: 06/27/23	

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F 677	Continued From page 19	F 677		

have notified him about Resident #11's catheter being kinked.

An interview was conducted with the interim Director of Nursing (DON) on 06/07/23 at 5:10 PM who explained that the staff should be making incontinent rounds every 2-3 hours and if anything was abnormal during the round that it should be reported to the nurse on duty.

2. a. Resident #13 was admitted to the facility on 05/17/22 with diagnoses that included cerebral vascular accident and dementia.

A review of Resident #13's physician orders revealed he was not on a diuretic.

The quarterly Minimum Data Set (MDS) assessment dated 03/31/23 revealed Resident #13 had severe cognitive impairment. The Resident required extensive assistance of one staff for bed mobility and toileting. Resident #13 was frequently incontinent of bladder and always incontinent of bowel.

On 06/07/23 at 7:50 AM an observation was made of Nurse Aide (NA) #5 who went in to provide incontinent care to Resident #13 and upon entering the room a strong urine odor was immediately noted. The Resident was noted to be wearing two briefs which were both soaked with urine and the turn sheet which was made from a flat sheet folded three times and the fitted sheet that were both soaked with urine as well. The briefs were so full of urine that they made a loud thud sound when the NA tossed the briefs into the trash can.

An interview with Nurse Aide #5 on 06/07/23 at

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F 677	Continued From page 20 7:50 AM who explained that she did not know how long it had been since Resident #13 had been checked and changed because the third shift staff had already left the hall before she came on shift around 7:00 AM. The NA explained that Resident #13 was a heavy wetter and needed to be checked and changed often. Multiple phone attempts were made to interview Nurse Aide #6 who worked on 06/06/23 third shift but the attempts were unsuccessful. An interview was conducted with the interim Director of Nursing (DON) on 06/07/23 at 5:10 PM. The DON explained the nurse aides should be making rounds every two hours and providing incontinent care when needed which would prevent having to change the bed linen. The DON stated the staff should not be double briefing the residents even if they were heavily incontinent because it gave the staff an excuse not to check and change them.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		6/27/23

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F 690	Continued From page 21 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to secure a resident's urinary catheter tubing in a manner to allow urine flow into the catheter drainage bag for 1 of 1 resident (Resident #11) reviewed for urinary catheter. The finding included: Resident #11 was admitted to the facility on 06/03/23 with diagnoses that included chronic urinary retention. Review of Resident #11's physician orders dated 06/03/23 revealed 1) Suprapubic urinary catheter to gravity drainage due to chronic urinary	F 690	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged	

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F 690	Continued From page 22 retention and 2) change urinary catheter bag monthly. The nursing admission assessment dated 06/03/23 revealed Resident #11 was alert and oriented to person, place and time and had a suprapubic urinary catheter in place on admission. On 06/07/23 at 8:15 AM an interview and observation of Resident #11 was made during morning catheter care given by Nurse Aide (NA) #3. The Resident's urinary catheter tubing was noted to be twisted backwards in a V shape and secured in the stabilizing device (a device that secures the catheter tubing to prevent trauma from tension on the tubing) which impeded the flow of urine through the tubing to the catheter bag. The Resident's brief and draw sheet were wet. No urine was in the catheter tubing and approximately 150 milliliters (ml) of urine was noted in the catheter bag. Resident #11 denied having pain in his bladder region. Nurse #1 was summoned to the room by NA #3 and replaced the stabilizing device and positioned the catheter tubing correctly in the device. Immediately, medium yellow colored urine started to drain from the Resident's bladder. An interview was conducted with Nurse Aide (NA) #4 on 06/07/23 at 3:10 PM. NA #4 worked with Resident #11 on 06/06/23 on first and second shift. The NA explained that on 06/06/23 the Resident had a large bowel movement, and his bed was wet at the same time, so she reported it to the nurse on duty who said the wetness was from the bowel movement. She stated she did not notice the catheter tubing was kinked in the stabilizing device. NA #4 reported that she	F 690	noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the Facility, or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 6/27/23. F690 □ Regarding the alleged deficient practice of failure to provide treatment and services to prevent urinary tract infection as evidenced by: a. Facility failed to secure a resident #13□s urinary catheter tubing in a manner to allow urine flow into the catheter drainage bag. On 06/07/2023, Residents #13□s catheter tubing was repositioned to allow urine to flow into the catheter bag by assigned licensed nurse. All residents who have urinary catheters have the potential to be affected. Audits were conducted by the Director of Nursing (DON), Infection Preventionist and Nurse Unit Coordinators on 06/08/2023 of all residents who require assistance with the toileting and incontinence care to identify any additional concerns related to provision of incontinence care, with no additional concerns noted. On 06/09/2023, DON, Infection Preventionist and nursing unit coordinators initiated inservice education	

