STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	C 11/30/2023

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/27/23 through 11/30/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #BU4R11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 11/27/23 through 11/30/23. Event ID #BU4R11. The following intakes were investigated NC00209839, NC00209296, NC00208976, NC00208499, NC00207976, NC00207495, NC00207050, NC00206313, and NC00208169. 7 of 28 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		12/28/23

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

Electronically Signed | 12/21/2023

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to treat a resident in a dignified manner when staff used a racial slur and vulgar hand gesture when interacting with a resident (Resident #97) for 1 of 1 resident reviewed for dignity. The findings included: Resident #97 was admitted to the facility on 9/19/23. Resident #97's Minimum Data Set assessment dated 9/24/23 revealed he was assessed as cognitively intact. He had no behaviors	F 550	F550 Resident Rights/Exercise Rights How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. An initial report of allegation of abuse was filed for Resident #97 with the DHHS on 11/24/2023 by the Administrator. Psych services were offered to resident #97 who refused stating he did not think he needed them. As a result of the investigation, the allegation was substantiated and nurse # 2□s employment was terminated by the	

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F 550	Continued From page 2 documented. During an interview on 11/27/23 at 1:06 PM Resident #97 stated his son came to visit the day before Thanksgiving. He heard that his son did something to a door by the nursing station and staff were walking him out and a nurse and his son exchanged words and an altercation ensued in which his son hit a nurse. The next day, Nurse #2 came to his room, opened the door, and asked him why he let his son come in and do what he did. Then she said, "you white cracker" in a conversational tone to conceal it, and stuck her middle finger up at him. After that, she left. He stated it made him "feel like shit" because she asked why he let his son up here when he was stuck in bed after having a stroke. The Administrator came to him the next morning, 11/24/23, to ask him about the incident. He told her about the incident, and she told him he did not need to worry about his safety and that she was going to take care of it. She then got a statement from him. During an interview on 11/28/23 at 10:19 AM Nurse #2 stated on 11/23/23 she was out in the hallway talking on the phone by Resident #97's room and she was speaking with her daughter and assisting two other staff members passing trays some time before 8 PM. She could not recall who the staff members were. The residents were getting potatoes and chili. Because she was running late for Thanksgiving, her daughter asked her what she was going to eat and what the residents were eating because sometimes she got a plate and brought it home to eat. This was why her daughter was asking what the residents were having for dinner. Nurse #2 was helping	F 550	Administrator on 11/30/2023. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. Interviews were completed by the Administrator on all alert and oriented residents on 12/4/2023. No other issues were identified. For residents not alert and oriented, the responsible party for each resident was interviewed. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. An all-staff in-service was conducted, regarding resident rights as it relates to treating residents with dignity and respect, by the Staff Development Nurse on 12/4/23 and was completed on 12/14/2023. Any employee not educated by 12/28/23 was not allowed to work until education was completed. All newly hired staff will receive this training during orientation and prior to assignment. The facility will utilize the Ambassador Program to interview residents 5 days each week, for 3 months in regard to being treated with dignity and respect.	

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F 550	Continued From page 3	F 550		

pass the trays while on the phone with her daughter outside of Resident #97's room. She told her daughter over the phone, "they are having potatoes and chili but no crackers." She stated two other nurse aides were in the hallway assisting with meals and she hung up her phone when she finished speaking with her daughter. She could not remember who the nurse aides were. Two minutes later the nurse aides started talking about the fact that Resident #97's son came to the facility and hit an employee. She stated she told the other employees she was glad she was not there when it happened. She concluded that was all that was said and occurred that night, 11/23/23, and nothing was said to her until the next day about Resident #97's complaint. The next day the Director of Nursing called her at home and told her the resident had stated she had stuck her middle finger up at the resident and called him a "cracker." She was informed by the Director of Nursing that she was suspended and could not come back to work. She concluded that was the last she had heard and that she did not return to work after this allegation was made known to the facility.

During an interview on 11/28/23 at 12:54 PM the Regional Nurse Consultant stated it was reported to her by the Director of Nursing that Nurse #2 approached Resident #97 and said, "why did you let your son hit my friend?" She did not know what Resident #97 replied. Resident #97 alleged that Nurse #2 then called him white trash and, "flew her middle finger up at him." She stated his roommate, Resident #71 had the curtain pulled and did not see anything but heard the word, "cracker."

During an interview on 11/28/23 at 1:06 PM

How the facility will monitor its performance to ensure the deficient practice does not recur.

The facility social worker or designee will interview 5 residents 5 x/week x 2 weeks, 5 residents 3x/week x 2 weeks and 5 residents weekly x 8 weeks as to whether they feel as if they are treated with dignity and respect.

The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved.

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F 550	Continued From page 4	F 550		

Resident #71 (per 9/4/23 MDS his cognition was intact) stated he had been in the bathroom the day before Thanksgiving (11/23/23) and came out to his side of the room and the curtain was drawn between the two beds and he was on the window side. Because of this he could not see who was at the door. He heard the door open, and he heard Nurse #2 say, "why did you let your son jump my friend?" He stated he recognized her voice. He stated he and Nurse #2 usually talked in passing on the hall when he was going out to visit other residents. She was also their nurse that day over their medication aide. His roommate was quiet and then he heard Nurse #2 say in conversational tone, "white cracker." He then heard the door close, and his roommate then said, "she just called me a white cracker and flipped me the middle finger." The roommate came around the curtain to inform his roommate that he had overheard her call him that. Resident #71 then wanted to confirm he knew who it was and went to the door and looked down both ways of the hall. The only staff member in the hall was Nurse #2 walking back to her medication cart at the nurse's station. He stated he came back in the room and let Resident #97 know he also confirmed it was Nurse #2. They talked about the incident, and it made his roommate very mad and so he told his roommate to tell someone in the facility.

During observation on 11/28/23 at 3:55 PM Resident #97's room was observed with the door closed while staff were speaking in the hallway. The surveyor was able to hear some voices in the hallway but unable to distinguish words or specific voices.

During an interview on 11/29/23 at 10:19 AM the

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F 550	Continued From page 5	F 550		

Director of Nursing stated she was unable to identify two nurse aides who could corroborate Nurse #2 statement that there were two nurse aide staff members with Nurse #2 outside of Resident #97's room at the time of the incident. The Director of Nursing stated when she called Nurse #2 to inform her she was suspended, Nurse #2 stated to the Director of Nursing at that time that she walked up to medication cart in the hallway outside Resident #97's room around dinner time and joined a conversation about what happened the day before with Resident #97's son. Nurse #2 did not remember what she said, stated she never said or did anything Resident #97 was saying she did, and then began to cry. The Director of Nursing stated that concluded the interview with the nurse.

During an interview on 11/28/23 at 1:27 PM the Administrator stated Friday morning (11/24/23) the Medical Records Director told her that a resident informed her that Nurse #2 came in his room and asked him why he let his son hit her friend. As she (Nurse #2) was leaving, she called him a white cracker and stuck her middle finger up at Resident #97. She immediately went down to Resident #97's room and asked him about the incident. He told her the exact same story and described Nurse #2 to a "T" but did not know her name. She asked Resident #97's roommate, Resident #71, what had occurred, and he informed her he did not see anything but heard the word cracker and corroborated Resident #97's story. The roommate also confirmed the nurse was Nurse #2. Resident #97 and Resident #71 were cognitively intact and reliable witnesses. She told the Director of Nursing to suspend Nurse #2 until they investigated the incident. The investigation was currently ongoing and due to

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F 550	Continued From page 6 the incident having a reliable witness, it was doubtful the nurse would be allowed to return. She concluded it was her expectation that staff treat residents with dignity and respect, and the interaction described and corroborated with a reliable witness indicated this interaction was not acceptable.	F 550		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		12/28/23

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F 578	Continued From page 7 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to 1) ensure advance directive information was accurate throughout the resident's medical record and 2) failed to provide written advance directive information and/or an opportunity to formulate an advance directive for 30 of 101 residents reviewed for advance directives. (Resident's #'s 6, 8, 14, 17, 22, 26, 27, 29, 32, 33, 36, 42, 47, 49, 56, 61, 62, 65, 67, 69, 72, 78, 80, 81, 84, 87, 97, 253, 254, and 303). Findings included: 1. Resident #22 was admitted to the facility on 11/3/2023. Physician orders dated 11/3/2023 included an order for Do Not Resuscitate (DNR). There was a signed DNR form dated 11/3/2023 located in Resident #22's paper medical record. The 5-day admission Minimum Data Set (MDS) assessment dated 11/7/2023 indicated Resident #22 was severely cognitively impaired.	F 578	F578 Request/Refuse/Discontinue/Form/Advance Directives How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Responsible parties for residents #6, 8, 14, 17, 22, 26, 27, 29, 32, 33, 36, 42, 47, 49, 56, 61, 62, 65, 67, 69, 72, 78, 80, 81, 84, 87, 97, 253, 254 and 303 were interviewed and educated regarding formulating an advanced directive by the Administrator and or administrative team on 12/28/23. The code status was clarified for resident # 22 on 11/29/23. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Regional Nurse completed an audit of code statuses for all residents on 12/19/2023. There were no other affected	

