STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345201	A. BUILDING: _____ B. WING _____	8/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN HEALTH AT CHARLOTTE	**2616 EAST 5TH STREET CHARLOTTE, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 567	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews the facility failed to provide resident's access to their personal funds accounts for 1 of 1 resident (Resident #30) reviewed for management of personal funds. The findings included: Resident #30 was admitted to the facility 06/09/21. Review of #30's quarterly Minimum Data Set (MDS) revealed Resident #30 was cognitively intact. An observation of the Business Office door on 08/20/21 at 11:00 AM revealed banking hours were Monday through Friday 10:00 AM to 3:00 PM and Saturday through Sunday from 10:00 AM to 1:00 PM. An interview conducted with Resident #30 on 08/20/23 at 11:30 AM revealed she was unable to retrieve money after hours and on the weekends. The resident indicated this had been an issue for several months. Resident #30 indicated staff would tell her that they did not have any money and she would have to wait. An interview conducted with the Business Office Manager on 08/22/23 at 9:20 AM revealed the facility had gone through different business managers and had issues establishing a system to allow residents to access their personal funds. The Business Office Manager indicated there had been days the facility did not have cash accessible and did not have staff available on weekends to assist residents to access their personal funds.

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 567	Continued From Page 1 It was revealed the facility cashed a check at the beginning of the month to use for disbursements to resdients. Once the cash was gone it was not refilled until the next month. An interview conducted with the Director of Nursing (DON) on 08/24/23 at 11:00 AM revealed there was not always a nurse supervisor on duty on the weekends to handle personal funds and they had not educated or assigned any staff to handle personal funds on the weekends. The DON further revealed she expected residents to always have access to their funds. An interview conducted with the Administrator on 08/24/23 at 12:20 PM revealed he was not aware residents had not had access to personal funds on the weekends and weekdays. The Administrator further revealed he had expected all residents to always have access.

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	345201	A. BUILDING _____ B. WING _____	C 08/29/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/20/2023 through 8/29/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 3GUN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 8/20/2023 through 8/29/2023. Event ID# 3GUN11. The following intakes were investigated NC00194690, NC00194854, NC00194890, NC00195459, NC00195842, NC00195852, NC00196132, NC00197787, NC00197827, NC00198902, NC00199019, NC00200538, NC00200543, NC00200566, NC00200715, NC00201073, NC00202050, NC00203320, NC00203614, NC00204887, NC00205474, NC00205994 and NC00206568. 31 of the 69 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.35 at tag F726 at a scope and severity (K) CFR 483.80 at tag F880 at a scope and severity (K) Immediate Jeopardy began on 08/20/23 and was removed on 08/23/23. An 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	F 550		9/26/23

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

Electronically Signed | 09/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550	Continued From page 1	F 550		

access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the 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 record review, and staff and resident

In accordance with the requirements set

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F 550	Continued From page 2 interviews the facility failed to maintain the dignity of a resident when a Nurse Aide yelled out to another staff member in the hallway that Resident #46 needed a full linen change for 1 of 7 residents reviewed for dignity (Resident #46). The findings included: Resident #46 was admitted to the facility on 3/22/21. A quarterly Minimum Data Set dated 7/2/23 revealed Resident #46 was cognitively intact. During an interview on 8/20/23 at 3:00 PM Resident #46 revealed earlier that day she activated her call light because she needed toileting assistance. The Scheduler came to the room to see what she needed and said she would send in the Nurse Aide (NA). Shortly after she could hear someone in the hall shout "we're going to need a whole bed change". Resident #46 stated she was so embarrassed; she did not understand why the staff would yell out that information. She further stated when NA #1 and NA #14 entered her room she asked them "did you have to tell the whole world"? NA #1 told Resident #46 it was not her. NA #14 told Resident #46 it was her that said it, and she apologized. Resident #46 explained she accepted NA #14's apology but she was still embarrassed. She further explained that this was not the first time something like this had happened, "staff have a bad habit of announcing your business to everyone and sometimes it's embarrassing." During an interview on 8/21/23 at 4:26 PM NA#14 revealed on the day prior, 8/20/23, the Scheduler	F 550	forth by the Centers for Medicare & Medicaid Services (CMS), we are submitting this Plan of Correction (POC) as a response to the cited deficiencies. However, by submitting this POC, the facility does not admit or concede to the accuracy, validity, or merit of the findings and allegations contained in the Statement of Deficiencies. The facility reserves the right to contest or appeal any findings or conclusions with which it disagrees. Our primary objective in submitting this POC is to demonstrate our ongoing commitment to ensuring the health, safety, and welfare of our residents and maintaining compliance with all applicable federal, state, and local regulations. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/20/23, the Unit Manager re-educated Nurse Aide #1 and Nurse Aide #14 about the importance of providing incontinent care with dignity. The re-education emphasized using calm, quiet voices and avoiding yelling or shouting in resident care areas. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving incontinent care are at risk of being affected by this practice. By 9/26/23, Unit Managers or designees will conduct observations to ensure that incontinent care is being provided in a	

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F 550	Continued From page 3 notified her that Resident #46 needed incontinence care. When she went into the room the resident was turned toward the window and had a large bowel movement. She called out to the Scheduler, who was in the hall, to bring a full linen change. When she went to the resident's bed Resident #46 asked NA #14 why did she have to announce that. NA #14 stated her intentions were not to make the resident feel bad. She further stated she apologized to Resident #46. During an interview on 8/21/23 at 5:23 PM the Scheduler revealed while walking down the hall on the afternoon of 8/20/23, she saw Resident #46' s call light on. The Scheduler went in and peaked around the curtain; Resident #46 was laying on her side facing the window. She stated she could see the resident needed to be cleaned, she left the light on and notified NA #14. The Scheduler revealed NA #14 asked her to get a full linen change, she did not recall how she said it. She then got the linen and brought it back to the room. An interview on 8/22/23 at 11:14 AM with NA #1 revealed on the day prior, 8/20/23, she helped NA #14 provide incontinence care to Resident #46. NA #1 stated she did not hear the full conversation, but she remembered NA #14 apologizing to the resident regarding something she said. During an interview on 8/24/22 at 10:15 AM the Director of Nursing revealed she expected staff to treat residents in a dignified manner. The NA should have paused and went and got supplies herself or spoke with another staff member discreetly about what she needed.	F 550	dignified manner. Any opportunities for improvement identified during these observations will be promptly reported to the Director of Nursing for targeted one-on-one education. This audit will be comprehensive, encompassing a review of interactions between staff and residents, and aimed to uphold the dignity and privacy of all residents receiving incontinent care. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: By 9/26/23, the Director of Nursing and Unit Managers or their designees will re-educate the nursing staff on maintaining dignity while providing incontinent care. The training will emphasize the importance of maintaining calm, quiet voices and avoiding yelling or shouting in resident care areas. The Director of Nursing will include this specific training in the orientation curriculum for all newly hired staff as well as agency staff. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of incontinent care practices using a monitoring tool developed specifically for this deficiency will be conducted by the Nurse Managers, Director of Nursing, or their designee for a period of four weeks. These audits will include observation of 5 Licensed Nurses as well as random interviews and	

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F 550	Continued From page 4 During an interview on 8/24/23 at 1:10 PM the Administrator stated staff should never yell out any resident information. Staff should maintain the residents' dignity.	F 550	observation of 5 incontinent residents to ensure care is provided with dignity. Following the initial four-week period, monthly audits will be conducted for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Date of compliance: Ongoing, with initial compliance by 9/26/2023	
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		9/26/23

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F 554	Continued From page 5 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, staff, and Nurse Practitioner interviews, the facility failed to assess the ability of residents to self-administer medications for 4 of 4 sampled residents observed with medications at the bedside (Resident #46, Resident #29, Resident #61, and Resident #49). The findings included: 1. Resident #46 was admitted to the facility on 3/22/21 with diagnoses that included diabetes, chronic kidney disease, and anemia. A quarterly Minimum Data Set dated 7/2/23 revealed Resident #46 was cognitively intact with no behaviors or rejection of care. Review of Resident #46's medical record revealed no documentation of an assessment for the self-administration of medications. Review of physician orders for Resident #46 revealed: Flonase 50 micrograms/ actuation, give 1 spray in both nostrils one time a day for allergies 7/10/23. There was no current order for an albuterol inhaler or for the resident to self-administer medications. An observation and interview were conducted on 08/20/23 at 3:41 PM, Resident #46 was observed with Flonase on her bedside table. Resident #46	F 554	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: By 08/21/2023, the Unit Managers collected medications identified at the bedside of residents #46, #61, and #49. These medications were reviewed with the Nurse Practitioner and discarded. Resident #11 was discharged from the facility on 09/05/2023. One-on-one education was provided to the Licensed Nurse on 08/21/2023, emphasizing the requirement to observe the resident swallow the medication before exiting the room. This education was supervised by the Nurse Manager. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents receiving medications have the potential to be affected by this alleged deficient practice. By 09/26/2023, Nurse Managers will conduct room-by-room reviews to confirm the absence of medications at the bedside of all residents. Any discrepancies discovered will be immediately reported to the Director of Nursing and corrected. 3. Address what measures will be put into place or systemic changes made to	

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F 554	Continued From page 6 stated she was unsure how long the medication had been there, but she used it occasionally. An observation and interview were conducted on 08/20/23 at 3:50 PM with Nurse #11. She was unaware Resident #46 had a bottle of Flonase at her bedside. She stated she administered Flonase to the resident that morning but, she administered the one that was in the medication cart. She further stated Resident #46 did not have an order to self-administer medications and medications should not be left at the bedside. An observation and interview were conducted on 08/21/23 at 9:10 AM, Resident #46 was observed with an albuterol inhaler on her bedside table. Resident #46 revealed she kept this inhaler in her pocketbook, "I take a puff if I feel I need it". She stated on the prior night, 8/20/23, she felt like she needed to use the inhaler and she took it out of her pocketbook and took 2 puffs. She did not call the nurse to ask for any medication. She further stated she did not recall how long she had this inhaler and if she received it from a nurse. An observation of the medication label had the name of another resident. The date on the label was illegible. An observation and interview were conducted on 08/21/23 at 9:14 AM. Nurse #12 stated she had never given an inhaler to Resident #46 it was not on her list to administer. She observed the inhaler on Resident #46's bedside table and stated it belonged to a different resident on that hall. She was unsure on how Resident #46 received this medication. She stated maybe the medication was shared by the residents as they were friends. Nurse #12 explained residents should not have medications at the bedside and	F 554	ensure that the deficient practice will not recur: By 09/26/2023, Nurse Managers will re-educated Licensed Nurses and Medication Aides, including agency staff, on the facility's policy for medication administration. This re-education will include the requirement to observe the resident swallow the medication before exiting the room. Going forward, this specific education will be integrated into the orientation process for newly hired staff and agency staff, overseen by the Director of Nursing or designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Nurse Managers and Director of Nursing or their designees will conduct observations of 5 Licensed Nurses weekly for a period of four weeks, followed by monthly observations for three months. The focus of these observations will be to ensure no medications are left at the bedside and that residents are observed swallowing medications before exiting the room. The results of these observations will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify	

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F 554	Continued From page 7 they should call the nurse when they needed a medication. During an interview on 08/21/23 at 09:30 AM the Director of Nursing (DON) stated residents should not have medications left at their bedside, medications should be locked. To have medications at beside for self-administration Residents must be assessed for safety and they need to have an order. If a resident does not have an order to self-administer medications the nurses must watch the resident take medications before leaving the room. On 08/23/23 at 11:35 AM during a phone interview with Nurse Practitioner #1, she stated that nursing should complete a self-administration assessment of the resident and if applicable contact her for an order for self-administration of medications. If a resident does not have the self-administration assessment completed and does not have an order for self-administration of medications, their medications should be kept on the medication cart. An interview was conducted with the Administrator on 08/23/2023 at 04:39 PM. The Administrator stated residents were only allowed to self-administer medications and keep medications at the bedside when the appropriate self-administration assessment was completed, and a physician's order was present. 2. Resident #29 was admitted to the facility on 8/16/22 with diagnoses that included stroke with hemiplegia and hemiparesis and chronic pain. An annual Minimum Data Set dated 8/3/23 revealed that Resident #29 was cognitively intact	F 554	necessary changes. Observations will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of observations may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the observation frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly observations will resume. Any changes to the observation schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	

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F 554	Continued From page 8	F 554		

with no refusals or rejection of care.

Review of Resident #29's medical record revealed no documentation of an assessment for the self-administration of medications.

Review of physician orders for Resident #29 revealed:
Guaifenesin Liquid 100 milligram/5 milliliter (ml), give 10ml by mouth every 4 hours as needed for Cough.
There was no order for the self-administration of medications.

An observation and interview were conducted on 08/20/23 12:51 PM. Resident #29 was observed with a medicine cup containing a red liquid on his bedside table. Resident #29 stated he thought it was his cough syrup from last night. He asked the nurse for it, and she left it on his bedside table. Resident #29 revealed he took a portion of the medication and left the rest. Sometimes he took a little of the medication because he did not need as much as the nurses brought in.

An observation and interview were conducted on 08/20/23 at 03:50 PM with Nurse #11. Nurse #11 stated she was not sure what the medication was, it was probably cough syrup, but she did not administer that medication to Resident #29. She further stated Resident #29 did not have an order to self-administer medications and medications should not be left at the bedside.

During an interview on 08/21/23 at 09:30 AM the Director of Nursing (DON) stated residents should not have medications left at their bedside, medications should be locked. To have medications at beside for self-administration

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(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
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residents must be assessed for safety and they need to have an order. If a resident does not have an order to self-administer medications the nurses must watch the resident take medications before leaving the room.

On 08/23/23 at 11:35 AM during a phone interview with Nurse Practitioner #1, she stated that nursing should complete a self-administration assessment of the resident and if applicable contact her for an order for self-administration of medications. If a resident does not have the self-administration assessment completed and does not have an order for self-administration of medications, their medications should be kept on the medication cart.

An interview was conducted with the Administrator on 08/23/2023 at 04:39 PM. The Administrator stated residents were only allowed to self-administer medications and keep medications at the bedside when the appropriate self-administration assessment was completed, and a physician's order was present.

3. Resident #61 was admitted to the facility on 03/17/2023. His diagnosis included gastric-reflux disease.

The quarterly Minimum Data Set (MDS) dated 07/17/2023 revealed Resident #61 had intact cognition and required limited to extensive assistance with activities of daily living.

Review of Resident #61's care plan dated 6/23/2023 revealed no documentation that Resident #61 was care planned for self-administration of medications.

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Review of the physician's orders for Resident #61 revealed no order for self-administration of medications.

Review of Resident #61's medical record revealed no documentation that Resident #61 was assessed for self-administration of medications.

Review of Resident #61's Medication Administration Record (MAR) for July and August 2023 revealed orders related to gastric reflux disease:
1. Omeprazole Oral Tablet Delayed Release 20 milligrams; give one tablet by mouth in the morning for gastric reflux disease. Order start date: 03/17/2023.
2. Ondansetron Oral Tablet 4 milligrams; give one tablet by mouth every 6 hours as needed for nausea. Order start date: 03/17/2023.

An interview with Resident #61 and an observation of his room were conducted on 08/20/23 11:33 AM. Resident #61 was sitting on the side of his bed with the overbed table directly in front of him and on top of the overbed table was an opened bottle of Calcium Carbonate Chewable Tablets. The Calcium Carbonate Chewable Tablet bottle was observed to have tablets in the bottle and was over half full. Resident #61 stated he had "acid stomach" and took the Calcium Carbonate Chewable Tablets for indigestion. He kept them on his overbed table so he could take them when he needed them. Resident #61 stated his son brought him the Calcium Carbonate Chewable Tablets a few days ago.

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On 08/21/2023 at 08:28 an observation of Resident #61's room revealed the opened Calcium Carbonate Chewable Tablets bottle remained on Resident #61's overbed table.

An interview was conducted with Nurse Manager (NM) #1 on 08/21/2023 at 09:28 AM. NM #1 stated no medication should be left at the bedside unless a self-administration assessment had been completed. She further stated a physician's order for self-administration was also needed. Nurse #1 indicated Resident #61 did not have an assessment for self-administration of medications or a physician's order for medications at bedside. NM #1 was not aware Resident #61 had any medications at the bedside.

On 08/21/23 at 09:39 AM an interview was conducted with the Director of Nursing (DON). The DON stated residents should not have any medications at bedside. Residents must be assessed for safety, and they need to have an order self-administration of medications. If a resident did not have an assessment for self-administration of medications along with a physician's order, they should not have any medications at the bedside.

On 08/23/23 at 11:35 AM a phone interview was conducted with Nurse Practitioner (NP) #1. NP #1 stated nursing would complete a self-administration assessment of the resident and if applicable would contact her for an order for self-administration of medications. If residents did not have the self-administration assessment completed and did not have an order for self-administration, she would expect all medications to be kept on the medication cart and not left at the bedside. NP#1 stated she was

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not aware Resident #61 was taking Calcium Carbonate Chewable Tablets and she would place an order for the medication.

An interview was conducted with the Administrator on 08/23/2023 at 4:39 PM. The Administrator stated residents were only allowed to self-administer medication and keep medications at the bedside when the appropriate assessment was completed, and a physician's order was present.

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4. Resident # 49 was admitted to the facility on 5/4/22 with diagnoses that included kidney failure.

A review of Resident # 49's quarterly MDS dated 7/21/23 revealed he was cognitively intact with no behaviors or rejection of care.

A review of Resident # 49's medical record revealed no documentation of an assessment for the self- administration of medications.

A review of Resident # 49's physician's orders revealed: Symtuza (antiretroviral medicine) Tablet 10MG Give 1 tablet by mouth one time a day in the morning 5/22/23.
Aspirin Tablet Delayed Release 81 MG1 tablet by mouth in the morning 5/05/2022.

Folic Acid Tablet 1 MG 1 tablet by mouth in the morning 5/22/22.

On 8/20/23 at 11:27 AM an observation of Resident # 49's room revealed the resident asleep in his bed with his overbed table across him. The over bed table contained a medicine cup with 3 pills inside. Resident # 49 was awakened and reported his assigned nurse brought them in for his morning medicine recently.

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On 8/20/23 at 11:31 AM Nurse # 2 was interviewed. Nurse # 2 stated Resident # 49 normally t took his pills at breakfast when he gave them to him. He said the resident must have fallen back asleep after he gave the medicine to Resident # 49 around 8:00 AM the same day. Nurse # 2 stated the resident takes his medicine between bites of food as his normal routine, and he thought Resident # 49 did the same today. Nurse # 2 said Resident # 49 does not have an order to self-administer medications.

During an interview on 8/21/23 at 09:30 AM the Director of Nursing (DON) stated residents should not have medications left at their bedside, medications should be locked. To have medications at beside for self-administration Residents must be assessed for safety and they need to have an order. If a resident does not have an order to self-administer medications the nurses must watch the resident take medications before leaving the room.

