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	345131	A. BUILDING _____ B. WING _____	C 11/17/2023

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CEDAR HILLS CENTER FOR NURSING AND REHABILITATION	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/12/23 through 11/17/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1Q8811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/12/23 through 11/17/23 . Event ID# 1Q8811. The following intakes were investigated NC00209542, NC00207516, NC00207028, NC00206949, NC00209106,NC00209518, NC00209123, NC00206124, NC002044820, NC00207355, NC00207997, NC00208368 and NC00205849. 20 of the 45 complaint allegations resulted in deficiency.	F 000		
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 observation, record review, resident interviews, and staff interviews, the facility failed to place residents' call lights (Resident #12, #19, #15 and #40) within reach to allow for the residents to request staff assistance. This was for 4 of 4 residents reviewed for accommodation of needs.	F 558	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or	12/15/23

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

Electronically Signed | 12/16/2023

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F 558	Continued From page 1 The findings included: 1) Resident #12 was admitted to the facility on 03/26/21 with diagnoses that included Vascular Dementia, anxiety disorder, orthostatic hypertension, osteoarthritis, and hearing loss. The quarterly Minimum Data Set (MDS) assessment dated 09/04/23 indicated Resident #12's cognition was severely impaired. She had no behavior and no rejection of care. She required extensive assistance of 1 for bed mobility, dressing, toilet use, and personal hygiene. She had functional limitation with range of motion on one side of her lower extremities. Resident #12's active care plan, last revised on 04/14/23, indicated she was at risk for falls due to a history of falls and decreased mobility. The interventions included provide a working and reachable call light. An observation was conducted on 11/13/23 at 10:15 AM. Resident #12 ' s call bell was located on the floor at the head of the bed. Resident indicated she could not locate her call bell. An interview was conducted with Nursing Assistant (NA) #3 on 11/15/23 at 11:15 AM. She verified she was the direct care NA for Resident #12. She stated she got sidetracked and forgot to put the call bells within the residents ' reach prior to leaving the room. She further stated she went to assist another resident and forgot to come back. An observation and interview with Resident #12 were conducted on 11/15/23 at 12:35 PM. Call bell was observed on the floor between bed A and	F 558	will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. An alleged deficiency cited has been or will completed by the dates indicated. Resident # 12, 19, 15, and 40□s call bell was placed within reach on 11/16/23 by the Unit Manager. All call bells were audited for each resident who are able to use them on 12/13/23 by the Activities Director. Any call bells not in reach of residents who can use them, were immediately placed within reach. The Director of Nursing (DON) initiated an in-service on 12/14/23 for proper placement of call bells with all staff to include all contract staff (to include therapy, housekeeping, dietary and agency, certified nursing assistants, licensed nurses, social worker, maintenance, admissions, business office, payroll, activities, transportation, medical records, and scheduler. Any staff who did not receive the in-service by 12/15/23 will not be allowed to work until the in-service has been completed. This education was included in the new hire orientation by the DON on 12/15/23. The Administrator or Designee will conduct call bell audits daily on 10 residents x 4 weeks. Then the audits will be 5 residents 3 days a week and then 5 residents weekly x 4 weeks. The Administrator will be responsible for bringing the call bell audit results to the	

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F 558	Continued From page 2 B. Resident #12 stated she used her call bell when she needed something from staff. She looked down at the floor and stated, "I can't use it when it's down there though, I can't reach it." She verified she used the call bell to call the Nursing Assistant (NA) or nurse for assistance. An observation was conducted on 11/16/23 at 8:46 AM. Upon entering Resident #12 ' s room Nursing Assistant (NA) #2 was exiting the room. Resident #12 ' s call bell was observed on the floor between bed A and B. An interview was conducted with Nursing Assistant (NA) #2 on 11/16/23 at 8:50 AM. She verified she was the direct care NA for Resident #12 ' s room. Na #2 verified Resident #12 ' s call bell was located on the floor between bed A and B and stated, "I haven't done her yet". She indicated she checked call bell placement prior to leaving the rooms. NA #2 verified Resident #2 does utilize her call bell for assistance. She then picked the call bell up from the floor and laid it onto the resident #12 ' s top blanket and then exited the room. An interview was conducted with the Director of Nursing (DON) on 11/16/23 at 11:17 AM. The DON stated the call bell device should always be within the resident ' s reach. 2. Resident #19 was admitted to the facility on 08/22/19 with diagnoses that included Dementia, Schizoaffective disorder, and congestive heart failure (CHF). The quarterly Minimum Data Set (MDS) assessment dated 09/05/23 indicated Resident #19's cognition was severely impaired. She had	F 558	Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the call bell audits. Date of Compliance: 12/15/23	

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F 558	Continued From page 3	F 558		

no behavior and no rejection of care. She required extensive assistance of 1 for bed mobility eating. She required limited assistance of 1 with dressing and personal hygiene.

Resident #19's active care plan, last revised on 08/25/23, indicated she was at risk for falls related to a history of falls, confusion (diagnosis of dementia), gait/balance problems, Incontinence, and psychoactive drug use. Resident has had falls. The interventions included for staff to be sure resident's call light was within reach and encourage the resident to use it for assistance as needed. Resident needs a prompt response to all requests for assistance.

An observation and interview with Resident #19 were conducted on 11/13/23 at 10:15 AM. Her call bell was located on the floor between bed A and B. Resident #19 indicated she sometimes uses her call bell for assistance.

An observation was conducted on 11/15/23 at 10:50 AM. Resident #19 ' s call bell was located clipped on to the back side of the privacy curtain against wall. Not within residents ' reach.

An interview was conducted with Nursing Assistant (NA) #3 on 11/15/23 at 11:15 AM. She verified she was the direct care NA for Resident #19. She stated she got sidetracked and forgot to put the call bells within the residents ' reach prior to leaving the room. She further stated she went to assist another resident and forgot to come back.

An observation was conducted on 11/16/23 at 8:46 AM. Upon entering Resident #19 ' s room Nursing Assistant (NA) #2 was exiting the room.

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Resident #19 ' s call bell was observed clipped to the top of pillowcase against the headboard, out of residents ' reach.

An interview was conducted with Nursing Assistant (NA) #2 on 11/16/23 at 8:50 AM. She verified she was the direct care NA for Resident #19 ' s room. Na #2 verified Resident #19 ' s call bell was located on the top of pillowcase against the headboard. She indicated she checked call bell placement prior to leaving a resident ' s room. NA #2 verified Resident #19 does utilize her call bell at times for assistance. She then picked the call bell up from the floor and clipped it onto Resident #19 ' s top blanket.

An interview was conducted with the Director of Nursing (DON) on 11/16/23 at 11:17 AM. The DON stated the call bell device should always be within the resident ' s reach.

3. Resident #15 was admitted to the facility on 12/31/22 with diagnosis that included Vascular Dementia with psychotic disturbance, history of falls, and type 2 diabetes.

The quarterly Minimum Data Set (MDS) assessment dated 08/18/23 indicated Resident #15's cognition was severely impaired. He had no behavior and no rejection of care. He required extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries.

Resident #15 ' s active care plan, last revised on 08/21/23, indicated he was at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. The interventions included for staff to be sure

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F 558	Continued From page 5	F 558		

resident's call bell was within reach and encourage the resident to use it for assistance as needed. Resident needs a prompt response to all requests for assistance.

An observation and interview with Resident #15 were conducted on 11/13/23 at 11:16 AM. His call bell was located wrapped around the call bell box on the wall out of Resident #15 ' s reach. Resident #15 indicated the call bell was not where he could reach it and he stated at times he uses the call bell for assistance.

An observation and interview were conducted with Nurse #1 on 11/15/23 at 10:01 AM. Call bell was observed at the top of the mattress not within Resident #15 ' s reach. Nurse #1 verified the call bell was not within reach for Resident #15. She stated call bells should be within the residents ' reach at all times and that she had reminded the Nursing Assistants (NA) yesterday about call bell placement.

An observation and interview were conducted on 11/15/23 at 12:38 PM with Nursing Assistant (NA) #1. When entering resident #15 ' s room his call bell was on the floor on the left side of his bed. She verified the call bell was not within his reach. She verified Resident #15 does use the call bell at times for assistance. She put the call bell on the top blanket where Resident #15 could reach it.

An interview was conducted with the Director of Nursing (DON) on 11/16/23 at 11:17 AM. The DON stated the call bell device should always be within the resident ' s reach.

4. Resident #40 was admitted to the facility on

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F 558	Continued From page 6	F 558		

12/31/22 with diagnosis that included Parkinson ' s Disease and Ogilvie Syndrome.

The admission Minimum Data Set (MDS) assessment dated 10/02/23 indicated Resident #40's cognition was severely impaired. He had no behavior and no rejection of care. He required total assistance for bed mobility, dressing, and personal hygiene.

Resident #40 ' s active care plan, last revised on 11/12/22, indicated he was at risk for falls related to gait and balance problems and incontinence The interventions included for staff to be sure resident's call bell was within reach and encourage the resident to use it for assistance as needed. Resident needs a prompt response to all requests for assistance.

An observation and interview with Resident #40 were conducted on 11/13/23 at 10:30 AM. His call bell was located on floor at head of bed out of Resident #40 ' s reach. Resident #40 answered yes and no simple questions to include nodding his head side to side for yes. He stated yes when asked if he used his call bed.

An observation and interview with Resident #40 were conducted on 11/15/23 at 10:55 AM. His call bell was located on floor at head of bed out of Resident #40 ' s reach.