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F 690	Continued From page 23 emptied about 400 ml of urine from Resident #11's catheter bag for both shifts on 06/06/23. At 4:15 PM on 06/07/23 during an interview with Nurse #1 she explained that she worked with Resident #11 on 06/06/23 on first shift. The Nurse explained that it was normal procedure for the nurses to check for stabilizing devices to be in place on residents who had urinary catheters. She stated that when she assessed Resident #11 yesterday (06/06/23) morning the catheter tubing was positioned correctly in the stabilizing device. During an interview with Nurse #2 on 06/07/23 at 4:30 PM the Nurse confirmed that she worked on 06/06/23 on second shift. The Nurse explained that she was made aware that Resident #11 was having bowel movements but was not told his bed was wet from urine. She stated she was so busy that she did not have time to ensure the Resident had a stabilizing device in place or if it was positioned correctly. On 06/09/23 at 2:30 PM during an interview with Nurse #3 the Nurse confirmed that he worked on third shift on 06/06/23. The Nurse explained that his normal routine was to observe the catheter tubing and bag to ensure the bag was below the residents' bladder and the tubing was not kinked to ensure flow of urine into the catheter bag. The Nurse stated when he looked at Resident #11's catheter tubing and catheter bag, he did not notice a problem that would indicate a drainage problem. The Nurse stated he could not recall if there was urine in the catheter tubing when he assessed the Resident's catheter. Attempts were made to interview via phone call Nurse Aide #6 who worked 06/06/23 third shift but	F 690	to nursing staff regarding proper securement of urinary catheters. Education of nursing staff to continue upon to return to work, to be completed by 06/24/2023. Education for newly hired or contracted nursing staff will be provided by DON or charge nurse upon hire, prior to receiving assignment. Effective 06/09/2023, urinary catheter audit and observation is added to weekly compliance rounds to be completed by the Infection Preventionist. DON or Infection Preventionist will conduct random observations of residents with urinary catheters per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks to ensure proper positioning to allow urine flow into the catheter bag. DON or Nursing Home Administrator (NHA) will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or NHA will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Completion Date: 06/27/23	

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F 690	Continued From page 24 the attempts were unsuccessful. An interview was conducted with the Interim Director of Nursing on 06/07/23 at 5:10 PM who explained that the urinary catheter tubing should be monitored every shift by the nurses to ensure the tubing was positioned correctly in the stabilizing device in order to prevent trauma and that there were no kinks or twists in the catheter tubing that would prevent urine flow to the catheter bag.	F 690		
F 697 SS=J	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff, family, Hospice Nurse, Hospice Medical Director, and Nurse Practitioner (NP) interviews, the facility failed to manage the pain of 1 of 1 resident (Resident #1) who complained of pain and exhibited non-verbal cues of pain that included moaning, groaning, and grimacing as staff moved or touched her after returning to the facility from Emergency Department (ED) following a fall that resulted in a cervical one (C-1 - upper vertebrae in the neck) fracture in her neck and left humerus (upper arm) fracture on 3/31/23. There was no pain treatment from the time Resident #1 returned from the ED until she was transferred to an inpatient hospice facility approximately 28 hours later.	F 697	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged	6/27/23