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F 578	Continued From page 8 Code status was not included in Resident #22's care plan dated reviewed 11/9/2023. On 11/27/2023 at 12:34 p.m., a review of Resident #22's electronic medical record (EMR) was conducted. Resident #22's EMR profile for code status read, "Set CPR (cardiopulmonary resuscitation) status", and under advance directives, the EMR reported to attempt CPR on Resident #22. On 11/29/2023 at 8:20 a.m. in an interview with Nurse #3, she stated the code status for Resident #22 was located on the EMR for nursing staff to reference to as needed, and if Resident #22 was a DNR, a gold-colored paper would be in Resident #22's paper medical record. She explained she compared the EMR with physician's orders and the paper medical record when determining code status of a resident because the EMR may be incorrect. She stated, without looking at the electronic and paper medical record, she thought Resident #22 was a DNR. When Nurse #3 reviewed Resident #22's EMR, she stated the EMR did not indicate Resident #22's code status, and her code status needed to be set. After Nurse #3 reviewed physician orders, she stated Resident #22 had a physician order for a code status of DNR, and under advance directives in the EMR, attempt CPR was highlighted. Nurse #3 clicked on DNR under advance directives and changed the code status of Resident #22 to DNR. On 11/30/2023 at 9:58 a.m. in an interview with the Director of Nursing (DON), she explained the EMR code status was determined by a code status agreement obtained on admission, physician orders and a DNR form. She further	F 578	residents. All licensed nurses were educated by the Director of Nursing on 12/4/23 to assure the resident□s code agreement, order and EHR status matched. All newly hired nurses will receive this education in orientation. All residents and responsible parties who did not have an existing advanced directive were provided additional education by the Administrator and DON on 12/28/23. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing (DON) and/or Administrative Nurse will complete an Advanced Directive audit monthly to ensure each resident has an accurate code status. The admission director or designee will inquire on admission as to whether the resident has an advanced directive if they would like to formulate one. This will be documented on an Advanced Directive form and recorded in the resident□s electronic health record. On 12/4/23, the Administrator educated the Admissions Director on the Right to formulate an Advanced Directive. The facility hired a new social worker on 12/1/23. She will be educated on Formulating an Advance Directive by the Administrator during orientation. The facility administrator completed the education with facility admission director on 12/4/23. related to ensuring that on admission, during care plan meetings, at	

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F 578	Continued From page 9 explained the EMR automatically set to attempt CPR under advance directives, and the admission nurse would have to change Resident #22's code status to DNR. She stated if the nurse entering the code status on admission did not hit the save button when setting the code status on the EMR, the information would not populate into the EMR. The DON stated the EMR code status of Resident #22 should match the physician order, and she did not have an explanation why Resident #22's code status on the electronic and paper medical record were not reporting the same code status. On 11/30/2023 at 11:30 a.m. in an interview with the Administrator, she explained the facility kept resident information in both electronic and paper medical records. She stated the code status for Resident #22 should match in the electronic and paper medical record per Resident #22 or Resident #22's Representative's request. 2. The Advance Directives policy, not dated, read in part: "Prior to or upon admission of a resident, the Director of Social Services or designee will inquire of the resident, his/her family members, and/or responsible party, about the existence of any written advance directives to determine if the resident has executed an Advance Directive and if not, determine whether the resident would like to formulate an Advance Directive." a. Review of Resident #6's medical record revealed the resident was admitted to the facility on 4/20/22, with diagnoses that include fracture of sternum, hypertension, osteoarthritis, and hyperlipidemia. There was no documentation in the record for education regarding formulation of	F 578	readmission, the residents and/or resident representative will be interviewed to ensure they understand the facility policy on advance directives and their options to implement an advance directive if they do not already have one in place. How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting to ensure continued compliance.	

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F 578	Continued From page 10	F 578		

advance directives and/or an opportunity to formulate an advance directive was offered.

b. Review of Resident #8's medical record revealed the resident was readmitted to the facility on 7/7/21, with diagnoses that include multiple sclerosis, hypertension, and chronic pain syndrome. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

c. Review of Resident #14's medical record revealed the resident was admitted to the facility on 10/25/22, with diagnoses that include dysphagia, congestive heart failure, and diabetes. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

Resident #14's most recent Minimum Data Set (MDS) assessment revealed that she was cognitively intact.

During an interview with Resident #14 on 11/28/23 at 2:58 PM, she revealed that she could not recall
a discussion by the facility about advance directives.

d. Review of Resident #17's medical record revealed the resident was admitted to the facility on 8/19/22, with diagnoses that include dementia, rheumatoid arthritis, and lymphedema. The resident was a "Do Not Resuscitate" (DNR). The care plan, dated 10/17/23 for "a Do Not Resuscitate code status." There was no documentation in the record for education

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regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

e. Review of Resident #22's medical record revealed the resident was admitted to the facility on 11/3/23, with diagnoses that include end stage renal disease, protein calorie malnutrition, and dysphagia. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

f. Review of Resident #26's medical record revealed the resident was admitted to the facility on 11/29/22, with diagnoses that include dementia, hypertension, and asthma. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

g. Review of Resident #27's medical record revealed the resident was admitted to the facility on 12/29/20, with diagnoses that include dementia, stroke, and congestive heart failure. The resident was a "full code." The care plan dated 11/2/23 for "Full code decision is documented and can be changed at any time." There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

h. Review of Resident #29's medical record revealed the resident was readmitted to the facility on 11/15/23, with diagnoses that include cognitive communication deficit, severe protein calorie malnutrition, and osteoarthritis. There was

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no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

i. Review of Resident #32's medical record revealed the resident was admitted to the facility on 9/22/19, with diagnoses that include dementia, hypertension, and hyperlipidemia. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

j. Review of Resident #33's medical record revealed the resident was readmitted to the facility on 4/4/22, with diagnoses that include dementia, protein calorie malnutrition, and dysphagia. The resident was a "full code." The care plan dated 10/29/23 for "Advance Directive: Full code. Full code decision is documented. Decision can be changed at any time." There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

k. Review of Resident #36's medical record revealed the resident was admitted to the facility on 8/29/23, with diagnoses that include dementia and diabetes. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

l. Review of Resident #42's medical record revealed the resident was admitted to the facility on 11/16/22, with diagnoses that include dementia, hypothyroidism, and chronic atrial

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fibrillation. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

m. Review of Resident #47's medical record revealed the resident was admitted to the facility on 1/24/20, with diagnoses that include diabetes and depression. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

n. Review of Resident #49's medical record revealed the resident was readmitted to the facility on 5/27/21, with diagnoses that include dementia and chronic kidney disease. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

o. Review of Resident #56's medical record revealed the resident was readmitted to the facility on 12/27/22, with diagnoses that include diabetes and depression. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

p. Review of Resident #61's medical record revealed the resident was admitted to the facility on 8/14/23, with diagnoses that include stroke, chronic kidney disease, and diabetes. The resident was a "full code." The care plan dated 8/14/23 for "Resident wishes to be a full code. Review advance directives with resident and/or appointed healthcare provider quarterly and

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sooner if changes occur." There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

q. Review of Resident #62's medical record revealed the resident was admitted to the facility on 11/15/23, with diagnoses that include congestive heart failure, chronic kidney disease, and chronic obstructive pulmonary disorder. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

r. Review of Resident #65's medical record revealed the resident was admitted to the facility on 4/20/21, with diagnoses that include diabetes, hypertension, and cognitive communication deficit. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

s. Review of Resident #67's medical record revealed the resident was admitted to the facility on 5/27/21, with diagnoses that include diabetes, stroke, and hypertension. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

t. Review of Resident #69's medical record revealed the resident was readmitted to the facility on 5/3/23, with diagnoses that include diabetes, stroke, and chronic respiratory failure. There was no documentation in the record for

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education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

u. Review of Resident #72's medical record revealed the resident was readmitted to the facility on 2/21/23, with diagnoses that include anoxic brain damage, adult failure to thrive, and hypertension. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

v. Review of Resident #78's medical record revealed the resident was admitted to the facility on 11/2/23, with diagnoses that include osteomyelitis. The resident was a "Full Code". There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. Full code order dated 11/2/23.

w. Review of Resident #80's medical record revealed the resident was readmitted to the facility on 10/30/23, with diagnoses that include dementia and chronic pain syndrome. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

x. Review of Resident #81's medical record revealed the resident was admitted to the facility on 5/9/22, with diagnoses that include dementia, stroke, and bell's palsy. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance

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directive was offered.

y. Review of Resident #84's medical record revealed the resident was admitted to the facility on 7/6/23, with diagnoses that include congestive heart failure and protein calorie malnutrition. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

z. Review of Resident #87's medical record revealed the resident was admitted to the facility on 1/18/23, with diagnoses that include cognitive communication deficit and protein calorie malnutrition. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

aa. Review of Resident #97's medical record revealed the resident was admitted to the facility on 9/19/23, with diagnoses that include diabetes, end stage renal disease, and stroke. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

bb. Review of Resident #253's medical record revealed the resident was admitted to the facility on 11/21/23, with diagnoses that include diabetes, end stage renal disease, and heart failure. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

cc. Review of Resident #254's medical record

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revealed the resident was admitted to the facility on 11/17/23, with diagnoses that include stroke, failure to thrive, and chronic obstructive pulmonary disease. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

dd. Review of Resident #303's medical record revealed the resident was admitted to the facility on 11/21/23, with diagnoses that include diabetes, hypertension, and hypothyroidism. There was no documentation in the record for education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered.

An interview was conducted with the Regional Nurse Consultant on 11/27/23 at 2:11 PM, she revealed that the facility did not go beyond full code/DNR code status. She stated that residents and responsible parties (RP) signed a full code/DNR form in the admissions packet, and there was not any further discussion about advance directives.

During a follow-up interview with the Regional Nurse Consultant on 11/27/23 at 2:30 PM, she revealed that the Care Transitions Coordinator was responsible for discussing advance directives with the resident/RP upon admission.

The Care Transitions Coordinator was interviewed on 11/27/23 at 2:35 PM, and she revealed that she was responsible for discussing advance directives with residents/RPs during the admission process. However, she stated she did not document the conversation/education. She stated she was new to the facility and was not

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F 578	Continued From page 18 instructed to document the advance directives discussion. An interview was conducted with the Administrator on 11/29/23 at 8:12 AM. She revealed that the Care Transitions Coordinator was responsible for the advance directives discussion with residents/families, which was also included in the admissions packet. Residents and families received a copy of the advance directives policy. Sometimes, the Administrator had to go over the admissions packet with residents and families when the Care Transitions Coordinator was not available. She stated she did not document the discussion because residents/families signed the advance directives (full code or DNR) form included in the admissions packet. She was unsure of advance directives beyond the full code/DNR status. She stated she would want the residents/families to have all the information possible to plan for life issues.	F 578		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F 582		12/28/23

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changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:

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F 582	Continued From page 20 Based on record review and staff interviews, the facility failed to provide the required Centers for Medicare and Medicaid Services (CMS) Notice of Medicare Non-Coverage(NOMNC) (form 10123) for 2 of 3 residents reviewed for beneficiary protection notification review (Resident #24 and Resident #30). The findings included: 1. Resident #24 was admitted to the facility on 7/4/23 with Medicare Part A skilled services. Resident #5's Medicare Part A skilled services ended on 7/5/22 and her Medicare Part A Skilled Nursing Facility benefit was not exhausted. She remained in the facility. Resident #24's admission Minimum Data Set assessment dated 7/9/23 revealed she had moderate cognitive impairment. Record review revealed no evidence that Resident #24 or the resident's responsible party were provided the Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC). During an interview with the Business Office Manager on 11/28/23 at 11:55 AM she stated there was an error in processing the notifications and Resident #24 did not receive the CMS 10123-NOMNC. She reported she was unaware the form was required if the resident remained in the facility. An interview was conducted with the Administrator on 11/29/23 at 3:45 PM who indicated Resident #24 should have received the CMS-10123-NOMNC as required by Federal guidelines.	F 582	F582 Medicaid/Medicare Coverage/Liability Notice How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #24 and Resident #30 are no longer in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Administrator completed a review of Medicare A and Managed Care Residents who have discharged in the past 30 days, to determine if a NOMNC was issued on 12/27/23. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: During daily stand-up meetings the clinical team, including Director of Nursing, Business Office Manager, administrator, social worker, and rehab director will review residents requiring NOMIC to be issues, including those issues by the resident private insurance, to ensure the NOMIC has been issued and sign by resident and/or responsible Party. Education provided to the Business Office Manager on issuing NOMNC when a resident no longer requires a Part A stay and remains in the facility, by the	

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F 582	Continued From page 21 2. Resident #30 was admitted to the facility on 8/2/23 with Medicare Part A skilled services. Resident #30's Medicare Part A skilled services ended on 10/16/23 and her Medicare Part A Skilled Nursing Facility benefit was not exhausted. She remained in the facility. Resident #30's admission Minimum Data Set assessment dated 8/4/23 revealed she was cognitively intact. Record review revealed no evidence that Resident #30 or the resident's responsible party were provided the Notice of Medicare Non-Coverage (Form CMS 10123-NOMNC). During an interview with the Business Office Manager on 11/28/23 at 11:55 AM she stated there was an error in processing the notifications and Resident #30 did not receive the CMS 10123-NOMNC. She reported she was unaware the form was required if the resident remained in the facility. An interview was conducted with the Administrator on 11/29/23 at 3:45 PM who indicated Resident #30 should have received the CMS-10123-NOMNC as required by Federal guidelines.	F 582	Administrator on 11/30/2023. How the facility will monitor its performance to ensure the deficient practice does not recur. The Administrator will review NOMIC□s weekly times 4 week bi-weekly time 4 weeks than monthly. The Administrator will report the results to the monthly QA meeting. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the	F 641	F641 Accuracy of Assessments	12/28/23

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F 641	Continued From page 22 facility failed to accurately code the use of an antiplatelet medication (prevents blood cells from clumping together to form a clot) for 4 of 31 residents whose Minimum Data Set (MDS) assessments were reviewed (Resident #56, Resident #47, Resident #8, and Resident #81). Findings included: 1. Resident #56 was admitted to the facility on 10/29/21. Diagnosis included, in part, cerebrovascular accident. A physician order dated 12/27/22 stated Aspirin (an antiplatelet medication), 81 milligrams (mg), daily. The October 2023 Medication Administration Record (MAR) was reviewed and revealed Resident #56 received Aspirin, 81 mg daily from 10/1/23-10/31/23. The quarterly MDS assessment dated 10/11/23 revealed Resident #56 received an anticoagulant medication during the look back period. The MDS was not coded for antiplatelet medication use. On 11/28/23 at 3:39 PM an interview was conducted with the MDS Coordinator. She explained that when she coded medications, she coded them by drug classification. She shared that she coded Aspirin as an anticoagulant rather than an antiplatelet since it was used as a blood thinner for Resident #56. In an interview with the Administrator on 11/28/23 at 4:10 PM, she stated MDS assessments should be correctly coded for the use of medications.	F 641	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. MDS assessment for Residents #47, #8, #81 and #56 was modified on 11/29/23 to reflect an anti-platelet instead of anti-coagulant, by the MDS Coordinator. How the facility will identify other residents having the potential to be affected by the same deficient practice. A 100% audit of all current residents was done on 11/29/23 by the Administrator and no other residents were found to be affected by this deficient practice. The MDS Coordinator was educated on accurate coding of section O of the MDS assessment for anti-platelets versus anti-coagulants on 11/29/23 by the Regional MDS Nurse. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Regional MDS Nurse will audit 25% of MDS assessments weekly times 4 weeks, then monthly times 2 months. All negative findings will be brought to the QA meeting monthly. The MDS Coordinator was educated on accurate coding of section O of the MDS assessment for anti-platelets versus anti-coagulants on 11/29/23 by the Regional MDS Nurse.	

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F 641	Continued From page 23 2. Resident #47 was admitted to the facility on 1/24/20. Diagnosis included, in part, hypertension. A physician order dated 1/24/20 stated Aspirin, 81 mg daily for prophylaxis (prevention). The November 2023 MAR was reviewed and revealed Resident #47 received Aspirin, 81 mg daily from 11/1/23-11/29/23. The quarterly MDS assessment dated 11/16/23 revealed Resident #47 received an anticoagulant medication during the look back period. The MDS was not coded for antiplatelet medication use. On 11/28/23 at 3:39 PM an interview was conducted with the MDS Coordinator. She explained that when she coded medications, she coded them by drug classification. She shared that she coded Aspirin as an anticoagulant rather than an antiplatelet since it was used as a blood thinner for Resident #47. In an interview with the Administrator on 11/28/23 at 4:10 PM, she stated MDS assessments should be correctly coded for the use of medications. 3. Resident #8 was admitted to the facility on 3/1/17. Diagnoses included chronic obstructive pulmonary disease and chronic atrial fibrillation. Review of Resident #8's medical record revealed she was not receiving anticoagulant medication. On 7/7/21 Resident #8 was ordered aspirin 81 milligrams chewable tablet take 1 tablet by mouth once daily for prophylaxis. Resident #8's Minimum Data Set (MDS)	F 641	How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved.	

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F 641	Continued From page 24	F 641		

assessment dated 10/19/23 revealed she was coded to receive an anticoagulant medication.

During an interview on 11/29/23 at 8:49 AM the MDS Coordinator stated Resident #8 was coded for anticoagulant use on the 10/19/23 quarterly minimum data set assessment due to taking aspirin. She concluded she had mistakenly considered aspirin a blood thinner medication.

During an interview on 11/28/23 at 4:10 PM the Administrator stated resident minimum data set assessments should be coded correctly for anticoagulants.

4. Resident #81 was admitted to the facility on 5/9/2022 with diagnoses including a stroke.

Physician orders dated 5/9/2023 included Chewable Aspirin (an antiplatelet medication that causes blood cells not to clump together to form a clot) 81 milligrams(mg) daily.

A review of the October 2023 Medication Administration Record recorded Resident #81 received Aspirin 81 mg daily from 10/1/2023 to 10/25/2023 except on the following dates: 10/6/2023, 10/19/2023 and 10/20/2023.

The quarterly Minimum Data Set (MDS) assessment dated 10/25/2023 indicated Resident #81 was severely cognitively impaired and was receiving anticoagulants. The MDS was not coded for antiplatelets.

In an interview with MDS Coordinator on 11/28/2023 at 4:03 p.m., she explained Resident #81's MDS dated 10/25/2023 was coded as Resident #81 was receiving anticoagulants, and Resident #81 was only taking Aspirin. The MDS

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F 641	Continued From page 25 coordinator stated she had been coding Aspirin incorrectly on the MDS assessments as an anticoagulant. In an interview with the Administrator on 11/28/2023 at 4:10 p.m., she stated Resident #81's MDS assessment should be coded correctly for the use of anticoagulants.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to refer a resident with a new diagnosis of schizoaffective disorder for a level II Pre-Admission Screening Resident Review (PASRR) for 1 of 1 resident reviewed for PASSR (Resident #87).	F 644	F644 Coordination of PASARR and Assessments How the corrective action will be accomplished for those residents found to have been affected by the deficient	12/28/23

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F 644	Continued From page 26 The findings included: Resident #87 was admitted to the facility on 1/18/23 with diagnoses that included major depressive disorder. Review of Resident #87's diagnoses revealed he was diagnosed on 4/20/23 with schizoaffective disorder. Review of Resident #87's record revealed no screening for a level II PASSR. Resident #87's annual MDS assessment dated 11/3/23 revealed he was assessed as having moderate cognitive impairment with no mood symptoms. His diagnoses on the assessment included post-traumatic disorder and schizoaffective disorder. Resident #47 received antipsychotic and antidepressant medication during the lookback period. An interview with the facility's Activities Director on 11/29/23 at 9:44 AM was conducted. She stated the facility Social Worker had left in October and she had attempted to assist since then. The Activities Director stated she did not refer Resident #87 for a level II PASRR screening. An interview was conducted with the Admissions Director on 11/29/23 at 11:20 AM and she stated Resident #87 should have been referred for a level II PASRR screening when he was diagnosed with schizoaffective disorder. She stated it was not done. An interview was conducted with the facility Administrator o 11/29/23 at 3:30 PM and she	F 644	practice. A Preadmission Screening and Resident review (PASARR) application for resident #87 was submitted on 12/8/23 by the Activities Director. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing (DON) reviewed psychiatric consults for residents assessed for the last 3 months on 12/20/23 to determine if any applications for Level II PASRR□s needed to be submitted for any new psych diagnosis. No others were identified. What measures will be put in place or changes made to ensure that the deficient practice will not recur. systemic The administrator educated the Director of Nursing on reviewing psych consults for Level II PASARR submissions on 12/20/2023. The administrator will educate the new social worker during her orientation. The Director of Nursing or Staff development coordinator will review all psych consultations weekly indefinitely to determine if an application for a level II PASARR is indicated. How the facility will monitor its performance to ensure the deficient	

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F 644	Continued From page 27 stated there had been significant turnover with the social work position which could have led to Resident #87 not being referred for a level II PASRR screening after his diagnosis of schizoaffective disorder.	F 644	practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Registered Dietician, and physician interviews, the facility failed to follow a physician order for obtaining a resident's weight twice per week for 1 of 5 residents (Resident #32) reviewed for nutrition. Findings included: Resident #32 was admitted to the facility on 10/30/17 with diagnoses that included dementia and hypertension. A review of the active November physician's orders indicated a physician order dated 8/19/21 that revealed, "obtain weight twice weekly. If weight changes 2-3 pounds overnight or 5 pounds in 1 week notify doctor". The quarterly Minimum Data Set dated 11/9/23 revealed Resident #32 had moderate cognitive impairment with no rejection of care or significant weight loss coding.	F 658	F658 Services Provided Meet Professional Standards How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The order for Resident #32 was discontinued after reviewing with the attending physician by the Director of nursing on 11/29/23 due to the resident having stable weight recordings. How the facility will identify other residents having the potential to be affected by the deficient practice: After a review of current residents' weight orders by the Registered Dietician on 12/7/23, there were no other orders found	12/28/23

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F 658	Continued From page 28 Review of Resident #32's weights from 10/1/23 through 11/29/23 revealed two weights obtained and recorded. The weight for 10/13/23 was 118.4 pounds and the weight for 11/11/23 was 119.8 pounds. Review of Resident #32's Medication Administration Records (MAR) for October and November 2023 revealed twice weekly weights were not obtained. The MAR indicated weights should be done on Tuesdays and Sundays. The entries for Tuesdays and Sundays were filled in with a "N" to indicate it was not done. An interview was conducted with the facility's Registered Dietician on 11/29/23 at 9:20 AM who stated she was not sure of the reason for twice weekly weights for Resident #32. She reported Resident #32's weights were stable and she was not at nutritional risk. An interview was conducted with Nurse #4 on 11/29/23 at 11:25 AM. She stated she was not aware Resident #32 was ordered twice weekly weights. She reviewed the record and stated the weights were not being done. An interview with Medication Aide #1 on 11/29/23 at 11:30 AM was conducted. She reported she had documented weights were not done on the October and November MARs when she was assigned to Resident #32 because the weights were not obtained. Medication Aide #1 stated she did not inform nurse aides working on the hall the weights needed to be done. During an interview on 11/29/23 at 11:29 AM with Nurse Aide #4 who was responsible for obtaining	F 658	that had not been completed. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. All physicians' orders will be reviewed daily in the clinical meeting to ensure they have been entered correctly and have been initiated by the Director of nursing and nurse managers 5x/week x 2 weeks. 3x/week x 4 weeks and 2x/week x 6 weeks. The Director of nursing, Staff development coordinator and unit manager were educated 12/20/23 by the Regional Nurse regarding reviewing physician orders daily Monday through Friday in the clinical meeting. How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved.	

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F 658	Continued From page 29 weights stated she was not aware that Resident #32 had an order for twice weekly weights. She stated she was informed by the unit nurse when a resident was due for weights. NA #4 stated she had not been obtaining twice weekly weights on Resident #32. During an interview with the Director of Nursing and Regional Nurse Consultant on 11/29/23 at 2:34 PM they stated they were not aware of an order for twice weekly weights for Resident #32. An interview was conducted with the Medical Director on 11/29/23 at 2:43 PM who stated the order for twice weekly weights should have been followed. He stated the order was initially written when Resident #32 had a concern for excess fluid which has since been resolved. He indicated the fluid issue had resolved in 2021 and he should have discontinued the order. The Medical Director indicated Resident #32 had no adverse effects from not having twice weekly weights. An interview was conducted with the facility Administrator on 11/29/23 at 3:30 PM and she stated she expected physician orders to be followed. She reported there had been some turnover with staff which could have lead to the order not being followed.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		12/28/23

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F 677	Continued From page 30	F 677		

by:
Based on observations, staff interviews, and record review the facility failed to rinse soap from a resident's skin per manufacturer's directions during a bath for 1 of 4 resident reviewed for activities of daily living care (Resident #26).

Findings included:

Review of the directions printed on the bottle of body wash and shampoo combination soap (which was used for the bath on 11/28/23 at 11:34 AM) read in part, "DIRECTIONS: Shampoo - Apply a small amount to wet hair or scalp and work into a lather. Massage scalp and hair. Rinse well. Shower or tub bath - Apply product to wet washcloth or directly to wet skin to create light lather. Gently cleanse skin. Rinse well."

Resident #26 was admitted to the facility on 11/29/22. Her active diagnoses included progressive neurological conditions, dementia, and anemia.

Resident #26's Minimum Data Set assessment dated 11/15/23 revealed she was assessed as severely cognitively impaired. She had no behavior noted. She was dependent on staff for eating, oral hygiene, toileting hygiene, bathing/showers, upper and lower body dressing, putting, and taking off hygiene, personal hygiene, and rolling right to left. She was always incontinent of bowel and bladder.

Resident #26's care plan dated 11/15/23 revealed she was care planned to require assistance with eating, mobility, transfers, dressing, grooming, toileting, and bathing related to impaired mobility. The interventions included to assist with activities

F677 ADL Care Provided for Dependent Residents

How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #26□s skin was rinsed and dried with clean water by the medication aide and the nurse aide on the hall on 11/28/23.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents who require assistance with bathing are at risk. Nurse Manager and certified nursing assistants completed observation rounds and interviews with residents who received a bath on 11/28/23 to ensure they were rinsed appropriately.

What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.
Bathing observations will be completed 5 residents, 5x/week x 2 weeks, 5 residents, 3x/week x 2 weeks and 5 residents weekly x 8 weeks by the nurse managers to assure soap is being rinsed off each resident. The Staff Development nurse educated licensed nurses and nursing assistants regarding rinsing soap off residents with clean water and a separate cloth on 12/11/2023. The education was completed on 12/28/23. All newly hired

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F 677	Continued From page 31 of daily living care as needed, assist with adjusting clothing, and assist with perineal cleansing as needed. During observation on 11/28/23 at 11:07 AM Nurse Aide #1 was observed providing morning activities of daily living care. She took one basin of warm water and placed it on the bedside table. She put soap in the basin of warm water and suds were visible in the basin of water. The nurse aide then used a washcloth to wash Resident #26's upper torso and arms. Suds were visible on the resident's skin. The nurse aide placed the washcloth in the basin of warm water and soap. The nurse aide then took a second washcloth and placed it in the basin of warm water and soap, wrung the new washcloth out and used this washcloth to wipe the upper torso and arms. Most suds were wiped off, but a few suds were still visible on the resident's skin. The nurse aide then used a towel to dry skin. The nurse aide completed Resident #26's bed bath in this manner. During an interview on 11/28/23 at 11:28 AM Nurse Aide #1 stated she used one wash cloth for soap and one to rinse. Stated she put both wash cloths in the water with the soap and suds but used one to wash and the other she would wring out the soapy water and then use it to rinse and then dry with a towel. She felt the wrung-out washcloth was able to be used to provide the rinse. During an interview on 11/28/23 at 11:35 AM the Director of Nursing stated the manufacturer's directions should be followed with the use of soap during a bath and if the directions said to rinse the soap from the skin, these directions should be	F 677	nursing employees will receive this training during orientation and prior to assignment on the floor. How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved.	

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F 677	Continued From page 32 followed. She further stated following washing the resident's body she would expect the nurse aide to dump the soapy water, replace the water and washcloth, and then get fresh water and rinse the resident. She further stated the nurse aide should have replaced the soapy water to provide the rinse to prevent soap residue from irritating the skin and prevent spreading any kind of germs to another part of the body, and to prevent dryness.	F 677		
F 727 SS=D	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 staff interviews and record review, the facility failed to prevent the Director of Nursing (DON) from serving as a charge nurse with a facility census greater than 60 residents for 1 out of 33 days (11/24/23) reviewed for staffing. Findings included: The daily nurse staff postings and nursing assignment sheets were reviewed for	F 727	F727 RN 8 Hrs/7days/Wk, Full Time DON How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this practice on 11/24/23.	12/28/23

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F 727	Continued From page 33 10/29/23-11/30/23. The daily posting for 11/24/23 revealed a census of 103. An interview was conducted with the Scheduler on 11/30/23 at 10:10 AM. She explained she scheduled the nursing staff for the facility and stated the DON worked on a medication cart on 11/24/23 and served as a charge nurse in the building. On 11/30/23 at 11:42 AM an interview was conducted with the DON and Regional Nurse Consultant. The DON stated 11/24/23 was the day after Thanksgiving and the RN who normally worked on Friday was off for the holiday. The DON confirmed she worked on a medication cart on 11/24/23. She shared the facility was actively recruiting for RNs and there were 3 RN full time positions open.	F 727	How the facility will identify other residents having the potential to be affected by the same deficient practice. After a review of the schedule of the last 60 days by the Administrator and scheduler, there were no other days where the DON served as the RN coverage. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The DON and scheduler were educated by the Regional Nurse Consultant on 12/18/2023 regarding the regulation of an RN being present in the building 8 hours each day/7 day a week consistently and the Director of Nursing cannot serve as the Registered Nurse coverage. A daily labor meeting will be held by the Administrator, DON and scheduler to review schedules and ensure an RN is scheduled daily for at least 8 hours. This meeting will be held 5 days a week x 2 weeks, 3x/week x 2 weeks and weekly x 8 weeks. How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved	

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F 730	Continued From page 34	F 730		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to complete a performance review every 12 months for 2 of 5 nursing assistants (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance reviews (NA #3 and NA #2). Findings included: 1. NA #3's personnel file was reviewed and revealed a date of hire of 4/16/17. Her most recent performance review had been completed on 7/16/18. During an interview with NA #3 on 11/30/23 at 10:40 AM, she stated the facility had not completed a performance review in the past twelve months and was unable to recall if the facility had ever evaluated her work during her employment at the facility. On 11/30/23 at 11:42 AM an interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant. The Regional Nurse Consultant stated performance reviews were supposed to be completed annually and the DON was responsible for completion of the	F 730	F730 Nurse Aide Perform Review-12 hr/yr In-Service How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility hired a Human Resources Director on 12/19/2023. Performance reviews were completed by the Director of Nursing for NA# 2 and NA#3 on 12/19/2023 How the facility will identify other residents having the potential to be affected by the same deficient practice. The Human Resources Director and the DON were educated on 12/19/2023 on the process of completing Annual Performance Reviews by the facility Administrator. Performance evaluations due in December were completed on 12/20/23 by the DON and Dietary manager. There were only three evaluations due through 12/31/23.	12/28/23

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F 730	Continued From page 35 performance reviews for NAs. She shared the performance reviews had not been completed due to turnover in the Human Resources and DON position. She added the Human Resources office typically tracked NA's anniversary dates in the computer system and they were supposed to give the performance review to the DON who completed it and returned it to Human Resources. The Regional Nurse Consultant reported the facility currently did not have a Human Resources employee. 2. NA #2's personnel file was reviewed and revealed a date of hire of 7/28/21. The personnel file for NA #2 did not include a performance review for July 2022 or July 2023. During a telephone interview with NA #2 on 11/30/23 at 10:52 AM, she stated the facility had not completed a performance review since she had been employed at the facility. On 11/30/23 at 11:42 AM an interview was conducted with the Director of Nursing (DON) and Regional Nurse Consultant. The Regional Nurse Consultant stated performance reviews were supposed to be completed annually and the DON was responsible for completion of the performance reviews for NAs. She shared the performance reviews had not been completed due to turnover in the Human Resources and DON position. She added the Human Resources office typically tracked NA's anniversary dates in the computer system and they were supposed to give the performance review to the DON who completed it and returned it to Human Resources. The Regional Nurse Consultant reported the facility currently did not have a Human Resources employee.	F 730	What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Human Resources Director (HR) will access the employee roster on the 1st of each month by hire date. Performance evaluations will be given to the appropriate department head who will in turn complete the evaluation and return it to the HR Director within 5 days of receipt. The Director of Nursing will review the evaluation with the nursing assistants and signature obtained. Any area of practice found to be unfavorable will be addressed and education provided by the department head assigned. How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved.	

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F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		12/28/23

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F 756	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Regional Nurse Consultant interview, and a Pharmacist Consultant interview, the facility failed to address recommendations made by the Pharmacist Consultant based on monthly Medication Regimen Reviews (MRR) for 2 of 6 residents reviewed for unnecessary medications (Resident #81 and Resident #56). Findings included: 1. Resident #81 was admitted to the facility on 5/9/2022 with diagnoses including dementia and schizophrenia disorder. The last Abnormal Involuntary Movement Scale (AIMS) assessment dated 11/22/2022 in Resident #81's electronic medical record (EMR) reported Resident #81 was not experiencing involuntary movements, an adverse side effect to psychotropic medications. A review of Resident #81's EMR reported monthly Medication Regimen Reviews (MRRs) were conducted by the Pharmacist Consultant. On 6/7/2023, 7/7/2023, 8/6/2023, 9/12/2023, 10/6/2023 and 11/7/2023, the Pharmacist Consultant wrote a recommendation each month for an AIMS assessment for Resident #81. A review of Resident #81's EMR included a physician order dated 6/27/2023 increasing Seroquel (an antipsychotic medication) to 50 milligrams (mg) twice a day for schizophrenia disorder. In an interview with the Regional Nurse	F 756	F756 Drug Regimen Review, Report Irregular How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for Resident #81 on 12/4/23. Resident #56□s Lorazepam order was discontinued on 11/29/23 per pharmacy recommendation. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Regional Nurse Consultant educated the Director of Nursing and administrative nurse team on completing Pharmacy Recommendations monthly on 12/20/23. Any new administrative nurse will receive this education during orientation. Pharmacy recommendations were completed in their entirety for November on 12/10/23 which included recommendations that had been pending. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Pharmacy recs will be completed by the DON and nurse managers monthly. The Pharmacy Consultant will be responsible for auditing pharmacy	

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F 756	Continued From page 38 Consultant on 11/29/2023 at 11:03 a.m., she reported the Pharmacist Consultant emailed monthly recommendation reports to the Director of Nursing. She explained the Director of Nursing and Unit Nurse Managers were responsible to address the nursing recommendations for AIMS assessments. She reported the book that stored the completed monthly pharmacy recommendations located in the Director of Nursing office had not been updated since January 2023. She further reported she was able to locate any signed pharmacy recommendations acknowledging completion of the pharmacy recommendations for Resident #81 in the Director of Nursing Office and the pharmacy. She explained the lack of administrative nursing staff (Unit Nurse Managers, Assistant Director of Nursing, and Staff Development Coordinator), and nursing turnover in the facility contributed to nursing not addressing pharmacy recommendations for AIMS assessment. In a phone interview with the Pharmacist Consultant on 11/29/2023 at 11:41 a.m., she explained AIMS assessments were completed on residents receiving antipsychotics, and she communicated pharmacy recommendations through emails to the Director of Nursing, Administrator and Regional Nurse Consultant and the need for an AIMS assessment for Resident #81. She said she last emailed the facility (Director of Nursing, Administrator and Regional Nurse Consultant) about completion of AIMS assessments on 11/16/2023 with specific names listed in the nursing recommendations after noticing a trend in her email recommendations for AIMS assessments for more residents than Resident #81	F 756	recommendations to ensure they are completed in their entirety monthly prior to sending new recommendations. Pharmacy recommendations, when completed, will be scanned into each resident□s EHR with a copy of the completed recommendations kept in the DON office. This will be an ongoing process. How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved.	

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In an interview with the Director of Nursing on 11/30/2023 at 9:09 a.m., she explained she started at the facility in May 2023 and did not recall receiving emails for pharmacy recommendations for an AIMS assessment for Resident #81 from the Pharmacy Consultant. She further explained the lack of unit nurse managers in the facility was part of the reason why AIMS assessments for Resident #81 had not been completed.

2. Resident #56 was admitted to the facility on 10/29/21. Diagnoses included, in part, anxiety disorder and depression.

A physician (MD) order dated 12/27/22 revealed Lorazepam (a medication used to treat anxiety), 0.5 milligrams (mg); one tablet by mouth every eight hours as needed (PRN). There was no stop date on the medication order.

A review of the pharmacy's Medication Regimen Review notice to the MD on 1/6/23 stated the following: "Please note this resident is currently ordered Lorazepam 0.5 mg, one tablet every eight hours PRN ...Please consider the following: Continue PRN Lorazepam 0.5mg every eight hours prn times four months. Resident was re-evaluated by provider and the medication was determined to have continued need with benefit outweighing the risk of therapy ..." The MD agreed with the pharmacy review and signed the recommendation on 1/30/23 which extended the prn Lorazepam for four months.

Medication Regimen Review notices to the physician were reviewed for 7/6/23, 8/2/23 and 11/3/23. Each notice included a request for the physician to re-evaluate the ongoing need for the prn Lorazepam and to include a specific duration

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for the medication. The facility was unable to locate the signed physician's response to the notices.

A telephone interview was conducted with the Pharmacy Consultant on 11/29/23 at 11:41 AM. She explained each month she emailed the Medication Regimen Review notices to the Regional Nurse Consultant, DON, and Administrator. When she returned the following month, she looked in the electronic health record for the signed review. The Pharmacy Consultant stated sometimes the facility emailed the notices back to her but not all the time. She added the facility reviewed every prn psychotropic medication during each of the facility's Quality Assurance Performance Improvement (QAPI) meetings which was attended by the Medical Director. She recalled during the QAPI meetings they discussed the prn Lorazepam for Resident #56 and the Medical Director indicated he wanted to continue it for her.

The Medical Director was interviewed by telephone on11/29/23 at 2:39 PM. He stated he prescribed prn Lorazepam to Resident #56 for agitation. He said typically he ordered a stop date of two weeks to one month for prn medications. When asked why there had not been a stop date since the Medication Regimen Review of January 2023 that extended the medication for four months, he replied it could have been an oversight or "we didn't get the recommendation from the pharmacy."

In an interview with the DON on 11/29/23 at 3:26 PM, she shared typically she received a copy of the Medication Regimen Review from the pharmacy each month. Once she received the

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F 756	Continued From page 41 reviews, she separated and distributed them to the appropriate physician. She said when the physician reviewed the information and made a decision it was returned to her, and she implemented the changes/orders. She then gave the Medication Regimen Review notice to the medical records office to be scanned into the resident's chart. The DON said she was unable to locate emails from the pharmacist about the prn Lorazepam for the months of July, August and November 2023. An interview was conducted on 11/29/23 at 11:03 AM with the Regional Nurse Consultant. She reported when the Pharmacy Consultant finished her monthly medication recommendations, she emailed them to Medical Records and the DON. The DON or Medical Records employee then separated them by physician and gave them to the physicians weekly when they were at the facility. The physicians then reviewed the recommendation, signed it, then returned it to the DON who implemented the physician's order. The signed recommendation was given back to Medical Records to be scanned into both the electronic health record and to the pharmacy. The Regional Nurse Consultant stated the pharmacy recommendation book was kept in the DON's office but had not been updated since January 2023 and the facility was unable to locate the completed Medication Regimen Review notices for Resident #56 since that time.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		12/28/23

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processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 758	Continued From page 43 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, interview with the Pharmacy Consultant, interview with the Physician (MD), the facility failed to assess for tardive dyskinesia (involuntary movements and a side effect of long-term treatment with antipsychotic medications) for a resident prescribed an antipsychotic medication (Resident #81). Additionally, the facility failed to ensure a physician's order for as needed (PRN) psychotropic medication for a resident (Resident #56) was time limited in duration. This affected 2 of 5 residents reviewed for unnecessary medications. Findings included: 1. Resident #81 was admitted to the facility on 5/9/2022 with diagnoses including a schizophrenia disorder. An Abnormal Involuntary Movement Scale (AIMS) assessment dated 11/22/2022 indicated Resident #81 was not experiencing abnormal involuntary movements, a side effect when taking antipsychotic medications. There were no other AIMS assessments documented in Resident #81's electronic medical record. A review of the Pharmacy monthly Medication Regimen Reviews (MRR) dated 6/7/2023, 7/7/2023, 8/6/2023, 9/12/2023, 10/6/2023 and 11/7/2023 for Resident #81 reported a pharmacy	F 758	F758 Free from Unnec Psychotropic Meds How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for Resident #81 on 12/4/23. Resident #56□s Lorazepam order was discontinued on 11/29/23 per pharmacy recommendation. How the facility will identify other residents having the potential to be affected by the same deficient practice. An AIMS assessment was completed on all residents by 12/12/23 by the Regional Nurse. All PRN (as needed) medications were reviewed by the Regional Nurse Consultant on 12/11/23 to assure each order had a stop date. All orders are complete. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. All administrative and licensed nurses	

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F 758	Continued From page 44 recommendation for AIMS. Physician orders dated 6/27/2023 included an order for Seroquel (an antipsychotic medication) 50 milligrams twice a day for schizophrenia disorder. The care plan initiated on 6/27/2023 included a focus for Resident #81 being at risk for side effects from the use of an antipsychotic drug Interventions included monitoring and documenting for signs of tremors and reporting the onset or increase of tremors to the physician. Nursing documentation dated 7/19/2023, 8/15/2023, 9/3/2023 by Nurse #3 recorded Resident #81 was not experiencing adverse reactions or side effects from psychiatric medications. There was no nursing documentation indicating Resident #81 was experiencing involuntary movements. The quarterly Minimum Data Set (MDS) assessment dated 10/25/2023 indicated Resident #81 was severely cognitively impaired and received antipsychotic medications (medicines that help ease the symptoms of a mental health condition that affects how he brain works) on a routine basis. The October and November 2023 Medication Administration Record (MAR) recorded Resident #81 received Seroquel daily. There was no documentation on the MARs recorded for monitoring of side effects for the use of Seroquel. During an interview with Resident #81 on 11/27/2023 at 3:00 p.m., there were no involuntary movements to Resident #81's body	F 758	were educated by The Regional Nurse Consultant on 12/4/23 regarding completing AIMS assessments quarterly according to the MDS (Minimum Data Set) calendar. They were also educated on applying a 14-day stop date on all initial PRN, as needed, Psychotropic orders and a 4 month stop date thereafter. The MDS nurse will provide a calendar each month with each resident□s ARD to assure nursing administration is aware of the date the quarterly assessment is due. The Director of Nursing will audit the assessment section of AHT (American Health Tech) prior to the seventh day to assure the assessment was completed timely. ¿All physician orders will be reviewed daily in the clinical meeting indefinitely by the unit managers and Director of Nursing to assure all new PRN (as needed) psychotropic orders have stop dates. This process will be ongoing, and the Director of Nursing will be responsible. How the facility will monitor its performance to ensure the deficient practice does not recur. The facility administrator will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting until compliance is achieved.	

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observed.

In an interview with the Regional Nurse Consultant on 11/29/2023 at 11:03 a.m., she stated the facility used AIMS assessments to monitor side effects such as tardive dyskinesia (repetitive muscle movement disorder) for residents receiving antipsychotic medications and were conducted quarterly along with MDS calendar. She explained the lack of administrative nursing staff (Unit Nurse Managers, Assistant Director of Nursing, Staff Development Coordinator) and nursing turnover in the facility contributed AIMS assessments not being completed in the scheduled time.

In a phone interview with the Pharmacist Consultant on 11/29/2023 at 11:41 a.m., she explained AIMS assessments were completed on residents receiving antipsychotics, and she communicated through emails to the Director of Nursing, Administrator and Regional Nurse Consultant the need for a AIMS assessment for Resident #81. She said she last emailed the facility (Director of Nursing, Administrator and Regional Nurse Consultant) about completion of AIMS assessments on 11/16/2023 with specific names listed in the nursing recommendations after noticing a trend in her email recommendations for AIMS assessments for more than Resident #81.

In an interview with Nurse #4 on 11/29/2023 at 4:24 p.m., she stated monitoring and documentation of Resident #81 behaviors would be on the MAR, and AIMS assessments were done on admission. She explained she began employment at the facility in October 2023, and did not know if resident receiving antipsychotics

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were required AIMS reassessments.

In an interview with the Director of Nursing (DON) on 11/30/2023 at 9:09 a.m., she stated she had been employed as the DON with the facility since May 2023. She explained AIMS assessments were conducted on admission and quarterly based on the MDS assessment schedule for residents receiving antipsychotics. She stated the Unit Nurse Managers were responsible for ensuring AIMS assessments were conducted by nurses or the unit nurse manager. She said she could not recall receiving emails from the pharmacy recommending AIMS assessments for Resident #81. She further explained the lack of unit nurse managers in the facility was part of the reason why AIMS assessments For Resident #81 had not been completed.

In an interview with the Administrator on 11/30/2023 at 11:33 a.m., she stated the nursing staff should be conducting AIMS assessments on Resident #81 quarterly.

2. Resident #56 was admitted to the facility on 10/29/21. Diagnoses included, in part, anxiety disorder and depression.

A MD order dated 12/27/22 revealed Lorazepam (a medication used to treat anxiety), 0.5 milligrams (mg); one tablet by mouth every eight hours as needed (PRN). There was no stop date on the medication order.

A review of the pharmacy's Medication Regimen Review notice to the MD on 1/6/23 stated the following: "Please note this resident is currently ordered Lorazepam 0.5 mg, one tablet every

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eight hours PRN ...Please consider the following: Continue PRN Lorazepam 0.5mg every eight hours prn times four months. Resident was re-evaluated by provider and the medication was determined to have continued need with benefit outweighing the risk of therapy ..." The MD agreed with the pharmacy review and signed the recommendation on 1/30/23 which extended the prn Lorazepam for four months.

The July 2023, August 2023, September 2023, October 2023 and November 2023 Medication Administration Records were reviewed and demonstrated Resident #56 received as needed dosages of the Lorazepam eleven times in July, fourteen times in August, twelve times in September, seven times in October and seven times in November.

Medication Regimen Review notices to the physician were reviewed for 7/6/23, 8/2/23 and 11/3/23. Each notice included a request for the physician to re-evaluate the ongoing need for the prn Lorazepam and to include a specific duration for the medication. The facility was unable to locate the signed physician's response to the notices.

The quarterly MDS assessment dated 10/11/23 revealed Resident #56 was cognitively intact. She received anti-anxiety medication during the lookback period.

The care plan, updated 10/11/23, included an area of focus for side effects from anti-anxiety medication. An intervention included, "Pharmacy consultant review of medication monthly."

An interview was conducted with Resident #56 on

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11/27/23 at 12:33 PM. She was unable to recall what medication she took for anxiety.

During an interview with Medication Aide #3 on 11/29/23 at 10:48 AM, she explained Resident #56 had hoarding behaviors that included keeping empty medication cups, silverware and empty cartons from her meal trays. She said the resident's mood varied; some days she was calm and other days she was agitated. During periods of agitation staff redirected her by inviting her to group activities, encouraged visits with other residents, or offered diversional activities outside of her room. Medication Aide #3 said she gave Lorazepam to Resident #56 when her agitation escalated or if she yelled out but first tried other non-pharmacological options before she gave the prn medication.

A telephone interview was conducted with the Pharmacy Consultant on 11/29/23 at 11:41 AM. She explained each month she emailed the Medication Regimen Review notices to the Regional Nurse Consultant, DON, and Administrator. When she returned the following month, she looked in the electronic health record for the signed review. The Pharmacy Consultant stated sometimes the facility emailed the notices back to her but not all the time. She added the facility reviewed every prn psychotropic medication during each of the facility's Quality Assurance Performance Improvement (QAPI) meetings which was attended by the Medical Director. She recalled during the QAPI meetings they discussed the prn Lorazepam for Resident #56 and the Medical Director indicated he wanted to continue it for her.

The Medical Director was interviewed by

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telephone on11/29/23 at 2:39 PM. He stated he prescribed prn Lorazepam to Resident #56 for agitation. He said typically he ordered a stop date of two weeks to one month for prn medications. When asked why there had not been a stop date since the Medication Regimen Review of January 2023 that extended the medication for four months, he replied it could have been an oversight or "we didn't get the recommendation from the pharmacy."

In an interview with the DON on 11/29/23 at 3:26 PM, she shared typically she received a copy of the Medication Regimen Review from the pharmacy each month. Once she received the reviews, she separated and distributed them to the appropriate physician. She said when the physician reviewed the information and made a decision it was returned to her, and she implemented the changes/orders. She then gave the Medication Regimen Review notice to the medical records office to be scanned into the resident's chart. The DON said she was unable to locate emails from the pharmacist about the prn Lorazepam for the months of July, August and November 2023.

An interview was conducted on 11/29/23 at 11:03 AM with the Regional Nurse Consultant. She reported when the Pharmacy Consultant finished her monthly medication recommendations, she emailed them to Medical Records and the DON. The DON or Medical Records employee then separated them by physician and gave them to the physicians weekly when they were at the facility. The physicians then reviewed the recommendation, signed it, then returned it to the DON who implemented the physician's order. The signed recommendation was given back to

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F 758	Continued From page 50 Medical Records to be scanned into both the electronic health record and to the pharmacy. The Regional Nurse Consultant stated the pharmacy recommendation book was kept in the DON's office but had not been updated since January 2023 and the facility was unable to locate the completed Medication Regimen Review notices for Resident #56 since that time.	F 758		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced	F 803		12/28/23

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by:
Based on a lunch meal tray line observation, staff interviews and record review the facility failed to provide portions of food per the menu. This had the potential to affect 55 residents with diet orders for regular and mechanical soft texture diets on the 400 and 500 halls.

The findings included:

Review of the diet order report for the 400 and 500 halls revealed that 55 residents received regular or mechanical soft textures, and 2 residents received tube feeding.

Review of the Daily Spreadsheet Menus recorded the 6-ounce ladle was to be used for service.

A continuous observation of the lunch meal tray line on 11/28/23 from 12:03 - 12:23 PM revealed chicken jambalaya was available to serve. Cook #1 was observed to serve chicken jambalaya with a 4-ounce ladle and was only served 1 scoop of jambalaya to each plate/bowl.

This surveyor notified the Certified Dietary Manager (CDM) of the serving error. For the residents on the 400 and 500 halls that had received a 4-ounce portion did not receive any more of the chicken jambalaya.

An interview was conducted with the CDM on 11/28/23 at 12:23 PM. He revealed that a 6-ounce ladle should have been used for the main entrée (chicken jambalaya). The CDM stated that the residents on the 400 and 500 halls who received chicken jambalaya with the 4-ounce ladle received an insufficient portion size. He further stated that he did not have any 6-ounce ladles in

F803 Menus Meet Resident Nds/Prep in Advan/Followed
How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The 55 residents who had received the smaller portions were offered a sandwich to compensate for the small portion served.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected by this practice, therefore portions were checked by the dietary manager to ensure that the residents not affected by the deficient practice received the right portion size. Residents were given a scoop and a half of the 4-ounce portion until the 6-ounce scoops arrived.

What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

The Dietary manager was educated by the Administrator on serving the correct portion size. The Dietary manager ordered 6-ounce scoops for serving on 11/28/2023 and they were delivered on 11/30/2023.

How the facility will monitor its performance to ensure the deficient practice does not recur.

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F 803	Continued From page 52 house and would order them as soon as possible. The CDM then instructed Cook #1 to use 1.5 portions of the 4-ounce ladle for the chicken jambalaya main entrée for the remainder of the tray line. During an interview with Cook #1 on 11/29/23 at 9:02 AM, she revealed that she referenced the diet spreadsheet for the appropriate portion sizes for each dish of each meal. She then chose the serving utensils based on those portion sizes. Cook #1 stated she chose the utensils for lunch meal tray line on 11/28/23 and overlooked the 6-ounce portion size for the chicken jambalaya. She was aware that there were not any 6-ounce ladles available in the kitchen. Cook #1 indicated she had received training/education regarding portion sizes from the diet spreadsheet last month. The Registered Dietitian (RD) was interviewed on 11/29/23 at 9:10 AM. She revealed the diet spreadsheet contained the portion sizes to serve at each meal. She was not aware of insufficient portion sizes at the facility, which could cause weight loss due to inadequate calories. Inadequate minerals and vitamins were also a concern. The CDM should have told kitchen staff to use any 2 utensils that equaled a 6-ounce portion. The RD indicated that the CDM should have ordered the proper serving utensils that coincided with the diet spreadsheet. During a follow-up interview with the RD on 11/29/23 at 11:31 AM, she revealed that she spoke to the CDM, and he ordered the 6-ounce ladles to serve proper portion sizes. She confirmed that the chicken jambalaya required a 6-ounce portion for the lunch meal served on	F 803	The dietary manager will monitor the portion sizes on the serving line two times a day, for 4 weeks, then 1 time daily for 4 weeks then monthly for 1 month. All negative findings will be brought to the QAPI meeting monthly until compliance is achieved	

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F 803	Continued From page 53 11/28/23. An interview was conducted with the Administrator on 11/29/23 at 11:48 AM. She revealed that the kitchen staff were expected to provide portion sizes that matched the diet spreadsheet. The utensils used should equal the proper portion size, whether it was 1 utensil or a combination of 2. The Administrator indicated that the kitchen staff should have used the proper portion size of 6-ounces for the chicken jambalaya at lunch meal on 11/28/23.	F 803		
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: §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	F 867		12/28/23

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F 867	Continued From page 54 indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or 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.	F 867		

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F 867	Continued From page 55 §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §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	F 867		

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F 867	Continued From page 56 (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, Medical Director, and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint surveys of 4/1/21 and 8/11/22 and the complaint survey of 1/18/23. This was for 3 deficiencies in the areas of Resident Rights/Exercise of Rights (F550), Registered Nurse 8 hours /7 days/Week/Full Time Director of Nursing (F727), and Menus Meet Resident Needs/Prepared in Advance/Followed (F803). The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: The tag is cross-referenced to: F550: Based on observations, record review, and staff interviews the facility failed to treat a resident in a dignified manner when staff used a racial slur and vulgar hand gesture when interacting with a resident (Resident #97) for 1 of 1 resident reviewed for dignity.	F 867	F867 QAPI/QAA Improvement Activities How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The administrator reviewed current prior citations of F-550, F-727, and F-803 on 12/13/23. How the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident had the potential to be affected by this alleged deficient practice. The facility Administrator has completed a 3-year review, as of 12/19/23, of the facilities surveys and identified areas of repeat non-compliance. The areas identified as repeat non-compliance will be reviewed by the Administrator and the Quality Assurance Performance Improvement (QAPI) committee and Action Plans developed to ensure continued compliance.	

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F 867	Continued From page 57 During the recertification and complaint survey of 4/1/21 the facility was cited for failing to provide a resident with pants resulting in the resident being embarrassed and feeling bad. During the recertification and complaint survey of 8/11/22 the facility was cited for failing treat residents in a dignified manner when staff entered a resident's room without knocking or asking permission to enter. During the complaint survey of 1/18/23 the facility was cited for failing to treat a resident with dignity by not providing incontinence care when needed. F727: Based on staff interviews and record review, the facility failed to prevent the Director of Nursing (DON) from serving as a charge nurse with a facility census greater than 60 residents for 1 out of 33 days (11/24/23) reviewed for staffing. During the recertification and complaint survey of 8/11/22 the facility was cited for failing to schedule a Registered Nurse (RN) for at least 8 consecutive hours per day for 20 of 158 days reviewed. F803: Based on a lunch meal tray line observation, staff interviews and record review the facility failed to provide portions of food per the menu. This had the potential to affect 55 residents with diet orders for regular and mechanical soft texture diets on the 400 and 500 halls. During the recertification and complaint survey of 8/11/22 the facility was cited for failing to serve the menu as planned. An interview with the Administrator was	F 867	What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. At the time of an identified area of non-compliance brought up during the facility monthly QAPI meeting, the facility administrator will ensure that a QAPI Action plan is implemented, to include changes to current facility systems to ensure that deficient practice will not recur and monitoring to ensure continued compliance. Regional Director of Operations (RDO) has re-educated Administrator and Director of Nursing on the QAPI process. The facility administrator completed training, as of 12/19/23 with the QAPI committee, which includes Social Services, Dietary Manager, Housekeeping/laundry manager, maintenance director, business office manager, therapy manager, staff development coordinator , medical records, admissions, activities director and medical director, to include implementation of action plans, monitoring tools, the evaluation of the QA process, and modification and if correction is needed to prevent the recurrence of deficient practice. The in-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. This education was completed as of 12/19/23.	

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F 867	Continued From page 58 conducted on 11/30/23 at 9:37 AM. She reported the facility attempted to correct any on-going issues that were identified. The Administrator further stated the facility had some turnover in administrative staff which may have contributed to the repeat citations. The Administrator reported that the facility's Quality Assessment and Assurance committee met monthly and they looked at trends to identify issues. She further stated employees were encouraged to discuss issues of concern.	F 867	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The administrator will complete a summary of monitoring results monthly for three months to include honoring resident choices, maintaining 8 hours of consecutive RN coverage 7 days per week, and ensuring menus meet resident needs/prepared in advance/followed. RDO (Regional Director of Operations) will review QAPI notes monthly for 3 months, then quarterly to ensure continued compliance of previous identified areas of non-compliance to ensure there is an effective plan of correction in place and continuous monitoring is being reviewed.	