On 8/23/23 at 11:35 AM during a phone interview with Nurse Practitioner #1, she stated that nursing should complete a self-administration assessment of the resident and if applicable contact her for an order for self-administration of medications. If a resident does not have the self-administration assessment completed and does not have an order for self-administration of medications, their medications should be kept on the medication cart.

An interview was conducted with the Administrator on 8/23/2023 at 04:39 PM. The Administrator stated residents were only allowed to self-administer medications and keep medications at the bedside when the appropriate

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F 554	Continued From page 15 self-administration assessment was completed, and a physician's order was present.	F 554		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide a functional shower chair to accommodate a resident's size so she could go to the shower room to receive a shower for one of two residents reviewed for accommodation on needs (Resident #46). The findings included: Resident #46 was admitted to the facility on 3/22/21 with diagnoses that included diabetes, chronic kidney disease, and anemia. A quarterly Minimum Data Set dated 7/2/23 revealed Resident #46 was cognitively intact with no behaviors or rejection of care. She was dependent on staff for bathing and required extensive one person assist with personal hygiene and dressing. The care plan for resident #46 dated 3/25/21 revealed Resident #46 had an activity of daily living self-care deficit related to limited mobility. The interventions included extensive two person assist with bathing.	F 558	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: A functional shower chair appropriate for Resident #46's size has been acquired and is now available in the shower room. Responsible Person: Maintenance Director/Designee Compliance Date: 9/26/2023 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing or designee will assess all residents requiring special shower chair accommodations to ensure their chairs fit properly. Compliance Date: 9/26/2023 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Policy Revisions: A new policy titled	9/26/23

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F 558	Continued From page 16 During an interview on 8/20/23 at 3:00 PM Resident #46 revealed she had not been able to go to the shower room for more than a month. She explained she used the larger sized shower chair, and staff told her it was broken. She further stated she gets regular bed baths but also liked to shower sometimes. When she showered, she felt cleaner. She was unsure if maintenance knew about the broken shower chair. An ongoing observation and interview were conducted on 08/21/23 at 8:49 AM with Nurse Aide (NA) #15 of the west unit shower rooms. In the west unit shower room 1 there were three shower chairs. One of the three shower chairs was a bariatric shower chair. When attempted to roll the bariatric shower chair it would not move, the wheels were fixed. NA #15 checked and repositioned the brakes on the shower chair wheels several times. The shower chair wheels would not move no matter the position of the brakes. An observation of the west unit shower 2 revealed two shower chairs, neither were bariatric. NA #15 stated he did not know the bariatric shower chair was broken. An ongoing observation and interview were conducted on 08/21/23 at 9:01 AM with NA #4 of shower rooms on the east unit. The east unit shower room 1 had one shower chair that was not bariatric. The east unit shower room 2 had three shower chairs one of the three shower chairs was a bariatric shower chair. The right back wheel lock on the bariatric shower chair was stuck and prevented it from rolling properly. NA #4 could not unlock the wheel. NA #4 stated before the observation she did not know the bariatric shower chair had an issue, otherwise	F 558	"Special Needs Accommodations Policy" has been created to detail procedures for verifying the suitability and functionality of special needs equipment, such as shower chairs. Staff Training/Education: An in-service training session will be conducted to educate nursing and maintenance staff about the new policy and the importance of ensuring that all special needs accommodations are functional and appropriate for each resident. New Staff Onboarding: All new hires will receive training on this policy during their orientation. Responsible Person: Administrator/Director of Nursing Services or Designee Compliance Date: 9/26/2023 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of shower chair adequacy and other special needs accommodations will be conducted using a monitoring tool developed specifically for these deficiencies. These audits will be conducted by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained,	

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F 558	Continued From page 17 she would have reported it. She further stated she could not transport a resident to the shower room in that chair due to its condition. During an interview on 08/21/23 at 4:26 PM NA #14 revealed cared for resident #46 at times. She was not aware of the broken bariatric shower chairs. She usually gave the resident a full bed bath. On 08/22/23 at 2:21 PM an interview was conducted with NA #13, she revealed she was aware the bariatric shower chair was broken. NA #13 stated the wheels on the shower chair did not work and it had been broken for a month or month and a half. She explained the unit used to have a shower tech and she did not report the broken shower chair because she thought it was reported by the shower tech. Multiple unsuccessful attempts were made to contact and interview the shower tech. During an interview on 8/23/23 at 8:27 AM the Maintenance Director revealed he was not made aware of any issues with the shower chairs. An ongoing observation and interview were conducted on 8/23/23 at 8:40 AM with the Maintenance Director and the Administrator. An observation of the West shower room 1 revealed the wheels on the bariatric shower chair did not work. An attempt was made to push the chair, but it would not roll. The brakes on the chair were repositioned multiple times. Both the Maintenance Director and the Administrator agreed the bariatric shower chair was not operable. An observation of the East shower room 2 revealed the bariatric shower chair had a	F 558	re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	

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back wheel that did not work, the lock was stuck. Multiple attempts were made to reposition the lock, but it would not move. Both the Maintenance Director and the Administrator agreed the bariatric shower chair was not operable.

During an interview on 8/23/23 at 10:20 AM Unit Manager #2 revealed she did not know the bariatric shower chairs were not working, it was not reported to her. She stated Resident #46 would need to use the bariatric shower chair along with three other residents on the unit. She explained the facility had shower beds, but she did not think they would be safe for these residents because the rails were low. She further explained staff were aware that they should report broken equipment to her, and the Maintenance Director.

During an interview on 8/24/23 at 1:10 PM the Administrator stated he expected the residents to be able to receive a shower by either using the shower chairs or an alternative method.

F 565 SS=E — Resident/Family Group and Response — F 565 — 9/26/23

CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)

§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.
(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.
(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.
(iii) The facility must provide a designated staff

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F 565	Continued From page 19 person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews the facility failed to resolve group grievances that were brought to resident council meetings for 4 of 10 months reviewed (December 2022, February 2023, April 2023, May 2023.) The findings included: A review of the Resident Council Minutes and grievance forms dated 12/2/22, 2/2/23, 4/6/23, 5/4/23 indicated resident council attendees voiced concerns/grievances about not getting their showers. A review of Resident Council Minutes from June 2023- August 2023 did not	F 565	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: Unresolved grievances from the resident council meetings for the cited months have been reviewed, and actions have been taken to address the concerns and resolution communicated with the resident council. Responsible Person: Administrator or Designee Compliance Date: 9/26/2023	

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F 565	Continued From page 20 identify resolutions or improvements related to shower concerns from previous months. Residents (#46, #15, #10) who attended the resident council meeting on 8/22/23 at 2:14 PM revealed they were still having issues related to not receiving showers for reasons such as the shower chair being broken for 2 months or inadequate bariatric lift device. During an interview on 8/23/23 at 3:15 PM the Activities Director indicated she was responsible for communicating concerns voiced by residents in resident council meetings, to the Social Worker (SW), who distributes the concerns to the appropriate department head for a resolution such as in-service for staff or feedback then returned to the SW for review before the resolutions are returned to the Activities Director. She further indicated Nursing supervisors usually address concerns directly with the affected residents and she presents the information at the next resident council meeting. She stated that she completed grievances for concerns related to residents not receiving showers regularly/ as scheduled, based on resident council concerns during December 2022, February 2023, April 2023, and May 2023. During an interview on 8/22/23 at 5:34 PM the Director of Nursing (DON) stated that she recently heard there were some residents on the west hall who were complaining of missed showers and she planned to have nursing staff sign off when NA's completed recent showers. During an interview on 8/24/23 at 1:20 PM the Administrator revealed he was not aware of any issues from resident council and that he had only	F 565	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: Audits of resident council meeting minutes, grievance logs, and staff interview records from the past 12 months will be conducted to identify any trends or patterns that may indicate broader issues affecting other residents. Responsible Person: Administrator or Designee Compliance Date: 9/26/2023 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Policy Revisions: The "Resident/Family Council Meeting and Grievance Resolution Policy" will be updated to explicitly outline the steps and timeframe for the timely resolution of grievances. Staff Training/Education: A mandatory in-service training session will be conducted by the Administrator. This training will focus on the revised policy and emphasize the importance of timely grievance resolution. The staff members who will be in-serviced include the Activities Director, Social Services Director, Director of Nursing, and all department heads involved in resolving grievances. All new staff will receive training on the revised policy during their orientation. Responsible Person: Administrator or Designee Compliance Date: 9/26/2023	

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F 565	Continued From page 21 started working at the facility one month ago. Therefore, he was unaware of the process for resolving resident council concerns.	F 565	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of the resolution of resident council meeting grievances will be conducted using a monitoring tool developed specifically for this issue. These audits will be carried out by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. The results will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. If results indicate that the desired outcome is not being maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. A root cause analysis will also be performed to identify necessary changes. Audits will continue until compliance is achieved for a minimum of three consecutive months. At that point, audit frequency may be re-evaluated and adjusted by the QA/QAPI Committee. Should any future deficiencies be found, weekly audits will resume until compliance is re-established and maintained for at least one month, at which point monthly audits will resume. Compliance Date: Ongoing, with initial compliance by 9/26/2023	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		9/26/23

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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 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.

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F 584	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with resident and staff, the facility failed to maintain a wheelchair in good repair for 1 of 2 residents reviewed for mobility device (Resident #25), failed to maintain bathrooms in good repair for 2 of 5 bathrooms reviewed (Resident #59 and Resident #25), failed to change a soiled privacy curtain for 1 of 8 rooms reviewed for privacy curtain (Room 227), and failed to provide towels/washcloths as needed for showers for 2 of 2 halls (100 Hall and 200 Hall). The findings included: 1. Resident #25 was admitted to the facility on 03/31/23. The significant change in status Minimum Data Set (MDS) assessment dated 05/23/23 coded Resident #25 with intact cognition. Review of weekly skin assessment from 06/24/23 through 08/18/23 revealed Resident #25's skin was intact without any issues. During an observation conducted on 08/20/23 at 11:36 AM, Resident #25 was seen sitting in her wheelchair outside of her room in the hallway. The right armrest of the wheelchair was broken with multiple torn spots, ripped edges, and cracked lines. The left armrest of the wheelchair was observed with torn spots and ripped edges. Resident #25 was wearing short sleeves shirt sitting in the wheelchair and both of her arms were in contact with the broken armrests during the observation.	F 584	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: Repairs were made to Resident #25's wheelchair. Bathrooms for Resident #59 and Resident #25 were renovated to be in good repair. The soiled privacy curtain in Room 227 has been replaced, and towels/washcloths have been restocked in 100 and 200 Halls. Responsible Person: Maintenance Director/Designee Compliance Date: 9/26/2023 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: Audits will be conducted to specifically assess the condition of all wheelchairs, the state of repair for resident bathrooms, the cleanliness and condition of privacy curtains in rooms, and the availability of towels and washcloths in 100 Hall and 200 Hall. Responsible Person: Maintenance Director or Designee Compliance Date: 9/26/2023 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff education and policy revisions have been initiated to address the identified	

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F 584	Continued From page 24 An interview was conducted with Resident #25 on 08/20/23 at 11:40 AM. She could not recall how long the armrests for her wheelchair had been in disrepair. She stated the broken armrests had caused skin irritation at times. During subsequent observations conducted on 08/21/23 at 4:51 PM and 08/22/23 at 10:14 AM, Resident #25 was seen sitting in her wheelchair with a short sleeve shirt and the armrests remained in disrepair. An interview was conducted on 08/22/23 at 10:48 AM with Nurse Aide (NA) #1. She stated she had provided care for Resident #25 in the past 2 weeks, but she did not notice the armrests for her wheelchair were in disrepair. She added Resident #25 used the wheelchair frequently and it was hard for her to check the condition of the armrests. During a joint observation conducted with Nurse #6 on 08/22/23 at 10:58 AM, the armrests for Resident #25's wheelchair remained in disrepair. Nurse #6 assessed the skin of Resident #25's bilateral arms and confirmed the areas of skins in contact with the broken armrests were intact. An interview was conducted with Nurse #6 on 08/22/23 at 11:01 AM. She stated she had provided care for Resident #25 in the past 2 weeks, but she did not notice the armrests for the wheelchair were broken. She acknowledged that it needed to be fixed immediately as it could cause skin irritation. An interview was conducted with the Maintenance Director on 08/22/23 at 11:12 AM. He stated the rehab department was responsible for fixing the	F 584	deficiencies, including wheelchair maintenance, bathroom repairs, privacy curtain cleanliness, and towel/washcloth availability. Two policies have been specifically revised: The "Wheelchair and Mobility Device Maintenance Policy" now includes a weekly inspection schedule, focusing on the cited issues such as the state of wheels, armrests, and seating cushions. The "Facility Cleanliness and Maintenance Policy" has been expanded to require daily checks for bathroom repairs and weekly checks for the cleanliness of privacy curtains. Staff Training/Education: A mandatory in-service will be held for nursing, maintenance, and housekeeping staff. The Director of Nursing and the Administrator will lead the training, which will cover: policy changes and updates, proper procedures for conducting and documenting checks, the urgency and process for reporting deficiencies. New Staff Onboarding: All new hires will be trained on these policies during orientation. Compliance Date: 9/26/2023 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of wheelchair conditions, bathroom states of repair, privacy curtain cleanliness and condition, and towel and washcloth availability in 100 Hall and 200 Hall will be conducted using a monitoring tool developed specifically for this deficiency. These audits will be conducted	

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F 584	Continued From page 25 armrests of resident's wheelchair. An interview was conducted with the Rehab Director on 08/22/23 at 12:03 PM. She confirmed the rehab department was responsible for fixing the wheelchair armrests. She was not aware that the armrests for Resident #25's wheelchair was broken and needed repair. She stated she started to conduct wheelchair audit to identify wheelchair repair needs last October, but the audit had only been done once so far. She explained the rehab department still depended heavily on nursing staff to report wheelchair repair needs with work orders or verbal notifications. 2. An observation was conducted of the bathroom in Room 224 that was shared with residents in Room 225 on 08/21/23 at 4:51 PM. The caulking for the base of the commode had fallen off and was filled with dark colored build-up approximately 1 centimeter in width around the base of the toilet. Further assessment of the commode revealed it was intact without any broken parts or loosened base. The broken caulking around the base of the commode had trapped a layer of dirty build-up which could have consisted of urine, mopping water, or other unknown substances that could be hazardous to Resident #25's health. During an interview conducted on 08/21/23 at 4:53 PM, Resident #25 could not recall when the caulking around the base of the commode had fallen off and filled with dirty build-up. She felt the commode was dirty whenever she used the toilet, and she wanted the caulking to be fixed as soon as possible.	F 584	by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	

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A subsequent observation conducted on 08/22/23 at 10:14 AM revealed the caulking around the base of the commode remained in disrepair and filled with dirty build-up.

During an interview conducted on 08/22/23 at 10:21 AM, Housekeeper #1 stated she started working on 200 Hall last week and had noticed the broken caulking with the dirty build-up around the base of the commode. She submitted a work order to the maintenance department and notified the Maintenance Director in person verbally last week. She did not know why the issue still had not been addressed.

An interview was conducted with the Housekeeping Manager on 08/22/23 at 10:33 AM. She stated the broken caulking needed to be fixed as soon as possible.

During an interview conducted on 08/22/23 at 10:44 AM, the Maintenance Director explained he walked through the facility once daily on regular basis to identify repair needs. He depended on the nursing staff to report repair needs either verbally or with work order. He did not notice the broken caulking and the dirty build-up for Resident #25's commode during the routine walk-through. He checked work order daily and denied he had ever received any written work order or verbal notifications related to Resident #25's bathroom.

During an interview conducted on 08/24/23 at 11:23 AM, the Director of Nursing expected the staff to be more attentive to resident's mobility devices and living environment, and to report all the repair needs to the maintenance department or rehab department in a timely manner. It was

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her expectation for all the mobility devices and bathrooms to be in good repair at all the times.

An interview was conducted with the Administrator on 08/24/23 at 11:45 AM. He expected all the staff to pay attention to the conditions of resident's mobility devices and their home, and fully utilize the work order system to ensure all the repair needs are being addressed in a timely manner. It was his expectation for all the mobility devices and living environment to be in good repair at all the times.

2. Resident #59 was admitted to the facility on 03/10/2022.

The quarterly Minimum Data Set (MDS) dated 06/16/2023 revealed Resident #59 had intact cognition and required supervision to limited assistance with activities of daily living.

An interview was conducted on 08/20/23 at 11:24 AM with Resident #59. Resident #59 stated the toilet in his room was loose at the floor and it slid to the right when he sat down on it. He explained the toilet was not secured to the floor; the seal was broken, and it leaked. He said he reported the toilet needed repairing but he did not know who he told, and it had been broken for about 2

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months. Resident #59 stated he felt like the toilet was not safe.

An observation of Resident #59's bathroom was conducted on 08/20/2023 2:43 PM. The toilet base was observed to have been off from where it was originally installed to the floor as evidenced by a black substance noted around the base of the commode on the floor.

An additional observation was conducted on 08/21/23 12:29 PM. The toilet was discovered to be in the same condition as it was observed on 8/20/23.

On 08/22/23 12:03 PM an observation was conducted. The toilet was discovered to be in the same condition as it was observed on 8/20/23 and there was water pooling around the base of the toilet.

An interview and observation were conducted on 08/22/2023 at 12:28 with Housekeeper #2, who stated he was assigned to the room and bathroom of Resident #59. Housekeeper #2 stated he did not notice the toilet being loose from the floor or any water pooling around the base of the toilet. He also stated he did not notice the black substance at the base of the toilet. He further stated, "If he had seen this, he would have called maintenance and had it repaired".

On 08/22/23 12:40 PM an interview and an observation of Resident #59's bathroom was conducted with Housekeeper #3. Housekeeper #3 stated the toilet was broken, leaking, and dirty; she needed to call Maintenance now.

An interview was conducted on 08/22/23 1:32 PM

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with Nurse Aide (NA) #4. NA #4 stated she noticed the broken toilet about one month ago and reported it to maintenance. She stated she did not complete a work order but verbally asked housekeeping and maintenance to check the toilet in Resident #59's room. She also stated she thought they repaired the toilet. She further stated she had not noticed anything wrong with Resident #59's bathroom or toilet lately.

An interview and observation were conducted on 08/22/2023 at 1:44 PM with the Maintenance Director. He stated that he did not know the toilet needed repair and he had not received a work order for the toilet. He also indicated staff usually just tell him if something needed repair and do not use the work order system very much. He also stated the toilet was leaking and was loose from the floor. He further stated the seal would need to be replaced.

A review of the Maintenance Log work orders was completed on 08/22/2023 at 2:05PM. Review of the work orders from January 2023 to August 2023 revealed no work orders were submitted for Resident #59's bathroom.