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F 697	Continued From page 25 Immediate Jeopardy began on 03/31/23 when Resident #1 complained of pain and exhibited nonverbal signs of pain and no pain management was offered or administered. Immediate Jeopardy was removed on 06/09/23 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D (no actual harm with more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of staff education. The findings included: Resident #1 was admitted to the facility from a hospital on 11/29/21 with diagnoses that included rheumatoid polyneuropathy (disease affecting multiple nerves of the body causing pain) with rheumatoid arthritis of multiple sites and chronic pain. Review of Resident #1's most current care plan dated 11/29/21 read, resident was at risk for uncontrolled pain because of the physical effects of aging, and history of chronic pain. Resident had diagnoses of rheumatoid arthritis, cervical spondylosis (deterioration of the spinal vertebrae), and acute pain related to fall with fracture to left lower leg. The goal read: The resident's pain would be managed to the greatest extent possible, so it did not affect day-to-day activities. Interventions included: evaluate the effectiveness of pain interventions every shift and as needed, to be gentle with care as movements could be very painful, give pain medications as needed within doctor's order guidelines, offer/provide non-medication interventions such as heat or cold, exercise, rest, guided imagery, repositioning. An additional intervention dated	F 697	noncompliance, the Facility submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or other action against the Facility, or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 6/27/23. F697 □ Regarding the alleged deficient practice of failure to ensure that pain management is provided to residents who require such as evidenced by: a. Facility failed to manage pain for Resident #1 on 03/31/2023. Resident #1 was discharged from facility on 04/01/2023. All residents who have pain have the potential to be affected. Pain assessments were conducted by the Director of Nursing (DON) and Nurse Unit Coordinators on 06/08/2023 of all residents to ensure all residents with pain had received intervention. On 06/09/2023, DON Nursing Unit Coordinators initiated inservice education to licensed nurses, medication aides and certified nursing assistants regarding pain management, assessment and interventions. Education of nursing staff to continue upon to return to work, to be completed by 06/24/2023. Education for newly hired or contracted nursing staff will be provided by DON, ADON or charge nurse upon hire, prior to receiving	

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F 697	Continued From page 26 12/07/21 was added: monitor for non-verbal expression of pain such as agitation, facial expression such as wincing, holding a body part, change in posture, refusing to eat, decreased level of activity, increased heart rate/rate of breathing, dilated pupils, sweating, anxiety, restlessness, difficulty sleeping, irritability or depression). Note vocalization such as moaning, crying, or screaming. Review of Resident #1's quarterly Minimum Data Set (MDS), dated 01/14/23 revealed Resident #1 was severely cognitively impaired, was not on a schedule pain medication regime, had not received any opioid's during the seven day look back period, and received Hospice services. Review of the physician orders revealed: 01/14/22 -Tylenol Tablet 325 milligram (mg) Give two 325 mg tablets by mouth every 6 hours as needed for fever/pain. 07/26/22 - Oxycodone HCL Tablet, give one 20 mg tablet by mouth every 6 hours as needed for pain. 12/22/22 - Hospice to provide care and services as appropriate. Resident #1's admission diagnosis was polyneuropathy of rheumatoid arthritis of multiple sites with a life expectancy of 6 months or less. Review of the March 2023 Medication Administration Record (MAR) from 03/01/23 through 03/30/23 revealed zero (no pain) was documented as Resident #1's pain level every shift. The MAR further revealed no pain medications were administered to Resident #1 during this time period. A nursing progress note written by Nurse #4	F 697	assignment. On 06/08/2023, visual reminders with pain assessment principles and non-pharmacological measures were placed by DON at each medication cart and throughout the facility for nursing staff. DON or nursing unit coordinators will review ten residents per week for four weeks to ensure pain is appropriately addressed, and then will review five residents per week for four weeks. DON or Nursing Home Administrator (NHA) will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or NHA will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. Completion Date: 06/27/23	

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dated 03/31/23 at 1:12 PM indicated the resident was observed sitting on floor and Nurse #4 and a Nurse Aide (NA) assisted Resident #1 into the bed. Resident #1 was assessed, and vital signs were taken. The Nurse Practitioner (NP) came to observe Resident #1 and gave an order to send Resident #1 to Emergency Department (ED). Resident #1 was given her ordered PRN (as needed) pain medication and Emergency Medical Services (EMS) was called.

Multiple attempts were made to contact Nurse #4 with no success.

The March MAR on 03/31/23 indicated a score of ten (worst possible pain) on 03/31/23 immediately after she fell from her wheelchair and Resident #1 received a 20-milligram tablet of Oxycodone at 1:09PM which was administered by Medication Aide (MA) #2.

