STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	C 11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/30/23 through 11/03/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 15B011.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 10/30/23 through 11/03/23. Event ID# 15B011. The following intakes were investigated: NC00202301, NC00208252, NC00203471, NC00203638, NC0204912, NC00205015, NC00205228, NC00205495, NC00208483, NC00206692, NC00206278, NC00204953, NC00204962, NC00202209, NC00205276, NC00205377, NC00205778, NC00206612, NC00206206, NC00208866, NC00205126. NC00205443. NC00207396, NC00208188, NC00207515, NC00209171, NC00209167 and NC00209191. 20 of the 70 complaint allegations resulted in deficiencies.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to allow a resident that had been assessed as unable to self-administer medications to self-administer	F 554	1. Upon identification of the incident with resident #227, the Director of Nursing (DON) educated the nurse that this resident had not been deemed capable of	12/4/23

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

Electronically Signed | 11/21/2023

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F 554	Continued From page 1 medications via gastrostomy tube (G-tube) (Resident #227). This occurred for 1 out of 1 resident reviewed for medication administration. The findings included: Resident #227 was admitted to the facility on 8/23/23 with diagnoses which included malnutrition. Resident #227's physician orders since her admission on 8/23/23 were reviewed and did not reveal an order to self-administer medication. Resident #227's entry Minimum Data Set (MDS) dated 8/28/23 revealed she was moderately cognitively impaired requiring supervision of one staff member for most activities of daily living (ADL). A self- medication assessment dated 9/9/23 revealed Resident #227 was assessed as being unable to administer her own medication. On 11/01/23 at 10:40 AM an observation was conducted of Nurse #2 removing Resident #227's medication from the medication cart, crushing, and placing the pills into a cup. Nurse #2 handed the cup of crushed pills to Resident #227 and left the room. Resident #227 was then observed picking up a large syringe and placing it into her G-tube. She proceeded to pour a nutritional supplement in a cup and mix the crushed medication while Nurse #2 remained out of sight. Resident #227 began to pour the nutritional supplement and medication down the large	F 554	administering her own tube feeding or medication and that these tasks should be completed by the nurse. 2. All residents who receive medications via enteral tube are at risk for the same alleged deficient practice. An audit of tube feeding administration was conducted by the DON/designee on or before 11/29/23. No additional incidents of inappropriate self-administration of tube feeding formula or medication were identified. 3. DON/designee will in-service all nurses on protocol for tube feeding administration beginning on 11/21/23. The education includes the requirement for a Medication Self-Administration Assessment and that residents may only self-administer tube feeding, medication, or treatments based on capacity determined through this assessment. If the assessment does not convey that the resident is capable of independently administering tube feedings, medications, or treatments, the nurse will administer all tube feedings, medications, or treatments as indicated. If a resident is assessed as capable of self-administering tube feedings, medications, or treatments, an order shall be obtained from physician to complete these tasks as appropriate, and a lock box will be provided to resident for medication storage if needed. All new nurses and agency staff will be educated on the self-administration protocol on or before their first shift. 4. DON/designee will audit administration of tube feeding administration for proper protocol 5 x a week x 2 weeks, then 2 x a week x 6 weeks.	

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F 554	Continued From page 2 syringe into her G-tube. Once the cup was empty, Resident #227 began to pour a 240 milliliter (ml) cup of water into her G-tube. Nurse #2 never re-entered the room. An interview was conducted on 11/1/23 at 10:47 AM with Resident #227. During the interview she stated most of the nurses would administer the medication themselves however Nurse #2 would usually just let her do her own medication. Resident #227 stated, "I don't know how much water I am supposed to pour into the tube I just keep pouring until it is clear". The interview revealed she had never had any issues with her G-tube in the past. An interview was conducted on11/1/23 at 10:55 AM with Unit B Coordinator. During the interview she stated no residents in the building have an order to self-administer their own medication. She stated Resident #227 was unable to self-administer her medication and had been assessed for it. An interview was conducted on 11/1/23 at 11:10 AM with the Director of Nursing (DON). She stated no residents in the facility had orders to self-administer their medication. She stated she expected nurses to administer the resident's medication and remain in the room with the resident until they took all of the medication that was ordered. The DON stated if a resident were to request to self-administer their medication, they would need to sign a form prior to doing so and be assessed as safe to self-administer their medication. An interview was conducted on 11/1/23 at 2:47 PM with Nurse #2. She stated she had worked in	F 554	DON/designee will review audit results and report to Quality Assurance Process Improvement (QAPI) meetings monthly until substantial compliance has been achieved. 5. The DON is responsible for this POC which will be completed by 12/4/23.	