An observation and interview were conducted on 11/15/23 at 12:38 PM with Nursing Assistant (NA) #1. When entering resident #40 ' s room his call bell was on the floor on the right side of his bed. She verified the call bell was not within his reach. She verified Resident #40 does use the call bell for assistance. She put the call bell on the top

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F 558	Continued From page 7 blanket where Resident #40 could reach it. An interview was conducted with the Director of Nursing (DON) on 11/16/23 at 11:17 AM. The DON stated the call bell device should always be within the resident ' s reach.	F 558		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the 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);	F 584		12/15/23

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F 584	Continued From page 8 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with residents and staff, the facility failed to maintain floors free from dried spills and debris for two rooms (Room 312 and 318) This deficient practice affected 1 of 3 resident halls (300 Hall). The findings included: 1. An observation of room 312 on 11/13/23 at 10:15 AM revealed a container of dental floss on floor between bed A and B, a donut shaped tan dried hardened substance approximately 12 x 12 inch area on floor between bed A and B, and food crumbs throughout the room floor. Room 312 was occupied with 2 residents at the time of survey. An observation of room 312 on 11/15/23 at 10:50 AM revealed the floor remained in the same condition with a dried substance and crumbs throughout. An observation of room 312 on 11/16/23 at 8:46 AM revealed the floor remained in the same condition with a dried substance and crumbs throughout. An interview with Housekeeper #1 on 11/16/23 at	F 584	Room 312 was cleaned on 11/16/23 by the Housekeeper. The area of tan dried hardened substance was scrapped and cleaned on 11/16/23 by the Housekeeping Director. Room 318 was cleaned on 11/16/23 by the Housekeeper. All residents have the potential to be affected by rooms not properly cleaned. All rooms were audited by the Administrator, Maintenance Director, and Housekeeping Supervisor on 12/14/23. A list of rooms requiring additional cleanliness was developed and the rooms were completed on 12/14/23 by the Housekeeping Director. The Administrator and the Housekeeping Supervisor provided education on room cleanliness, picking up trash in rooms, reporting any spills not able to be wiped up by staff to include all contract staff (to include therapy, housekeeping, dietary and agency, certified nursing assistants, licensed nurses, social worker, maintenance, admissions, business office, payroll, activities, transportation, medical records, and scheduler. Any staff who did not receive the in-service by	

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F 584	Continued From page 9 3:26 PM was conducted. She explained daily cleaning of resident rooms involved sweeping, mopping, wiping furniture down, and cleaning the bathroom. She verified that she was the housekeeper for room 312 and that she had already cleaned room 312 today (11/16/23). An observation was conducted with Housekeeper #1 and Housekeeper #2 of the area of tan dried hardened substance on the floor. She stated she tried to clean the area up but could not get it up because she did not have anything to scrape the hardened substance off the floor. The dental floss and crumbs were no longer on the floor. An interview with the Housekeeping Manager on 11/16/23 at 3:33 PM was conducted. She stated the spill would have to be scrapped or scrubbed up off the floor. She was unaware the area was there. She further stated that most of the housekeeping staff were recently hired, and she was in the process of training them. The Housekeeping Manager stated Housekeeper #3 was the housekeeper that cleaned room 312 from 11/13/23-11/15/23. She further stated Housekeeper #3 did not report the area on the floor in room 312. Attempted to interview Housekeeper #3 on three separate occasions were unsuccessful. An interview with the Administrator on 11/16/23 at 4:01 PM was conducted. She stated that most of the housekeeping staff were recently hired, and the Dietary Manager was in the process of training them. She indicated it was her expectation that housekeeping was to thoroughly clean each room and common areas. 2. An observation of room 318 on 11/13/23 at	F 584	12/15/23 will not be allowed to work until the in-service has been completed. This education was included in the new hire orientation by the DON on 12/15/23. The Housekeeping Supervisor added a new housekeeping orientation on 12/15/23. The Administrator or designee will conduct 10 room inspections weekly x 4 weeks for cleanliness, then 5 rooms weekly x 4 weeks then 2 rooms weekly x 4 weeks. The Administrator will be responsible for bringing the room cleanliness audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the room cleanliness audits. Date of Compliance: 12/15/23	

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F 584	Continued From page 10	F 584		

10:46 AM revealed two 30ml clear medication administration cups on floor, one under the foot of A bed and one beside the packaged terminal air conditioner (PTAC) unit. Crumbs on top of PTAC unit and on the floor throughout room.

An observation of room 318 on 11/15/23 at 11:22 AM revealed two 30ml clear medication administration cups on floor, one under the foot of A bed and one beside the packaged terminal air conditioner (PTAC) unit. Crumbs on top of PTAC unit and on the floor throughout room.

An observation of room 318 and interview with Resident #4 was conducted on 11/16/23 at 8:40 AM. Observation revealed two 30ml clear medication administration cups on floor, one under the foot of A bed and one beside the packaged terminal air conditioner (PTAC) unit. Crumbs on top of PTAC unit and on the floor throughout room. She stated her floor was always dirty with food crumbs and trash on the floor. She also stated that housekeepers don ' t sweep and mop the whole floor when they enter the room. They barely run the broom over the floor.

An observation of room 318 on 11/16/23 at 9:12 AM revealed two 30ml clear medication administration cups on floor, one under the foot of A bed and one beside the packaged terminal air conditioner (PTAC) unit. Crumbs on top of PTAC unit and on the floor throughout room.

An interview with the Housekeeping Manager on 11/16/23 at 3:33 PM was conducted. She stated daily cleaning of resident rooms involved sweeping, mopping, wiping furniture down, and cleaning the bathroom. She was unaware the room had been unkept this week. She indicated

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F 584	Continued From page 11 the cleanliness of the room had not been brought to her attention. She further stated that most of the housekeeping staff were recently hired, and she was in the process of training them. An interview with the Administrator on 11/16/23 at 4:01 PM was conducted. She stated that most of the housekeeping staff were recently hired, and the Dietary Manager was in the process of training them. She indicated it was her expectation that housekeeping was to thoroughly clean each room and common areas.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review the facility failed to accurately code Minimum Data Set (MDS) assessments and failed to accurately assess a resident's cognition and participation in the assessment for goal setting, and for insulin use (Resident #185, Resident #184 and Resident #54), for 3 of 34 residents reviewed for MDS assessments. 1. Resident #185 was admitted to the facility on 10/28/23 with diagnoses that included end stage renal disease and dependence on dialysis, type 2 diabetes, hypertension, and chronic obstructive pulmonary disease. Review of baseline care plan dated 10/28/23 revealed Resident #185 was alert and oriented x4(person, place, time and situation).	F 641	Residents #185, 184, and 54, Minimum Data Set (MDS) was modified on 12/14/23 by the MDS Nurse. On 12/15/23, an MDS accuracy audit for residents for cognition status, and an MDS accuracy audit for residents receiving insulin was conducted by the MDS Consulting Group. Any resident who had inaccurate coding in cognition or insulin was modified by the MDS Coordinator on 12/15/23. The MDS Consultant educated the MDS nurse on proper coding on the MDS. This education was completed on 12/15/23. The Regional Clinical Reimbursement Consultant will conduct 10 MDS audits for MDS accuracy related to cognition and insulin injections x 4 weeks, then 5 audits	12/15/23

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F 641	Continued From page 12 Review of an admission MDS assessment dated 11/01/23 documented Resident #185 cognition was not assessed, and staff assessment revealed his memory was ok. An interview with the MDS Nurse on 11/16/23 at 12:58 pm indicated she worked remotely for the facility and was not in the facility to do the cognition section. She indicated when she completed the MDS and if the cognition section was not complete, she would talk with staff in the facility and do the staff section. She stated the cognition section should have been completed with Resident #185 because he was able to do so. 2. Resident #184 was admitted to the facility on 10/27/23 with diagnosis that included chronic obstructive pulmonary disease, coronary artery disease, and peripheral vascular disease. Review of baseline care plan dated 10/27/23 revealed Resident #184 was able to easily communicate with staff and able to understand staff. Review of Resident #184's admission MDS assessment dated 11/02/23 documented Resident's cognition was not assessed, and staff assessment indicated his memory was ok. An interview with the MDS Nurse on 11/16/23 at 12:58 pm indicated she worked remotely for the facility and was not in the facility to do the cognition section. She indicated when she completed the MDS and if the cognition section was not complete, she would talk with staff in the facility and do the staff section. She stated the	F 641	weekly x 4 weeks then 1 MDS weekly x 4 weeks. The Administrator will be responsible for bringing the MDS accuracy audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the MDS accuracy audits. Date of Compliance: 12/15/23	

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F 641	Continued From page 13	F 641		

cognition section should have been completed with Resident #185 because he was able to do so.

An interview was conducted with the Director of Nursing on 11/16/23 at 2:30 pm and she indicated she expected the MDS assessments to be completed with the residents to reflect their cognition accurately.

3. Resident #54 was initially admitted to the facility on 12/31/20 with diagnoses that included diabetes.

Review of the quarterly Minimum Data Set (MDS) assessment dated 9/23/23 indicated Resident #54 received one injection of insulin during the last seven days looked at for the 9/23/23 assessment.

Review of the Medications Administration Record (MAR) for September 2023 showed Resident #54 received dulaglutide (once a week injection used to improve blood sugar) an injection of 0.75 milligram (mg) subcutaneously (under the skin, between the skin and muscle) on 9/21/23.

Review of the MAR for September 2023 showed Resident #54 received insulin lispro (fast acting injectable insulin) on the following days: 9/16/23, 9/17/23, 9/18/23, 9/20/23, 9/21/23, and 9/22/23.

An interview was conducted on 11/16/23 at 12:45 P.M. with the MDS Nurse #2 . MDS Nurse #2 reviewed the quarterly MDS and confirmed it was inaccurate. MDS Nurse #2 stated when she looked at Resident #54's MAR she only saw the medication dulaglutide and did not scroll far enough down the MAR to see Resident #54 had received insulin lispro. The MDS nurse stated it

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F 641	Continued From page 14 was on oversite on her part. An interview was conducted on 11/16/23 at 2:32 P.M. with the Director of Nursing (DON). During the interview, the DON stated the MDS assessment should be accurate, and she was unable to provide a reason why the number of insulin injections was not accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		12/15/23

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F 656	Continued From page 15 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to develop an individualized and comprehensive care plan or interventions after falls (Resident #15), for a resident at risk for pressure ulcers and urinary incontinence (Resident #78) and failed to care plan a wanderguard (Resident #14). This was for 3 of 20 residents whose care plans were reviewed. The findings included: 1. Resident #15 was admitted to the facility on 12/31/22 with diagnosis that included Vascular Dementia with psychotic disturbance and history of falls. The quarterly Minimum Data Set (MDS) assessment dated 08/18/23 indicated Resident #15's cognition was severely impaired. He had no	F 656	Resident #15 care plan was updated with interventions for all falls since 6-28-23. This was completed by the Minimum Data Set (MDS) Nurse on 12/15/23. Resident #78 care plan was updated on 12/15/23 by the MDS Nurse to include pressure ulcer risk and urinary incontinence. Resident #14 care plan was updated on 12/15/23 by the MDS Nurse for wander risk and wander guard. Resident care plans were audited for falls, pressure risk, urinary incontinence and wander risk, wander guard. This audit was completed on 12/15/23 by the Director of Nursing and MDS consultant. Any care plan(s) that were incorrect, were corrected by the MDS Nurse on 12/15/23. The MDS Consultant educated the MDS Nurse on accurate care planning for all residents. This education was completed	

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F 656	Continued From page 16 behavior and no rejection of care. He required extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15 ' s active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. (Initiated: 01/14/23). The interventions (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for assistance as needed. Residents need a prompt response to all requests for assistance, follow facility fall protocol, and Physical Therapy (PT) to evaluate and treat as ordered. An intervention for staff to offer to get resident out of bed upon rising (initiated on 08/18/23). The care plan revealed no focus for Resident #15 having actual falls. Incident reports revealed Resident #15 had six falls between 06/28/23 and 09/14/23 without injuries. Incident report dated 06/13/23 revealed Resident #15 slid out of bed onto the floor. No focus or interventions were added to the care plan. An incident report dated 07/26/23 revealed he attempted to transfer himself from bed unassisted and fell. No focus or interventions were added to the care plan. An incident report dated 07/28/23 revealed he was located on the floor in his room. No focus or interventions were added to the care plan. An incident report dated 08/02/23 revealed Resident #15 rolled out of bed while sleeping. No focus or interventions were added to the care plan. An incident report dated 08/18/23 revealed Resident #15 rolled out of bed while sleeping. A focus that read	F 656	on 12/15/23. The MDS Consultant will audit 5 resident care plans weekly x 4 weeks for fall interventions, pressure risk, urinary incontinence and wandering or wander guard, then 3 resident care plans weekly x 4 weeks then 1 resident care plan weekly x 1 week. The Administrator will be responsible for bringing the care plan audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the care plan audits. Date of Compliance: 12/15/23	

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in part that resident was at risk for falls with an intervention that read for staff to offer to get him out of bed upon rising (initiated on 08/18/23). Incident report dated 09/14/23 revealed Resident #15 slid out of bed onto the floor. No focus or interventions were added to the care plan.

The Director of Nursing (DON) was interviewed on 11/16/23 at 11:15 AM. She indicated she was aware of Resident #15 having a couple of falls but was unaware the falls had not been care planned. She also stated falls were discussed during the morning meetings and the Minimum Data Set (MDS) nurse would update the care plan according to the root cause of the fall. MDS Nurse #1 had been out on maternity leave and had not been present for morning meetings. The DON indicated she was to update the care plans during the time Minimum Data Set (MDS) Nurse #1 was out on maternity leave. She further stated she should have care planned Resident #15 ' s falls and felt it was an oversite that the falls were not added to the care plan. She then indicated the care plans should be person centered and should have included Resident #15's falls and interventions.

The Administrator was interviewed on 9/13/23 at 3:57 PM, and stated it was her expectation for the care plan to be person centered and should have included Resident #15's falls with interventions.
2. Resident #78 was admitted to the facility on 09/08/23 with diagnoses including chronic obstructive pulmonary disease, history of cerebral infarction, and chronic pain.

Review of the admission Minimum Data Set (MDS) dated 09/18/23 revealed Resident #78 was cognitively intact and needed extensive

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assistance with 1-person physical assist with bed mobility, 1-person physical assist with transfers, supervision with setup help with eating, and supervision with 1-person physical assist with toilet use. Further review of the MDS revealed Resident #78 was at risk for pressure ulcers and was incontinent of bladder. Section V of the MDS indicated pressure ulcer risk and urinary incontinence were addressed in the care plan.

A review of the comprehensive care plan for Resident #78 revealed no care plans for pressure ulcer risk or urinary incontinence was developed.

An interview was conducted with MDS Nurse #2 on 11/16/23 at 1:01 pm, and she indicated the pressure ulcer risk and urinary incontinence care plan should have been developed. She indicated she worked as needed and was trying to help get care plans completed.

3. Resident #14 was admitted to the facility on 12/16/22 with diagnoses that included Alzheimer's disease, dementia with behavioral disturbances, and anxiety.

Resident #14'a physician order dated 4/26/23 read "wanderguard check placement every shift and function every night." A wanderguard check placement order was still active on 11/17/23.

Review of the quarterly Minimum Data Set (MDS) dated 5/12/23 showed Resident #14 was severely cognitively impaired, he had no wandering behaviors, and he used a wander/ elopement alarm daily.

Review of Resident #14's care plan showed a focus area the resident was an elopement

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F 656	Continued From page 19 risk/wander related to disoriented to place. The elopement risk/wander care area was initiated on 8/28/23. An interview was conducted on 11/16/23 at 12:45 P.M. with the MDS nurse. The MDS nurse reviewed the quarterly assessment dated 5/12/23 and confirmed Resident #14's care plan was required to be updated either when the physician order was created or when the MDS assessment dated 5/12/23 was completed and showed Resident #14 used a wanderguard. The MDS nurse was unable to provide a reason Resident #14's care plan was not updated. An interview was conducted on 11/16/23 at 2:32 P.M. with the Director of Nursing (DON). The DON stated care plans should be updated in a timely manner. The DON further explained, when Resident #14 had the wanderguard applied in April 2023, his care plan should have been updated at that time by the MDS nurse. The DON further explained when Resident #14's MDS assessment dated 5/12/23 was completed, Resident #14's care plan should have been updated to reflect his risk for elopement.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, and staff interviews, the facility failed to provide nail care for dependent residents	F 677	Residents # 15, 19, and 40, nails were cleaned, trimmed and filed on 11/16/23 by the floor nurse. Resident #64□s hair was	12/15/23

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F 677	Continued From page 20 (Resident #15, #19, and #40) and failed to wash a dependent residents (Resident #64) hair. This was for 4 of 12 residents reviewed for activities of daily living (ADL). The findings included: 1. Resident #15 was admitted to the facility on 12/31/22 with diagnosis that included Vascular Dementia with psychotic disturbance, history of falls, and type 2 diabetes. The quarterly Minimum Data Set (MDS) assessment dated 08/18/23 indicated Resident #15's cognition was severely impaired. He had no behavior and no rejection of care. He required extensive assistance of 2 for personal hygiene. Resident #15 ' s active care plan, last revised on 08/21/23, indicated he had an ADL self-care performance deficit related to cognitive impairment, weakness and debility. The interventions included for staff to check nail length, trim and clean on bath day and as necessary. Report any changes to the nurse. The resident required extensive to total care of one staff with personal hygiene and bathing/showering. A review of Resident #15's nursing progress notes from 08/22/23 to 11/17/23 revealed resident refused his shower on 10/03/23 and 09/13/23. No refusals of nail care documented. An observation and interview with Resident #15 were conducted on 11/13/23 at 11:16 AM. The observation revealed Resident #15 ' s fingernails on his left and right hands extended approximately 1/4 to 1/2 of an inch beyond his	F 677	washed on 11/14/23 by a floor certified nursing assistant. All in house residents were assessed for nail care on 12/13/23 by the Activities Director or assistant. Any resident found to have long, unclean, or jagged nails, were cleaned, filed and trimmed to resident preference. This was completed by the Director of Nursing (DON) on 12/13/23. All in house residents hair was audited for cleanliness on 12/13/23 by Activities. Any resident who needed his/her hair washed; this was completed on 12/15/23 by nursing staff. The Director of Nursing initiated an in-service on nail care and washing residents hair to all licensed nurses, and certified nursing assistants. This in-service was completed on 12/15/23. No staff was allowed to work after 12/15/23 if the in-service on nail care and hair washing was not completed. This in-service was added to the new hire orientation by the Director of Nursing on 12/15/23. The Administrator or Designee will conduct 20 resident audits on nail care and hair washing weekly x 4 weeks, then 10 residents weekly x 4 weeks then one resident monthly x 1 month. The Administrator will be responsible for bringing the nail care and hair washing audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the nail care and hair washing audits. Date of Compliance: 12/15/23	

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fingertips. Under the fingernails on the left and right hands was a brown/black substance. During an interview with Resident #15 he stated he wanted his nails cut, but the staff have not cut them in a long time.

An observation and interview with Resident #15 were conducted on 11/15/23 at 9:12 AM. The observation revealed Resident #15 ' s fingernails were still long and dirty. Resident stated no one had offered to cut or clean his nails.

An observation and interview were conducted with Nurse #1 on 11/15/23 at 10:01 AM. The observation revealed Resident #15 ' s fingernails were still long and dirty. Nurse #1 verified Resident #15 ' s fingernails were long and dirty. She stated Nursing Assistants (NAs) perform nail care when doing showers/baths and as needed. If a resident refused the NA would notify her and she would call the Responsible Party (RP) to let them know and then document the refusal in the nurse ' s notes. She also stated Resident #15 refused baths/showers at times and could be combative with staff. Observed Resident #15 tell Nurse #1 he would let her cut his nails.

An observation and interview were conducted on 11/15/23 at 12:38 PM with Nursing Assistant (NA) #1. NA #1 was not the direct care NA this shift but had worked with Resident #15 often. She stated she performed nail care when performing ADL care, showers/baths and as needed. She also stated Resident #15 refused care at times and can be combative at times. She had not realized his nails needed to be cut. She could not recall when she last gave him a shower.

An interview was conducted with the Director of

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Nursing (DON) on 11/16/23 at 11:17 AM. She stated nail care was to be looked at daily and on shower days and that nails should be cleaned and cut as needed.

2. Resident #19 was admitted to the facility on 08/22/19 with diagnoses that included Dementia, Schizoaffective disorder, and congestive heart failure (CHF).

The quarterly Minimum Data Set (MDS) assessment dated 09/05/23 indicated Resident #19's cognition was severely impaired. She had no behavior and no rejection of care. She required extensive assistance of 1 with bathing and personal hygiene.

Resident #19's active care plan, last revised on 08/25/23, indicated she needed assistance with ADL's related to unsteady gait and impaired safety awareness. The interventions included for staff to assist Resident #19 with personal hygiene and 2-3 showers per week and prn.

A review of Resident #19's nursing progress notes from 06/20/23 to 11/15/23 revealed resident refused his shower on 10/03/23. No refusals of nail care documented.

An observation and interview with Resident #19 were conducted on 11/13/23 at 10:15 AM. The observation revealed Resident #19 ' s fingernails on her left and right hands extended approximately 1/4 to 1/2 of an inch beyond her fingertips. Right hand middle finger was jagged.

An observation was conducted on 11/15/23 at 10:50 AM of Resident #19. The observation revealed Resident #19 ' s fingernails were still

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long.

An interview was conducted with Nursing Assistant (NA) #3 on 11/15/23 at 11:15 AM. She verified she was the direct care NA for Resident #19. She indicated she bathed Resident #19 this morning but did not trim or file her nails. She stated she did not realize Resident #19 ' s nail needed to be cut. She stated she performed nail care when doing showers/baths and as needed.

An interview was conducted with Nursing Assistant (NA) #2 on 11/16/23 at 8:50 AM. She verified she was the direct care NA for Resident #19 ' s room. She stated she had just completed morning care with resident #19. NA #2 verified Resident #19 ' s nails were long and needed to be cut. NA #2 stated she did not realize her nails needed to be cut. She stated she performed nail care when doing showers/baths and as needed.

An interview was conducted with the Director of Nursing (DON) on 11/16/23 at 11:17 AM. She stated nail care was to be looked at daily and on shower days and that nails should be cleaned and cut as needed.

3. Resident #40 was admitted to the facility on 12/31/22 with diagnosis that included Parkinson ' s Disease.

A review of Resident #40's nursing progress notes from 05/26/23 to 11/17/23 revealed resident had no refusals for bath/showers and no refusals of nail care documented.

The admission Minimum Data Set (MDS) assessment dated 10/02/23 indicated Resident #40's cognition was severely impaired. He had no

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behavior and no rejection of care. He required total assistance for baths/showers and personal hygiene.

Resident #40 ' s active care plan, last revised on 11/12/22, indicated he had an ADL self-care performance deficit related to cognitive impairment, weakness and debility. The interventions included for staff to check nail length, trim and clean on bath day and as necessary. Report any changes to the nurse. Resident #40 required extensive to total care of one staff with personal hygiene and bathing/showering.

An observation and interview with Resident #40 were conducted on 11/13/23 at 10:30 AM. The observation revealed Resident #40 ' s fingernails on his left and right hands extended approximately 1/4 to 1/2 of an inch beyond his fingertips. During an interview with Resident #40 he nodded yes when asked if he wanted his nails cut.

An observation and interview were conducted with Nurse #1 on 11/15/23 at 10:01 AM. The observation revealed Resident #40 ' s fingernails were still long and dirty. Nurse #1 verified Resident #40 ' s fingernails were long. She stated Nursing Assistants (NAs) perform nail care when doing showers/baths and as needed. If a resident refused the NA would notify her and she would call the Responsible Party (RP) to let them know and then document the refusal in the nurse ' s notes.

An observation and interview were conducted on 11/15/23 at 12:38 PM with Nursing Assistant (NA) #1. NA #1 was not the direct care NA this shift but

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had worked with Resident #40 often. She stated she performed nail care when performing ADL care, showers/baths and as needed. She had not realized Resident #40 ' s nails needed to be cut. She could not recall when she last gave him a shower.

An interview was conducted with the Director of Nursing (DON) on 11/16/23 at 11:17 AM. She stated nail care was to be looked at daily and on shower days and that nails should be cleaned and cut as needed.

4. Resident #64 was admitted to the facility on 3/24/23 with diagnosis that included Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting left non-dominant side,

The quarterly Minimum Data Set (MDS) assessment dated 09/08/23 indicated Resident #64's was cognitively intact. Resident #64 required extensive assistance of 2 for personal hygiene.

Resident #64 ' s active care plan, last revised on 09/18/23, indicated she had an ADL self-care performance and required extensive to total care of one/two staff with personal hygiene and bathing/showering, needed assistance with toileting, transfer, and nails were to be trimmed on shower days, and report any changes to the nurse. Further review of the care plan indicated that Resident #64 was resistive to care relating to anxiety.

Review of Resident #64's medical record revealed no indication of Resident getting her hair washed on shower days.

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An observation of Resident #64 was conducted on 11/14/23 at 1:30 pm. Resident's hair observed to be matted.

During an observation, an interview was conducted on 11/14/23 at 1:30 pm with Resident #64 and she indicated her hair had not been washed in several weeks. Resident #64's hair was matted.

On 11/15/23 at 9:28 am an observation was conducted of NA #6, perform ADL care on Resident #64. The ADL care was completed, NA #6 asked Resident did she wanted her hair combed and the Resident stated no because it was matted and needed to be washed.

An interview was conducted with NA #6 on 11/15/23 at 9:40 am and she indicated Resident #64 did not want her hair washed because the facility did not have a hair dryer to dry her hair. NA #6 stated that Resident #64 wants to do as much as she can for herself but did not like to have her hair washed because the facility did not have a hand hair dryer or a hairdresser that could do her hair. NA #6 indicated the facility did not have a hair dryer.

Observation of all the shower room were observed on 11/16/23 at 9:30am, revealed no hair dryer.

An interview was conducted with Resident #64 on 11/16/23 at 2:30 pm. Resident #64 indicated her hair had not been washed since 9/23/23 because the facility did not have a hand hair dryer and they did not have anyone to do ethnic hair. Resident

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F 677	Continued From page 27 #64 stated she would love to get her hair done. Another observation was conducted on 11/17/23 at 11:30 am of Resident #64. Resident's hair remained matted. An interview was conducted with the Administrator on 11/17/23 at 2:36 pm and she indicated her expectation for residents to receive ADL care daily, including their hair being washed and done as needed by the staff in the facility.	F 677		
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, resident, and staff interview the facility failed to obtain a physician's order and perform dressing changes for a skin tear to a Resident's left upper arm for 1 of 1 resident reviewed for skin condition (Resident #78). The findings included: Resident #78 was admitted to the facility on 09/08/23 with diagnoses including chronic obstructive pulmonary disease, history of cerebral infarction, and chronic pain.	F 684	Resident #78□s skin tear was fully healed when dressing was removed by the floor nurse on 11/15/23. No order for dressing was required at that time. Medical Director (MD) was notified of healed skin tear. No new orders given. All in house residents were observed for any skin tears, order from the MD for a dressing and dressing changes completed. This audit was conducted on 12/14/23 by the Director of Nursing (DON). Any resident who had a skin tear, an order was verified or received and	12/15/23

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F 684	Continued From page 28 Review of the admission Minimum Data Set (MDS) dated 09/18/23 revealed Resident #78 was cognitively intact and needed extensive assistance with 1-person physical assist with bed mobility, 1-person physical assist with transfers, supervision with setup help with eating, and supervision with 1-person physical assist with toilet use. A review of progress note written on 11/08/23 at 10:28 am read in part, "Resident found on floor in resident's bathroom laying in front of toilet with both knees bent. Resident wearing nonskid socks at time of incident. Resident assessed for orientation, pain, and injuries. Resident A&Ox4 (alert and oriented to person, place, time and situation) able to make needs known. The skin tear to left elbow noted, cleansed and treatment implemented by wound care nurse. No c/o pain or distress currently. Skin tear cleansed and treatment implemented, neuro checks initiated." An observation was conducted on 11/12/23 at 4:18 pm of a dirty gauze dressing to Resident #78's left upper arm with the date of 11/08/23. A review of Resident #78's current physician orders was conducted, and no order was noted for skin tear to left upper arm. There were no standing orders for skin tears. During an interview on 11/12/23 at 4:19 pm with Resident #78 he reported he had a fall the other day and hit his arm and got a "cut". He stated, "They put this on it." Resident #78 indicated he did not remember the exact day the fall happened, or which nurse put the gauze dressing on his left upper arm.	F 684	entered the resident chart. The dressing was put in place, changed, or discontinued by DON on 12/15/23. The Director of Nursing initiated an in-service on 12/14/23 for all licensed nurses to enter orders from the MD into the resident chart for skin tear dressings and to change the dressing as indicated in the order. No nurse was allowed to work after 12/15/23 if the in-service had not been completed. DON added this education to the new hire orientation on 12/15/23. The DON will conduct 5 resident observations x 4 weeks for residents who have skin tears with dressing to verify and order is in place in the resident chart and that the dressing has been changed, then 3 resident observations x 4 weeks then 1 resident observation x 4 weeks. The Director of Nursing will be responsible for bringing the skin tear order and dressing change audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the skin tear order and dressing change audits. Date of Compliance: 12/15/23	

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On 11/14/23 at 12:32 pm an observation was made and the dirty gauze dressing with the date of 11/08/23 remained on Resident #78's left upper arm.