In an interview on 06/07/23 at 11:41 AM with MA #2, she revealed she came into Resident #1's room on 03/31/23 when she heard a commotion and saw staff helping Resident #1 back to bed after she fell out of her wheelchair in her room. She stated she medicated Resident #1 with an Oxycodone 20mg tablet at 1:09 PM for pain just before Resident #1 went to the hospital.

An ED physician progress note dated 03/31/23, revealed a computerized tomography scan (CT scan - technique used to obtain detailed internal images of the body) of the cervical spine revealed a cervical one (C-1 - upper vertebrae in the neck) fracture in her neck and an x-ray of the left shoulder/arm confirmed a left humerus (upper arm) fracture. The ED physician documented Resident #1 was medicated with 15 mg of

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Ketorolac Tromethamine (non-steroidal anti-inflammatory pain medication) for pain on 03/31/23 at 2:31PM. Additionally, he documented that Resident #1 already had pain medication ordered for her at the facility, so no additional pain medication orders were written.

A nursing progress note written by Nurse #2 on 03/31/23 at 6:00 PM, read, resident was assisted into the bed by two EMS staff. Resident has a splint on her left arm. Elbow placed on pillow for comfort. Resident is arousable but sleepy.

During an interview on 06/06/23 at 1:10 PM with Nurse #2, she stated she cared for Resident #1 after EMS brought her back to the facility on 03/31/23 from the ED. Nurse #2 stated Resident #1 was calm and sleepy and was put directly in bed upon re-admission. Nurse #2 stated Resident #1 was confused but did not require any extra care more the normal level of care that shift. Nurse #2 stated she gave Resident #1 her regular medications but did not give any pain medications because she did not feel Resident #1 was in any pain as she did not ask for pain medicine.

In an interview on 06/07/23 at 3:24 PM with Nurse Aide (NA) #8, she stated she was not assigned to Resident #1 on 03/31/23 but assisted with Resident #1's transfer from the EMS stretcher back to bed when she returned from the ED on 03/31/23 at approximately 5:45 PM. She stated she could tell Resident #1 was in pain because she was moaning, groaning, her face was curled up, and she grimaced as they moved her. She stated she informed the nurse of Resident #1's pain but unsure if Resident #1 received any pain medication. She stated she could not recall who

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the nurse was to whom she reported the pain concerns.

The MAR for 03/31/23 for the night shift revealed Nurse #3 documented a pain level of 10 and no pain medication was administered.

In a phone interview with Nurse #3 on 06/07/23 at 10:10 AM, he stated he cared for Resident #1 on the night shift that began on 03/31/23 and ended on 04/01/23 when Resident #1 returned from the ED. He stated she was confused and not communicative or verbal, had an uneventful shift and was in bed all night. He stated she could not vocalize her needs, but he looked for non-verbal cues of pain such as clenching her teeth or grimacing and did not recall any. He stated he did not recall that he documented Resident #1 had a pain level of 10 on the 03/31/23 night shift pain scale. He stated her pain level might have been a 1-2, but not a 10. He stated he had never scored anyone's pain as a 10. Nurse #3 stated if Resident #1's pain had been a 10, he would have medicated her for pain and called the physician. He stated he would not let a resident be in that kind of pain. He stated he did not administer any pain medication to Resident #1. Nurse #3 indicated he was unable to recall which NA worked with him and/or cared for Resident #1.

The April 2023 MAR revealed only one pain level was recorded by Nurse #6. On 04/01/23 during the day shift, Resident #1's pain score was recorded as zero. The MAR further revealed Resident #1 had not been administered pain medication at the facility.

In an interview on 06/07/23 at 11:07 AM with Nurse Aide #7 he stated he cared for Resident #1

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on 04/01/23, the day shift after her fall. He stated Resident #1 had arm pain that afternoon and she asked for pain medicine. He stated she was often confused but that day she could tell him that she was in pain. He stated Resident #1 showed signs of pain such as she grimaced when she moved and wouldn't eat since the fall. He stated he reported Resident #1's pain and request for pain medicine to the MA working the 100 hallways, but he could not recall the MA's name or if she ever medicated Resident #1. He stated she stayed in bed all day on his shift.