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F 554	Continued From page 3 the building for 2 months and thought Resident #227 could self-administer her medication. The interview revealed Resident #227 had told her she could administer her medication herself. Nurse #2 stated she had provided Resident #227 a cup of water that was 240ml, she stated she didn't know the order for the resident's flush was 60 ml before and after the administration of the medication. She stated she just made a mistake.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		12/4/23

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F 580	Continued From page 4 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident, staff, responsible party, and family interviews, and record reviews the facility failed to notify the Responsible Party of a new wound (Resident #17) and the Power of Attorney (POA) or family of a fall and being sent out to the hospital for evaluation (Resident #95) for 2 of 2 sampled residents reviewed for notification of changes. The findings included: 1. Resident #17 was admitted to the facility on 11/08/2022 with diagnoses including dementia, high blood pressure, congestive heart failure (CHF), atrial fibrillation, pulmonary embolism, and embolism of left lower extremity with long term anticoagulant use.	F 580	1. Resident #17□s responsible party was notified of new open area on 10/26/23 by the wound nurse. Resident #95□s responsible party was aware of the fall as noted in CMS Form 2567, and this resident no longer resides in the facility. 2. All residents with new open areas are at risk for the same alleged deficient practice. An audit of all new wounds over the last 30 days will be completed by the wound nurse on or before 11/29/23. Any new wound or open area where resident or responsible party did not receive notification of this change, will be informed of the issue. All residents with falls are also at risk of the same alleged	

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F 580	Continued From page 5 The quarterly Minimum Data Set (MDS) dated 08/26/2023 revealed Resident #17 had severely impaired cognition and required total dependence for all activities of daily living (ADLs). She was incontinent of bowel and bladder and was identified as being high risk for pressure ulcer development. Review of Resident #17's care plan dated 8/24/2023 revealed Resident #17 was at high risk for skin breakdown; a revision to her care plan dated 10/31/2023 reveal Resident #17 had an open wound to her right heel with interventions to encourage intake, monitor wound and provide wound care as ordered by physician. A review of the wound assessment report dated 10/18/2023 completed by the wound treatment nurse revealed Resident #17 was assessed to have a new wound during nursing rounds and the wound care provider was notified. A right heel intact blister which measured 10.0 centimeters in length and 11.2 centimeters in width was identified. Treatment was initiated with daily liquid dressing application. The wound assessment report did not indicate the responsible party was notified of the new wound. During an interview with the responsible party (RP) on 11/01/2023, the RP revealed the facility did not notify her of the right heel wound. During an interview with the wound care treatment nurse on 11/2/2023 at 3:46 PM, the wound treatment nurse stated the wound was identified by the nursing staff on 10/18/2023 and was reported to her on 10/18/2023. She initiated treatment and notified the wound care provider on	F 580	deficient practice. An audit of all falls with transfers out to the hospital over the last 30 days will be completed on or before 11/29/23 by Director of Nursing (DON)/designee. Any additional wounds or falls/transfers without notification found in this audit will be reported to the responsible party immediately upon identification. 3. Beginning on 11/21/23 the Director of Nursing (DON)/designee will educate all nurses that any open area or wound that is newly identified and any fall or transfer out to the hospital requires timely notification of the issue to the resident or the resident□s responsible party. This notification will be documented in an e-Interact Change in Condition Evaluation form. All new nurses and agency staff will be educated on the wound notification protocol on or before their first shift. 4. DON/designee will audit all new wounds or open areas weekly to ensure that appropriate notification has occurred through review of the e-Interact Change in Condition Evaluation in the morning clinical meeting. These audits will occur for 8 weeks. DON/designee will also audit all falls with transfers out to hospital to ensure that appropriate notification has occurred through review of the e-interact Change in Condition Evaluation in the morning clinical meeting. These audits will occur for 8 weeks. DON/designee will review audit results and report to Quality Assurance Process Improvement (QAPI) meetings monthly until substantial compliance has been	

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F 580	Continued From page 6 10/18/2023. She further stated she did not contact Resident #17's responsible party to notify them of the new wound. Wound care provider evaluated Resident #17's right heel wound on 10/20/2023 with no necrotic tissue observed. Wound care provider continued daily liquid dressings (a dressing which forms a film on the skin to help reduce friction) to right heel. An interview was conducted with the Director of Nursing (DON) on 11/3/2023 at 11:50 AM. The DON indicated all families should be notified anytime there was a change in a resident's condition. An interview was conducted with the Administrator on 11/3/2023 at 11:50AM. The administrator indicated her expectation was for all responsible parties to be updated on all clinical changes. 2) Resident #95 was admitted to the facility on 9/13/23 from the hospital after an aortic heart valve replacement and to continue intravenous (IV) antibiotic infusion in the facility. Record review of the SBAR (Situation, Background, Assessment, and Recommendation) report dated 10/2/23 at 11:30 PM revealed that Resident #95 fell on 10/2/23 at 11:20 PM. The recommendation of the Primary Care Provider (PCP) was to send Resident #95 to the Emergency Room (ER) for evaluation. Nurse #5 completed the SBAR report.	F 580	achieved. 5. The DON is responsible for this POC which will be completed by 12/4/23.	

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F 580	Continued From page 7	F 580		

Review of the admission Minimum Data Set (MDS) dated 10/9/23 revealed Resident #95 was moderately cognitively impaired.

The nursing progress note dated 10/3/23 at 1:40 PM written by the Unit B Coordinator revealed Resident #95 was sent to the ER after the fall for evaluation due to being on blood thinner medication. The note revealed Resident #95 came back to the facility via the facility van on 10/3/23.