An interview and observation of Resident #59's bathroom was conducted on 08/22/23 at 3:27 PM with the Administrator. The Administrator stated he expected all residents to have access to a clean and functional bathroom including the toilet. The toilet was discovered to be in the same condition as it was observed on 8/22/23.

An observation of the Resident #59's bathroom was conducted on 08/23/2023 at 11:45 AM. The toilet was secured to the floor. The floor around the toilet was clean and dry.

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3. An observation was made of a privacy curtain in room 227 on 8/20/23 at 10:50 AM revealed the privacy curtain had multiple black and brown stains on it.

During an interview on 8/20/23 at 11:37 AM the Housekeeping Manager revealed privacy curtains were changed as needed, if they saw a dirty privacy curtain, they changed it.

On 8/21/23 at 8:38 AM the privacy curtain in room 227 was soiled with multiple black and brown stains.

An observation and interview were conducted on 8/22/23 at 10:55 AM with the Regional Director of Housekeeping. An observation was made of the privacy curtain in room 227. The Regional Director of Housekeeping stated the privacy curtain was soiled and should be changed immediately. She further stated privacy curtains should be changed during the monthly deep clean and as needed.

During an interview on 8/24/23 at 1:10 PM the Administrator revealed privacy curtains should be changed on a schedule and as needed.
4. Resident #30 was admitted to the facility 06/09/21.

Review of #30's quarterly Minimum Data Set (MDS) 05/11/23 revealed Resident #30 was cognitively intact.

Review of progress note dated 02/15/23 revealed Resident #30 stated she would have bed bath given to her on 02/16/23 due to the lack of bath

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towels.

Review of progress note dated 02/16/23 revealed Unit Manager (UM) #1 followed up with Resident #30 about missed shower due to linens and Resident #30 received shower on the evening of 02/16/23.

An observation conducted on 08/20/23 at 10:30 AM revealed no washcloths located on the 100 hall supply closet where linens were kept. Observation of the 100 hall further revealed three separate hallways that joined at a nurses station.

An observation conducted on 08/21/23 at 9:05 AM revealed no towels located on the 100 hall in the supply closet where linens was kept.

An observation conducted on 08/21/23 at 9:10 AM revealed no towels or washcloths located on the 200 hall on the linen cart parked at the nursing station. Observation of the 200 hall further revealed three separate hallways that joined at a nurses station.

An observation conducted on 08/22/23 at 9:05 AM revealed no towels or washcloths located on the 200 hall on the linen cart parked at the nursing station.

An observation conducted on 08/23/23 at 9:45 AM revealed no wash clothes located in the supply closet located on the 100 hall.

An interview conducted with Resident #30 in Room 106 on 08/20/23 at 11:30 AM revealed she had missed showers and bed baths due to washcloths and towels not being available. Resident #30 further revealed nursing staff had

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multiple times moved her showers to the next day or have to wait to be cleaned due to no having washcloths and towels available.

An interview and observation conducted Laundry Aide #1 on 08/21/23 at 9:15 AM revealed laundry takes out linens three times a day to the supply closet and cart. This included morning, after lunch, and in the evening. The Laundry aide indicated the facility had plenty of linens but had issues turning over laundry timely and keeping washcloths and towels available at all times. It was observed plenty of linens stacked and piled in the laundry room.

An interview conducted with Nurse #16 on 08/21/23 at 2:10 PM revealed she had worked first shift often and the facility was constantly running out of towels and washcloths and showers were not getting completed as scheduled. Nurse #16 revealed residents would have to wait to get cleaned up and showers would often get pushed to another day.

An interview conducted with UM #1 on 08/22/23 at 11:25 AM revealed the facility had issues keeping linens available for nursing staff and residents. UM #1 stated the facility had a current second shift laundry aide and could not recall why towels or washcloths continued to not be available. The UM revealed Resident #30 had missed her shower on 02/15/23 due to linens not being available and was pushed to the next day.

An interview conducted with the Housekeeping Manager on 08/24/23 at 9:45 AM revealed there had been issues with towels and washcloths not getting out on the cart and resident showers being missed due to staff call outs in laundry for

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F 584	Continued From page 33 several months. The Housekeeping Manager further revealed the facility had plenty of linens but had an ongoing issue with keeping towels and washcloths on the cart and supply closet. It was further revealed the housekeeping manager tried to keep laundry on schedule and educate nursing staff to come back to the laundry room if towels and washcloths are not available on the floors. An interview conducted with the Administrator on 08/24/23 at 12:20 PM revealed he had not been notified on any issues with linens The Administrator further reveal he expected for there to be an adequate number of washcloths and towels for residents out on the halls.	F 584		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.	F 622		9/26/23

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F 622	Continued From page 34	F 622		

Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving

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F 622	Continued From page 35 facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews the facility failed to provide records and resident information to the receiving hospital for 1 of 1 resident reviewed for hospitalization (Resident #423). The findings included: Resident #423 was admitted to the facility on 12/07/19. Review of a nursing progress note dated 11/22/22 revealed Resident #423 had an unwitnessed fall	F 622	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: The medical records and pertinent resident information for Resident #423 were eventually sent to the receiving hospital. Since the resident is no longer in the facility, we will ensure that future hospital transfers will be completed promptly and in accordance with established policies. Responsible Person:	

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F 622	Continued From page 36 and was sent to the hospital for evaluation and treatment. This note was entered by Unit Manager (UM) #2. An interview conducted with Unit Manager (UM) #2 on 08/23/23 at 2:30 PM revealed she had assisted nursing staff with sending Resident #423 out to the hospital on 11/22/22. UM #2 further revealed she thought Resident #423's information included administration records, medications, orders, summary of resident, and progress note was sent with Resident #423 to the hospital. An interview was conducted with the Resident Representative (RR) on 08/20/23 at 12:20 PM revealed Resident #423 was admitted to the hospital on 11/22/22 and the hospital did not have the residents' medical records. The RR further revealed the hospital and RR made multiple calls to the facility and were unable to get anyone to answer the phone. The RR stated she had to go to the facility to retrieve Resident #423's orders and take them back to the hospital for the resident. Review of progress note dated 12/07/22 revealed a meeting was held with the Unit Manager (UM) #1, Nurse Consultant, and Resident #423's resident representative. It was noted an in-service would be completed on the process and procedure regarding what is needed to go out with the resident when sent to the hospital. An interview conducted with the Unit Manager (UM) #1 on 08/22/23 at 11:25 AM revealed Resident #423 was sent to the hospital on 11/22/22 for an evaluation after a fall. UM #1 indicated the hospital had tried to contact the facility to receive Resident #423's orders and was	F 622	Administrator/Director of Nursing Services or Designee Compliance Date: 9/26/2023 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: Retroactive audits going back 90 days will be conducted to review the transition of records and resident information for all hospital transfers. These audits will include a detailed examination of communication logs, transfer forms, and hospital acknowledgment receipts. Responsible Person: Administrator/Director of Nursing Services or Designee Compliance Date: 9/26/2023 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Policy Revision: The facility's existing "Transfer and Discharge Procedure" policy will be revised to include stringent checks for the verification and transfer of records to receiving hospitals. Staff Training/Education: An in-service training session will be conducted to orient nursing staff on the revised policy and emphasize the importance of timely and accurate information transfer. New Staff Onboarding: All newly hired staff will receive training on the revised "Transfer and Discharge Procedure" policy as part of their orientation. Compliance Date: 9/26/2023	

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F 622	Continued From page 37 unable to contact anyone at the facility. UM #1 revealed Resident #423's RR came to the facility to retrieve records to take to the hospital for Resident #423. UM #1 stated she had spoken to nursing staff about answering calls and sending out appropriate records. UM #1 indicated resident information and orders should always be sent with the resident when transferred to the hospital. An interview conducted with the Director of Nursing (DON) on 08/24/23 at 11:00 AM revealed she does not recall Resident #423 being sent to the hospital without medical records on 11/22/22. The DON indicated nursing staff were aware of what needed to be sent out with residents when sent to the hospital.	F 622	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Monitoring Method: Weekly audits of the transfer of records and resident information to receiving hospitals will be performed using a monitoring tool developed specifically for this deficiency. These audits will be conducted by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be	

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F 622	Continued From page 38	F 622	documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of discharge (Resident #323), medications (Resident #25), and bladder and bowel (Resident #14, Resident #11, and Resident #47) for 5 of 10 residents whose MDS assessments were reviewed. The findings included: 1. Resident #323 was admitted to the facility on 01/18/23 with a diagnosis that included diabetes mellitus and cerebral infarction. The readmission Minimum Data Set (MDS) dated 03/09/23 assessed Resident #323 with moderate cognitive impairment. Review of nurse's progress note dated 03/30/23 revealed Resident #323 was discharged to the hospital for evaluation and treatment. The physician's order dated 03/30/23 indicated Resident #323 was sent to emergency	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: MDS assessments for affected residents (#323, #25, #14, #11, and #47) have been reviewed, corrected, and resubmitted to ensure accurate coding in the areas identified. Responsible Person: MDS Coordinator and Director of Clinical Reimbursement Compliance Date: 8/24/2023 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: An audit was completed on 8/24/2023 to identify all resident discharges over the last 60 days, all assessments completed within the last 60 days where the resident received an anti-psychotic medication, and all residents with a foley catheter or other urinary appliance. The audit aimed to	9/26/23

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F 641	Continued From page 39 department for evaluation. Review of Section A2100 of the discharge MDS dated 03/30/23 indicated Resident #323 was discharged to community and return was not anticipated. During an interview on 08/22/23 at 2:29 PM, the MDS Coordinator stated Resident #323 was not discharged to the community but to the hospital on 03/30/23. She confirmed section A2100 of the discharge MDS dated 03/30/23 should have been coded as discharged to hospital. The MDS Coordinator explained it was a data entry error, and a modification would be done immediately for the MDS to correctly reflect the discharge status of Resident #323. 2. Resident #25 was admitted to the facility on 03/31/23 with diagnosis that included schizophrenia. Review of physician order dated 04/01/23 revealed Resident #25 had an order to receive 50 milligrams (mg) of Seroquel by mouth twice daily for behaviors. Further review of physician order dated 04/03/23 indicated the order for Seroquel had been increased to 150 mg by mouth once daily at bedtime for schizophrenia. The Medication Administration Records for April 2023 revealed the dosage of Seroquel was changed and Resident #25 had received the medication as ordered. The significant change in status MDS dated 05/23/23 coded Resident #25 with intact cognition.	F 641	ensure items at A2100, H0300, and N0450B were coded correctly. Responsible Person: MDS Coordinator and Director of Clinical Reimbursement Compliance Date: Completed by 8/24/2023 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff education and policy revisions: Re-education was completed on 9/14/2023 by the Director of Clinical Reimbursement for the MDS Coordinator, focusing on RAI guidelines for correct coding of items A2100, H0300, and N0450B. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of MDS coding accuracy will be conducted using a monitoring tool developed specifically for these deficiencies. These audits will be conducted by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. The results will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should results indicate that desired outcomes are not being achieved, re-education will be provided and a root cause analysis performed to identify necessary changes. Audits will continue	

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F 641	Continued From page 40 Review of Section N0450 part B and C of the significant change in status MDS dated 05/23/23 indicated gradual dose reduction (GDR) had been attempted on 04/03/23. An interview was conducted with the MDS Coordinator on 08/24/23 at 9:17 AM. She confirmed Resident #25 had a dose increase instead of dose reduction for Seroquel on 04/03/23. She acknowledged that it was an error to code GDR of antipsychotic had been attempted on 04/03/23 for Section N0450 part B and C for the significant change in status MDS dated 5/23/23. She explained she had misinterpreted the coding guidelines and perceived any changes in dosage for antipsychotic could be considered as a GDR. During an interview conducted on 08/24/23 at 11:23 AM, the Director of Nursing stated that it was her expectation for the MDS Coordinator to code all the MDS correctly to reflect the residents' discharge destination and GDR status. An interview was conducted with the Administrator on 08/24/23 at 11:45 AM. He stated that he expected the MDS coordinator to interpret the MDS guidelines correctly and code each MDS accurately.	F 641	until sustained compliance is consistently achieved for a minimum of three consecutive months. Any changes to the audit schedule will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	

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3. Resident #14 was admitted to the facility on 3/30/23 with diagnoses that included urinary retention and acute cystitis (bladder infection).

Resident #14's quarterly Minimum Data Set (MDS) assessment dated 7/11/23 indicated Resident #14 had an indwelling catheter and was always incontinent of urine.

Resident #14's Medication Administration Record for July 2023 indicated Resident #14 had an indwelling urinary catheter to straight drainage related to urinary retention.

An interview with the MDS Coordinator on 8/23/23 at 3:32 PM revealed she should have marked "not rated" under urinary continence in Resident #14's quarterly MDS because Resident #14 had an indwelling catheter. The MDS Coordinator stated the computer automatically selected "always incontinent" based on the responses documented by the nurse aides which were in error. She stated she should have corrected this area before submitting Resident #14's MDS.

An interview with the Director of Nursing (DON) on 8/24/23 at 11:16 AM revealed she couldn't speak for the MDS Coordinator's error, and she did not know why she completed Resident #14's MDS inaccurately.

4. Resident #11 was admitted to the facility on 4/30/21 with diagnoses that included obstructive

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and reflux uropathy (condition in which the flow of urine is blocked) and urinary retention.

Resident #11's significant change in status Minimum Data Set (MDS) assessment dated 6/28/23 indicated Resident #11 had an indwelling catheter and was occasionally incontinent of urine.

Resident #11's Medication Administration Record for June 2023 indicated Resident #11 had an indwelling urinary catheter due to urinary retention related to obstructive uropathy.

An interview with the MDS Coordinator on 8/23/23 at 3:32 PM revealed she should not have marked Resident #11 as incontinent in his MDS because he had an indwelling catheter. The MDS Coordinator stated the computer automatically selected "occasionally incontinent" based on the responses documented by the nurse aides which were in error. She stated she should have corrected this area before submitting Resident #11's MDS.

An interview with the Director of Nursing (DON) on 8/24/23 at 11:16 AM revealed she couldn't speak for the MDS Coordinator's error, and she did not know why she completed Resident #11's MDS inaccurately.

5. Resident #47 was admitted to the facility on 9/27/18 with diagnoses that included obstructive and reflux uropathy (condition in which the flow of urine is blocked) and urinary retention.

Resident #47's quarterly Minimum Data Set (MDS) assessment dated 7/19/23 indicated Resident #47 had an indwelling catheter and was

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F 641	Continued From page 43 always incontinent of urine. Resident #47's Medication Administration Record for July 2023 indicated Resident #47 had a suprapubic catheter (placement of a drainage tube into the urinary bladder just above the pelvic joint) due to obstructive uropathy. An interview with the MDS Coordinator on 8/23/23 at 3:32 PM revealed she should not have marked Resident #47 as incontinent in his MDS because he had an indwelling suprapubic catheter. The MDS Coordinator stated the computer automatically selected "always incontinent" based on the responses documented by the nurse aides which were in error. She stated she should have corrected this area before submitting Resident #47's MDS. An interview with the Director of Nursing (DON) on 8/24/23 at 11:16 AM revealed she couldn't speak for the MDS Coordinator's error, and she did not know why she completed Resident #47's MDS inaccurately.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		9/26/23

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F 657	Continued From page 44 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident's interviews, the facility failed to revise care plans for 2 of 5 residents reviewed for care plan revision (Resident #18 and #27). Resident #18's care plan was not revised related to transfer assistance and refusal to wear lift slings. Resident # 27's care plan was not revised to indicate changes to an external catheter system. Findings included: 1.Resident #18 was admitted to the facility on 11/28/22 with diagnoses that included atrial fibrillation, Type 2 Diabetes Mellitus, and tremors. A physician order dated 12/7/22 specified Resident #18 required Apixaban (blood thinner) 5mg (milligrams) by mouth twice a day for atrial fibrillation.	F 657	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: Immediate care plan revisions were made for affected residents on 8/23/2023. Resident #27's care plan now specifies the updated external catheter system, and Resident #18's care plan includes updated guidance on transfer assistance and refusal to wear lift slings. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: An audit was completed on 8/23/2023 by the MDS Coordinator to ensure that all resident care plans were updated appropriately. The audit specifically looked at areas	

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F 657	Continued From page 45 A review of Resident #18's quarterly Minimum Data Set (MDS) dated 7/25/23 revealed Resident #18 was cognitively intact and required extensive 2-person assistance with transfers and was not steady for surface-to-surface transfer (transfer between bed and chair or wheelchair). The MDS also revealed the resident used a wheelchair for mobility and had not fallen since her admission. Resident # 18's care plan last revised on 8/22/23 included the resident was at risk for falls due to non-ambulatory and generalized weakness. The care plan contained interventions that included 1-2 person assist with all transfers (7/5/17), encourage the resident to ask for assistance with all transfers with resident stating she could transfer by herself. Documented falls on the care plan included 8/10/23 and 8/5/23. Nurse # 9 was interviewed on 08/22/23 at 2:42 PM. She stated the resident fell on 8/10/23 in the shower room with nurse aide (NA) # 6 transferring her with a sit-to-stand lift. Nurse #9 stated she educated NA # 6 she should have used a sling with the sit-to-stand when transporting a resident and it required 2 person assist to use the lift. An interview with the MDS Nurse on 8/24/23 at 11:07 AM stated she was aware Resident # 18 had refused to wear straps on the sit-to-stand lift after a fall that occurred on 8/5/23. The MDS nurse said Resident #18's care plan should have been updated to reflect the resident's refusal of slings. The MDS Nurse also stated Resident # 18's care plan should be updated to include the resident requires 2-person assistance with lifts. The DON stated on 8/23/23 at 4:34 PM that the	F 657	concerning bladder/urinary appliances, transfer status, and refusal of care as indicated. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Education and Policy Revisions: Education to the MDS Coordinator was provided on 9/14/2023 by the Director of Clinical Reimbursement, focusing on regulations concerning appropriate and timely care plan revisions. New Staff Onboarding: All new MDS hires will undergo training on updated care plan policies as a part of their orientation. Compliance Date: 9/26/2023 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of care plan accuracy and completeness will be conducted using a monitoring tool developed specifically for these deficiencies. These audits will be led by the Director of Nursing or their designee and will focus on reviewing a random sample of resident care plans, including those for residents with bladder/urinary appliances and those requiring transfer assistance. Following the initial four-week period, monthly audits will be conducted for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the	

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F 657	Continued From page 46 facility requires the use of 2-person assist when using a mechanical lift of any kind and a resident cannot refuse to wear slings with mechanical lifts. The resident's care plan should reflect she is 2-person lift and refuses to wear slings with the sit-to-stand. 2. Resident #27 was admitted to the facility on 1/12/21 with diagnoses that included acute pyelonephritis (inflammation of the kidney due to a bacterial infection). Resident #27's Medication Administration Record for June 2023 indicated an order for an external catheter system was discontinued on 6/1/23. Resident #27's quarterly Minimum Data Set (MDS) assessment dated 8/9/23 indicated Resident #27 was cognitively intact, had no external catheter and was always incontinent of urine. Resident #27's care plan last revised on 8/11/23 included a focus indicating Resident #27 had an external catheter system. Interventions included to change the external catheter sponge every 12 hours and as needed, place machine to protect privacy as able and empty canister each shift and when full. An interview with the MDS Coordinator on 8/23/23 at 3:32 PM revealed all nurses had access to update the care plans as needed when there were changes in a resident's care. The MDS Coordinator stated she last revised Resident #27's care plan on 8/11/23 but she did not discontinue Resident #27's external catheter system. She stated that she overlooked the care plan and did not note that the external catheter	F 657	results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023.	