In a phone interview 06/08/23 at 2:30 PM with Nurse #6, she stated she worked the day shift on 04/01/23 on the 100 hallway. She stated she was supposed to still be in her training period but had to work a cart until 3:00 PM because a MA did not show up for work. She stated she did not receive any report and did not know anything about Resident #1. She stated she recalled when she first saw Resident #1 on 04/01/23 she was covered in bruises. She stated no one could tell her what happened to Resident #1, and she did not know how to navigate the electronic medical record well enough to look at her history. She explained that she had received "very little" training on the electronic medical record system prior to working on the floor on 04/01/21. She did not recall that Resident #1 was in any pain, so she didn't offer pain medications. She stated when she gave Resident #1 her other scheduled medications, she spit them out. She stated at 3:00 PM, a MA came to take over the cart, but she did not know the name of the MA. She stated Resident #1's Family Member #2 came to see her in the afternoon and asked her what exactly had happened, and she had to tell the family member she did not know. Nurse #6

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stated the family member did not tell her Resident #1 was in pain.

An interview was conducted on 06/06/23 at 10:10 AM with Family Member #1. The Family Member #1 stated Resident #1 fell out of her wheelchair in her room and was sent to the ED and she was diagnosed with a fractured left arm and a neck fracture. Family Member #1 stated Resident #1 was always in a lot of pain from her rheumatoid arthritis and other medical issues. Family Member #1 stated they knew the facility could only give a certain amount of pain medication, and Hospice could give more pain medication and had heard Hospice was much better at pain control, so the family placed her in Hospice care. Family Member #1 stated the day after Resident #1 fell (04/01/23), Family Member #2 was with her during the day and called him and stated Resident #1 had been sitting up all day in her wheelchair and was in "excruciating" pain and did not get any pain medicine all day. Family Member #1 stated after he heard from Family Member #2, he immediately called the Hospice Nurse and asked her to come relieve Resident #1's pain because he knew she could do more for her than the facility staff, and he wanted Hospice to take her out of the facility and transfer her to an inpatient hospice facility.

In a phone interview on 06/06/23 at 1:50 PM with the Hospice Nurse who was on-call the weekend of the fall (03/31/23), she stated she received a voicemail from the facility on Friday night, 03/31/23, and was told that Resident #1 had fallen but they did not mention that they had sent her to the hospital. She explained that she was the on-call nurse for hospice and was not familiar with Resident #1. The Hospice Nurse stated she

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tried to call the facility several times on Friday night (03/31/23), but the phone was never answered. She stated she called the facility on Saturday, 04/01/23 around noon, and was told that Resident #1 was fine so she assumed the resident was not sent to the hospital. She stated Resident #1's Family Member #1 called her on 04/01/23 at 6:28 PM and told her Resident #1 had fallen the day before and was sent out to the hospital and sustained fractures in her neck and left arm. The Hospice Nurse stated Family Member #1 told her Resident #1 was in "excruciating pain" and had been up in a wheelchair all day. The Hospice Nurse stated Family Member #1 asked the Hospice Nurse for help with Resident #1's pain and told her the family wanted their mother transferred to an inpatient facility for Hospice services. The Hospice Nurse stated she called the Hospice Medical Director who was on-call for the weekend and received new pain medication orders for liquid morphine (pain medicine) and Ativan (anti-anxiety medication). She stated she again tried to call the facility and former Director of Nursing (DON) #1 (DON at the time of the incident on 03/31/23 - 04/01/23) regarding the new pain medication orders without success. The Hospice Nurse arrived at the facility on 04/01/23 at 8:10 PM and was directed by staff to several incorrect hallways but finally located Resident #1 on the 100 hallway. She stated Resident #1 was confused and grimaced when she moved and was guarded and did not want the Hospice Nurse to touch her left arm. The Hospice Nurse stated Resident #1 was grinding her teeth while trying to breathe and her respirations were 28-30 a minute. The Hospice Nurse stated she spoke with a facility nurse whose name she could not remember and told

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the facility nurse she had new pain medication orders for Resident #1. The facility nurse stated she did not know if they had any liquid morphine or Ativan in the facility. The facility nurse stated former DON #2 was coming in at 11:00 PM (the nursing supervisor at the time of the incident on 03/312/23 - 04/01/23) and she would know if they had the medications. The facility nurse stated she didn't want to call former DON #2 because she was working that night and she didn't want to wake her up.