Interview with Resident #95 and the family member who was in the room was conducted on 10/30/23 at 11:20 AM. The family member stated that Resident #95 was sent to the hospital after he fell on 10/2/23 and that the family and the POA (Power of Attorney) were not notified of the fall. Resident #95 stated he called his family from ER.

Attempts to interview Resident #95's POA were not successful.

Interview with the Unit B Coordinator was conducted on 11/2/23 at 10:58 AM. She stated that she closed the incomplete SBAR documentation that was left open by Nurse #5. Unit B Coordinator stated that she could not find documentation that Nurse #5 notified the POA or the family member.

Nurse #5 was called via phone several times and did not return the call for an interview.

Interview with the interim Director of Nursing (DON) was conducted on 11/3/23 at 11:53 AM. She stated the nurse should have notified Resident #95's POA and family just after the time

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F 580	Continued From page 8 of the fall and being sent to the hospital. An interview with the Administrator on 11/3/23 at 12:17 PM was conducted. She stated that the POA and the family should have been notified of the fall.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record reviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of oral and dental status (Resident #97) for 1 of 2 sampled residents. The findings included: Resident #97 was admitted to the facility on 05/13/2022. The annual Minimum Data Set (MDS) dated 03/16/2023 revealed Resident #97 had intact cognition and was independent with activities of daily living (ADL's). The MDS also indicated Resident #97 had no dental issues. An observation and interview was conducted with Resident #97 on 10/30/2023 at 1:30 PM. Resident #97 stated he had no upper or lower teeth, and he has been waiting to see the dentist since he was admitted. He also indicated he had a dental appointment in July but was sick and could not go. He stated he was frustrated with	F 641	1. The assessment for resident #97 was modified by the Minimum Data Set (MDS) Coordinator when the error was identified and accepted on 11/6/23. The assessment was changed to appropriately reflect the resident□s dental status. 2. An audit of all current residents will be completed by an alternate MDS Coordinator on or before 11/29/23 to ensure that dental status is accurately reflected on the most recent MDS. Any additional incorrect assessments found will be corrected as applicable. 3. On 11/21/23, MDS Coordinators were educated by the Regional MDS Nurse on the need to ensure that after review of the resident□s condition, that the coded data is consistent with information in the progress notes, plan of care, and resident observations and interviews. 4. Through review of MDS assessments ready for export, the MDS Coordinator will audit 5 assessments per week x 8 weeks to ensure that the resident□s dental	12/4/23

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F 641	Continued From page 9 waiting so long to see a dentist and does not understand what is taking so long. An interview was conducted with both MDS Coordinators on 10/31/2023 at 4:45 PM. The MDS Coordinators stated the MDS was coded incorrectly and should have indicated Resident #97 had no teeth. The MDS Coordinators also stated an assessment of the resident's mouth is completed to determine dental status and the MDS Coordinators were aware Resident # 97 had no teeth. An interview was conducted with the Administrator on 11/2/2023 at 4:45 PM. The administrator indicated her expectation was for the MDS to be completed accurately.	F 641	status is coded accurately. The MDS Coordinator will review the audits and report the findings to Quality Assurance Process Improvement (QAPI) meetings monthly until substantial compliance has been achieved. 5. The MDS Coordinator is responsible for this plan of correction which will be completed by 12/4/23.	
F 689 SS=G	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, record review, staff and physician assistant interviews, the facility failed to safely assist a resident without causing injury to 1 of 5 residents (Resident #86) reviewed for accidents. Resident #86 was left standing without assistance in her room and fell. Resident #86 sustained a laceration to the head and a right fractured hip.	F 689	1. Resident # 86 no longer resides in the center. 2. All residents who require extensive assistance with transfers and walking are at risk. MDS Nurses completed an audit of all current residents who require extensive assistance with transfers and	12/4/23

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F 689	Continued From page 10 The findings included: Resident #86 was admitted to the facility on 02/26/21 with diagnoses that included Alzheimer ' s, hypertension, anxiety, age related osteoporosis, muscle weakness, and adult failure to thrive. Resident #86 resided in the facility ' s memory care unit. Review of Resident #86's care plan revised on 02/21/23 revealed the resident was at increased risk for falls due to deconditioning, poor communication, psychoactive drug use, and unaware of safety needs. The goal was for Resident #86 to not sustain serious injury through the review date. Interventions included anticipate and meet the resident's needs, ensure that the resident is wearing appropriate footwear when ambulating, and follow facility fall protocol. Review of Resident #86's quarterly Minimum Data Set (MDS) dated 07/24/23 revealed Resident #86 was severely cognitively impaired and required extensive assistance with one person assist for bed transfers, walk in corridor, and walk in room. The MDS further revealed that under balance during transitions and walking Resident #86 was coded for not being steady but able to stabilize without staff assistance. Review of Resident #86's undated Kardex (a written plan of care for staff to know the needs of a resident). revealed Resident #86 was extensive assistance with one person assist for transfer and mobility. Review of incident report completed by Nurse #3 dated 10/25/23 revealed NA #3 ambulated	F 689	ambulation to ensure that the Care plan and Kardex accurately reflects the level of assistance that is required. The audit will be completed on or before 11/29/23. 3. Beginning on 11/21/23, the Assistant Director of Nursing (ADON) completed education for all nursing staff, including Full Time, Part time, prn and agency staff, on ensuring that they are following the care plan/Kardex guidance for how to ambulate and assist residents with transfers. Resident□s level of support required for ambulation and transfers will be evaluated quarterly and with significant changes in status to ensure that the Care plan and Kadex are updated accordingly. 4. ADON and Nurse Managers will audit 5 residents per week that require extensive assistance with ambulation and transfers to ensure that staff are providing the required assistance. Any deviation from Care Plan/Kardex will be immediately addressed. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance 12/04/2023	

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Resident #86 to her room when NA #3 turned to shut the door and Resident #86 lost balance and fell on her right side. The report further revealed Resident #86 sustained a cut above right eyebrow measuring approximately 3 centimeters (CM) by 1/2 CM. The cut had a small amount of bleeding with light purple bruising and was cleaned and strips were applied. The report indicated Resident #86 remained at her baseline neurological status and unable to voice pain due to cognition during assessment. The note revealed Resident #86 was assessed and assisted to bed and neurological checks were initiated. The responsible party and Assistant Director of Nursing (ADON) were notified, and the resident was placed in the book to be followed up by the provider the next day. The report revealed immediate action taken was Resident #86 was assessed for injuries, wound care applied to laceration above right eye, and neurological check initiated. Predisposing physiological factors indicated Resident #86 was confused and had impaired memory.

Review of progress note completed by Nurse #3 dated 10/25/23 revealed Nurse Aide #3 ambulated Resident #86 to her room when NA #3 turned to shut the door and Resident #86 lost balance and fell on her right side. The note further revealed Resident #86 sustained a cut above right eyebrow measuring approximately 3 centimeters (CM) by 1/2 CM. The cut had a small amount of bleeding with light purple bruising and was cleaned and strips were applied. The note indicated Resident #86 remained at her baseline neurological status and unable to voice pain due to cognition during assessment. The note revealed resident #86 was assessed and assisted to bed and neurological checks were initiated.

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The RP, on call provider, and Assistant Director of Nursing (ADON) were notified. The indicated Resident #86 was not sent out but was placed in the book to be followed up by the provider the next day.

Review of progress note completed by the ADON dated 10/26/23 revealed Resident #86 was assessed by the provider and was ordered an x-ray of right arm and shoulder and was sent to the hospital. The note further revealed IDT recommended educating staff about safe transfers.

Review of the x-ray results completed at the hospital on 10/27/23 revealed Resident #96 sustained a transverse fracture at the right femoral neck seen at its base with slight angulation and displacement. The note further revealed osteopenia is noted, bony pelvic structures appear intact, and left hip appeared to be normal.

Review of hospital progress note dated 10/27/23 revealed Resident #86 was admitted to the hospital and was diagnosed with a right femur fracture and laceration above the right eye. The note further revealed Resident #86 ' s resident representative (RR) indicated Resident #86 was not ambulatory before the fall.

Review of progress note dated 10/27/23 revealed Resident #86 was transferred back to the facility from the hospital and the resident sustained a hip fracture and urinary tract infection (UTI). The note further revealed Resident #86 is in bed and had a follow up appointment in 4 to 6 weeks with orthopedic.

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Review of progress note dated 10/29/23 revealed Resident #86 was admitted to hospice.

Review of progress note completed by the Medical Director (MD) on 10/30/23 revealed Resident #86 was transported to the hospital for a fall. The note further revealed the resident was found to have a right sided hip fracture and would not be managed operatively and would return to the facility. The note indicated Resident #86 would be followed by hospice and all medicines had been discontinued other than comfort measures.

An observation was conducted on 10/30/23 at 11:00 AM revealed Resident #86 was in bed with with her eyes closed. Observation further revealed laceration over the resident ' s right eyebrow to have green and purple bruising with three steri strips on it.

An interview conducted with NA #3 on 11/02/23 at 3:50 PM revealed on 10/25/23 she had assisted Resident #86 back to her room to put her in the bed. NA #3 further revealed Resident #86 had a good day and was walking with little assistance. NA #3 was an extensive assistance with one person support which meant to have hands on the resident assisting them. NA #3 indicated she walked Resident #86 into her room and stopped at the sink and left Resident #86 unattended to close the bedroom door because the resident had a good day and seemed stable to stand alone. NA #3 indicated she does not recall why she did not assist Resident #86 to the bed before shutting the bedroom door. NA #3 stated as she closed the door Resident #86 lost balance and fell to the ground on her right side. NA #3 revealed Nurse #3 assessed Resident #86 and the resident

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showed no signs of pain or injury other than the laceration above the right eye. NA #3 on 10/26/23 Resident #86 was assessed by the provider in the facility and Resident #86 started to show signs of discomfort and was sent to the hospital to be further assessed.

An interview conducted with Nurse #3 on 11/01/23 at 11:10 AM revealed Resident #86 was an extensive assist with one person for ambulating. Nurse #3 indicated Resident #86 ' s health and memory had declined in the last couple months. Nurse #3 further revealed on 10/25/23 NA #3 had assisted resident #86 to her room and left Resident #86 unassisted standing when shutting the resident's door. Nurse #3 indicated at that time Resident #86 fell to the floor on her right side. Nurse #3 revealed she was called to Resident #86's room and observed Resident #86 on her right side near the bathroom door. Nurse #3 revealed she assessed Resident #86, and the resident sustained a laceration above the right eyebrow but did not show indications of pain or other injuries. Nurse #3 indicated Resident #86 was assisted back to bed and the Medical Director (MD), RR, and ADON were notified. Nurse #3 stated Resident #86 did not complain of pain and neurological assessments were completed.

An interview conducted with the ADON on 11/01/23 at 11:10 AM revealed she was not present at the time of the incident. The ADON further revealed Resident #86 was extensive assistance with one person assist for ambulating and transfers. The ADON stated NA#3 should have not left the resident unattended in her room. The ADON indicated prior to the incident on 10/25/23 Resident #85's health was declining and

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F 689	Continued From page 15 had become weaker. An interview conducted with the Director of Nursing (DON) on 11/01/23 at 1:45 PM revealed Resident #86 was unstable and required extensive assistance with one person for ambulation and transfers. The DON further revealed NA #3 should have not left Resident #86 unassisted while closing the bedroom door. An interview conducted with the Physician Assistant (PA) on 11/03/23 at 12:25 PM revealed Resident #86 ' s health had declined rapidly since the residents fall on 10/25/23. The PA further revealed Resident #86 had been admitted to hospice before and could not state the fall had caused the resident ' s rapid health decline. The PA indicated Residents #86's weakness and dementia had progressed prior to the incident on 10/25/23. An interview conducted with the Administrator on 11/03/23 at 12:25 PM revealed if Resident #86 was coded and documented for extensive with one person assist then NA #3 should not have left the resident unattended. The Administrator indicated she expected nursing staff to follow the Kardex and what each Resident was coded for.	F 689		
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 applicable.	F 761		12/4/23

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F 761	Continued From page 16 §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 observations, record review, and staff interviews, the facility failed to store medications according to manufacturer's guidelines on acceptable temperature range for 2 of 3 medication refrigerators (Unit A Station Medication Room), failed to date an opened Tuberculin Purified Protein Derivative (PPD) for 1 of 3 medication refrigerators (Unit A Station Medication Room) and failed to store unopened insulin in the medication refrigerator as specified by manufacturer's guidelines for 1 of 6 medication carts (Unit C Station Medication Cart #2) reviewed for medication storage. Findings included: Review of the facility policy for medication storage dated April 2019 handed by the Assistant Director of Nursing (ADON) read in part, "Drugs and	F 761	1) Medication Room Refrigerator Thermometer was changed out on 11/03/23, all Medication Room Refrigerators are currently maintaining a temperature between 36-45 degrees. The ppd solution and insulin were disposed of at time of discovery. 2) All residents have the potential to be affected. The Nursing Leadership Team will complete an audit of all medication rooms, medication carts and med room refrigerators on or before 11/29/23 to ensure that the refrigerator temperature is within range, medications are stored and labeled appropriately. 3) Beginning on 11/21/23, the Assistant Director of Nursing (ADON) provided	

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F 761	Continued From page 17 biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity control." Review of the manufacturer's package insert indicated the Alteplase and insulin lispro should be stored between 36*F to 46*F. Review of the manufacturer's package insert indicated the flu vaccines should be stored between 35*F to 46*F. Review of the manufacturer package insert for Tuberculin Purified Protein Derivative (PPD) indicated to store in refrigerator at 35*F to 46*F. Do not freeze and discard product if exposed to freezing. Protect from light and a vial of PPD which has been entered and in use for 30 days should be discarded. Review of manufacturer package insert for insulin glargine injection indicated unopened pen should be stored in refrigerator at 36*F to 46*F until expiration and kept away from direct heat and light. Once the insulin was opened, it could be stored at room temperature below 86*F or under refrigeration for under 28 days. 1) An observation of the Unit A medication room on 11/3/23 at 8:58 AM with the presence of the Unit B Coordinator revealed there were two refrigerators to store vaccines and insulins. The refrigerator/freezer temperature log sheet where they documented the temperature readings daily indicated clearly on the top that the temperature should be 36*F to 45*F. The following were observed from the temperature log in front of the refrigerator.	F 761	education to all licensed staff and medication aids on medication storage to include appropriate temperatures of medication refrigerators, labeling and dating and proper storage of medications. Education also included what steps to take if the medication refrigerators are found to not be running at the appropriate temperature, which includes notifying nursing leadership and maintenance immediately. 4) Nursing Leadership will audit temperatures of medication refrigerators 5 x week for 4 weeks, then 2 x week for 4 weeks and randomly thereafter. Nursing Leadership will audit Medication Carts and Medication Rooms for appropriate medication storage and labeling/dating of medications 3 X week for 4 weeks, then 1 X week for 4 weeks and randomly thereafter. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5) Date of compliance 12/4/2023	

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a. The gray refrigerator with the thermometer inside showed 38*F. It contained Alteplase (use to dissolve blood clots that have formed in the blood vessel) and insulin lispro was seen with the temperature log that was below 36*F. The temperature log was in front door of the refrigerator. For the month of September 2023 log, there was one day with 32*F recorded (9/18/23) and for the month of October 2023 log, there were 17 days of 32*F to 34*F recorded (10/1, 10/13, 10/14, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/23, 10/24, 10/25, 10/27, 10/28, 10/29, 10/30, 10/31).

b. The black refrigerator with the thermometer inside showed 32*F. It contained flu vaccines and glargine insulin was seen with the temperature log that was below 35*F. The temperature log was in front door of the refrigerator. For the month of September 2023 log, there were 12 days of temperature of 32*F (9/5, 9/7, 9/8, 9/9, 9/10, 9/11, 9/12, 9/13, 9/15, 9/16, 9/17, 9/19). For the month of October 2023 log, there were 13 days of temperature between 32*F to 34*F (9/15, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, 9/26, 9/27, 9/28, 9/29, 9/30, 9/31). And for the first week of November 2023 log, there was 1 day of 34*F (11/1).

Interview with the Unit A coordinator was conducted on 11/3/23 at 9:10 AM. The Unit A Coordinator stated that she checked the refrigerator every day at around 7:45 AM and just recorded the temperature without paying attention to the reading. She stated that she did not ask for the maintenance to fix the issue.

2) An observation on the Unit A station medication room refrigerator with the presence of

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the Unit A Coordinator revealed a Tuberculin PPD with the expiration date of June 2024 was open with no date when opened. The Unit A Coordinator stated that the ADON was the one giving the PPD and would have the information when it was opened.

3) An observation on Unit C medication cart #2 on 11/3/23 at 9:50 AM with the presence of Medication Aide #1 revealed an unopened insulin glargine injection delivered by the pharmacy on 11/1/23 was in the medication cart.

Interview with the Medication Aide (MA) #1 on 11/3/23 at 9:54 stated that the insulin glargine injection should be stored in the refrigerator when not opened for use.

Interview with the Assistant Director of Nursing (ADON) on 11/3/23 at 09:56 AM was conducted. The ADON stated that the refrigerator temperature should follow the manufacturer's recommendations. The ADON stated that she opened the PPD but forgot to write the date of opening in the PPD bottle. She was supposed to date it before storing it back in the refrigerator.

Interview with Director of Nursing (DON) on 11/3/23 at 10:01 AM was conducted. The DON stated that the medication in the storage should be checked daily by the nurses and the unit coordinator. She stated that the refrigerator temperature should be within 36*F to 46*F as specified on the refrigerator log sheet. The DON said that she was not made aware of temperature issues and if she had known about it, she would have asked the maintenance to fix it. The DON also stated that unopened insulin should be stored in the refrigerator.

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F 761	Continued From page 20 Interview with the Administrator on 11/3/23 at 12:04 PM was conducted. She stated that the medication refrigerator's temperature should be within the acceptable range of temperature.	F 761		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 791		12/4/23

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F 791	Continued From page 21 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record reviews the facility failed to provide dental services for a resident who desired dentures. This was evident for 1 of 2 residents reviewed for dental services (Resident #97). The findings included: Resident #97 was admitted to the facility on 05/13/2022 with diagnoses including diabetes mellitus (DM), diabetic neuropathy, chronic obstructive pulmonary disease (COPD), high blood pressure, and post-traumatic stress disorder (PTSD). The annual Minimum Data Set (MDS) dated 03/16/2023 revealed Resident #97 had intact cognition and was independent with activities of daily living (ADL's). The MDS also indicated Resident #97 had no dental issues. Review of Resident #79's current care plan revealed no care plan for addressing dental concerns. A review of the facility's dental schedules showed	F 791	1. Residents #97 was referred on 11/1/23 by the Social Worker to be seen in the next dental clinic. 2. All residents are at risk for the same deficient practice. The nurse managers completed an oral exam audit of all current residents to determine if there was a need for dental services. This audit will be completed on or before 11/29/23. Any resident identified in this audit who requires dental services will be scheduled for a dental visit on or before 12/4/23. 3. Beginning on 11/21/23, the Director of Nursing/designee will educate all nurses on the need to ensure that any resident who is identified as having a need for dental services will be referred to Social Services to be placed on a list for dental services. Social Services will ensure that all referrals are seen at the next available dental clinic or sent to a dental office. All new nurses and agency staff will be educated on the wound notification protocol on or before their first shift. All residents will have an oral assessment completed quarterly and with significant	

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F 791	Continued From page 22 Resident #97 was scheduled for a dental visit on 07/11/2023. Resident #97 was unable to go to the dental appointment on 07/11/2023. There were no other dental appointments scheduled for Resident #97 from his admission date of 05/13/2023 to 10/31/2023. A review of Resident #97's admission information revealed he was his own responsible party. A review of Resident #97's weight revealed no weight loss since admission. An observation and interview was conducted with Resident #97 on 10/30/2023 at 1:30 PM. Resident #97 stated he had no upper or lower teeth and he had been waiting to see the dentist since he was admitted. He also revealed he had no upper or lower teeth when he was admitted to the facility. He also indicated he had a dental appointment in July but was sick and could not go. He stated he was frustrated with waiting so long to see a dentist and does not understand what is taking so long. He further stated he was on a regular diet and had not experienced any weight loss. An interview with the Business Office Manager on 11/1/2023 at 10:45 AM revealed Resident #97 had qualified for Medicaid eligible services. An interview with the Social Worker (SW) was conducted on 11/1/2023 at 11:03 AM. The SW stated she did not have Resident #97 on the list to see the dentist and she was not aware he needed fitting for dentures. An interview was conducted with the Administrator on 11/2/2023 at 4:45 PM. The	F 791	changes to determine any dental needs. If dental needs are identified, they will be referred to Social Services to schedule an appointment. 4. Social Services will interview 5 residents per week for 2 weeks and then 2 residents per week for 6 weeks to ensure that there are no dental needs that have not been addressed. Social Services will review the audits and report the findings to Quality Assurance Process Improvement (QAPI) meetings monthly until substantial compliance has been achieved. 5. The Social Worker is responsible for this plan of correction which will be completed by 12/4/23.	

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F 791	Continued From page 23 administrator indicated her expectation was for all residents to receive dental services timely and appropriately.	F 791		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure staff wore hair coverings when working in food production areas for 1 of 1 meal production observations. This practice had the potential to affect food served to residents. The findings included: An observation and interview conducted on 11/01/23 at 5:15 PM revealed dietary aide #1 had a beard and did not have a facial covering on.	F 812	1. Staff members were immediately educated to proper sanitation requirements for the use beard coverings at all times while working in the kitchen. 2. All residents food has the potential to be affected by this deficient practice. A walking round was completed by the Dietary Manager on 11/6/23 to ensure that all dietary employees were compliant with the requirement for use of hair coverings. No other infractions were found.	12/4/23

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F 812	Continued From page 24 The Dietary Aide was observed pouring and handling tea and drinks. The dietary aide stated he was not aware he had to wear a facial covering. An observation and interview conducted on 11/01/23 at 5:20 PM revealed dietary aide #2 had a beard and did not have a facial covering on. The Dietary Aide was observed prepping food on the meal line. The dietary aide stated he was not aware he had to wear a facial covering. An interview with the Dietary Manager (DM) on 11/01/23 and 5:25 PM revealed she was used to dietary staff wearing masks during covid and had not thought to have the dietary aides wear facial coverings that have facial hair. The DM further revealed she had not educated the dietary aides. An interview conducted with the Administrator on 11/03/23 at 3:30 PM revealed all kitchen staff were expected to wear hair coverings and facial coverings if needed. The Administrator further revealed she was not aware dietary aides were not wearing facial coverings but expected them to be for sanitary reasons.	F 812	3. Beginning on 11/6/23, all dietary employees were educated by the Administrator on the requirements to adhere to sanitation protocols and dress code that ensures that the kitchen tasks are completed in a clean, safe, and sanitary manner with hair coverings. 4. The Dietary Manager/designee will audit all staff working in the kitchen 2 x per week x 8 weeks to ensure appropriate protective garments are used to maintain a clean, safe, and sanitary environment. The Dietary Manager will review the audits and report the findings to Quality Assurance Process Improvement (QAPI) meetings monthly until substantial compliance has been achieved. 5. The Dietary Manager will be responsible for this plan of correction which will be completed by 12/4/23.	
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 following:	F 867		12/4/23

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§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 improvements are realized and sustained.

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§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 available resources, as reflected in the facility assessment required at §483.70(e).

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F 867	Continued From page 27 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 reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation surveys that occurred on 10/28/22 and 11/12/21. This failure was for three deficiencies cited in the areas of Free of Accidents/Hazards, Labeling and Storing of Drugs and Biologicals, and Food Procurement and Storage which were subsequently recited on the current recertification and complaint investigation survey of 11/03/23. The repeat deficiencies during multiple surveys of record	F 867	1) Facility received repeat citations of F 689, F 761 and F 812 during annual survey which had been cited on two prior surveys in the last three years. A revised plan has been developed to address Accidents and Hazards, Medication Storage and Kitchen Sanitation, with ongoing monitoring by the Quality Assurance and Performance Improvement Committee. 2) All residents have potential to be affected. Root Cause Analysis will be completed by the Interdisciplinary Quality Assurance Team for F 689, F 761 and F	

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F 867	Continued From page 28 show a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: 1. F689: Based on observation, record review, staff and physician assistant interviews, the facility failed to safely assist a resident without causing injury to 1 of 5 residents (Resident #86) reviewed for accidents. Resident #86 was left standing without assistance in her room and fell. Resident #86 sustained a laceration to the head and a right fractured hip. During the recertification and complaint investigation survey conducted on 11/12/21, the facility failed to secure smoking materials, provide a smoking apron, and supervise 1 of 2 residents reviewed for smoking. During an interview on 11/03/23 at 1:00 PM with the Administrator, she reported her quality assurance (QA) team met monthly and ad hoc as needed. She stated the team included the Medical Director, the Nurse Practitioner, administrative staff, department heads, and the Registered Dietician and Pharmacist by phone. She reported they currently had Process Improvement Plans (PIPs) addressing agency personnel and providing them more education regarding processes at the facility but said this PIP had just been put into place and still had work to be done. She further reported there were PIPs on falls and preventive measures for falls, but obviously they needed a more extensive PIP to educate Nurse Aides and Nurses on properly assisting residents according to their documented	F 867	812 on or before 11/29/23 to determine the systemic break that led to the deficient practice with revised plan to address. 3) Education provided to the Quality Assurance and Performance Improvement Committee (QAPI) by the Regional Director of Operations or the Regional Director of Clinical Services. (QAPI Team consists of: Administrator, Director of Nursing, Dining Director, Business Office Director, Human Resource Manager, Maintenance Director, Social Services Director, Housekeeping/Laundry Manager, Nursing Supervisors, Activities Director, Infection Preventionist, Medical Director and Therapy Director). Education included review of Quality Assurance and recognizing areas for Performance Improvement, Root Cause Analysis and monitoring of Plans for improvement. 4) The Administrator to conduct Monthly Quality Assurance Performance Improvement Meetings, with oversight provided by the Medical Director. The QAPI Committee will review all active Performance Plans for compliance, any deviations noted will be addressed by the QAPI Committee to determine Root Cause Analysis of non-compliance with revisions to plan as indicated. Regional Nurse to review all monthly QAPI Minutes x 6 months and attend QAPI Meetings Quarterly to ensure that the Committee is maintaining implemented procedures/interventions to prevent recurring non-compliance. The	

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F 867	Continued From page 29 need for assistance. 2. F761: Based on observations, record review, and staff interviews, the facility failed to store medications according to manufacturer's guidelines on acceptable temperature range for 2 of 3 medication refrigerators (Unit A Station Medication Room), failed to date an opened Tuberculin Purified Protein Derivative (PPD) for 1 of 3 medication refrigerators (Unit A Station Medication Room) and failed to store unopened insulin in the medication refrigerator as specified by manufacturer's guidelines for 1 of 6 medication carts (Unit C Station Medication Cart #2) reviewed for medication storage. During the recertification and complaint investigation survey conducted on 10/28/22, the facility failed to date opened breathing treatment foiled pouches on 2 of 5 med carts (B-2 hall and 300 hall) and failed to remove loose pills from 1 of 5 med carts (300 hall). During the recertification and complaint investigation survey conducted on 11/12/21, the facility failed to discard expired medication from 5 of 5 med carts (C hall, A1 hall, A1B hall, B1 hall and B2 hall) and 2 of 3 medication rooms (Med room A and Med room C) and failed to properly discard controlled medications from 2 of 5 med carts (B1 hall and B2 hall). During an interview on 11/03/23 at 1:00 PM with the Administrator, she reported her quality assurance (QA) team met monthly and ad hoc as needed. She stated the team included the Medical Director, the Nurse Practitioner, administrative staff, department heads, and the Registered Dietician and Pharmacist by phone.	F 867	Administrator will be responsible for the implementation of the plan. 5) Date of Compliance 12/04/23	

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F 867	Continued From page 30	F 867		

She reported they currently had Process Improvement Plans (PIPs) addressing agency personnel and providing them more education regarding processes at the facility but said this PIP had just been put into place and still had work to be done. She further reported there were PIPs on falls and preventive measures for falls, abuse, medication administration, and fire and safety for employees and residents. She further stated the PIPs were ongoing and they would be adding another PIP on labeling and storing medications and it would be monitored extensively to ensure future compliance.

3. F812: Based on observations and staff interviews the facility failed to ensure staff wore hair coverings when working in food production areas for 1 of 1 meal production observations. This practice had the potential to affect food served to residents.

During the recertification and complaint investigation survey conducted on 10/28/22, the facility failed to remove unlabeled and undated foods in the nourishment room refrigerators in 2 of 3 nourishment rooms (B and C station) and failed to clean and remove rust from inside a microwave oven in a nourishment room (A station) for 3 or 3 nourishment rooms reviewed.

During an interview on 11/03/23 at 1:00 PM with the Administrator, she reported her quality assurance (QA) team met monthly and ad hoc as needed. She stated the team included the Medical Director, the Nurse Practitioner, administrative staff, department heads, and the Registered Dietician and Pharmacist by phone. She reported they currently had Process Improvement Plans (PIPs) addressing agency

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F 867	Continued From page 31 personnel and providing them more education regarding processes at the facility but said this PIP had just been put into place and still had work to be done. She further reported there were PIPs on falls and preventive measures for falls, abuse, medication administration, and fire and safety for employees and residents. She further stated the PIPs were ongoing and they would be adding another PIP on proper use of personal protective equipment (PPE) in the kitchen to ensure the kitchen staff abide by wearing hair nets to cover all head and facial hair while providing meal service to residents. .	F 867		