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F 657	Continued From page 47 system wasn't re-ordered when Resident #27 came back from the hospital. She added that Resident #27's care plan should have been updated to reflect her current care and treatment. An interview with the Director of Nursing (DON) on 8/24/23 at 11:16 AM revealed the external catheter system should have been taken out of Resident #27's care plan when it was discontinued. The DON stated that the MDS Coordinator was responsible for updating the care plans and she expected her to do her job and not have to check behind her work.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans 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 observations, record review, and staff interviews, the facility failed to follow the physician order for no straws for 1 of 1 resident (Resident #65) reviewed for professional standards. The findings included: Resident #65 was readmitted to the facility on 7/1/23 with diagnoses inclusive of dysphagia, pneumonia, and congestive heart failure. An admission Minimum Data Set assessment dated 6/6/23 indicated Resident #65 had moderate cognitive impairment, required extensive assistance with eating.	F 658	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: On 8/24/23, the Unit Manager removed all straws from the room of Resident #65 in compliance with the physician order. Immediate education was provided to NA#3 by the Unit Manager to ensure a complete review of the meal ticket prior to serving trays, emphasizing the importance of adhering to physician orders, specifically against the use of straws for Resident #65.	9/26/23

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F 658	Continued From page 48 A revised care plan dated 7/1/23 indicated Resident #65 had a nutritional problem related to mechanically altered diet, need for assistance at meals and no straws were to be used. A review of a physician order dated 8/9/23 indicated Resident #65 was not to have straws. During an observation on 8/21/23 at 12:00 PM Nurse Aide (NA) #3 assisted Resident #65 with his lunch meal and allowed him to sip sweet tea from the straw. An observation of Resident #65's room on 8/24/23 at 11:07 AM revealed a cup of water with a straw sitting on the bedside table with Resident #65's name and date written on the cup. During a phone interview on 8/24/23 at 11:17 AM the Registered Dietician revealed she entered the care plan of "no straws" for Resident #65, according to the diet order on 7/1/23 and she expected the order to be followed by nursing staff. During an interview on 8/24/23 at 12:06 PM NA #12 indicated she was assigned to Resident #65 at the time of the interview and that she did not use a straw when she fed the resident at breakfast because she reviewed the meal ticket that indicated "no straws." During a follow-up interview on 8/24/23 at 12:13 PM NA #3 indicated she was usually assigned to Resident #65 and she normally used a straw to administer his sweet tea and water. She further stated she was unaware he was not supposed to have straws. She reported, although she	F 658	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: An audit will be conducted to identify residents with physician's orders for special meal instructions. This audit will be led by Unit Managers, Speech Therapist, and the Dietary Manager. The primary focus of the audit will be to ensure that all special instructions from physicians related to meal intake are accurately reflected on the meal tickets. Compliance Date: 9/26/23 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: By September 26, 2023, nursing staff will be re-educated on the importance of reviewing meal tickets prior to serving meal trays to ensure compliance with physician's special instructions. This educational initiative will be led by the Director of Nursing or their designee. The Resident Dietary and Feeding Policy will also be revised to explicitly outline the necessity of cross-referencing meal tickets with physician's orders for special dietary instructions. A mandatory in-service training session will be conducted, also led by the Director of Nursing or their designee. This session will cover the revised policy and emphasize the need for meticulous review of meal tickets. This revised training and policy information will be included in the	

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F 658	Continued From page 49 reviewed the meal ticket that accompanied his meal tray, she may have overlooked the words "no straws." NA #3 immediately entered the resident's room and removed the straw from his cup of water that was located on his over bed table. During an interview on 8/24/23 at 12:17 PM Nurse #6 revealed she administered Resident #65's dietary supplement via a straw and that she was unaware he was not supposed to have a straw unless she specifically reviewed his diet order. Otherwise, alerts were usually displayed on the medication administration record (MAR). During an interview on 8/24/23 at 12:27 PM the Speech Therapist revealed Resident #65 was discharged from speech therapy on 6/8/23 with the recommendation for "no straws" due to cognitive deficits related to having no concept of grasping and drinking from a cup independently, whereas he needed maximum assistance with feeding. During an interview on 8/24/23 at 12:40 PM, Unit Manager #1 indicated she did not realize that staff was administering liquids via a straw, especially since "no straws" was indicated on the meal tray ticket. Her expectation was for staff to read the meal tickets before assisting Resident #65 with his meals or providing fluids throughout the day. During an interview on 8/24/23 at the Director of Nursing revealed she expected all staff to adhere to physicians orders, meal tickets and care plans that indicated "no straws" for Resident #65.	F 658	orientation for all newly hired staff and agency staff. Compliance Date: 9/26/2023 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: To ensure that solutions are sustained, the Director of Nursing or their designee will carry out targeted weekly audits for a period of four weeks. These audits will focus on monitoring three residents with special meal instructions to ensure that the guidelines are correctly listed on meal tickets and properly followed. After the initial four-week period, monthly audits will be conducted for three months. The auditing process will involve a review of the meal tickets alongside the actual practices in place. These results will then be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee either during their regular monthly meetings or immediately if any deficiency is found. Should the audits indicate that the desired outcomes or goals are not being maintained or achieved, immediate re-education will be led by the Director of Nursing or their designee. A root cause analysis will also be performed to identify necessary adjustments to policies or procedures. Auditing will continue until sustained compliance and desired outcomes have been consistently achieved for at least three consecutive months. At that point, the frequency of audits may be reconsidered and adjusted as deemed appropriate by the QA/QAPI Committee. If	

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F 658	Continued From page 50	F 658	future audits reveal any deficiencies, the frequency will revert back to weekly until compliance is re-established for a minimum of one month, after which the monthly audits will resume. Any changes to the auditing schedule or procedures will be properly documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, family and staff interviews, the facility failed to complete daily foot inspections as specified in the plan of care and weekly skin assessments for a resident with a diagnosis of diabetes for 1 of 1 sampled resident (Resident #65). Due to the lack of assessments the facility was not aware the resident had swollen and scabbed toes on his right foot. The findings included: Resident #65 was admitted 5/26/23 and	F 684	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 8/22/23, Unit Managers conducted a comprehensive skin assessment, including a foot inspection, for Resident #65. Based on the findings, the physician was promptly notified, and treatments were ordered and executed on the same day by the Unit Manager. 2. Address how the facility will identify	9/26/23

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readmitted to the facility on 7/1/23 with diagnoses inclusive of metabolic encephalopathy, type 2 diabetes without complications, and congestive heart failure.

An Admission skin inspection report dated 5/26/23 indicated no rashes or ulcers completed by a nurse.

An admission Minimum Data Set (MDS) assessment dated 6/6/23 indicated Resident #65 had moderate cognitive impairment, speaks Spanish, and understands little English, required extensive assistance with bed mobility, transfers, personal hygiene, toileting, eating, dressing, and total dependence for bathing. The admission MDS indicated the Resident was at risk for pressure ulcers and had no foot infection or diabetic foot ulcers.

A care plan dated 6/7/23 indicated Resident #65 had diabetes with a goal for no complications. Interventions included referral to podiatrist/ foot care nurse to monitor/ document foot care needs and to cut long nails, inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness.

A review of Resident #65's medical record revealed nursing staff performed a skin assessment on 7/7/23 and indicated no skin issues. There were no additional weekly skin assessments documented in the Resident's medical record.

A review of the Visual/Bedside Kardex (desktop file system that gives a brief overview of resident and updated every shift) Report indicated Resident #65 required skin inspection with daily

other residents having the potential to be affected by the same deficient practice:
By 9/26/23, the Director of Nursing and Nurse Managers will complete a thorough review of all weekly skin assessments for residents with similar care needs, particularly those with diabetes or conditions requiring specialized skin and foot care. This review will ensure the completion and ongoing weekly scheduling of skin assessments in the electronic medical record. Physicians will be notified of any changes in condition, and appropriate treatment orders will be issued as needed, including podiatry referrals.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
By 9/26/23, the Director of Nursing or Nurse Manager will educate current Licensed Nurses and Nurse Aides on the proper procedure for completing weekly skin assessments, including foot inspections. Staff will also be instructed on the required steps for notifying the Physician and the Director of Nursing of any changes in resident condition. This education will become a standardized component of orientation for newly hired staff and agency staff. The Director of Nursing will ensure that this training is consistently provided to all new staff members.

4. Indicate how the facility plans to monitor its performance to make sure that

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F 684	Continued From page 52 care rounds that included observation of redness, open area, scratches, cuts, bruises and for staff to report changes to the Nurse. The Kardex can be accessed by nursing staff. Review of the medical record revealed no documentation of daily foot inspections. During an interview and observation on 8/22/23 at 1:00 PM, Resident #65's family was visiting and complained of bringing a concern about his right foot to staff about two weeks after admission, but nothing had been done. The family member stated they reported their concern to a tall nurse with long braids in mid-July (could not recall specific date) and was told that a wound doctor or nurse would assess the toes but that never happened. The family member removed the sock on his right foot to expose the toes. Resident #65's right 1st, 2nd, and 3rd toes were observed to be swollen, scabbed, and reddened. No drainage or odor were noted. The family member also provided pictures dated 7/11/23 of the Resident's swollen and scabbed toes. During an observation and interview (while family was present) on 8/22/23 at 1:05 PM, the Unit Manager #1, observed Resident #65's three toes (1st, 2nd and 3rd toes) on right foot and stated they appeared swollen and discolored. She revealed she was unaware that the Resident needed foot care and added that nursing staff were responsible for completing weekly skin assessments. She assessed for pain and the Resident reported pain to right foot. She reassured the family that she would submit a referral to the wound nurse. A review of the Unit Manager's change in	F 684	solutions are sustained: Weekly audits of skin assessments, including foot inspections, will be conducted by the Director of Nursing, Unit Managers, or their designee for a period of four weeks, followed by monthly audits for three months. These audits will include observation of 5 randomly selected residents. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Director of Nursing or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Date of compliance: Ongoing, with initial compliance by 9/26/2023	

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condition progress note dated 8/22/23 revealed she evaluated Resident #65 due to change in skin color or condition and observation of scabbed bunions to right 1st, 2nd, and 3rd toes with discoloration. The note further indicated the Resident described tingling feeling to the area.

During a follow up interview on 8/23/23 at 1:50 PM the Unit Manager revealed she was unaware skin assessments had not been completed by nursing staff for Resident #65 since 7/7/23 and skin assessments were usually completed weekly as standard practice. However, she was unaware the Resident's care plan and Kardex indicated daily foot inspections or daily skin inspections, which were not being performed and documented. Nursing staff were expected to review the Kardex for each Resident they cared for during their shift. Also, nurses would be alerted via the MAR about the need to perform weekly skin assessments.

During an interview on 8/22/23 at 1:08 PM Nurse Aide (NA) #3 indicated she usually gave Resident #65 a bed bath because he usually refused a shower. NA #3 stated she saw the blisters on his feet when she dressed him that day but did not think they were bad enough to report to the nurse or the nurse may have already known about the blisters. She stated that she did not always read the Kardex.

During an interview on 8/23/23 at 1:01 PM NA #2 revealed she was assigned to Resident #65 at the end of July and early August 2023. She further revealed she noticed sores on his right foot when she washed his feet and put on his socks. She indicated she could not recall which nurse she reported her observations to.

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During an interview on 8/24/23 at 9:28 AM NA #11 indicated she had worked with Resident #65 on two occasions and never observed sores or bruises on his feet.

During an interview on 8/22/23 at 1:18 PM Nurse #8 revealed she was assigned to Resident #65 for the third time, and she normally completed a skin assessment if it came up on the medication administration record (MAR) as she administered medications. Nurse #8 stated she would only know to complete skin assessments if it populated on the MAR and his did not populate/ prompt her to complete one. She further revealed if an NA observed an area of the body that needed to be assessed, she expected the NA to report it to Nursing staff and she was not aware Resident #65 had areas on his foot that needed wound care.

During an interview on 8/23/23 at 4:19 PM the Director of Nursing (DON) indicated skin assessments were to be completed on a weekly basis by nursing staff, who would then send a referral to the wound nurse for an assessment of the skin area, who would then inform the wound doctor who will determine wound care treatment. The interview further revealed the DON was not aware Resident #65 was to have his feet inspected daily.

F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		9/26/23

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

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F 689	Continued From page 55 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, resident, and Nurse Practitioner interviews the facility failed to secure a resident for transfer using a mechanical sit-to-stand lift according to manufacturer's recommendations resulting in two falls. This was for 1 of 5 residents reviewed for supervision to prevent accidents (Resident #18). The findings included: Resident #18 was admitted to the facility on 11/28/22 with diagnoses that included atrial fibrillation, Type 2 Diabetes Mellitus, and tremors. A review of Nurse Aide (NA) # 7 and NA # 6's competency check lists revealed both NAs had completed all competencies, that including transferring a resident. The competencies were completed by the Director of Nursing (DON) on 2/25/23. A review of Resident #18's quarterly Minimum Data Set (MDS) dated 7/25/23 revealed Resident #18 was cognitively intact and required extensive 2-person assistance with transfers and was not steady for surface-to-surface transfer (transfer between bed and chair or wheelchair). The MDS also revealed the resident used a wheelchair for mobility and had not fallen since her admission. Resident #18's current care plan revised on	F 689	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: The affected resident was reevaluated and educated by the Director of Nursing or Designee concerning proper safety measures for transfers using a sit-to-stand lift, according to manufacturer's guidelines. Additionally, the resident was evaluated by a physician following the falls. The CNAs involved in the transfer were also educated on proper securement techniques during mechanical sit-to-stand transfers. Responsible Person: Director of Nursing or Designee Compliance Date: 9/26/2023 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: An audit will be conducted by the Director of Nursing or Designee on all incident/accident risk reports for the previous 90 days to ensure that no other incidents related to improper securement on mechanical lifts are identified. All nursing staff will be interviewed to identify any potential resident behaviors related to the refusal of safety equipment on mechanical lifts,	

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F 689	Continued From page 56 8/22/23 revealed the resident was at risk for falls related to being non-ambulatory with generalized weakness and listed falls on 8/5/23 and 8/10/23. Interventions included to encourage and remind the resident to ask for assistance before transfers (11/15/22) and reinforce safe use of adaptive devices during transfers (8/11/23). Furthermore, an intervention for referral to Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat as indicated for transfer training to include assistive devices as indicated (8/5/23, 8/10/23). A review of the facility incident report dated 8/5/23 at 8:15 PM revealed while NA # 7 transferred Resident # 18 from the sit-to-stand lift to toilet the resident fell to the floor when she was lowered to the toilet. Nurse # 9 found Resident #18 sitting on the floor in the toilet area of the shower room. Resident #18 stated as she was being transferred from the sit- to -stand to the toilet, her hands gave out and she couldn't hold on to the sit-to-stand. Nurse # 9 assessed Resident #18 for injury and then placed into her wheelchair by a 2-person lift. Resident #18's vitals were obtained and were within normal limits. No injuries occurred to Resident #18, and a therapy referral for transfer training and strengthening was ordered. A review of progress notes revealed on 8/6/2023 at 2:18 AM Nurse #9 was notified by Resident #18's assigned NA that while the resident was transferred from the sit-to-stand lift to toilet the resident fell to the floor when she was lowered to the toilet. The fall occurred in the toilet area of the shower room. Nurse #9 assessed Resident # 18 for injuries, none were noted. The resident was transferred from the floor into her wheelchair by 2-person sling lift with two staff. Resident #18's	F 689	including lift slings and straps. Responsible Person: Director of Nursing or Designee Compliance Date: 9/26/2023 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Training/Education: Mandatory training sessions led by the Director of Nursing or Designee will be implemented to educate nursing staff, including CNAs and nurses, on proper procedures for securement during mechanical sit-to-stand transfers as per the manufacturer's recommendations. Policy Revisions: The existing Patient Transfer and Mechanical Lifts Policy will be thoroughly reviewed and updated to enforce stringent compliance with manufacturer guidelines for lift operations. New Staff Onboarding: As part of the orientation process, all new hires will undergo specialized training to ensure they are well-versed in the updated policies and procedures related to mechanical lift transfers. Compliance Date: 9/26/2023 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits will be conducted by the Administrator, Director of Nursing, or their designee for an initial four-week period. These audits will include a minimum of 3 direct observations of actual mechanical lift transfers and a comprehensive review	

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F 689	Continued From page 57 vitals were obtained and were within normal limits and will continue with plan of care. NA #7 was unable to be reached for an interview and no longer employed at the facility. On 8/22/23 at 2:42 PM Nurse #9 was interviewed and explained that she was working on 8/5/23 when Resident #18 fell. Nurse #9 reported on 8/5/23 she heard NA# 7 yell for help while Nurse # 9 was in the hallway. Nurse# 9 stated she went to the shower room and saw Resident #18 sitting on the floor on her buttocks. The NA# 7 stated Resident #18 was being transferred to the toilet from the sit-to-stand and lost grip of the handles and slipped to the floor. Nurse # 9 said the resident did not have her strap for the sit-to-stand around Resident #18 or on the sit-to-stand and there was not another NA present during the transfer. The nurse provided education to the NA that straps are required for transfer with the sit-to-stand and required 2 people to use the lift with the resident. The resident reported to Nurse # 9 that her hands had slipped from the handles of the sit-to-stand and she slipped to the ground. The resident reported she was not in pain. Nurse #9 assessed the resident for injury then transferred the resident from the floor to her wheelchair with a 2-person sling lift and was taken to the resident's room. The Nurse stated she informed the MD, the resident's responsible party, and the DON. Nurse #9 stated the DON provided education to the Nurses and NAs on lift safety the following day. A review of the lift and transfer safety education dated 8/6/23 revealed all nurses and NAs received education conducted by the DON.	F 689	of all incident reports related to falls. After this initial four-week period, monthly audits will be conducted for the subsequent three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. If the audits indicate that the desired outcomes are not being achieved or maintained, re-education will be administered by the Administrator, Director of Nursing, or their designee. A root cause analysis will also be undertaken to determine necessary changes. Audits will continue until sustained compliance and desired outcomes are achieved for a minimum of three consecutive months. Thereafter, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should future deficiencies emerge, audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, after which monthly audits will resume. Any changes to the audit schedule or methodology will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	

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A review of the facility incident report dated 8/10/23 at 9:20 PM revealed Nurse # 9 was called to the shower room and observed Resident #18 on the floor in the toilet area. Resident # 18 was observed without lift straps on. Resident # 18 was assessed for injuries with no injuries noted and vital signs were obtained and within normal limits. Resident # 18 complained of pain to the thoracic, lumbar and coccyx area. The resident stated she felt her hands slip off the sit-to-stand and fell to the floor. Resident # 18 was lifted from the floor with a 2-person lift, transferred to a wheelchair and then to her bed. Resident #18 reported she had pain in her thoracic, lumbar and coccyx area of her back (spine from the shoulders to tail bone) level as 7 out of 10, she was given acetaminophen 325 mg, and a verbal order was given by the Nurse Practitioner (NP) for an X-Ray to her back dated 8/10/23. The resident was not transported to the hospital.

On 8/10/23 at 9:21 PM Nurse #9 wrote in part she was called to the shower room and observed Resident #18 in the toilet area without a lift pad on. The nurse assessed the resident for injuries and noted none and the resident's vitals were obtained and were within normal limits. Resident #18 did have complaints of pain to the thoracic, lumbar and coccyx area and was assessed for injuries with none noted. The resident was lifted from the floor with the 2-person lift to her wheelchair and then to her bed. The resident was administered pain medication. A verbal order was given by the NP for the resident to get an X-Ray of her back.

A review of the physician's orders dated 8/10/23 revealed an order for acetaminophen 325 mg

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every 4 hours as needed for pain and an ice pack every 2 hours for 15 minutes as needed for pain.

Review of the physician orders for Resident #18 revealed an order for X-Ray to lower back for complaints of pain dated 8/10/23.

Review of the x-ray report dated 8/11/23 revealed the thoracic spine, lumbar spine, sacrum, and coccyx did not contain an acute fracture.

The Therapy Director was interviewed on 8/21/23 at 5:00 PM. She stated Resident # 18 had been receiving continuous therapy while at the facility. Resident # 18 started receiving PT on 7/18/23 and OT on 7/20/23. The Therapy Director added Resident # 18 had good upper body strength and was able to use the sit-to-stand safely.

Nurse # 9 was interviewed on 08/22/23 at 2:42 PM regarding the fall on 8/10/23 was similar as the fall on 8/5/23 but with a different NA. Nurse #9 was in the hall and heard NA # 6 yell for help from the shower room. The nurse saw Resident #18 sitting on the floor in the toilet area. The resident did not have her strap around her back and the strap was not present in the shower room. Resident #18 was assessed for injury and complained of lower back pain, the resident did not hit her head. Resident #18 stated she lost her grip on the sit-to-stand and fell to the floor when transferring to the toilet. NA #6 reported the resident had refused to wear the straps when using the sit-to-stand lift. The resident was placed into her wheelchair by a 2-person sling lift and transported to her room and was assessed

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further. Nurse #9 stated she educated NA # 6 she should have used a sling with the sit-to-stand when transporting a resident and it required 2 persons to use the lift.

A review of the lift and transfer safety education dated 8/11/23 revealed all nurses and NAs received education conducted by the DON.

Attempts were made to interview NA #6 but she was not able to be interviewed during the investigation.

The facility's NP #2 was interviewed on 8/23/23 at 11:59 AM. NP #2 stated she recalled Resident #18's fall that occurred on 8/10/23 and had seen the resident on 8/11/23 for an assessment. Resident #18 told the NP that her hands had slipped off the bar and that she had refused to use the straps on the lift. The NP said Resident #18 did receive an X-Ray that found no injuries. NP# 2 stated she had assessed the resident and found no injuries from the fall.

The DON stated on 8/23/23 at 4:34 PM the fall on 8/5/23 occurred in the shower room with NA #7 transferring Resident #18 to the toilet. Nurse # 9 was not able to give much detail on the fall. The DON made attempts to interview NA #7 about the fall and was not able to speak with the NA. NA # 7 did not return to work and terminated from the facility. On 8/10/23, NA #6 was transferring Resident #18 to the toilet from the sit-to-stand when the resident slipped from the sit-to-stand onto the floor. The DON stated it was not possible for a resident to slip from the sit-to-stand when the resident is wearing straps required for

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the sit-to-stand to be used and the resident did not have the straps on when being transferred. The DON stated NA #6 was given 1 to 1 education from her on lift safety and how to use the sit-to-stand lift. NA # 6 stated that Resident #18 refused to use the straps required for the sit -to -stand when transferring, and the straps were not used. The DON added the use of mechanical lifts, including the sit-to-stand had to be used based on manufacturers procedures even if a resident refuses to use a strap. A resident can't refuse to use the straps on a lift that could cause a resident to fall. The DON said she was not aware the sit-to-stand lift for Resident # 18 was being used without both straps until the 8/5/23 fall. The resident should have been transferred using a 2-person full lift sling when the sit-to-stand strap was refused. The DON stated the facility is a 2-person lift facility and all mechanical lifts require 2-persons to operate.

An interview with Resident # 18's assigned NA on 8/23/23 at 11:29 AM was conducted. NA # 8 stated Resident #18 required the use of a sit-to-stand to transfer from bed to chair or to toilet. The NA said 2 straps were required to use the sit-to-stand lift, one for the legs and one around the back and under the resident's arms. NA #8 stated it takes 2 staff to use a lift on a resident, and she always used the required straps for the lifts.

Resident #18 was interviewed on 8/21/23 at 3:14 PM and on 8/24/23 at 11:42 AM. Resident #18 reported she could not remember in detail what happened with the fall on 8/5/23, but she had slipped to the floor after losing grip on the handles of the sit-to-stand lift. The resident stated she did not get hurt and could not recall if the

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strap was placed around her during the transfer. Resident # 18 stated there was only one NA with her when she slipped and could not remember her name. On 8/10/23, the resident said she fell back against the toilet and onto the floor when transferring from the sit-to-stand to the toilet. Resident #18 told the NA that her hands were slipping from the grip, and she could not hang on before falling. When her assigned nurse came in the shower room, she was told to always use the strap when standing up on the lift and to not stand up without the strap on. Resident # 18 stated that her back was sore after that fall and had an X-Ray that showed no fractures. The resident said she could not remember the NA's name with her and there was only 1 NA in the shower room with her. Additionally, Resident #18 stated she did not need the straps on her when using the sit-to-stand because she was able to stand up without support and had told NA's not to use the straps.

An observation of Resident #18 during a sit-to-stand transfer occurred on 8/23/23 at 11:35 AM. Present in the room was NA #8 and Resident #18's assigned Nurse #10 for the transfer. Resident #18 was sitting on the edge of her bed as NA # 8 placed the strap around her back and under her arms before attaching the strap to the sit to stand. The resident's feet were placed on the sit-to-stand platform and Resident #18's legs were strapped onto the lift. Resident #18 was lifted and transferred to the wheelchair without incident.

The Administrator stated on 8/24/23 at 1:02 PM. The Administrator stated he was not aware Resident #18 had fallen without the use of the

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F 689	Continued From page 63 required slings around her back and legs on 8/5/23 and on 8/10/23. He stated staff transferring a resident using a mechanical lift should follow the facility's policy requiring a 2-person lift and the manufactures requirements for using the lift. The Administrator added, residents are required to use all safety straps and equipment required for the safe transfer of residents.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		9/26/23

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F 690	Continued From page 64 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to prevent a urinary catheter bag from touching the floor for 1 of 1 resident (Resident #14) reviewed for urinary catheters. The findings included: Resident #14 was admitted to the facility on 3/30/23 with diagnoses that included urinary retention and acute cystitis (bladder infection). Resident #14's care plan revised dated 4/18/23 indicated Resident #14 had potential for urinary tract infection (UTI) related to urinary retention and use of indwelling catheter. Interventions included to monitor, document and report signs and symptoms of UTI. The quarterly Minimum Data Set (MDS) assessment dated 7/11/23 indicated Resident #14 was moderately cognitively impaired, did not exhibit rejection of care behaviors and had an indwelling catheter. An observation was made on 8/22/23 at 4:19 PM of Resident #14 while she was sitting in her wheelchair in the hallway facing the lobby. Resident #14 had a urinary catheter with the	F 690	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: Immediate elevation of the urinary catheter bag for Resident #14 was accomplished to ensure it no longer touched the floor. A complete assessment and cleaning of the urinary catheter and bag system for Resident #14 were also completed. Responsible Person: Director of Nursing or Designee Compliance Date: 9/26/2023 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: Observations will be conducted on all residents with Foley catheters to ensure no other catheter bags are touching the floor. Responsible Person: Director of Nursing/Unit Manager or Designee Compliance Date: 9/26/2023 Address what measures will be put into place or systemic changes made to	

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F 690	Continued From page 65 urinary catheter bag touching the floor. A second observation of Resident #14 on 8/22/23 at 5:42 PM revealed her urinary catheter bag touching the floor while she was sitting in her wheelchair in the hallway. A third observation of Resident #14 on 8/23/23 at 12:06 PM revealed her sitting in her wheelchair while in her room with her urinary catheter bag touching the floor. An interview with Nurse Aide (NA) #2 on 8/23/23 at 12:07 PM revealed she tried to position Resident #14's urinary catheter bag off the floor but it kept on sliding down and touching the floor. NA #2 stated that she knew Resident #14's urinary catheter bag was supposed to be off the floor, but she didn't know where to hook it up under her wheelchair where it won't touch the floor. An interview with Nurse #7 on 8/23/23 at 12:34 PM revealed she had noticed Resident #14's urinary catheter bag touching the floor earlier when Resident #14 was sitting in her wheelchair near the medication cart. Nurse #7 stated she planned on re-adjusting Resident #14's leg strap and see if that would help with getting her catheter bag off the floor, but she had not gotten around to doing it. An interview with NA #3 on 8/24/23 at 10:01 AM revealed she was assigned to Resident #14 on 8/22/23 but did not notice her urinary catheter bag touching the floor. NA #3 stated she hooked it in the middle of the bar under Resident #14's wheelchair because it would be in the way when she propelled herself if she hooked it on the side	F 690	ensure that the deficient practice will not recur: Staff Training/Education: A mandatory in-service will be held for nursing staff led by the Director of Nursing/Unit Manager or designee. The training will cover Foley catheter care and the importance of keeping catheter bags elevated off the floor. New Staff Onboarding: All newly hired nursing staff will be educated on these policies as part of their orientation. Compliance Date: 9/26/2023 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of Foley catheter care will be conducted using a monitoring tool developed specifically for these deficiencies. These audits will be conducted by the Director of Nursing or their designee for a period of four weeks, followed by monthly audits for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a	

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(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 690	Continued From page 66 of her wheelchair. An interview with Nurse #8 on 8/24/23 at 10:11 AM revealed she remembered seeing Resident #14 sitting in her wheelchair when she took care of her on 8/22/23 but did not notice her catheter bag touching the floor. Nurse #8 stated she did not receive any report from the nurse aides about issues with positioning Resident #14's catheter bag so it would not touch the floor. An interview with Nurse Manager #1 on 8/23/23 at 12:12 PM revealed she did not notice Resident #14's urinary catheter bag touching the floor and she had not been notified of any issues with keeping it off the floor. Nurse Manager #1 stated Resident #14's urinary catheter bag should have been positioned off the floor. An interview with the Director of Nursing (DON) on 8/24/23 at 11:16 AM revealed she had not noticed Resident #14's urinary catheter bag touching the floor whenever she was sitting in her wheelchair. The DON stated she did not know why her staff would let it sit on the floor when they knew what they were supposed to do. She added that Resident #14's catheter bag should not be on the floor.	F 690	minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	
F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 726		9/26/23

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	345201	A. BUILDING _____ B. WING _____	C 08/29/2023

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F 726	Continued From page 67 resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, the facility failed to ensure Medication Aide (Agency MA #1) and other nursing staff were trained and competent in cleaning and disinfecting glucometers (blood glucose machine) according to manufacturer recommendations using an Environmental Protection Agency (EPA) approved disinfectant cloth, between resident usage. Agency MA #1 was observed not cleaning and disinfecting a shared glucometer between use with three residents (Resident #28, Resident #30, and Resident #57). Interviews with Nurse #2, Nurse #6 and Nurse #10 revealed each nurse was unable to describe glucometer disinfection	F 726	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: All glucometers used on Resident #28, Resident #30, and Resident #57 were immediately cleaned and disinfected as per manufacturer recommendations. An assessment was also conducted for these residents to check for any potential adverse health impacts. The involved Medication Aides were promptly removed from the unit and sent home pending	

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F 726	Continued From page 68 procedures. This deficient practice involved four of four nursing staff. The immediate jeopardy began on Sunday, 8/20/23 when a Medication Aide (Agency MA #1) demonstrated she was not competently disinfecting a shared glucometer between resident use per manufacturer's recommendations. The immediate jeopardy was removed on 8/23/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "E" (no actual harm that is immediate jeopardy) to ensure monitoring systems are put into place are effective. The findings included: Cross refer to tag F 880. Based on observations, record reviews, staff, Nurse Practitioner #1, Medical Director, and Local Health Department Nurse interviews, the facility failed to clean and disinfect a glucometer used for more than one resident (blood glucose meter) according to manufacturer's recommendations using an Environmental Protection Agency (EPA) - approved disinfectant cloth, between resident usage. The risk of spreading bloodborne infections is very serious if the products and procedures are not followed. The facility confirmed there were residents who had bloodborne pathogens. This occurred for 3 of 3 sampled residents who were required to have their blood sugars checked (Resident #28, Resident #30, and Resident #57) and 1 of 1 staff observed performing blood glucose monitoring (MA#1). This practice affected 3 of 4 residents on	F 726	further training and evaluation. Responsible Person: Director of Nursing Services or Designee Compliance Date: 9/26/2023 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: A comprehensive audit will be implemented to assess all nursing staff's compliance with the manufacturer's recommendations for cleaning and disinfecting glucometers. Responsible Person: Director of Nursing Services or Designee Compliance Date: 9/26/2023 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Training/Education: Mandatory in-service training sessions will be held for nursing staff. The Director of Nursing Services will lead these sessions, focusing on glucometer disinfection protocols, including the correct use of EPA-approved disinfectant cloths. Medication aides will be informed that they are no longer authorized to perform blood sugar checks. Policy Revisions: The Medical Equipment Disinfection Policy will be updated to include explicit procedures for cleaning and disinfecting glucometers. Additionally, the policy will now explicitly states that medication aides are not authorized to perform blood sugar checks and that this duty will be limited to qualified nursing	

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F 726	Continued From page 69 the assigned unit and could potentially affect 17 residents in the facility who required glucose monitoring. A review of Agency MA #1's employee training records from the nursing home and staffing agency revealed there was no medication aide training to include cleaning and disinfecting of a glucometer. An interview with Medication Aide (MA #1) with the DON present on 8/20/23 at 1:30 PM revealed she acknowledged was previously shown glucometers should be cleaned and disinfected between resident use, however, she stated she rushed to obtain blood glucose monitoring before the residents received their lunch trays and did not take the time to clean and disinfect the shared glucometer. MA #1 was also unable to verbalize the correct procedure to use with the EPA approved disinfecting wipes. An interview with Nurse #10 who was working the East Wing Cart #2 at 4:50 PM revealed she was responsible for obtaining blood glucose monitoring and aware the glucometers should be cleaned between residents but was unable to verbalize the correct procedure for cleaning and disinfecting the glucometers using the EPA approved disinfecting wipe. An interview with Nurse #2 who was working the West Wing Cart #1 at 4:53 PM revealed he was responsible for obtaining blood glucose monitoring and aware the glucometers should be cleaned between residents but was unable to verbalize the correct procedure for cleaning and disinfecting the glucometers using the EPA approved disinfecting wipe.	F 726	staff only. New Staff Onboarding: All new hires in relevant roles will be trained on the updated policy during orientation, including the restriction on medication aides from performing blood sugar checks. Compliance Date: 9/26/2023 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of glucometer cleaning and disinfecting practices using a monitoring tool developed specifically for these deficiencies will be conducted by the Nurse Managers, Director of Nursing, or their designee for a period of four weeks. These audits will include random reviews of 5 residents requiring blood glucose monitoring to ensure proper cleaning procedures are followed. Following the initial four-week period, monthly audits will be conducted for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three	

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A telephone interview with Nurse #6 on 8/21/23 at 8:55 AM revealed she had last worked in the facility as an agency nurse on Thursday 8/17/23. Nurse #6 had been responsible for blood glucose monitoring and was aware the glucometers were required to be cleaned and disinfected between each resident use but was unable to recall the correct procedure for performing this task or the correct kill time for the EPA wipes used in the facility.

An interview with the Director of Nursing (DON) on 8/20/23 at 1:30 PM revealed DON verified she was responsible for all staff training because the facility did not have a staff development coordinator. She also explained MA #1 had no education/training on how to clean and disinfect the glucometers by the facility or the staffing agency which she was hired as a nurse aide. MA #1 had received Nurse Aide competencies in the facility, but no medication aide training to include glucometer cleaning and disinfecting. The DON stated the facility did not currently have a system in place to verify credentials and competencies of agency staff and relied on the staffing agency to verify these.
A telephone interview with the Medical Director on 8/29/23 at 9:49 AM revealed he would expect all staff to perform care in a manner to prevent potential cross contamination of bloodborne illnesses.

An interview with the Administrator on 8/24/23 at 1:09 PM revealed he was new to the facility and left all training of nursing personnel to the DON, but he would have expected the glucometer to be cleaned and disinfected before and after use to decrease the spread of any potential illness.

consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval.
Compliance Date: Ongoing, with initial compliance by 9/26/2023

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Facility administration (Administrator and Director of Nursing) was notified of immediate jeopardy on 8/22/23 at 12:09 PM.

The facility provided the following plan for IJ removal.

Noncompliance Allegation: Based on observation, record reviews, and staff interviews, the facility failed to ensure Medication Aide #1 and other nursing staff were trained on how to thoroughly clean and disinfect a glucometer (blood glucose machine) according to manufacturer guidelines using an EPA- approved disinfectant cloth, between resident usage. This occurred for 3 of 3 residents who were required to have their blood sugars checked (Resident #28, Resident #30, and Resident #57).

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
" Observation, record review, resident, and staff interviews completed by the surveyor on 8/20/23 identified the facility failed to ensure training was provided to nursing staff for glucometer cleaning according to manufacturer guidelines using an EPA-approved disinfectant cloth between each resident usage. This occurred for 3 residents who were required to have their blood glucose levels checked (Resident #28, Resident #30, and Resident #57). Clinical staff failed to use the appropriate procedure to clean and disinfect a shared glucometer.
" On 8/20/23 and 8/21/23 the Director of Nursing and Unit Managers conducted interviews to evaluate understanding of the facility's glucometer disinfectant procedure prior to

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providing education with 25 Licensed Nurses- 11 of 25 are facility employees and 14 of 25 are agency nurses It was determined there was a knowledge deficit related to the facility process for disinfecting glucometers and Licensed Nurses were unable to recall previous training. No documentation of previous glucometer disinfection training during the last 3 months was identified by the Director of Nursing after reviewing completed training logs. Re-education of the facility process for disinfecting glucometers was initiated immediately by the Director of Nursing and Unit Managers.

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 Administrator educated the Unit Managers regarding the Glucometer Disinfection policy and procedures for using fingerstick blood glucose checks, managing glucometers and cleaning requirements. This was completed on 8/21/23.
" Current Licensed Nurses have received training from the Director of Nursing and Unit Managers:
o The purpose for following the cleaning checklist process, for glucometers due to the likelihood of cross-contamination and the spread of bloodborne pathogens among residents.
o The importance of cleaning and disinfecting the glucometer per manufacturer's guidelines, using the training/education checklist for Cleaning Glucometers that includes the process of cleaning and includes observation and return demonstration.
o This includes cleaning and disinfecting the individually issued glucometers that are stored at

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F 726	Continued From page 73 the residents' bedside. o On 8/22/23 return demonstration of process was observed by the Director of Nursing and Unit Managers to validate understanding. " The Director of Nursing and Unit Managers completed this education for current Licensed Nurses, including those working for agencies, on 8/21/23. This education was provided verbally with written documents for reference and a return demonstration completed by the Director of Nursing and Unit Managers. The orientation for new hires and agency staff will be updated to include the procedure for cleaning glucometers after use. The Director of Nursing approves all new Nursing Department hires and will maintain a log of all Licensed Nurses to ensure no staff are allowed to work without receiving this training. " The facility alleges the removal of Immediate Jeopardy on 8/23/23. On 8/24/23, the facility's immediate jeopardy removal plan effective 8/23/23 was validated by the following: Staff interviews revealed all nurses were able to verbalize they had received training on the proper cleaning procedure to clean and disinfect the glucometer before and after each use using an EPA approved disinfectant wipe and allow it to dry the appropriate amount of time based on the wipe used. Inservice training records of return demonstrations and of the updated policy were reviewed.	F 726		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		9/26/23

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F 732	Continued From page 74 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to post the accurate census on the daily nurse staffing sheet for five of five days of the recertification survey (8/20/23, 8/21/23, 8/22/23, 8/23/23, and 8/24/23).	F 732	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: The daily	

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F 732	Continued From page 75 The findings included: Review of the facility's detailed census report for the week of 8/20/23 revealed the resident census was 69 on 8/20/23 through 8/24/23. An observation of the daily nurse staffing sheet on 8/20/23 at 10:00 AM revealed a resident census of 71. An observation of the daily nurse staffing sheet on 8/21/23 at 8:31 AM revealed a resident census of 71. An observation of the daily nurse staffing sheet on 8/22/23 at 8:17 AM revealed a resident census of 71. An observation of the daily nurse staffing sheet on 8/23/23 at 8:15 AM revealed a resident census of 71. An observation of the daily nurse staffing sheet on 8/24/23 at 8:10 AM revealed a resident census of 71. During an interview on 8/24/23 at 10:15 AM the Director of Nursing (DON) revealed the scheduler was responsible for updating and posting the daily nurse staffing sheet and all the information on the sheet was expected to be accurate. The DON stated the resident census on 8/20/22 through 8/24/23 was 69 on each day. She was unsure why the daily nurse staffing sheets for those days were inaccurate. During an interview on 8/24/23 at 11:11 AM the Scheduler revealed she was responsible for the updating and posting of the daily nurse staffing sheets. She stated the facility was using a new system to create the daily nurse staffing sheet and the census automatically populated and she	F 732	nurse staffing sheets were reviewed and updated for accuracy to reflect the correct census. All inaccuracies for the dates specified have been corrected. Responsible Person: Administrator/Director of Nursing Services or Designee Compliance Date: 9/26/2023 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: Audits will be conducted to specifically assess the accuracy of the daily nurse staffing sheets for the past 90 days. These audits will include the verification of the correct census against the actual number of residents in the facility. Any incorrect staffing sheets with incorrect census will be corrected. Responsible Person: Administrator/Director of Nursing Services or Designee Compliance Date: 9/26/2023 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Policy Revisions: A comprehensive review and revision of the "Nurse Staffing Posting Policy" has been completed. The revised policy now includes a mandatory double-check system to specifically verify the accuracy of the daily nurse staffing sheets. Staff Training/Education: A targeted training session will be held for Scheduler,	

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F 732	Continued From page 76 did not know how to change the numbers. An interview was conducted with the Administrator on 8/24/23 at 1:10 PM. He stated the information on the daily nurse staffing sheet should be accurate.	F 732	Unit Managers, Receptionists, and Business Office Staff. The training will be led by the Administrator, Director of Nursing Services, or their designee and will specifically cover the correct procedures for updating and verifying the daily nurse staffing sheets. New Staff Onboarding: New hires for the positions of Scheduler, Unit Managers, Receptionists, and Business Office Staff will receive specialized training on the revised "Nurse Staffing Posting Policy" as part of their orientation process. Compliance Date: 9/26/2023 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of the accuracy of daily nurse staffing sheets will be conducted using a monitoring tool developed specifically for this deficiency. These audits will be conducted by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue	

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F 732	Continued From page 77	F 732	until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. • Compliance Date: Ongoing, with initial compliance by 9/26/2023	
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		9/26/23

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PELICAN HEALTH AT CHARLOTTE	2616 EAST 5TH STREET CHARLOTTE, NC 28204

(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 755	Continued From page 78 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with resident, staff, Pharmacist, Nurse Practitioner (NP #2) and the Medical Director (MD), the facility failed to acquire medications ordered for administration resulting in multiple doses of the prescribed controlled substance medication being missed for 1 of 1 resident reviewed for the provision of pharmaceutical services to meet a residents' needs (Resident #33). As a result of this deficient practice, Resident #33 had to be sent to the emergency department where she required 3 days of treatment for benzodiazepine (class of medications used to treat anxiety) withdrawal with delirium symptoms. The findings included: Resident #33 was admitted to the facility on 10/28/16. Her cumulative diagnoses included depression, anxiety, and bipolar disorder. Review of the physician's orders revealed an order dated 09/25/21 which indicated Resident	F 755	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/18/22, immediate action was taken to address the needs of Resident #33. After identifying the missed medication, Resident #33 was promptly sent to the emergency department for appropriate medical intervention and returned to the facility on the same date. Subsequently, the Unit Manager validated the current medication transcription for Resident #33 on 8/23/23 to ensure that all medications were being administered as ordered, and any discrepancies were promptly corrected. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The facility will undertake a comprehensive audit of all residents	

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F 755	Continued From page 79 #33 was to receive Xanax (Alprazolam) 0.5 milligram (mg): Give one (1) tablet by mouth three (3) times a day for anxiety disorder. Review of Resident #33's electronic Medication Administration Record (MAR) for October 2022 revealed she had not received Xanax as ordered on the following dates: On 10/15/22 at 10:00 PM, the MAR showed no dose of Xanax was administered. A chart code of "9" was documented on the MAR to indicate "other/see nurses' notes". There were no notes for 10/15/22 in the medical record that mentioned Resident #33 not receiving her Xanax. An interview with Nurse #18 on 8/23/23 at 6:09 PM revealed she recalled a day last fall where she came on shift and Resident #33 was already upset because she had been told the facility was out of her Xanax and was unable to refill the medication due to the provider not sending a new prescription to the pharmacy. Nurse #18 indicated Resident #33 called the police once if not twice that night on her shift due to not having her medication available. Nurse #18 stated she attempted to contact the on-call provider but was unable to obtain a new prescription for Resident #33 on her shift due to the provider being unfamiliar with the resident and the medication requested being a controlled substance. Nurse #18 stated she recalled Resident #33 experienced some delusions that shift, but later learned Resident #33 possibly had a urinary tract infection (UTI). Nurse #18 stated she had been taught nurses were to notify the provider between 3-5 days before a resident should run out of a controlled substance and day shift nurses should notify the provider who is in the facility daily	F 755	receiving narcotics to ensure the availability of medications for ordered administration. This audit will be led by the Director of Nursing and Unit Managers. Any discrepancies that are identified will be immediately reordered from the pharmacy to ensure proper medication administration moving forward. Date of Compliance 9/26/2023 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Education: To mitigate the risk of medication discrepancies, particularly for narcotics, comprehensive staff re-education has been initiated. The Director of Nursing and Unit Managers will lead a mandatory in-service focusing on proper protocols for obtaining narcotics after hours, including the use of automatic dispensing units and contacting the pharmacy for delivery. This mandatory in-service will be conducted for Nursing staff. Led by the Director of Nursing and Unit Managers, the training will focus on the established procedures for obtaining narcotics after hours, including utilization of the automatic dispensing unit and contacting the pharmacy for timely medication delivery. New Staff Onboarding: All new Nursing staff will receive training on the revised policy as part of their orientation to ensure consistent practices across the team. Compliance Date: 9/26/2023	

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F 755	Continued From page 80 during the week when inventory is low to prevent any residents from being without their routine ordered medications. A nurses' note dated 10/16/22 at 5:18 AM indicated during the 7P- 7A shift, Resident #33 had made telephone calls to 9-1-1 for various things to include: staff withholding medications. The note did not mention Resident #33 not receiving her Xanax. On 10/16/22 at 8:00 AM, the MAR showed no dose of Xanax was administered. A chart code of "9" was documented on the MAR to indicate "other/see nurses' notes". There were no notes for 10/16/22 in the medical record that mentioned Resident #33 not receiving her Xanax. On 10/16/22 at 2:00 PM, the MAR showed no dose of Xanax was administered. A chart code of "5" was documented on the MAR to indicate "hold/see nurses' notes". There were no notes for 10/16/22 in the medical record that mentioned Resident #33 not receiving her Xanax. An interview with Medication Aide #2 on 8/24/23 at 9:36 AM revealed she no longer worked in the facility and could not recall Resident #33 or why did not receive her scheduled medication. MA #2 verified her initials were who had signed the MAR as the medication not administered at 8 AM and 2 PM on 10/16/22. MA #2 stated if the medication is in the cart and ordered, she gives the medication as ordered. On 10/16/22 at 10:00 PM, the MAR showed no dose of Xanax was administered. A chart code of "9" was documented on the MAR to indicate "other/see nurses' notes". There were no notes	F 755	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of medication administration procedures, focusing specifically on the availability and timeliness of narcotics, will be conducted by the Nurse Managers, Director of Nursing, or their designee for a period of four weeks. These audits will include observation of 5 Licensed Nurses and verification of medication availability for 5 randomly selected residents receiving narcotics. Following the initial four-week period, monthly audits will be conducted for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will	

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F 755	Continued From page 81 for 10/16/22 in the medical record that mentioned Resident #33 not receiving her Xanax. An interview with Nurse #18 on 8/23/23 at 6:09 PM revealed she worked on night shift (7P-7A) on 10/16/22 and recalled she was unable to obtain Resident #33's medication due to a new prescription required by pharmacy. On 10/17/22 at 8:00 AM, the MAR showed a dose of Xanax was administered. On 10/17/22 at 2:00 PM, the MAR showed no dose of Xanax was administered. No reason provided as the time was left blank. There were no notes for 10/17/22 in the medical record that mentioned Resident #33 not receiving her Xanax. An interview with Nurse #17 on 8/26/23 at 9:46 AM revealed she worked day shift (7AM -7 PM) on 10/17/23. Nurse #17 stated she could not recall the exact date but recalled an event last fall where Resident #33 called the police accusing her and other nurses of not giving her medication that was not available or it was not time to receive the next dose. She did state there had been times with various residents where medications were out of stock and was not available for pharmacy to dispense due to the medication being a controlled substance and the on-call providers not being willing to refill the medication because they were not familiar with the resident. On 10/17/22 at 10:00 PM, the MAR showed no dose of Xanax was administered. A chart code of "9" was documented on the MAR to indicate "other/see nurses' notes". There were no notes for 10/17/22 in the medical record that mentioned Resident #33 not receiving her Xanax.	F 755	resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	

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F 755	Continued From page 82	F 755		

An interview with Nurse #4 on 8/24/23 at 9:03 AM revealed she worked on 10/17/22 on night shift and could not recall why Resident #33 did not receive her medications on 10/17/22; however, she stated if she realized Resident #33 did not have her medications available, she was first to contact the pharmacy to see if it could be dispensed. If the pharmacy was unable to dispense for reasons of a new prescription needed, she was to contact the on-call provider to obtain one. Nurse #4 stated that due to Resident #33's medication being a controlled substance, her experience with the on-call providers was that they were not comfortable providing a prescription because they were unfamiliar with the resident and the resident would have to go without her medication regardless of potential side effects or adverse reactions Resident #33 might experience until the routine provider was on duty during the weekdays (Monday through Friday).

On 10/18/22 at 8:00 AM, the MAR showed no dose of Xanax was administered. A chart code of "9" was documented on the MAR to indicate "other/see nurses' notes". There were no notes for 10/18/22 in the medical record that mentioned Resident #33 not receiving her Xanax; however, a note written at 7:40 AM mentioned Resident #33 had confusion related to her ex-husband's death and having increase anxiety over the weekend.

The facility was unable to identify the initials of the staff member who signed the MAR on 10/18/22 at 8 AM and therefore this staff member was unable to be interviewed during the investigation.

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F 755	Continued From page 83	F 755		

On 10/18/22 at 2:00 PM, the MAR showed no dose of Xanax was administered. A chart code of "9" was documented on the MAR to indicate "other/see nurses' notes". There were no notes for 10/17/22 in the medical record that mentioned Resident #33 not receiving her Xanax.

A provider progress note written by NP #2 on 10/18/22 indicated Resident #33 reported to her that she had not been given her Xanax since Friday 10/14/22 because the nurses didn't request a refill despite NP asking medicating nurses to check the stock each Friday and was assessed to be very anxious with jerky motions, a facial tick and slight elevation in her blood pressure from her baseline. It further indicated Resident #33 was known to have been without her Xanax for the last 4 days.

A nurses note dated 10/18/22 at 10:55 PM indicated Resident #33 was transferred to the Emergency Room for evaluation at the request of Resident #33's son due to increase anxiety, delusions, and inability to keep Resident #33 comfortable.

An after-visit summary report dated 10/21/22 revealed Resident #33 was seen in the emergency department on 10/18/22 for benzodiazepine withdrawal with delirium due to not receiving anti-anxiety medications as ordered. The document indicated she was evaluated by psychiatric services and discharged to the facility on 10/21/22.

A provider progress note written by NP #2 on 10/25/22 revealed that Resident #33 was sent to the Emergency Room for 2 nights due to

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F 755	Continued From page 84	F 755		

benzodiazepine withdrawal due to failure of nursing to give Xanax for approximately 4 days. Resident #33 was kept for psychiatric evaluation and possible involuntary commitment. Resident #33 was found to be stable and did not require admission. The note further indicated Resident #33 was assessed to be mentally stable without presentation of psychosis at her baseline and plan would be to continue Xanax and current plan of care.

An interview with NP #2 on 8/29/23 at 11:26 AM revealed she was familiar with Resident #33 under the Longevity program's care (special needs program where care is directed by additional medical staff who are onsite during the week in addition to traditional facility medical providers). NP #2 stated she did not wish to add any further information regarding the facility's nursing staff failing to alert her to Resident #33 being without her medication and stated, "I detailed it all clearly in my notes on 10/18/22 and 10/25/22- refer to those notes for my evaluation of the situation."

An interview with the Director of Nursing on 8/23/23 at 5:00 PM revealed she was not the DON at the time and was unable to locate Resident #33's narcotic controlled monitoring forms for September and October 2022 and therefore was not sure why the medications had not been administered as ordered. The DON stated she expected medications to be given as ordered.

An interview with the Administrator on 8/24/23 at 1:09 PM revealed he was not the Administrator of the facility during October 2022 and was not sure why Resident #33 would have not received her

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F 755	Continued From page 85 medications; however, he expected all medications to be ordered from pharmacy and administered as ordered by the provider.	F 755		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean and sanitary kitchen floor, remove expired food in the dry storage area, remove expired food in 1 in of 4 kitchen refrigerators, Additionally, the facility failed to maintain the kitchen's walk-in freezer free from ice build-up and replace a faulty door seal for 1 of 3 reach-in refrigerators. These practices had the potential to affect food and beverages served to residents.	F 812	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: Immediate cleaning of the kitchen floor has been conducted. Expired food items in dry storage, refrigerators, and the walk-in freezer have been inventoried and discarded. The faulty door seal on the reach-in refrigerator has been replaced	9/26/23

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F 812	Continued From page 86 Findings Included: During an initial tour of the kitchen conducted on 08/20/23 the following concerns were identified: a. On 8/20/23 at 10:50 AM an observation of the kitchen's walk-in refrigerator found 1 opened bag of shredded cheese wrapped in plastic wrap without an open or use by date on the package. b. On 8/20/23 at 10:55 AM an observation of the kitchen's walk-in freezer found ice buildup approximately 3 inches thick around all sides of the seal of the door. The freezer door was unable to be closed due to the ice buildup with a gap of approximately 2 inches between the door and the door frame. c. On 8/20/23 at 11:00 AM an observation of milk storage reach in refrigerator revealed the rubber seal of the door was hanging below the door when shut. The door was unable to close tightly to prevent the refrigerated air from leaving the reach in cooler. d. On 8/20/23 at 11:01 AM an observation of the two-door reach in cooler revealed 12 pints of expired whole milk. The milk expiration date was 8/17/23. An interview with the weekend kitchen supervisor on 8/20/23 at 11:01 AM stated the maintenance director was aware of the damaged walk-in freezer seal and reach in cooler seal and parts had been ordered. A work order was submitted the previous week to maintenance. The kitchen supervisor observed the expired whole milk and stated they needed to be thrown out and removed the milk cartons. Furthermore, the weekend kitchen manager stated the opened shredded cheese needed to be dated before it was placed back into the walk-in refrigerator.	F 812	and its functionality verified. Responsible Person: Certified Dietary Manager or Designee, Maintenance Director or Designee Compliance Date: 9/26/2023 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: A comprehensive audit will be performed to assess the general cleanliness of kitchen areas, the condition of food storage units, and the expiration dates of food items in dry storage, refrigerators, and the walk-in freezer. This will also include a functionality test for all refrigerator and freezer seals. Responsible Person: Certified Dietary Manager or Designee, and Maintenance Director or Designee Compliance Date: 9/26/2023 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Education, Policy Revisions, and Systemic Change: A mandatory in-service training session will be conducted for kitchen and dietary staff, led by the Certified Dietary Manager. This training will focus on proper food storage protocols and cleaning procedures, aligning with the Facility Food Safety Policy. Additionally, the Administrator will provide specialized training for the Maintenance Director, covering responsibilities like the upkeep of	

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F 812	Continued From page 87 During a follow up observation of the kitchen on 8/22/23 at 10:37 AM with the Regional Dietary Manager the reach in door seal remained hanging below the closed door. During the observation, the Regional Manager stated the temperature of the reach in cooler was 40 degrees Fahrenheit (F) and the damaged door seal made it difficult for the refrigerator to maintain a safe temperature of 41 degrees F and below. e. On 8/22/23 at 10:45 AM an observation of the dry storage area with the Regional Dietary Manager revealed 5 pre-thickened ready to use containers with expiration date of 5/9/23. The expired container where immediately removed by the manager, and he stated they were overlooked when he had checked the area for expired food the previous day. On 8/22/23 at 10:53 AM an observation with the Regional Dietary Manager revealed the walk-in freezer door remained unchanged with ice buildup around the door. The manager stated the freezer door had not been repaired in the 3 months he had been covering the facility and he was unsure of how long it had been in its current condition. The manager said he believed a replacement door had been ordered. f. An observation of the floor area under the meal service tray line on 8/22/23 at 11:14 AM revealed the area to contain crumbs of various sizes on the floor. The floor contained a thick black, sticky to touch area approximately 2 x 2 feet. The kitchen's chef and the Regional Dietary Manager were interviewed on 8/22/23 at 11: 26	F 812	refrigerator seals and kitchen appliances. To sustain these improvements, regular weekly inspections of all food storage areas will be carried out, along with a monthly review to ensure ongoing compliance and identify areas for improvement. New Staff Onboarding: All new hires in the kitchen and dietary departments will undergo training on these updated policies during their orientation. Compliance Date: 9/26/2023 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of food storage conditions and kitchen cleanliness will be conducted using a monitoring tool developed specifically for these deficiencies. These audits will be conducted by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a	

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F 812	Continued From page 88 AM. The chef stated the kitchen floor was cleaned daily at the end of the day after the dishes are washed. The dietary staff were responsible for sweeping and mopping the kitchen floor before leaving their shift at night. The chef stated the kitchen staff work as a team to clean at night and specific tasks are not assigned to kitchen staff. The Regional Dietary Manager added any area of the kitchen that can be reached by kitchen staff should be cleaned, including under the tray line area. He said the tray line area was overlooked. The Administrator stated in an interview on 8/24/23 at 1:02 PM that the kitchen staff should remove and dispose of any expired food items and clean and maintain all areas of the kitchen.	F 812	minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		9/26/23

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§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 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

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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 collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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F 867	Continued From page 91 §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 review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following a recertification and complaint survey conducted on 3/22/22 and a complaint investigation survey on 9/20/22. This was for four repeat deficiencies that were cited in the areas of resident rights/exercise of rights, safe, clean, comfortable and homelike environment, prepare/store/serve food under sanitary conditions, and maintain effective pest control program that were originally cited on 3/22/22 during a recertification and complaint survey, recited on the complaint investigation survey on 9/20/22 and subsequently recited during the recertification and complaint survey completed on 8/29/23. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.	F 867	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: By 9/26/2023, the Quality Assurance and Assessment (QAA) Committee will convene a special meeting to proactively address the identified deficient areas. The VP of Clinical Operations and the VP of Operations will be in attendance to provide guidance, support, and education in the development and implementation of the QAA committee processes. They will collaborate with the facility staff to create a comprehensive action plan, focusing on strengthening oversight, monitoring processes, and implementing targeted interventions. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: As all residents have the potential to be	

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F 867	Continued From page 92 The findings included: This tag is cross referenced to: F550 - Based on record review, and staff and resident interviews, the facility failed to maintain the dignity of a resident when a Nurse Aide yelled out to another staff member in the hallway that Resident #46 needed a full linen change for 1 of 7 residents reviewed for dignity (Resident #46). During the recertification and complaint survey on 3/22/22, the facility failed to treat a resident in a dignified manner by not ensuring there was enough linen for incontinence care which made the resident feel like she was being treated like a dog and the facility didn't care about her. F584 - Based on observations, record review, and interviews with resident and staff, the facility failed to maintain a wheelchair in good repair for 1 of 2 residents reviewed for mobility device (Resident #25), failed to maintain bathrooms in good repair for 2 of 5 bathrooms reviewed (Resident #59 and Resident #25), failed to change a soiled privacy curtain for 1 of 8 rooms reviewed for privacy curtain (Room 227), and failed to provide towels/washcloths as needed for showers for 2 of 2 halls (100 Hall and 200 Hall). During the recertification and complaint survey on 3/2/22, the facility failed to maintain the walls in residents' rooms in good repair, failed to maintain a clean, sanitary, homelike environment for resident rooms observed to have scraped and cracked walls, peeling paint and plaster, dirty floors, stains on the walls, stained privacy curtains, exposed wires and cables, exposed nails, and missing outlet covers, failed to replace	F 867	affected by the cited deficiencies in the facility's QAPI program, the facility will prioritize addressing these issues across the entire resident population. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: To ensure that deficient practices do not recur, the facility will commit to strengthening the Quality Assurance and Assessment (QAA) program by focusing on ongoing training and support for QAA committee members. The VP of Operations will provide a targeted in-service training by 9/26/2023, with an agenda that will cover the roles and responsibilities of QAA committee members, strengthening oversight and monitoring processes, targeted interventions, ongoing education and development, and monitoring performance and ensuring sustainability. This training aims to equip QAA Committee members with the knowledge and tools needed to ensure compliance and continuous improvement in resident care within the facility. The facility will recognize the importance of fostering a culture of continuous improvement and compliance with best practices. As part of this commitment, the QAA committee will increase the frequency of its meetings to allow for more in-depth analysis, discussion, and collaboration on addressing the identified areas of concern. The QAPI team will meet weekly to closely monitor progress and ensure	

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F 867	Continued From page 93 metal shoe molding with sharp exposed edge and screws, failed to clean dirt and debris from the heating and air conditioning unit and failed to fasten the covers to the heating and air conditioning units, failed to maintain a proper working toilet, failed to maintain clean and sanitary tub rooms used for resident bathing, failed to have two curtains on window for privacy, failed to replace the laminate on main dining room tables, failed to ensure residents had clean linen in their rooms. During the complaint survey on 9/20/22, the facility failed to repair a clogged sink in a resident room. F812 - Based on observations and staff interviews, the facility failed to maintain a clean and sanitary kitchen floor, remove expired food in the dry storage area, and remove expired food in 1 of 4 kitchen refrigerators. Additionally, the facility failed to maintain the kitchen's walk-in freezer free from ice build-up and replace a faulty door seal for 1 of 3 reach-in refrigerators. These practices had the potential to affect food and beverages served to residents. During the recertification and complaint survey on 3/22/22, the facility failed to date an opened bag of buttered garlic bread stored in the walk-in refrigerator. During the complaint survey on 9/20/22, the facility failed to serve lunch on dinnerware in good condition. F925 - Based on observations, record review, resident and staff interviews, the facility failed to maintain an effective pest control program as	F 867	that the implemented procedures and interventions are consistently maintained across all departments. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: To ensure that solutions are sustained and the facility continues to provide the highest quality of care, the Regional VP of Operations or Designee will audit the QAA Committee minutes weekly for the first four weeks, followed by monthly audits for the subsequent three months. Audit findings will be reported to the Administrator and the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified issues will be addressed through corrective action and staff re-education as needed. Additionally, the facility will track and trend audit data to ensure ongoing compliance with food safety requirements and other critical aspects of resident care. Progress toward achieving and maintaining compliance will be reviewed quarterly by the QAPI Committee, and adjustments to the plan will be made as necessary to ensure ongoing improvement. Compliance Date: Ongoing, with initial compliance by 9/26/2023	

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F 867	Continued From page 94 evidenced by pest observed in common areas, and residents' rooms (Resident #60 and Resident # 12). During the recertification and complaint survey on 3/22/22, the facility failed to maintain an effective pest control program as evidenced by pest observed in common areas and a resident's room. During the complaint survey on 9/20/22, the facility failed to maintain an effective pest control program for sampled residents. An interview with the Administrator on 8/24/23 at 1:43 PM revealed he hadn't been at the facility long, but he knew that the reason for the continued non-compliance in certain areas was due to staff turnover and leadership changes almost every month. This led to the administrative staff not being on top of these issues that came up and no one was holding staff accountable for their work. He stated that the lack of consistency with leadership was the cause of not being able to implement effective and sustainable systems to maintain compliance.	F 867		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		9/26/23

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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F 880	Continued From page 96 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, Nurse Practitioner #1, Medical Director, and Local Health Department Nurse interviews, the facility failed to clean and disinfect a glucometer used for more than one resident (blood glucose meter) according to manufacturer's recommendations using an Environmental Protection Agency (EPA) - approved disinfectant cloth, between resident usage. The risk of spreading bloodborne infections is very serious if the products and procedures are not followed. The facility confirmed there were residents who had bloodborne pathogens. This occurred for 3 of 3 sampled residents who were required to have their blood sugars checked (Resident #28, Resident #30, and Resident #57) and 1 of 1 staff observed performing blood glucose monitoring (MA#1). This practice affected 3 of 4 residents on the assigned unit and could potentially affect 17 residents in the facility who required glucose monitoring.	F 880	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Immediate Actions Taken for Noncompliance in Glucometer Cleaning (F880) Dated 8/20/23: Identification of Affected Residents: On the same day of the noncompliance identification, the Director of Nursing and Unit Managers audited all current residents and identified those who were at risk, specifically naming Resident #28, Resident #30, and Resident #57. Change in Policy and Responsibility: The facility promptly changed its policy to assign the task of checking blood glucose levels solely to Licensed Nurses. Individual glucometers were also issued for each resident requiring blood glucose monitoring.	

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F 880	Continued From page 97 The immediate jeopardy began on Sunday, 8/20/23 when a Medication Aide (MA #1) hired through an agency was observed to perform blood glucose checks on residents using a shared glucometer without disinfecting per manufacturer's guidelines. The immediate jeopardy was removed on 8/22/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at lower scope and severity "E" (no actual harm that is immediate jeopardy) to ensure monitoring systems are put into place are effective. The findings included: The facility policy titled, "Glucometer Disinfection" (a blood glucose meter) dated 11/1/20 indicated 1) facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. 2)If the manufacturers are unable to provide information specifying how glucometers should be cleaned and disinfected then the meter should not be used for multiple patients. 3)The glucometer should be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against Human Immunodeficiency Virus (HIV), Hepatitis C, and Hepatitis B virus. 4) Glucometers should be cleaned and disinfected after each use and according to manufacturers' instructions regardless of whether they are intended for single resident use or multiple resident use. The blood glucose meter manufacturer's instructions for cleaning and disinfecting page 47-48 of the booklet indicated healthcare workers	F 880	Education and Training: On 8/20/23 and 8/21/23, the Director of Clinical Services, the Director of Nursing, and the Administrator educated and trained the Unit Managers and current Licensed Nurses about the new policies and procedures for glucometer disinfection. This training included both verbal and written instructions, along with a return demonstration to ensure complete understanding. Notification of Risk: On 8/21/23, responsible parties and affected residents were informed about the potential exposure to bloodborne pathogens and were notified that the facility would now be using individual glucometers. Notification to Authorities: The county Health Department and attending physicians were informed of the issue for further guidance and recommendations. Implementation of Individual Glucometers: Each resident requiring fingerstick blood glucose levels was assigned an individual glucometer, which was completed on 8/21/23. Restriction on Medication Aides: Starting from 8/21/23, Medication Aides were no longer assigned to perform blood glucose checks; they were instructed to notify a Licensed Nurse for the task. Documentation and Ongoing Training: A log of all trained Licensed Nurses was maintained to ensure compliance, and extra glucometers were made available in the Nurses Medication Room for new admissions. 2. Address how the facility will identify	

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F 880	Continued From page 98 should wear gloves when cleansing the meter. "Option 1) Wash hands after gloves are doffed. Contact with blood products presents a potential infection risk. We suggest cleaning and disinfecting between each use. Many wipes function as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used; one wipe to clean and a second wipe to disinfect." The wipes container which was in the bottom drawer of the medication cart located on the East Wing read in part to disinfect nonfood contact surfaces to thoroughly wet surface, allow treated surface to remain wet for 3 minutes and let air dry. These wipes were an EPA-registered germicidal wipe and approved for bloodborne pathogen use. An observation was made on 8/20/23 at 11:28 AM and revealed a Medication Aide (MA#1) carried a glucometer from the medication cart to the dining room located just adjacent to the nurses' station on the East Unit where Resident #28 was sitting in his wheelchair. MA #1 performed a task with her back to the door, then exited the dining room holding a used blood glucose test strip, the glucometer, and a used lancet in her right hand. When she arrived near the medication cart, she discarded the used lancet in the sharps box and then removed the used test strip from the glucometer and discarded it and her gloves in the trash can located on the medication cart. MA #1 then documented the blood glucose reading for Resident #28 on a piece of paper located on the medication cart before leaving the medication cart. MA #1 was not observed to clean the glucometer after usage. MA #1 left the medication cart to speak to another staff member and then	F 880	other residents having the potential to be affected by the same deficient practice: Evaluation Method: An audit will be conducted to specifically review the cleaning and disinfection process for individual glucometers assigned to residents requiring glucose monitoring. This is particularly crucial as any resident requiring blood glucose monitoring has the potential to be affected by inadequate cleaning practices. The audit aims to ensure that glucometers are cleaned and disinfected according to manufacturer's guidelines and using an EPA-approved disinfectant cloth. Responsible Person: The Director of Nursing or Designee will be responsible for conducting this audit. Compliance Date: 9/26/2023 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Comprehensive Retraining Program: Nursing staff and medication aides will undergo comprehensive retraining on infection control protocols, specifically focusing on glucometer handling. The training will cover the correct usage of Environmental Protection Agency (EPA) - approved disinfectant cloths and strict adherence to the manufacturer's guidelines for glucometer cleaning and disinfection. Directed Plan of Correction (DPOC): In compliance with state requirements, the facility will conduct a Root Cause Analysis to identify underlying factors contributing	

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F 880	Continued From page 99 returned at 11:33 AM. A continuous observation on 8/20/23 from 11:33 AM to 11:45 AM revealed MA #1 retrieved a bottle of glucose test strips and a lancet from the top drawer of the medication cart then, pick up the glucometer which had been used on Resident #28 and walked down the hallway to locate Resident #30 outside the facility at the main lobby entrance along with other residents and visitors. MA #1 then applied gloves and performed a fingerstick using the lancet and obtained blood from Resident #30 on the blood glucose test strip. Once she got a reading on the monitor, MA #1 left Resident #30 outside and entered the building (both hands remained gloved) carrying the glucometer with the test strip and soiled lancet in her right hand. MA #1 then removed her right glove and the test strip from the meter and the lancet in her left hand. MA #1 was observed to carry the glucometer to the medication cart in her ungloved hand where she laid the glucometer again on a white towel located on the top of the medication cart and discard the used lancet and test strip in the sharps box and soiled gloves in the trash can. MA #1 was not observed to perform hand hygiene or disinfect the glucometer before she reached into the top drawer of the medication cart and retrieved a clean blood glucose test strip from a bottle and a clean lancet. MA #1 closed the top drawer, picked up the glucometer from the white towel on the cart and rapidly walked down the hall towards Resident #57's room. MA #1 retrieved a pair of gloves from the hallway outside Resident #57's room and entered the room. She approached Resident #57 who was lying in her bed, and she placed the test strip in the glucometer before sitting it on Resident #57's bedside table to apply her gloves.	F 880	to the deficient practice. A Directed Plan of Correction will then be developed in collaboration with an Infection Control Consultant. DPOC Topic: Disinfection of shared/multi-use glucometer. Partnership with Mecklenburg County Department of Health: To assist in the DPOC process, we have engaged with the Mecklenburg County Department of Health and their Infection Control Nurse. This collaboration aims to provide expert guidance in developing and implementing a corrective action plan. Responsible Persons: Administrator, Director of Nursing, QA Nurse Compliance Date: 9/26/2023 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of glucometer cleaning and disinfecting practices using a monitoring tool developed specifically for these deficiencies will be conducted by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. These audits will include observation of five random glucometer cleaning procedures. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their	

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F 880	Continued From page 100 The surveyor attempted to stop MA #1 from performing any further contamination and asked MA #1 to stop and exit the room. MA #1 demanded the surveyor to come there instead and again turned to Resident #57 and lifted her right-hand pricked Resident #57's finger. The surveyor again told MA #1 to stop before she picked up the glucometer and the MA #1 grabbed the glucometer, test strip and lancet and briskly walked past the surveyor who was standing in the doorway without acknowledging the surveyors questions, hurried toward the medication cart, and placed the glucometer on the cart on the same white towel. The surveyor asked MA #1 about cleaning and disinfecting the glucometer between resident use. Without answering MA #1, grabbed a container of disinfecting wipes from the bottom drawer of the cart and wiped the glucometer for approximately 3-5 seconds and walked off from the surveyor without answering any further questions. Following the observation and attempt of interview, the Director of Nursing (DON) was made aware of the observation and request for interview. An interview with Medication Aide (MA #1) with the DON present on 8/20/23 at 1:30 PM revealed she acknowledged she performed blood glucose monitoring on multiple residents at both 7:30 AM and at 11:00 AM using the multi-use glucometer located in the top drawer of the medication cart. MA #1 verified she did not clean and disinfect the glucometer between each resident using an EPA approved disinfecting wipe. She stated during the lunch time observations, she wanted to make sure she obtained the blood glucose level before each resident received their lunch and did not take the time to clean the monitor or perform hand hygiene between each resident. She stated	F 880	designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Date of compliance: Ongoing, with initial compliance by 9/26/2023	

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she had always used a multi-use glucometer on all residents in the facility when obtaining fingerstick blood glucose monitoring and had never used individually assigned glucometers in this facility.

An interview with the Director of Nursing (DON) on 8/20/23 at 1:30 PM revealed she had no knowledge MA #1 had performed fingerstick glucose checks on multiple residents without disinfecting the device between use until the surveyor notified her. The DON indicated the glucometer device should have been disinfected between usage and MA #1 should not perform blood glucose checks without proper cleaning and disinfecting using approved EPA wipes. The facility was unable to determine if any residents who resided in the facility had a bloodborne pathogen illness during the survey.

An observation of the East Wing Cart #1 (the medication cart where Resident #28, Resident #30, and Resident #57 resided) and interview with Nurse #5 on 8/20/23 at 4:45 PM revealed a multi-use glucometer in the top drawer of the medication cart along with a partially used bottle of glucose test strips. Nurse #5 stated the procedure had changed on 8/20/23 and all residents at that time, now had their own glucometers stored in their room and the multi-use glucometer observed should not have been on the medication cart and available for potential usage. Using a gloved hand, the glucometer and test strips were removed from the cart and taken to the DON who was in her office.

An observation of the East Wing Cart #2 at 4:50 PM revealed no multi-use glucometers on the cart and an interview with Nurse #10 revealed

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she was aware each resident was now assigned their own glucometers which was kept in their rooms but was unable to verbalize the correct procedure for cleaning and disinfecting the glucometers using the EPA approved disinfecting wipe.

An observation of the West Wing Cart #1 at 4:53 PM revealed no multi-use glucometers on the cart and an interview with Nurse #2 revealed he was aware each resident was now assigned their own glucometers which were kept in their rooms but was unable to verbalize the correct procedure for cleaning and disinfecting the glucometers using the EPA approved disinfecting wipe.

A telephone interview with Nurse #6 on 8/21/23 at 8:55 AM revealed she had last worked in the facility as an agency nurse on Thursday 8/17/23. Nurse #6 stated she had been assigned to work on each unit and had always used a multi-use glucometer from the top drawer of each medication cart when she worked at this facility. Nurse #6 was aware the glucometer required to be cleaned and disinfected between each resident use but was unable to recall the correct procedure for performing this task or the correct kill time for the EPA wipes used in the facility.

A telephone interview with the Local Health Department Nurse on 08/22/23 at 12:15 PM revealed she was notified about Medication Aide #1 obtaining blood glucose checks on Resident #28, Resident #30, and Resident #57 while not cleaning and disinfecting the shared glucometer meter on 8/20/23. The Local Health Department Nurse indicated she had advised the facility to obtain a Hepatitis Panel (lab to test for Hepatitis B, Hepatitis C) and a Human Immunodeficiency

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Virus (HIV) lab, review the three resident's immunization records, notify the medical provider, residents, and Resident Representatives (RP) of the occurrence and monitor for any adverse effects.

A review of labs presented by the facility for Resident #28 and Resident #30 revealed the facility drew labs to assess immunity instead of the Hepatitis Panel originally requested by the local health department. When the facility was notified, the facility presented a letter from the local health department dated 8/29/23 that indicated since MA #1 used a clean lancet and a clean test strip, the local health department no longer considered it to be a potential transmission and labs no longer needed to be drawn to determine each resident's health status for Hepatitis B, Hepatitis C or HIV.

A telephone interview with the facility Nurse Practitioner (Nurse Practitioner #1) on 8/28/23 at 3:53 PM revealed she became aware of the potential for transmission of a bloodborne illness involving Resident #28, Resident#30, and Resident #57 which occurred on 8/20/23 when she arrived the at facility in the afternoon on Monday, 8/21/23 by the DON. The NP #1 indicated the DON notified her MA #1 had not thoroughly cleaned and disinfected the blood glucose monitoring device between residents when blood sugar levels were obtained on 8/20/23. The NP did not understand why the labs had been ordered because she said she would not have drawn labs without one of the residents having a known bloodborne communicable disease diagnosis listed in the medical record.

A telephone interview with the Medical Director on

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8/29/23 at 9:49 AM revealed he had not been made aware of the occurrence where a single glucometer was used on multiple residents without disinfecting. He stated he would expect all staff to perform care in a manner to prevent potential cross contamination of bloodborne illnesses.

An interview with the Administrator on 8/24/23 at 1:09 PM revealed he learned about the occurrence on 8/20/23 when MA #1 performed fingerstick glucose checks using a single glucometer without cleaning and disinfecting it between residents which placed the residents at risk for a bloodborne illness. The Administrator indicated he would have expected the glucometer to be cleaned and disinfected before and after use to decrease the spread of any potential illness.

Facility administration (Administrator and Director of Nursing) was notified of immediate jeopardy on 8/20/23 at 5:02 PM.

The facility provided the following plan for IJ removal.

Noncompliance Allegation: The facility has been found noncompliant in ensuring that the glucometer was cleaned according to manufacturer guidelines using an EPA approved disinfectant cloth between each resident usage. This has resulted in potential exposure to bloodborne pathogens for the residents who were required to have their blood glucose levels checked. The noncompliance was identified through observation, record review, resident, and staff interviews, and is specifically attributed to a Certified Medication Aide failing to follow the

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proper procedure for cleaning and disinfecting a shared glucometer.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
" Observation, record review, resident, and staff interviews completed by the surveyor on 8/20/23 identified the facility failed to ensure a glucometer was cleaned, according to manufacturer guidelines using an EPA approved disinfectant cloth, between each resident usage. This occurred for 3 residents who were required to have their blood glucose levels checked (Resident #28, Resident #30, and Resident #57). Clinical staff failed to use the appropriate procedure to clean and disinfect a shared glucometer.
" Every resident that receives a fingerstick blood glucose level is at risk.
" On 8/20/23 the Director of Nursing and Unit Managers completed an audit of all current residents and identified those with physician's orders requiring blood glucose levels.
" On 8/21/23, the Director of Nursing and Unit Managers ensured that each resident requiring fingerstick blood glucose levels was assigned an individual use glucometer stored at their bedside.

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 Administrator and Director of Nursing changed the facility's policy and procedure to include a new process to assign completion of blood glucose levels to only Licensed Nurses as well as issuing individual glucometers to each

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resident requiring blood glucose levels.

" On 8/20/23 the Director of Clinical Services educated the Director of Nursing and the Administrator regarding the new process for obtaining blood glucose levels by only assigning Licensed Nurses and the revisions to the Glucometer Disinfection policy and procedures including cleaning and disinfecting of each device and the management of glucometers by issuing individual glucometers to each resident requiring blood glucose levels.

" The Director of Nursing and Administrator educated the Unit Managers regarding the revisions to the Glucometer Disinfection policy and procedures including cleansing and disinfecting of each device and the management of glucometers by issuing individual glucometers to each resident requiring blood glucose levels. The Unit Managers were also educated regarding the change in process to allow only Licensed Nurses to complete blood glucose levels. This was completed on 8/21/23.

" On 8/21/23, responsible parties (RP) for residents and those residents that receive fingerstick blood glucose levels have been notified by the Director of Nursing or Unit Manager of the potential exposure of bloodborne pathogens due to not properly disinfecting a shared glucometer. They were informed that we will now be using individual glucometers for each resident. RPs and Residents were informed that the local Health Department had been notified and we will be following any recommendations that they provide regarding the potential exposure to blood borne pathogens.

" Current Licensed Nurses have received training by the Director of Nursing and Unit Managers on the following:

o Only Licensed Nurses will perform blood

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glucose levels beginning 8/21/23. In the event a Medication Aide is assigned to administer medications to a resident requiring a blood glucose level, the Medication Aide will notify the Licensed Nurse for completion of the blood glucose level.

o The purpose for following a cleaning checklist process, for disinfecting glucometers due to the likelihood of cross-contamination and the spread of bloodborne pathogens among residents
o The importance of cleaning and disinfecting the glucometer per manufacturer's guidelines, using the training/education checklist for Cleaning Glucometers that includes the process of cleaning and includes observation and return demonstration.
o This includes cleaning and disinfecting the individually issued glucometers that are stored at the residents' bedside.
o The glucometer cleaning process is as follows:

" Upon entering the resident's room with 2 EPA approved disinfectant wipes, wash hands and don clean gloves.
" Obtain the resident's individual glucometer from the bedside table.
" Insert a test strip into glucometer, complete fingerstick using a lancet, and collect a small amount of blood on the sample test strip.
" Wait for the results of the sample to appear.
" Remove the test strip and dispose of the lancet and test strip in the sharps container on the med cart.
" Use one EPA approved disinfectant wipe to wipe the glucometer of any visible materials covering all surfaces.
" Remove soiled gloves and don clean gloves.

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" Use the second wipe to allow the glucometer to remain moist for 3 minutes and allow to air dry, return to storage case and place case in the bedside drawer.
" Remove gloves, wash hands well.
" Record Blood Sugar result in the electronic record.
" On 8/21/23 Licensed Nurses were notified by the Director of Nursing and Unit Managers that extra glucometers are available in the Nurses Medication Room to ensure new admissions or residents with new orders for blood glucose levels have their own glucometer assigned.

" This education was completed for current Licensed Nurses including those working for agencies on 8/21/23 by the Director of Nursing and Unit Managers. This education was provided verbally with written documents for reference and a return demonstration completed by the Director of Nursing and Unit Managers. The Director of Nursing will maintain a log of all Licensed Nurses to ensure no staff are allowed to work without receiving this training.
" On 8/21/23, the Administrator and Director of Nursing notified the county Health Department Nurse and the Physician of the concerns identified regarding a Medication Aide failing to use the appropriate procedure to disinfect a shared glucometer for 3 residents and requested guidance for follow-up for possible exposure to bloodborne pathogens. Recommendations were completed by the Director of Nursing and Unit Managers.
" On 8/21/23, the Director of Nursing and Unit Managers ensured that each resident requiring fingerstick blood glucose levels was assigned an individual use glucometer stored at their bedside. This was completed on 8/21/23.

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F 880	Continued From page 109 " Current Medication Aides have received training from the Director of Nursing and Unit Managers that only Licensed Nurses will perform blood glucose levels beginning 8/21/23. Medication Aides will no longer be assigned to perform blood glucose levels. In the event a Medication Aide is administering medications on an assignment with residents requiring blood glucose levels the Medication Aide will notify the Licensed Nurse for completion. " The facility alleges removal of Immediate Jeopardy 8/22/23. On 8/24/23, the facility's immediate jeopardy removal plan effective 8/22/23 was validated by the following: Staff interviews revealed all nurses were able to verbalize they had received training that medication aides were no longer allowed to perform fingerstick glucose monitoring, each resident who required blood glucose monitoring had been assigned an individual glucometer which would be kept in the residents' room and the proper cleaning procedure to clean and disinfect the glucometer before and after each use using an EPA approved disinfectant wipe and allow it to dry the appropriate amount of time based on the wipe used. Inservice training records of return demonstrations and of the updated policy were reviewed and observation of glucometers in each individual resident's room were made.	F 880		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident;	F 914		9/26/23

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F 914	Continued From page 110 §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews, the facility failed to provide a privacy curtain for 1 of 10 rooms on the 100 hall reviewed for privacy (Room #108). The findings included: Resident #60 was admitted to the facility on 04/25/22. The quarterly Minimum Data Set (MDS) dated 06/06/23 revealed Resident #60 was cognitively intact for decision making. An observation and interview conducted with Resident #60 on 08/20/23 at 12:30 PM revealed Resident #60 did not have a privacy curtain and shared a room with another resident. Resident #60 further revealed she had not had a privacy curtain in a few weeks. Resident #60 stated she had expressed to nursing staff that she would like a curtain, but staff had told her that it was being washed. An observation conducted on 08/21/23 at 9:05 AM revealed Resident #60 did not have a privacy curtain hanging. An interview and observation conducted with Nurse Aide (NA) #5 on 08/21/23 at 2:15 PM	F 914	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: A privacy curtain was installed in Room #108 to assure full visual privacy for the resident. An audit was performed to confirm proper installation and functionality. Responsible Person: Maintenance Director/Designee Compliance Date: 9/26/2023 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: Audits will be conducted specifically to assess the presence and condition of privacy curtains in all rooms within the facility. Responsible Person: Maintenance Director/Designee Compliance Date: 9/26/2023 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Education and Policy Revisions: Staff education sessions will be initiated to	

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F 914	Continued From page 111 revealed she was aware Resident #60 did not have a privacy curtain, but indicated it was housekeeping's responsibility to furnish privacy curtains. An interview and observation conducted with the Director of Housekeeping on 08/21/23 at 2:20 PM revealed Resident #60 did not have a privacy curtain. The Director of Housekeeping further revealed it was housekeeping's responsibilities to check curtains daily during housekeeping duties and should have noticed Resident #60 was missing a privacy curtain. An interview and observation conducted with the Director of Nursing (DON) on 08/24/23 at 11:00 AM revealed she was not aware Resident #60 did not have a privacy curtain. The DON further revealed nursing staff and housekeeping should have caught that and Resident #60 should have not gone without. An interview conducted with the Administrator on 08/24/23 at 12:25 PM revealed residents were expected to have a privacy curtain. The Administrator further revealed nursing staff and housekeeping were responsible for checking for curtains daily.	F 914	address the importance of providing visual privacy in all resident rooms. The "Resident Privacy and Room Maintenance Policy" will be revised to explicitly require the presence and regular inspection of privacy curtains. Staff Training/Education: A mandatory in-service will be conducted by the Administrator/Director of Nursing Services or designee to educate all nursing and housekeeping staff on the policy changes and the importance of maintaining privacy for residents. New Staff Onboarding: All new hires will undergo training on the revised privacy policy during their orientation. Compliance Date: 9/26/2023 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of the presence and condition of privacy curtains in all resident rooms will be conducted using a monitoring tool developed specifically for this deficiency. These audits will be conducted by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their	

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	345201	A. BUILDING _____ B. WING _____	C 08/29/2023

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F 914	Continued From page 112	F 914	designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to maintain an effective pest control program as evidenced by pests and "droppings" observed in common areas, and residents' rooms (Resident #60 and Resident # 12). The findings included:	F 925	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Description of Corrective Action: Immediate corrective action was taken by contracting a specialized pest control service to treat the affected areas in common spaces as well as the rooms of	9/26/23

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F 925	Continued From page 113 Review of the facility's invoices from a local pest control company dated: 06/05/23 read in part; service was limited in various rooms due to clutter and stored items and excess water noted in the dishwasher area found during inspection. 06/21/23 read in part; cock roach activity was noted during the inspection service. Facility rooms serviced were 200 wing rooms and nurse's station. 07/15/23 read in part; findings found during the inspection service included hole/gap in AC unit northeast side of building, and trash cans in need of cleaning in various rooms during inspection. Action required was holes to be sealed to prevent pest entry and requested for the facility to clean to reduce pest attraction and source for breeding. An observation and interview conducted on 08/21/23 at 9:00 AM with Resident #60 revealed a fly had landed on the residents' breakfast tray and Resident #60 took her hand and motioned for the fly to fly away. Resident #60 revealed flies had been an ongoing issue and she had to constantly motion for them to get away from her food and face. Resident #60 indicated she had reported to nursing staff there was an issue with flies. An observation conducted on 08/21/23 at 2:45 PM of Resident #12's room revealed multiple small dark brown droppings under the sink on Resident #12's plastic tote. It was further observed multiple droppings behind the tote on the floor.	F 925	Resident #60 and Resident #12. Responsible Person: Maintenance Director or Designee Compliance Date: 9/26/2023 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Evaluation Method: An initial comprehensive audit will be conducted to assess the effectiveness of the pest control program and identify any other areas or resident rooms that require treatment. This audit will involve the inspection of common areas and resident rooms. Responsible Person: Maintenance Director or Designee Compliance Date: 9/26/2023 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Education and Systemic Changes: An increase in the frequency of pest control services to four times a month is initiated, along with the addition of a new pest control vendor to treat the outside of the building twice a month. Responsible Person: Maintenance Director or Designee Compliance Date: 9/26/2023 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly audits of pest control effectiveness using a monitoring tool	

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F 925	Continued From page 114 An observation conducted on 08/23/23 at 9:50 AM revealed three flies in the dining room doorway. Multiple residents were in the dining room finishing breakfast and visiting with each other. An observation and interview with Resident #12 on 08/23/23 at 10:00 AM revealed he had seen mice in his room for over a month and had told nursing staff. Resident #12 further revealed he had asked to be moved a few times because he could hear the mice at night and his drawer with his personal items had mice droppings. It was observed throughout the 4 dresser draws multiple brown droppings on Resident #12's belongings. An observation conducted on 08/24/23 at 9:05 AM revealed a fly at the nurses' desk where residents were sitting. An interview conducted with Housekeeping Aide #3 on 08/23/23 at 10:10 AM revealed she had been working in the facility for several months and had observed roaches in the hallways. Housekeeping aide #3 further revealed facility staff had notified nursing staff of pest control issues but did not recall what the facility had done to assist the ongoing pest issue. An interview and observation conducted with the Regional Maintenance Director on 08/23/23 at 10:20 AM revealed the facility had an ongoing pest contract and they had sprayed at least one time per month. The Regional Maintenance Director further revealed he was not aware pests had been an ongoing issue in the building. It was observed in Resident #12's room multiple dark brown small droppings throughout Resident #12's dresser drawers and on the floor. The Regional	F 925	developed specifically for this deficiency will be conducted by the Administrator, Director of Nursing, or their designee for a period of four weeks, followed by monthly audits for three months. The results of these audits will be reported to the Quality Assurance/Performance Improvement (QA/QAPI) Committee during monthly meetings or immediately if any deficiency is identified. Should the results indicate that the desired outcome or goal is not being achieved or maintained, re-education will be provided by the Administrator, Director of Nursing, or their designee. Additionally, a root cause analysis will be performed to identify necessary changes. Audits will continue until sustained compliance and desired outcomes are consistently achieved for a minimum of three consecutive months. At that point, the frequency of audits may be re-evaluated and adjusted as deemed appropriate by the QA/QAPI Committee. Should any future deficiencies be identified, the audit frequency will revert to weekly until compliance is re-established and maintained for a minimum of one month, at which time monthly audits will resume. Any changes to the audit schedule or procedure will be documented and submitted to the QA/QAPI Committee for review and approval. Compliance Date: Ongoing, with initial compliance by 9/26/2023	

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F 925	Continued From page 115	F 925		

Maintenance Director stated that this was an issue and would need to be deep cleaned and the residents in this room be moved as soon as possible.

An interview conducted with the Maintenance Director on 08/23/23 at 12:00 PM revealed pests had been an ongoing issue due to residents having food in their rooms. The Maintenance Director further revealed he had observed flies throughout the facility and had observed mice before in the facility. The Maintenance Director stated the facility had an ongoing pest contract and they had been coming out at least once a month to spray for pest but continued to have issues with pest due to cleanliness of rooms and structural issues in the air conditioner units.

An interview conducted with the Pest Control Technician on 08/23/23 at 12:35 PM revealed he had been the service technician for the facility for several months and pests had been an ongoing issue. The Technician further revealed the facility was an old building and pests were coming through holes on several air conditioner units. The Technician stated another issue was multiple residents had food and the sanitation of rooms.

An interview with the Administrator on 08/24/23 at 12:25 PM revealed all facilities have pests but believes housekeeping does a great job of keeping the facility clean. The Administrator further revealed the facility was an old building, but pest control sprayed often in the building. The Administrator indicated he expected pest control to be contacted on the same day of any major issues.