In a second phone interview with the Hospice Nurse on 06/06/23 at 3:46 PM, she stated when she spoke with the MA on the 100 hallway, the MA stated she did not know Resident #1 and she had not gotten to her room yet to see her. The Hospice Nurse then tried to find someone in charge to help her with getting the new pain medication orders faxed to the pharmacy. The Hospice Nurse stated she ended up on the 500 hallway and a nurse whose name she did not recall, and she was also unsure about what medications were on hand in the facility. An unknown facility nurse finally called former DON #2 who told the Hospice Nurse she would be there at 11:00 PM and she would then check on what medications they had on hand. The Hospice Nurse stated she asked the former DON #2 if they transferred out Resident #1 for immediate pain management, would Resident #1 still have a bed available when she was ready to return to the facility. The Hospice Nurse indicated former DON #2 stated she thought the bed would be held for 30 days. The Hospice Nurse stated originally they planned to move Resident #1 the next day on 04/02/23, but once it was clear Resident #1 would have to wait until at least 11:00 PM for pain medication, and because the level of Resident

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#1's pain, she called her Hospice Medical Director and the Hospice Administrator and they all felt it was unsafe to leave Resident #1 in the facility until the next day and decided to immediately transfer Resident #1 to an inpatient hospice facility for pain management. Resident #1 was transferred to an inpatient hospice facility by EMS on 04/01/23 at 10:15 PM.

In a phone interview with MA #3 on 06/08/23 at 3:22 PM, he stated he worked on 04/01/23 the day after Resident #1 fell. He stated he took over a medication cart at 3:00 PM from Nurse #6, but soon was pulled to another hall and could not remember who took over for him or where he was pulled to work. He stated he never saw Resident #1 that shift and denied that he spoke to a Hospice Nurse regarding Resident #1. He confirmed that anyone assigned to a cart, nurse, or MA, had keys to the narcotic box and could obtain and administer narcotics. He further stated liquid morphine was kept in narcotic cart.

In an interview on 06/08/23 at 5:19 PM with NA #9, she stated she worked the 100 hallway for the 3:00 PM-11:00 PM shift on 04/01/23 and stated she recalled Resident #1 and did care for her on that shift. She stated she was the only NA on the 100 hallway that shift. She stated Resident #1 was calm and hard to wake up, but she would open eyes and mumbled. She stated she informed a nurse that Resident #1 was not communicating or showed any kind of reaction to anything. NA #9 could not recall which nurse she spoke with about Resident #1. She stated later in her shift a nurse, or a doctor came to check on Resident #1 and then someone called EMS and an ambulance came and took Resident #1 away. She stated she did not know who called EMS or

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where Resident #1 was going.

In a phone interview with former DON #2 on 06/09/23 at 2:20 PM, she stated that nobody ever called her about liquid morphine or Ativan or any other pain medication on 04/01/23, for Resident #1. She stated if they had called her, she only lived three minutes away from the facility and would have immediately gone to the facility and assisted with Resident #1's pain management issues.
In a phone interview on 06/09/23 at 3:18 PM with Nurse #5, she stated she was not assigned to Resident #1, but did go see her sometime on 04/01/23 on the 3-11 PM shift because she just wanted to see her. She stated Resident #1 was able to tell her she was in pain, and she was grimacing when she tried to move and was making facial grimaces. She stated she didn't tell anyone because she knew Resident #1 was already on daily pain medication. She stated she recalled that a Hospice Nurse came and asked for help with gathering the paperwork for Resident #1's transfer to an inpatient hospice facility. Nurse #5 denied that she had any discussion with the Hospice Nurse about pain medication for Resident #1.

In an interview with the Unit Manager on 06/06/23 at 10:26 AM, she stated the facility had a safe for narcotics for emergencies and they had liquid morphine and Ativan. She stated all the nurses and MAs had the code and access to the safe.