An interview was conducted on 11/14/23 at 1:00 pm with the Wound Care Nurse and she indicated she was not aware that Resident #78 had sustained a skin tear to his left upper arm. She indicated Resident #78 did not have an order for a skin tear and she was not aware he had a gauze dressing to his left upper arm. She indicated the Nurse should have called the Physician and obtained an order for the skin tear. The Wound Care Nurse indicated there were no standing orders to treat skin tears.

On 11/15/23 at 9:16 am an interview was conducted with Nurse #4, and she indicated she went to assist the NA get Resident #78 off the bathroom floor and observed a skin tear on Resident's left upper arm. She stated the Wound Nurse came into Resident's room and immediately treated the skin tear. Nurse #4 stated, "I thought she wrote the orders because she put the dressing on it." She indicated she had not worked with Resident #78 since the 11/08/23 fall and was not aware that there was not a treatment order for the skin tear to Resident #78's skin tear.

11/15/23 at 11:13 am a follow up interview was conducted with the Wound Care Nurse, and she stated she did not remember dressing Resident #78's skin tear but was busy the day of his fall and if she did put the gauze dressing on Resident. It was Nurse #4's for notifying the Physician and putting the order in the computer.

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F 684	Continued From page 30 During an interview with the Director of Nursing (DON) on 11/16/23 at 12:13 pm, she indicated it was her expectation when a resident sustained a skin tear the Nurse was to notify the Physician and get an order and transcribe the order to the treatment record.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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 §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, staff interviews, and record review the facility failed to identify the root cause for six falls and implement effective interventions to prevent six falls (Resident #15). This was for 1 of 7 residents reviewed for accidents. The findings included: Resident #15 was admitted to the facility on 12/31/22 with diagnosis that included Vascular Dementia with psychotic disturbance and history of falls. The quarterly Minimum Data Set (MDS) assessment dated 08/18/23 indicated Resident #15's cognition was severely impaired. He had no behavior and no rejection of care. He required	F 689	Resident #15 care was corrected on 12/15/23 by the Director of Nursing (DON) for fall interventions based on root cause analysis. All in house residents who had falls in the last 30 days, the falls were reviewed for root cause analysis and fall interventions by the DON on 12/14/23. Any resident who did not have a root cause analysis and intervention, was corrected on 12/15/23 by DON. The Director of Nursing initiated in-servicing on 12/14/23 to all licensed nurses on root cause analysis and fall interventions. Any licensed nurse who did not receive this education by 12/15/23 was not allowed to work until this was completed. The Director of Nursing	12/15/23

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F 689	Continued From page 31 extensive assistance of 2 for bed mobility, dressing, and personal hygiene. He had 2 or more falls with no injuries. Resident #15 ' s active care plan, last revised on 08/21/23, included a focus for Resident #15 being at risk for falls related to impaired mobility, lower extremity amputee, and the use of psychotropic medications. (Initiated: 01/14/23). The interventions (Initiated: 01/14/23) included for staff to be sure resident's call bell was within reach and encourage the resident to use it for assistance as needed. Residents need a prompt response to all requests for assistance, follow facility fall protocol, and Physical Therapy (PT) to evaluate and treat as ordered. An intervention for staff to offer to get resident out of bed upon rising (initiated on 08/18/23). The care plan revealed no focus for Resident #15 having an actual fall. a. A incident report dated 06/13/23 revealed Resident #15 was observed sitting on his buttocks on the floor beside his bed with no injuries. The resident ' s description was that he slid out of bed onto the floor. No focus or interventions were added to the care plan. No investigation to include root cause of fall noted. b. A incident report dated 07/26/23 revealed Resident #15 was observed sitting on floor, leaning against his bed with no injuries. The resident ' s description was that he thought he might get up but did not know that he was not strong enough. No focus or interventions were added to the care plan. No investigation to include root cause of fall noted. c. A incident report dated 07/28/23 revealed Resident #15 was observed on floor in his room	F 689	added this to the new hire orientation for licensed nurses on 12/15/23. The Director of Nursing or designee will review all falls weekly for root cause analysis and fall interventions x 12 weeks. The Director of Nursing will be responsible for bringing these audit results to the Quality Assurance Performance Improvement Committee meeting x 3 consecutive meetings. The Quality Assurance Performance Improvement Committee will determine the need for continued monitoring or additional education. Date of Compliance: 12/15/23	

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lying on his left side with no injuries. No focus or interventions were added to the care plan. No investigation to include root cause of fall noted.

d. A incident report dated 08/02/23 revealed Resident #15 was observed on the floor in his room adjacent to bed, lying on left side. The resident ' s description was that he rolled out of bed while sleeping. No focus or interventions were added to the care plan. No investigation to include root cause of fall noted.

e. A incident report dated 08/18/23 revealed Resident #15 was observed on floor in his room lying on his side with no injuries. The resident ' s description was that he slid off his bed. A focus that read in part that resident was at risk for falls with an intervention that read for staff to offer to get him out of bed upon rising (initiated on 08/18/23). No investigation to include root cause of fall noted.

f. A incident report dated 09/14/23 revealed Resident #15 was witnessed sliding out of bed onto the floor. No injuries noted. No focus or interventions were added to the care plan. No investigation to include root cause of fall noted.

Nurse #1 was interviewed on 11/15/23 at 10:01 AM. She stated she was not aware that Resident #15 had several falls. She indicated she did not recall completing an incident report dated 08/03/23. She further stated when a resident had a fall she would assess for injuries, complete a incident report, write a progress note, and notify the responsible party and the physician.

The Director of Nursing (DON) was interviewed on 11/16/23 at 11:15 AM. She indicated she was

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F 689	Continued From page 33 aware of Resident #15 having a couple of falls but was unaware the falls had not been care planned. She also stated falls were discussed during the morning meetings and the Minimum Data Set (MDS) nurse would update the care plan according to the root cause of the fall. MDS Nurse #1 had been out on maternity leave and had not been present for morning meetings. The DON indicated she was to update the care plans during the time Minimum Data Set (MDS) Nurse #1 was out on maternity leave. She further stated she should have care planned Resident #15 ' s falls and felt it was an oversite that the falls were not added to the care plan. She then indicated the care plans should be person centered and should have included Resident #15's falls and interventions. The Administrator was interviewed on 9/13/23 at 3:57 PM, and stated it was her expectation for the care plan to be person centered and should have included Resident #15's falls with interventions.	F 689		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interviews and record review, the facility failed to provide a lunchtime meal to a dialysis resident on 11/02/23, 11/04/23, 11/07/23, 11/09/23, 11/11/23, 11/14/23 and 11/16/23 for 1 of	F 698	On 11/18/23 Resident #185 began receiving an early breakfast tray or bag to go to dialysis by the Director of Nursing (DON). All in house dialysis residents were	12/15/23

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F 698	Continued From page 34 1residents reviewed for dialysis (Resident #185). Findings included: Resident #185 was admitted to the facility on 10/28/23 with diagnoses that included end stage renal disease and dependence on dialysis. Review of an admission Minimum Data Set (MDS) assessment dated 11/01/23 revealed Resident #185 cognition was not assessed, and staff assessment indicated his memory was ok. The MDS documented Resident #185 was able to understand others and was understood. In an interview with Resident #185 on 11/12/23 at 5:06 pm and he stated, he had not gotten a breakfast meal either at the facility or bag to go since his admission on 10/28/23. He reported he went to dialysis on Tuesday, Thursday, and Saturday. He explained his chair time at dialysis was 6:15 am and he was usually transported between 5:30 am to 6:00 am each dialysis day. He indicated he was not receiving breakfast or a bag lunch on dialysis days. He stated he did not think he needed to tell the staff at the facility because they knew he did not eat breakfast because he left the facility before breakfast. An interview was conducted on 11/15/23 at 1:00 pm with the Dietary Manager and it was indicated bags of food were prepared for dialysis residents on the evening shift and put in the refrigerator for nursing staff to come get for residents before dialysis. On 11/16/23 at 2:54 pm an interview was conducted with Nurse #3, and she indicated she worked the 7p to 7 am shift and has cared for	F 698	audited for receiving a meal or bag to go with to dialysis on 12/14/23 by the Administrator. All dialysis residents were found to be receiving a meal or a bag to go. The Director of Nursing initiated an in-service on providing early meals or bag to go with dialysis resident to dialysis on 12/14/23 to the Dietary Manager, cooks, and dietary aides, certified nursing assistants, and all licensed nurses. Anyone who did not receive this education by 12/15/23 was not allowed to work until this education was completed. The Director of Nursing added this to the new hire orientation on 12/15/23. The Director of Nursing or designee will audit all dialysis residents 1 x a week for 12 weeks to ensure they are receiving a meal prior to or a bag to go with them to dialysis. The Director of Nursing is responsible for bringing the dialysis meal or bag audit to the Quality Assurance Performance Improvement Committee meeting x 3 consecutive meetings. The Quality Assurance Committee will determine the need for changes or continued monitoring. Date of Compliance: 12/15/23	

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F 698	Continued From page 35	F 698		

Resident #185. She reported she did not recall Resident #185 having breakfast sent with him to dialysis.

An interview was conducted on 11/16/23 at 3:01 pm with NA #4 and she indicated she had worked with Resident #185 on the night shift. NA #4 indicated Resident #185 usually had a bag ready when he went to dialysis, but she did not know what was in it. She stated, "I have not gone to get a bag out of the kitchen for him."

An interview was conducted on 11/16/23 at 3:03 pm with NA #5 who reported she worked with Resident #185 at least 3 nights a week. She reported Resident #185 always had a little duffle bag to take with him, but she did not know what was in the bag. She indicated she never got a bag with food from the kitchen, and he did not eat breakfast before going to dialysis because he goes before breakfast came out. NA #5 stated," I did not know I was to go and get anything for him to eat before dialysis."

On 11/16/23 at 3:34 pm an interview with Resident # 185 and family member was in attendance, and they both indicated the staff did not send any meals with Resident to dialysis. Resident # 185 stated, "I have not asked for anything, I didn't think I needed to." The family member stated, "I bring him snacks to take with him because he can get sick if he doesn't have something on his stomach before getting on the machine."

An interview was conducted on 11/17/23 at 10:23 am with the Administrator and she indicated it was her expectation that staff ensure residents have their food bag from kitchen before going to

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F 698	Continued From page 36 dialysis.	F 698		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day, for 16 of 30 days (10/13,10/18,10/19,10/20, 10/23. 10/24, 10/27, 10/28, 10/29, 11/01, 11/02, 11/06, 11/07, 11/10, 11/11, and 11/12)) reviewed for staffing. Findings included: Review of the daily staffing sheets from 10/12/23 through 11/12/23 revealed there was no RN scheduled for the following days, 10/13, 10/18, 10/19, 10/20, 10/23, 10/24, 10/27, 10/28, 10/29, 11/1, 11/2, 11/6, 11/7, 11/10, 11/11, and 11/12. During an interview with the Scheduler on 11/16/23 at 3:00pm who indicated she had only	F 727	Staff schedules were adjusted on 11/13/23 by the Scheduler to ensure proper Registered Nurse (RN) coverage. Current residents are affected by this current deficiency. The Chief Operating Officer educated the scheduler, the Director of Nursing and Administrator on 12/14/23 on providing a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week. The Director of Nursing and/or designee will audit schedule to ensure a Registered Nurse is in the facility for 8 consecutive hours for a day, 7 days a week weekly x 8 weeks. The Director of Nursing will be responsible for bringing the Registered	12/15/23

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F 727	Continued From page 37 been doing this job for 6 weeks. She revealed that she had no knowledge of not being able to count the Director of Nursing (DON) as the RN on staff if no other RN was not present. Scheduler acknowledge many days of no RN. The Administrator was interviewed on 11/16/23 at 4:58pm. The Administrator acknowledged the days the facility did not have an RN scheduled but she stated the DON was present and she had been the RN for that day. However, the Administrator acknowledge that DON cannot serve as RN now.	F 727	Nurse audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine if further auditing will be required. Date of Compliance: 12/15/23	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews with staff and interview with the Pharmacist Consultant, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.54% for 2 of 3 residents (Resident #45 and Resident #11) observed during the medication administration observation. The findings included: 1. a. Resident #45 was admitted to the facility on 09/13/23. Her cumulative diagnosis included Chronic Obstructive Pulmonary Disease (COPD).	F 759	Medication Aide# 1 received immediate education on medication administration by the Unit Coordinator on 11/15/23 to include swish and spit with water to rinse mouth after Advair Diskus aerosol, following physician orders for applying ointments, and not leaving medications at bedside. All current residents have the potential to be affected. The Director of Nursing initiated an in-service on medication administration on 12/14/23 to all licensed nurses and medication aides. This in-service included rinsing mouth with water or	12/15/23

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F 759	Continued From page 38 A review of Resident #45 active Physician Orders included a current order for Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE, 1 inhalation inhale orally one time a day for SOB (initiated 11/10/23). Advair Diskus Aerosol is an inhaled medication containing a combination of two medications, fluticasone (a corticosteroid) and Salmeterol (a long-acting bronchodilator). Used to treat Chronic Obstructive Pulmonary Disease (COPD). On 11/15/23 at 8:22 AM, Medication Aide (MA) #1 was observed as she prepared and administered 16 medications to Resident #45. The administered medications included one Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE 1 inhalation inhale orally. The resident was observed as she inhaled one puff of the aerosol medication. The MA did not prompt the resident to rinse her mouth out with water; no water was offered to the resident so she could rinse and spit out the water after the Advair Diskus inhaler was used. A review of the full prescribing information from the manufacturer ' s website for Advair Diskus Aerosol Powder inhaler (Revised 01/19) included the following administration information, in part: Advair Diskus Aerosol should be administered; use 1 inhalation of Advair Diskus 2 times each day. Use Advair Diskus at the same time each day, about 12 hours apart. Advair Diskus can cause serious side effects, including fungal infection in your mouth or throat (thrush). Advair Diskus specified the following administration guidelines: "Rinse your mouth with water and spit the water out after each dose of Advair Diskus to help reduce your chance of getting thrush."	F 759	coaching/instructing resident to swish and spit water after Advair Discus, applying ointments per physician orders and not leaving medications at bedside. Any licensed nurse or medication aide who did not receive the in service by 12/15/23 would not be allowed to work until the in service is completed. The Director of Nursing or designee will audit 5 licensed nurses or medication aides weekly x 8 weeks for proper medication administration. The Director of Nursing will be responsible for bringing the medication administration audits to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine if further auditing or education is needed. Date of Compliance: 12/15/23	

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An interview was conducted on 11/15/23 at 8:34 AM with Medication Aide (MA) #1. During the interview, the MA confirmed she did not provide water or coaching/instruction to Resident #45 to rinse her mouth without swallowing after using the Advair Diskus inhaler.

An interview was conducted on 11/16/23 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, the DON reported education had recently been provided to nurses and Medication Aide ' s related to medication administration. She further expected all medications to be administered per the physicians ' orders.

1. b. Resident #45 was admitted to the facility on 09/13/23. Her cumulative diagnosis included osteoarthritis and lumbar region intervertebral disc degeneration.

A review of Resident #45 active Physician Orders included a current order for Aspercreme/Aloe External Cream 10 %, apply to right shoulder and left hip topically four times a day for pain.

On 11/15/23 at 8:22 AM, Medication Aide (MA) #1 was observed as she prepared and administered 16 medications to Resident #45. The administered medications included Aspercreme/Aloe External Cream 10 %, apply to right shoulder and left hip topically. The MA did not apply the Aspercreme to Resident #45 ' s left hip.

An interview was conducted on 11/15/23 at 8:34 AM with Medication Aide (MA) #1. During the interview, the MA confirmed she did not apply the

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Aspercreme to Resident #45 ' s left hip.

An interview was conducted on 11/16/23 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, the DON reported education had recently been provided to nurses and Medication Aide ' s related to medication administration. She further expected all medications to be administered per the physicians ' orders.

2. Resident #11 was admitted to the facility on 03/08/18. Her cumulative diagnosis included constipation.

A review of Resident #11 active Physician Orders included a current order for Lokelma Packet 10 gram (GM) (Sodium Zirconium Cyclosilicate) Give 10 gram by mouth one time a day. Which is used for the treatment of hyperkalemia (high potassium) in adults.

On the packet of Lokelma medication it read to administer Lokelma orally as a suspension in water. Empty the entire contents of the packet(s) into a drinking glass containing approximately 3 tablespoons of water or more, if desired. Stir well and drink immediately if powder remains in the glass, add water, stir, and drink immediately. Repeat until no powder remains.

On 11/15/23 at 8:22 AM, Medication Aide (MA) #1 was observed as she prepared and administered 4 medications to Resident #11. MA #1 mixed the 10 GM packet of Lokelma with approximately 3 tablespoons of water and took the Lokelma and other medications to Resident #11. The resident was observed to partially complete the cup of Lokelma and mixed water solution along with her

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F 759	Continued From page 41 other medications. The MA left the cup with approximately 2 tablespoons of Lokelma and water mixed solution on the bedside table and exited the room. An interview was conducted on 11/15/23 at 8:45 AM with Medication Aide (MA) #1. During the interview, the MA confirmed she left the remainder of the Lokelma and water mixed solution in a cup on the bedside table. She stated the medication was just a supplement and she could leave it for the Resident #11 to sip on. An interview was conducted on 11/16/23 at 11:17 AM with the facility's Director of Nursing (DON). During the interview, the DON reported education had recently been provided to nurses and Medication Aide ' s related to medication administration. She further expected all medications to be administered per the physicians ' orders. A phone interview was conducted on 11/17/23 at 10:19 AM with the facilities Pharmacist Consultant. She stated Lokelma medication should not be left at bedside where other residents may be able to have access to it. She also stated Lokelma should be mixed with water and should be consumed right away.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		12/15/23

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F 761	Continued From page 42 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to remove expired medications and failed to remove loose pills from 1 of 2 medication carts reviewed and failed to remove expired medications from 1 of 2 medication storage rooms reviewed (300B medication cart and 200 hall medication storage room). Findings included: 1a. An observation of the 300B medication cart was conducted on 11/14/2023 at 1:30pm in the presence of Nurse #1 and Medication Aide (MA) #3 revealed the following medications as expired, that were in the medication cart and available for use:	F 761	Expired medications and loose medications on 300B medication cart were removed on 11/14/23 by the floor nurse. The expired medications located in the 200-hall medication storage room were removed on 11/15/23 by the Unit Manager. All medication carts and medication rooms were audited for expired or loose medications on 12/15/23 by the Unit Manager. Any expired or loose medications were discarded by the Director of Nursing on 12/15/23. The Director of Nursing initiated an in-service on medication storage, to include removing expired medications and chekcing medication carts for loose pills. the in-service also included third shift	

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F 761	Continued From page 43 - One bottle of Milk of Magnesia liquid that expired September 2023. - One bottle of Multivitamin liquid that expired July 2023. MA #3 indicated that the two medications in the 300B medication cart were expired, and he was unaware that the medications had expired. Nurse #1 indicated that the two medications on the 300B medication cart were expired and indicated that both medications must be removed from the medication cart. Nurse #1 further indicated that night shift nurses were responsible for checking and removing expired medications in the medication cart and medication storage rooms. The Director of Nursing (DON) was interviewed on 11/15/2023 at 1:41pm and indicated medication that was expired should not be in the medication cart or medication storage room available for use but should be discarded. She further indicated that the night shift nurses were responsible for ensuring the medication carts and medication storage rooms had no expired medications. 1b. An observation of the 300B medication cart was conducted on 11/14/2023 at 1:30pm in the presence of Nurse #1 and MA #3. The medication cart contained 10 loose pills of various shapes, colors and sizes laying in the bottom of cart drawers. Nurse #1 indicated night shift nurses were responsible for cleaning the medication carts and ensuring that it was organized and well stocked.	F 761	nurses and certified medication aides are to check medication carts nightly for expired medications and loose pills to all certified medication aides, all licensed nurses and central supply on 12/14/23. Any certified medication aide, licensed nurse or central supply who did not receive the in service by 12/15/23 were not allowed to work. This education was added to the new hire orientation by the Director of Nursing on 12/15/23. The Director of Nursing or designee will audit all medication carts and medication storage rooms weekly x 4 weeks, the biweekly x 4 weeks then monthly x 1. The Director of Nursing will be responsible for bringing the medication storage audits to the Quality Assurance Performance Committee meeting x 3 consecutive meetings. The Quality Assurance Performance Committee will be responsible for determining the need for additional audits. Date of Compliance: 12/15/23	

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F 761	Continued From page 44 An interview was conducted with the DON on 11/15/2023 at 1:41pm. The DON indicated night shift nurses should clean, organize the medications carts, and discard any loose pills. 2. An observation of the 200-hall medication storage room was conducted on 11/15/2023 at 12:47pm in the presence of Nurse #2 and MA #4, revealed the following medications as expired that were in the medication storage room and available for use: -Two bottles of One-Daily Multivitamin dietary supplement 1000 tablets with an expiration date of August 2023. MA #4 indicated the medications were expired. Nurse #2 indicated the two bottles of One-Daily Multivitamin in the 200-hall medication storage room were expired and indicated that both medications must be removed and not made available for use. Nurse #2 further indicated that night shift nurses were responsible for checking and removing expired medications in the medication cart and medication storage rooms. The Director of Nursing (DON) was interviewed on 11/15/2023 at 1:41pm and indicated medication that was expired should not be in the medication cart or medication storage room available for use but should be discarded. She further indicated that the night shift nurses were responsible for ensuring the medication carts and medication storage rooms had no expired medications.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		12/15/23

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F 804	Continued From page 45 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on test tray observation, record reviews, and interviews with residents and staff the facility failed to serve food that was palatable and at temperatures acceptable to 5 of 8 residents reviewed for food palatability (Resident #1, Resident #3, Resident #22, Resident #26, and Resident #38). This practice had the potential to affect other residents. Findings included: a. Resident #1 was admitted to the facility on 09/01/2017. Resident #1 resided on the 100 hall. A review of the Minimum Data Set (MDS) dated 8/12/23 revealed Resident #1 was cognitively intact and independent with eating after assistance with meal set up. During an interview with Resident #1 on 11/12/23 at 4:32pm she indicated she had concerns with all her meals being cold. Resident #1 alleged the food was unappealing because the food was often undercooked or overcooked.	F 804	One on one education was provided to the Dietary Manager on 12/15/23 by the Regional Dietary Manager, on palatability of food and food temperatures. All current residents have the potential to be affected by this current deficiency. The Regional Dietary Manager initiated an in-service to all Dietary staff to include cooks and aides on palatability of food, and food temperatures on 12/15/23. Any dietary staff who did not receive this education by 12/15/23 are not allowed to work until this in-service has been completed. On 11/17/23 a new food delivery cart was delivered, and on 12/12/23, 4 additional new food delivery carts were ordered. On 12/1/23, the contract for dietary service was terminated and all dietary staff were converted to facility staff on 12/2/23. This will allow increased education and monitoring by the Regional Dietary Manager. The Regional Dietary Manager or designee will conduct 10 resident interviews for palatability of food and temperatures x 8 weeks. The Regional	

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F 804	Continued From page 46 A second interview was conducted with Resident #1 on 11/15/23 at 1:15 pm, Resident #1 indicated that lunch was cold today. Resident #1 indicated that the pork loin, mashed potatoes and broccoli were cold, and all the food lacked seasoning. Resident #1 indicated that she had told the staff and dietary manager about her concern. b. Resident #3 was admitted to the facility on 02/16/18. Resident #3 resided on the 100 hall. A review of the Minimum Data Set (MDS) dated 8/09/23 revealed Resident #3 was cognitively intact and independent with eating after assistance with meal set up. During an interview with Resident #3 on 11/12/23 at 4:38pm she indicated she had concerns with all her meals being cold, Resident #2 alleged the food was unappealing because the food was often undercooked or overcooked. A second interview was conducted with Resident #3 on 11/15/23 at 1:20 pm, Resident #3 indicated that lunch was cold today. Resident #3 indicated that the pork loin, mashed potatoes and broccoli were cold, and all the food lacked seasoning. Resident #3 indicated that staff were aware of her concerns with the food. c. Resident #22 was admitted to the facility on 06/22/22. Resident #22 resided on the 300 hall. A review of the Minimum Data Set (MDS) dated	F 804	Dietary Manager or designee will conduct food temperature audits 5 x a week x 8 weeks. Date of Compliance: 12/15/23	

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8/25/23 revealed Resident #22 was cognitively intact and independent with eating after assistance with meal set up.

During an interview with Resident #22 on 11/13/23 at 12:45 pm she indicated she had concerns with her meals being cold. Resident #22 indicated that she has complained before, and no one did anything about the meals being cold. Resident #22 had reported her complaint to the dietary manager many times.

A second interview conducted with Resident # 22, on 11/15/23 at 12:40 pm she indicated that the food was cold. She indicated also that her pork loin was cold and dry. Mashed potatoes and broccoli were cold too. During this interview Resident #22's meal tray was observed as she was in the main dining room. Resident #22 had only consumed about 40% of her meal during this observation.

d. Resident #26 was admitted to the facility on 06/15/22.

Resident #26 resided on the 300 hall.

A review of the Minimum Data Set (MDS) dated 8/29/23 revealed Resident #26 was moderately impaired and independent with eating after assistance with meal set up.

During an interview with Resident #26 on 11/13/23 at 12:45 pm she indicated that sometimes her food is cold here daily. Resident #26 indicated that sometimes she ate the food cold, because no one would heat the food up. Resident #26 indicated that she and her family member had complained before, and no one did

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anything about the meals being cold.

During an interview with Resident #26's family member on 11/14/23 indicated that family had concerns with Resident #26.

A second interview conducted with Resident #26, on 11/15/23 at 12:50 pm, she indicated that the food was cold and dry.

e. Resident #38 was admitted to the facility on 06/15/22.

Resident #38 resided on the 200 hall.

A review of the Minimum Data Set (MDS) dated 11/01/23 revealed Resident #38 was cognitively intact and independent with eating after assistance with meal set up.

During an interview with Resident #38 on 11/12/23 at 2:45 pm she indicated that sometimes her food is cold daily. Resident #38 indicated that she talked with the Dietary Manager and things would get better but this week all her meals have been cold. Resident #38 indicated that she has complained before about her meals. Resident #38 reported her concerns to the Dietary Manger and the old Administrator.

A second interview conducted with Resident # 38, on 11/15/23 at 12:50 pm, she indicated that her pork loin was cold and dry, mashed potatoes and broccoli cold as well.

An observation of the meal tray line service in the kitchen was conducted on 11/15/23 at 11:20am. The food items were placed on heated plates from a plate warmer. The plated meals were

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F 804	Continued From page 49 covered with insulated, dome-shaped lids with bottoms. A test meal tray of the regular textured foods was included in the meal delivery cart. On 11/15/23 at 12:18am, after the residents of the 300 halls were served, the Dietary Manager and the Surveyor observed the test meal tray for palatability. The pork loin, mashed potatoes, fried potatoes and broccoli were cold. The DM participated in the testing of the meal tray and acknowledged these findings. During an interview on 11/16/23 at 1:30pm., the Dietary Manager revealed he had been working at the facility for two years and did not frequently receive complaints from residents concerning the quality of the food. During an interview with the Dietary Manager on 11/16/23 at 1:35pm indicated that their expectation was that all residents would receive good hot food and food on time daily. During an interview with the Administrator on 11/03/23 at 2:30pm she indicated that her expectation was that the dietary staff provide palatable food and temperature according to the regulations for all residents.	F 804		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the	F 867		12/15/23

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following:

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

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

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

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

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

§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

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improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

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

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

§483.75(e)(3) As part of their performance 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

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F 867	Continued From page 52 available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor intervention the committee put in place following a complaint survey conducted on 12/17/20. This was evident for 1 deficiency that was cited in the area Comprehensive Resident Centered Care Plan (Develop/Implement Comprehensive Care Plan) and on the current recertification and complaint survey conducted on 11/17/23. The facility's Quality Assessment and Assurance (QAA) Committee also failed to	F 867	The facility□s Quality Assurance committee failed to maintain implemented procedures and monitor the interventions the facility put in place, based on observations, record review, resident and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor intervention the committee put in place following a complaint survey conducted on 12/17/20. This was evident for 1 deficiency that was cited in the area Comprehensive Resident	

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F 867	Continued From page 53 maintain implemented procedures and monitor intervention the committee put in place following a complaint survey conducted on 1/28/21. This was evident for 1 deficiency that was cited in the area of Quality of Care and on the current recertification and complaint survey on 11/17/23. The QAA additionally failed to maintain implemented procedures and monitor interventions the committee put in place following recertification and complaint survey conducted on 02/26/21. This was evident for 2 deficiencies that were cited in the areas of Resident Comprehensive resident Centered Care Plan (develop/implement), and Pharmacy Services "Free of Medication Error Rate of 5 % or more and on the current recertification and complaint survey conducted on 11/17/23. The QAA additionally failed to maintain implemented procedures and monitor interventions the committee put in place following recertification and complaint survey conducted on 08/23/21. This was evident for 3 deficiencies that were cited in the areas of Environment (homelike), Quality of Care (Dialysis) and Pharmacy Services "Free of Medication Error Rate of 5 % or more and on the current recertification and complaint survey conducted on 11/17/23. The QAA committee additionally failed to maintain implemented procedures and monitor intervention the committee put in place following recertification and complaint survey conducted on 07/29/22 and recited on the current recertification and complaint survey of 11/17/23. This was evident of 3 deficiencies in the areas Resident Assessment/Accuracy of Assessment and Comprehensive Resident Centered Care Plans/Develop/Implement Comprehensive Care Plan and Provision of activities of daily living for dependent residents, Quality of Care. The QAA	F 867	Centered Care Plan (Develop/Implement Comprehensive Care Plan) and on the current recertification and complaint survey conducted on 11/17/23. The facility's Quality Assessment and Assurance (QAA) Committee also failed to maintain implemented procedures and monitor intervention the committee put in place following a complaint survey conducted on 1/28/21. This was evident for 1 deficiency that was cited in the area of Quality of Care and on the current recertification and complaint survey on 11/17/23. The QAA additionally failed to maintain implemented procedures and monitor interventions the committee put in place following recertification and complaint survey conducted on 02/26/21. This was evident for 2 deficiencies that were cited in the areas of Resident Comprehensive resident Centered Care Plan (develop/implement), and Pharmacy Services "Free of Medication Error Rate of 5 % or more and on the current recertification and complaint survey conducted on 11/17/23. The QAA additionally failed to maintain implemented procedures and monitor interventions the committee put in place following recertification and complaint survey conducted on 08/23/21. This was evident for 3 deficiencies that were cited in the areas of Environment (homelike), Quality of Care (Dialysis) and Pharmacy Services "Free of Medication Error Rate of 5 % or more and on the current recertification and complaint survey conducted on 11/17/23. QAA committee additionally failed to maintain	

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F 867	Continued From page 54 committee additionally failed to maintain implemented procedures and monitor interventions the committee put in place following complaint survey conducted on 04/27/23. This was evident for 1 deficiency that was cited in the area of Quality of care (Free of Accident hazards/Supervision/Devices) and recited on the current recertification and complaint survey on 11/17/23. The duplicate citations during six federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Findings included: F584 Based on observations and interviews with residents and staff, the facility failed to maintain floors free from dried spills and debris for two rooms (Room 312 and 318) This deficient practice affected 1 of 3 resident halls (300 Hall). During the recertification and complaint survey conducted on 8/23/21 the facility failed to maintain clean floor tiles in resident rooms. The facility failed to maintain clean call bell string cords. This was evident on 2 of 3 resident care units. F641 Based on record review and staff interviews, the facility failed to accurately complete the Minimum Data Set (MDS) for insulin use for 1 of 34 who MDS assessments were reviewed. During the recertification and complaint survey conducted on 2/26/21 the facility failed to code a	F 867	implemented procedures and monitor intervention the committee put in place following recertification and complaint survey conducted on 07/29/22 and recited on the current recertification and complaint survey of 11/17/23. This was evident of 3 deficiencies in the areas Resident Assessment/Accuracy of Assessment and Comprehensive Resident Centered Care Plans/Develop/Implement Comprehensive Care Plan and Provision of activities of daily living for dependent residents, Quality of Care. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put in place following complaint survey conducted on 04/27/23. This was evident for 1 deficiency that was cited in the area of Quality of care (Free of Accident hazards/Supervision/Devices) and recited on the current recertification and complaint survey on 11/17/23. The duplicate citations during six federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Corrective Action: A plan of correction was put into place at the time of the deficiency cited. The plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined period of time. Monitoring of the plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period	

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F 867	Continued From page 55 therapeutic diet on the Minimum Data Set (MDS) assessment for 1 of 6 residents reviewed for nutrition. During the recertification and complaint survey conducted on 7/29/22 the facility failed to accurately code the quarterly Minimum Data Set (MDS) for 1 of 25 residents reviewed for MDS. F656 Based on record review, observations and staff interviews, the facility failed to develop an individualized and comprehensive care plan or interventions after falls (Resident #15), for a resident at risk for pressure ulcers and urinary incontinence (Resident #78) and failed to care plan a wander guard (Resident #14). This was for 3 of 20 residents whose care plans were reviewed. During the complaint survey conducted on 12/17/20 the facility failed to develop an individualized and person-centered care plan that addressed a Midline intravenous (IV) catheter that was inserted per doctor's order for IV fluids for 1 of 3 residents reviewed for dehydration. During the recertification and complaint survey conducted on 02/26/21 the facility failed to develop a plan of care for an indwelling urinary catheter. This was evident for 1 of 1 resident that was reviewed for urinary catheters. During the recertification and complaint survey conducted on 7/29/22 the facility failed to develop the resident ' s comprehensive care plan for the diagnosis and care of epilepsy for 1 of 25 care plans reviewed.	F 867	and were discontinued. The Administrator initiated an in-service to all administrative staff on 12/6/2023 regarding Quality Assurance Performance Improvement (QAPI) process including identifying and prioritizing quality deficiencies, systemically analyzing causes of quality deficiencies, developing, and implementing corrective action or performance improvement activities. This in-service included accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff worked until they received appropriate education. The QAPI committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: 12/15/23	

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F677 Based on observations and interviews with residents and staff, the facility failed to maintain floors free from dried spills and debris for two rooms (Room 312 and 318) This deficient practice affected 1 of 3 resident halls (300 Hall).

During the recertification and complaint survey conducted on 7/29/22 the facility failed to provide a resident who was dependent on activities of daily living resident (ADL) washed hair, cut nails, cleaned glasses, and shaved facial hair for 1 of 7 residents reviewed for ADLs.

F684: Based on observations, record review, resident, and staff interview the facility failed to obtain a physician's order and perform dressing changes for a skin tear to a Resident's left upper arm for 1 of 1 resident reviewed for skin condition.

During the complaint survey conducted on 01/28/21 the facility failed to monitor a resident ' s blood pressure and heart rate as ordered by the physician for 1 of 1 resident reviewed who received multiple antihypertensive (blood pressure) medications.

F689: Based on observation, staff interviews, and record review the facility failed to identify the root cause for six falls and implement effective interventions to prevent six falls (Resident #15). This was for 1 of 7 residents reviewed for accidents.

During the complaint survey conducted on 04/27/23 the facility failed to report a problem with the door latching between the second-floor unit and the ramp leading down to the first-floor unit. A resident who was severely cognitively impaired

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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 867	Continued From page 57	F 867		

exited through the second-floor door on her own, lost control of the wheelchair and rolled down a 150-foot ramp to the first floor. The resident collided with an interior wall on the first floor of the facility. She sustained bilateral femur fractures, a pelvic fracture, and a laceration to her head. The hospital determined she would not survive surgery to repair her fractures and she was admitted to a hospice house for palliative care measures. This deficient practice affected one of three residents reviewed for accident hazards.

F698: Based on observation, resident interview, family interview, staff interviews and record review, the facility failed to provide a lunchtime meal to a dialysis resident on 11/02/23, 11/04/23, 11/07/23, 11/09/23, 11/11/23, 11/14/23 and 11/16/23 for 1 of 1residents reviewed for dialysis.

During the recertification and complaint survey conducted on 08/23/21
the facility failed to follow-up and / or implement nutritional recommendations provided by the dialysis center. This was evident for 1 of 1 resident reviewed for dialysis.

F759: Based on observations, record reviews, interviews with staff and interview with the Pharmacist Consultant, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 26 opportunities, resulting in a medication error rate of 11.54% for 2 of 3 residents observed during the medication administration observation.

During the recertification and complaint survey conduct on 2/26/21 the facility failed to have a medication error rate of less than 5% as evidenced by 4 medication errors out of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 11/17/2023

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F 867	Continued From page 58 medication opportunities, resulting in a medication error rate of 14.29% for 1 of 3 residents observed during medication pass. During the recertification and complaint survey conducted on 08/23/21 the facility failed to have a medication error rate less than 5% as evidenced by 4 medication errors out of 27 opportunities, resulting in a medication error rate of 14.81% for 3 of 6 residents observed during medication pass. An interview with the Administrator was conducted on 11/17/23 at 2:30pm revealed that her expectation was to sustain an effective QAPI Committee to ensure the facility does not recite a previous deficient practice.	F 867		