In an interview on 06/07/23 at 12:00 PM with the Nurse Practitioner (NP), she stated Resident #1 was usually in a confused state. She saw the resident after the fall on 03/31/23 and sent her to the ED for evaluation. She stated Resident #1

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had severe rheumatoid arthritis, but she hadn't heard any complaints of pain lately. She stated when she was alert and oriented, she was very vocal about getting her pain medication, but as she declined, she had stopped asking for pain medication. The NP stated she didn't see Resident #1 after she went to the hospital.

A phone interview was conducted on 06/07/23 at 5:15 PM with the Hospice Medical Director and she stated she was contacted by the Hospice Nurse on 04/01/23 to discuss Resident #1's lack of pain management after a fall where she sustained serious injuries. The Hospice Medical Director stated she gave the Hospice Nurse new pain medication orders, but the Hospice Nurse ran into many barriers in the facility as she tried to get Resident #1 adequately medicated for pain. She stated the Hospice Nurse, the Hospice Administrator and herself made the decision to have Resident #1 transferred to an inpatient hospice facility that evening for pain management. She stated that Hospice inpatient called her when Resident #1 arrived and told her Resident #1 was in intense pain, yelling and moaning in pain when touched or with any gentle movement, and had bruises on her hands, face, and legs. She stated once they stabilized her neck, medicated her for pain, she was calm and comfortable. The Hospice Medical Director stated they gave her pain medications around the clock to keep her comfortable. The Hospice Medical Director stated it was never their first choice to put a resident through the pain and stress of a transfer out of their home, but in this case, Resident #1 was not receiving appropriate pain management so for her well-being an intervention was required. She stated it would have been much easier on Resident #1 if she

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could have stayed in the facility and had her pain managed appropriately. She stated the staff were clearly not reading or responding to Resident #1's non-verbal pain cues. The Medical Director stated Resident #1 died on 04/03/23.

In an interview with the Interim DON, on 06/07/23 at 4:30 PM, she stated Resident #1's pain should have been handled better. She stated the staff should have completed more pain assessments and looked more carefully for non-verbal pain cues such as guarding, moaning, grinding teeth, and have medicated Resident #1 and called the provider.

On 06/22/23 at 1:52 PM, the Interim Director of Nursing and the Regional Vice President of Operations were notified via phone of immediate jeopardy.

The facility provided the IJ removal plan:

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

Based on record review and staff interviews, the facility failed to manage the pain of Resident #1. Resident #1 had complained of pain and exhibited non-verbal cues of pain which included moaning, groaning, and grimacing. Resident #1 had returned from the Emergency Department on 3/31/23 at 5:45 PM following a fall with serious injuries. Resident had an order for PRN (as necessary) pain medication upon readmission. Resident received routine medication of Ativan at 10:00 PM and had no documentation of pain after the 10:00 PM medication administration. Resident #1 received no PRN pain medication after her

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return from the Emergency Department, although medication was available if needed. Resident #1 expressed pain at the facility to a non-facility staff person (Hospice Nurse) which precipitated transfer to an inpatient hospice for pain management.
Current facility residents are at risk of being affected by the alleged deficient practice of not managing pain despite non-verbal cues observed by staff. The Director of Nursing and nurse supervisors completed an audit of facility residents on 6/8/23 to include a pain assessment to ensure no other residents were affected by the deficient practice. There were no adverse effects or other residents identified.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

The Director of Nursing and Nurse supervisors completed education to nurses, medication aides, and nursing assistants on 6/8/23, regarding non-verbal cues of pain. Nurses, medication aides and nursing assistants not working on 6/8/23 received education prior to starting shift, including Agency staff. New nursing staff will receive education regarding non-verbal cues of pain and medication for pain management by the Director of Nursing or nurse supervisors. The Director of Nursing or nursing supervisor will be responsible for ensuring that this education is provided prior to the start of any assignment in which they are working.
On 6/8/23 licensed nursing staff were educated by the Director of Nursing and nurse supervisors to ensure appropriate documentation was completed on residents with pain. Nurses and

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F 697	Continued From page 39 medication aides not working on 6/8/23 received education prior to starting shift, including agency staff for substantial compliance. The facility alleges the removal of the immediate jeopardy on 6/9/23. Validation of the immediate jeopardy removal plan was conducted in the facility on 06/26/23. The facility's initial audit was verified and signature sheet for education reviewed with no concerns. Facility nurses were interviewed and were aware of the pain management protocol, how and when to assess pain and how to appropriately respond to a resident's request or nonverbal signs of pain. Facility Medication Aides were also aware of the pain protocol and how to observe for nonverbal signs of pain and how to respond. Facility Nurse Aides were also interviewed and were able to verbalize how to respond to resident complaint of pain and recognize nonverbal signs of pain and who to report them to. The facility's immediate jeopardy removal date of 06/09/23 was validated.	F 697		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and	F 867		6/27/23

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resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

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

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

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to

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determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

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

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

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data

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F 867	Continued From page 42 collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 10/03/22. This failure was for 01 deficiency that was originally cited in the area of Quality of Life (F677) that was subsequently recited on the current complaint investigation survey of 06/26/23. The repeat deficiency during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to:	F 867	This Plan of Correction is submitted as required under State and Federal law. This Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Facility's policies and procedures should be considered to be subsequent remedial measures and should be inadmissible in any proceeding on that basis. Without admitting or denying the validity or the existence of the alleged noncompliance, the Facility submits this Plan of Correction with the intention that it	

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F 867	Continued From page 43 F677: Based on observations, record reviews and interviews the facility failed to provide incontinent care on dependent residents that would prevent residents from soaking through their briefs, turn sheets and fitted sheets for 2 of 4 residents (Resident #11 and #13) reviewed for activities of daily living (ADL). During the recertification and complaint investigation of 10/03/22 the facility failed to provide dependent residents with their preferred method of bathing and number of showers per week for 2 of 3 residents reviewed for Activities of Daily Living (ADL). The Administrator was interviewed via phone on 06/07/23 at 5:42 PM. The Administrator stated that QA committee met monthly and explained she had only been at the facility for one month and had the opportunity to meet with QA committee one time. She stated that they had made big changes in the last month, and she was sure they were moving the in the right direction. The Administrator stated that they had lots of performance improvement plans in place and were working on them all simultaneously and she believed that would help them achieve and maintain compliance long term.	F 867	be inadmissible by any third party in any civil or other action against the Facility, or any employee, agent, officer, director or shareholder of the Facility. The Facility is utilizing this Plan of Correction as its allegation of substantial compliance as of 6/27/23. F 867 Regarding the alleged deficient practice of failure to provide necessary services to maintain good nutrition, grooming and personal hygiene as evidenced by: A.Residents #11 & Resident # 13 did not receive incontinent care that would prevent residents from soaking through their briefs, turn sheets and fitted sheets on 06/07/23. On 06/07/2023, Residents #11 & #13 were provided incontinent care. All residents who have incontinence and require assistance with toileting have the potential to be affected. Observations were conducted by the Director of Nursing (DON) and Nurse Unit Coordinators on 06/08/2023 of all residents who require assistance with the toileting and incontinence care to identify any additional concerns related to provision of incontinence care, with no additional concerns noted. On 06/08/2023, DON & Assistant Director of Nursing (ADON) initiated in-service	

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F 867	Continued From page 44	F 867	education to nursing staff regarding proper provision of incontinence care to dependent residents. Education of nursing staff to continue upon return to work, to be completed by 06/24/2023. Education for newly hired or contracted nursing staff will be provided by DON, ADON or charge nurse upon hire, prior to receiving assignment. The Regional Director of Operations provided in service education for the Management team consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set coordinators, Social Worker, Activities Director and Unit Coordinators regarding QAPI, how to identify, plan and implement a quality plan for improvement and ongoing monitoring to assure compliance on 6/9/23 with follow up on 6/23/23. DON or ADON will conduct random observations of residents who are incontinent and require staff assistance per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks to ensure incontinent care is being provided per protocol (timely and without use of double incontinent products). The DON will review audits for patterns/trends and will adjust plan to maintain compliance and will review plan during the monthly QAPI meeting for 6 months or until compliance is maintained. Completion Date: 6/27/23	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT GASTONIA	969 COX ROAD GASTONIA, NC 28054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE