STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING ______ B. WING ______	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT HILLS CENTER FOR NURSING AND REHAB	**109 S HOLDEN RD GREENSBORO, NC 27407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 11/26/2023 through 12/04/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #OXY711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey were conducted from 11/20/23 through 12/01/23. The survey team returned to the facility on 12/4/23 to validate the credible allegation of IJ removal. Therefore the exit date was changed to 12/4/23. The following intakes were investigated NC00198014, NC00198524, NC00200129, NC00200561, NC00200629, NC00201377, NC00201704, NC00202011, NC00202691, NC00202858, NC00202874, NC00204111, NC00204188, NC00204223, NC00205557, NC00206077, NC00206323, NC00207612, NC00208067, NC00208291, NC00208309, NC00208737, NC00208962, NC00209426, NC00209769, NC00210136, NC00210296. Intake NC00201704 resulted in immediate jeopardy. 38 of the 88 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F697 at a scope and severity (J) The tag F697 constituted Substandard Quality of Care.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/28/2023

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

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F 000	Continued From page 1 Immediate Jeopardy began on 11/20/23 and was removed on 12/1/23. An extended survey was conducted on 12/01/23.	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, 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.	F 550		1/1/24

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews the facility failed to maintain a resident's dignity by not providing toileting assistance to a resident continent of bowel and bladder (Resident #518). Resident was instructed to use the bathroom in an incontinent brief and she indicated this did not "feel-good" wearing briefs and did not like it because she was able to tell when she needed to be toileted . This occurred for 1 of 13 residents reviewed for dignity. Findings included. Resident #518 was admitted to the facility on 11/7/23. An admission Minimum Data Set (MDS) assessment dated 11/24/23 revealed Resident #518 was cognitively intact with no behaviors or rejection of care and frequently incontinent to both bowel and bladder. On 11/29/23 at 5:13am, an observation of incontinence care was made with Resident #518 and NA #3. Resident #518 was noted to be wearing a brief that was soaking wet. After providing incontinence care, NA #3 was observed reapplying a new brief on Resident #518.	F 550	Resident #518, was interviewed for use of brief on 11/30/23 by the Unit Manager. Resident preference is to use a brief and not get up to bathroom or use a bedpan. All inhouse residents were assessed by the Director of Nursing, Unit Managers, and Staff Development Coordinator for continence, inability to walk to the bathroom and offering of bedpan or bedside commode. Any resident who was continent, and unable to walk to the bathroom was offered a bedpan or bedside commode on 12/20/23 by Unit Managers. The Director of Nursing and staff development coordinator initiated an in-service to all licensed nurses, and certified nursing assistants that residents who are continent and unable to walk to the bathrooms have the right to be offered the use a bed pan or bedside commode for toileting needs, not placed in a brief unless this was the resident preference. Any licensed nurse or certified nursing assistant who do not complete the education by January 1, 2024, will not be allowed to work until the in-service has been completed. The education was added to the new hire orientation by the Director of Nursing on 12/20/23.	

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F 550	Continued From page 3 An interview was conducted with NA #3 on 11/29/23 at 5:40am. NA #3 indicated she applied the brief on Resident #518 after the start of the night shift (11:00pm). NA #3 indicated she applied the brief on Resident #518 because resident had been wearing a brief since admission and NA #3 assumed Resident #518 was incontinent. Resident #518 was interviewed on 11/29/23 at 5:49am. Resident #518 indicated she was continent of both bowel and bladder but was asked by staff to wear a brief since admission (11/17/23) because she could not walk to the bathroom. Resident #518 indicated she used her call light to ask for toileting assistance, but staff would not respond, and she would go on herself. Resident #518 indicated she did not "feel-good" wearing briefs and did not like it because she was able to tell when she needed to be toileted. Resident #518 indicated the facility did not offer her a bed pan to use while in bed and just placed her in briefs. Resident #518 indicated she had used a bed pan and bedside commode while at an acute care hospital prior to being admitted to facility. On 11/29/23 at 3:34pm, an interview was conducted with Nurse #1. Nurse #1 indicated Resident #518 was continent to both bowel and bladder but not able to transfer safely or walk to bathroom. Nurse #1 further indicated Resident #518 required the nurse aide to offer a bed pan for toileting. An observation was made on 11/30/23 at 10:07am while NA #5 provided incontinence care to Resident #518. NA #5 indicated she had never offered a bed pan to Resident #518 because the resident was wearing a brief since admission (11/17/23), and she assumed Resident #518 was	F 550	The Director of Nursing or designee will audit 10 continent residents weekly x 4 weeks, 5 continent residents x 4 weeks then 1 continent resident x 4 weeks for use or offering of bedpan or bedside commode, and not use of brief if not a resident preference. The Director of Nursing will be responsible for bringing the offering of bedpan or bedside commode to continent residents who could not walk to the bathroom to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring Date of COmpliance 1-4-2024	

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F 550	Continued From page 4 incontinent. On 11/30/23 at 10:54am, an interview was conducted with certified occupational therapist assistant (COTA). The COTA indicated Resident #518 was not able to use the bathroom commode or bedside commode for toileting because she was not safe with transfers, but she was able to use a bed pan while in bed. An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated if a resident was admitted and continent of both bowel and bladder but were not able to walk to the bathroom, she would expect staff to offer the resident a bedpan for toileting. On 12/1/23 at 11:30am an interview was conducted with the Administrator. The Administrator indicated if a resident was admitted as being continent of both bowel and bladder and could not safely transfer, she would expect staff to maintain the resident's dignity by offering the resident a bed pan while in bed for toileting.	F 550		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other	F 561		1/1/24

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F 561	Continued From page 5 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to honor resident requests for two showers per week for 1 of 2 sampled residents reviewed for self-determination (Resident #101) Findings included: Resident #101 was admitted to the facility on 4/28/23. A Quarterly Minimum Data Set (MDS) assessment dated 10/9/2023 revealed Resident #101 was cognitively intact, with no behaviors or rejection of care and required moderate assistance with showers. The facility's shower schedule revealed Resident #101 was scheduled for a shower on Monday and Thursday on the evening shift (3:00pm to 11:00pm).	F 561	Resident #101 received a shower on 12/14/23 by Certified Nursing Assistant on 1st floor. All current in-house residents were audited for shower or bed bath preferences. Residents who are alert and oriented, or able to make his/her needs known were interviewed by Director of Nursing, Staff Development Coordinator and Unit Managers on 12/22/23 for preference of shower versus bed bath. Any resident who is unable to make wants known, the responsible party was contacted by Unit Managers on 12/22/23 for preference for shower or bed bath. Any resident who was not receiving per the preference, was offered a bed bath or shower by the Unit Managers and/or certified nursing assistant. The Unit Managers updated the shower/bath schedule to show resident preference of	

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F 561

Continued From page 6

Resident #101's medical record did not reveal any refusal of showers that were documented in the progress notes.
The facility shower documentation from 10/01/23 through 11/30/23 revealed that Resident #101 had one shower documented on 10/02/23,10.08.23,10.12.23,10/14/23,10/16/23,10/20/23,11/01/23,11/02/23,11/07/23, and 11/30/23. The documentation revealed that Resident #101 was provided a bed bath instead of shower on the scheduled show dates of: 10/05/23,10/09/23,10/23/23,11/09/23,11/16/23,11/27/23. The documentation revealed that Resident #101 was not provided with a bath or shower on the following scheduled shower dates :10/19/23,10/26/23,10/30/23,11/06/23,11/13/23 and 11/20/23.

An interview with Resident #101 was conducted on 11/27/23 at 10:13am. Resident #101 indicated she had not received a shower on her scheduled shower days and when she had asked staff, they would acknowledge that they were aware of her shower but would not return to the room.

An interview was conducted on 12/01/23 at 9:53am with Resident #101. Resident #101 indicated she did not receive her shower on 11/30/23. Resident #101 indicated that she spoke to NA #3 who acknowledged she would give Resident #101 a shower but did not return to her room. Resident #101 indicated she used her call bell to ask for someone to give her a shower, and the NA (unknown) informed her that NA #3 had left. Resident #101 indicated to the NA (unknown) that she really wanted to take a shower, and the nurse aide did not offer her a shower.

F 561

shower or bed bath on 12/26/23.
The Director of Nursing initiated an in-service on 12/22/23 for providing residents a shower or bed bath on scheduled shower/bath days as preferred and documenting any refusals or change in delivery of shower or bed bath. The in-service included using a shower sheet to document the shower or bed bath to all licensed nurses and certified nursing assistants. Any licensed nurse or certified nursing assistant who did not receive this in-service by 12/27/23 will not be allowed to work until the in-service is completed.
The Director of nursing or designee will audit 10 resident weekly x 4 weeks, then 5 residents weekly x 4 weeks then 1 resident weekly x 4 weeks for completion of shower or bed bath as per resident preference on scheduled shower/bath days.
The Director of Nursing will be responsible for bringing the shower/bed bath audits to the Quality Assurance Performance Improvement Committee x 3 consecutive months. The Quality Assurance Committee will be responsible for determining the need for further monitoring.
Date of Compliance: 1/1/2024

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F 561	Continued From page 7 Review of Resident's #101's medical records revealed that NA #3 documented giving Resident #101 a shower on 11/30/23. Interview with NA #3 was conducted on 12/01/23 at 10:01am and she indicated she did not recall giving Resident #101 a shower on 11/30/23. An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated if a resident refused a shower, the nurse aide had to get three refusals, and then notify the nurse, and if the resident refused the shower again, then she would require for the nurse and nurse aide to document the refusal in the medical record. The DON also indicated if a resident asked for a shower and it was not on their normal scheduled day, she would require the nurse aide to accommodate the residents, but she could not keep any promises. On 12/1/23 at 11:30am an interview was conducted with the Administrator. The Administrator indicated that she required nursing staff to document care that had been provided. The administrator further indicated that she required nurse aides to provide showers to residents on their scheduled shower days.	F 561		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult	F 575		1/1/24

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F 575	Continued From page 8 protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to post the required posting of a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups, or a statement the resident may file a complaint with the State Survey Agency. Findings included: During a resident council meeting on 11/28/23 at 1:30 PM, the 8 resident council members that attended the meeting revealed they were not aware of how to file a complaint with the State Survey Agency and did not know how to access information regarding pertinent state agencies and advocacy groups. A tour of the facility, with the Administrator, on 12/1/23 at 10:25 AM, revealed that there was no information posted in the facility with information	F 575	On 12/2/23, How to file a complaint with the State Survey Agency posting was posted by the Administrator. All required postings pertinent to State agencies and advocacy groups were audited by the Administrator on 12/2/23. Any required posting pertinent to State agencies and advocacy groups not posted will be posted by 12/2/23. The Administrator was educated on 12/1/23 by Administrator Mentor of the expectation for the postings pertinent to State agencies and advocacy groups. The Administrator or designee will complete weekly audits x 4 weeks, then bi weekly audits x 4 weeks then monthly audits x 1 month for required postings to State agencies and advocacy groups. The Administrator will be responsible for bringing the audits to the Quality Assurance Performance Improvement	

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F 575	Continued From page 9 regarding pertinent State agency and advocacy group information or how to file a complaint with the State Survey Agency. An interview with the Administrator on 12/1/23 at 10:50 AM revealed the signage must have been removed at some point and not replaced.	F 575	Committee x 3 consecutive months. The Quality Assurance Committee will be responsible for determining the need for further monitoring. Date of Compliance:1/1/2024	
F 578 SS=D	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		1/1/24

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F 578	Continued From page 10 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 observations, record review, staff and resident interviews the facility failed to ensure advanced directive information was correct throughout the medical record for 1 of 2 residents (Resident #71) reviewed for advanced directives. Findings included: Resident #71 was admitted to the facility on 10/06/2021. Resident #71's electronic medical record revealed an active physician's order dated 10/07/2021 that read Full Code. A review of the Social Service Progress Note dated 03/17/2023 revealed a care plan meeting was held with Resident #71 and the Interdisciplinary Care Team. Resident #71's code status was changed to Do Not Resuscitate (DNR) per her request. A review of the code status chart for the 200-hall revealed Resident #71 had a signed Medical Orders for Scope of Treatment (MOST) form dated 03/17/2023 signed by the resident and the	F 578	Resident #71 code status was removed from the electronic health record (EHR)banner. The current code status preference was entered into the EHR, correct Medical Orders for Scope of Treatment and care plan updated for the code status preference on 12/20/23 by the Social Service Director. All current in-house residents EHR was audited for code status preference in the EHR, the MOST form and careplan on 12/26/23 by the Director of Social Services, Director of Nursing and Director of Medical Records. Any resident who did not have the preferences matching in the EHR, MOST form and/or care plan, this was corrected by 12/31/23 by the Director of Nursing, Unit Managers, Director of Social Services, Regional Reimbursement Nurse and Staff Development Coordinator. The Director of Social Services, Director of Nursing, Unit Managers and Staff Development Coordinator were in-serviced by Administrator on 12/19/23, that the MOST form, EHR and careplan	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 11 Nurse Practitioner that read DNR. Resident #71's quarterly Minimum Data Set (MDS) dated 09/05/2023 revealed Resident #71 was cognitively intact. Resident #71's care plan dated 09/12/2023 indicated resident's code status to be Full Code. An interview was conducted on 11/28/2023 at 2:41 P.M. with Resident #71. Resident #71 indicated she was presented a form upon admission to the facility concerning her code preference and checked a box next to DNR. Resident #71 stated she desired for her code status to be DNR. An interview was conducted on 11/28/2023 at 3:00 P.M. with Medication Aide #1. Medication Aide #1 stated to determine a resident's code status he looked at the Electronic Health Record (EHR). Medication Aide #1 pulled up Resident #71 in the EHR, pointed to the computer screen and stated Resident #71 was a Full Code. Medication Aide #1 further stated if a resident's code status was not indicated in the EHR he would look at the code status book located on the unit. An interview was conducted with the Director of Nursing (DON) on 11/29/2023 at 10:14 A.M. The DON stated when a resident was admitted to the facility their code status was determined by the hospital discharge summary and verified by the resident or responsible party. The DON stated when the resident's code status was verified an order was obtained from the physician, a MOST form would be completed and the EHR and care plan would be updated accordingly. The DON	F 578	must be completed and accurate to the resident code status preference. The Director of Social Services or designee will audit 10 MOST forms, EHR and care plan for code status preference weekly x 4 weeks, then 5 residents biweekly x 4 weeks, then 1 resident x 1 month. The Director of Social Services or designee will be responsible for bringing code status and MOST form accuracy audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	

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	345116	A. BUILDING ______ B. WING ______	C 12/04/2023

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F 578	Continued From page 12 stated the completed MOST forms were in a binder located at the nurse's station. The DON further stated that the Social Worker would review code status with the resident and responsible party quarterly and the unit nurse managers would audit advanced directives monthly to ensure the resident's code status matched throughout their medical record.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		1/1/24

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F 580	Continued From page 13 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews, and the Medical Director interview, the facility staff failed to notify medical provider of resident's complaint of right shoulder pain, and genitalia area for 1 of 1 resident reviewed. (Resident #518). Findings included: Resident #518 was admitted to the facility on 11/17/23 with diagnosis that included chronic pain syndrome, disorder of thyroid, adult failure to thrive, bipolar disorder, constipation, anorexia, hypothyroidism, chronic pain syndrome, and spondylosis. An admission Minimum Data Set (MDS)	F 580	The medical provider was made aware of resident #518 report of pain on 11/30/23 by Unit Manager. Resident was provided pain medication on 11/30/23 by Unit Manager. All current in-house residents were assessed for verbal and non-verbal pain by the Director of Nursing (DON) and Regional Nurse on 11/30/23. Any resident who had verbal or nonverbal pain, the medical provider was notified on 11/30/23 by DON. The Director of Nursing initiated an in-service on 11/30/23 and 12/1/23 for notification to the medical provider for complaints of pain, whether verbal or nonverbal, and documentation in the	

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F 580 Continued From page 14

assessment dated 11/24/23 revealed Resident #518 was cognitively intact.
Record review of Resident #518 Nurse Practitioner (NP) progress note dated 11/20/23 indicated Resident #518 was not sleeping well due to pain.

Review of Medical Director's progress note for Resident #518 dated 11/22/23 indicated that "resident has pain and numbness in bilateral arms and legs."

Review of physical therapy treatment encounter note for Resident #518 dated 11/22/23 indicated that "resident reported pain all over body and limiting resident's ability to scoot."

Review of occupational therapy treatment encounter notes for Resident #518 dated 11/22/23 indicated that "resident reporting ongoing pain and discomfort "all over."

A review of Resident #518 admission MDS assessment with an ARD of 11/24/23 indicated Resident #518 did not have pain and did not have trouble sleeping.

Review of Resident #518's physician orders from 11/17/23 to 11/29/23 revealed no pain medication was ordered or any non-medication pain alternatives were ordered.

Review of Resident #518 Medication Administration Record (MAR) revealed no pain medication ordered since admission to the facility on 11/17/2023.

Resident #518 was interviewed on 11/29/23 at 5:49am. Resident #518 indicated she notified a

F 580

resident chart, to include the necessity to stop care (including peri care) or activity until pain is manageable for the resident. The in-service included use of pain scales for verbal and nonverbal pain, providing non pharmacological and pharmacological interventions. This in-service was provided to all staff to include agency.
The Director of Nursing or designee will audit resident pain scales and nursing notes for notification to the medical provider for complaints of pain, verbal or nonverbal. This audit will be conducted on 10 residents charts weekly x 4 weeks, then 5 resident charts weekly x 4 weeks then 1 resident chart x 1 month.
The Director of Nursing will be responsible for bringing the notification of pain to the medical provider audit to the Quality Assurance Performance Improvement Committee x 3 consecutive months. The Quality Assurance Committee will be responsible for determining the need for further monitoring.
Date of Compliance: 1/1/2024

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F 580		F 580		

Continued From page 15
nurse (Unknown) a couple of days prior, about her perineal area pain and irritation, and her shoulder pain. Resident #518 indicated that the Nurse (unknown) came back to her room and applied A and D ointment (skin protectant) to her genitalia area and did not offer anything to relieve her shoulder pain.

An interview was conducted with NA #5 on 11/29/23 at 3:12pm. NA #5 indicated that she worked with Resident #518 on 11/27/23 during the day shift (7:00am to 3:00pm shift). NA #5 indicated that Resident #518 did complain of shoulder pain during care on 11/27/23, and she notified Nurse #3 and Medication Aide (MA) #2.

On 11/29/23 at 3:19pm, an interview was conducted with Nurse #3. Nurse #3 indicated that the outgoing (11:00pm to 7:00am) nurse, Nurse #2 reported to her during shift report on 11/29/23, that Resident #518 was assessed to have right shoulder pain. Nurse #3 further indicated that after surveyor intervention, she notified the Nurse Practitioner (NP) who was in the facility. Nurse #3 indicated the NP did not initiate anything for Resident #518's pain.

An in-person interview was conducted on 11/30/23 at 4:04pm with the Medical Director (MD). The MD indicated that he was unaware Resident #518 was having pain in her Right shoulder and perineal area. The MD indicated that he would expect nursing staff to notify the medical provider if a resident complained of new onset of pain, unaddressed pain, or lack of relief from pain medication.

An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON

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F 580	Continued From page 16 indicated if a resident complained of pain, she would require nursing staff to report the pain to the medical provider.	F 580		
F 582 SS=D	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 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	F 582		1/1/24

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F 582	Continued From page 17 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: Based on staff interviews and record review, the facility failed to issue a Centers for Medicare and Medicaid Services (CMS), CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) at least two days before the end of Medicare part A services to two of three residents (Residents #48 and 105) reviewed for SNF Beneficiary Protection Notification Review. Findings included: 1a. Resident #48 was admitted to the facility under part A Medicare services on 9/21/23. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was discussed by telephone with Resident #48's responsible party on 11/21/23. The notice indicated that Medicare coverage for	F 582	Unable to correct deficient practice in regard to residents #48, #105. Resident #105 was notified on 10/3/23 by the Regional Reimbursement Consultant, and resident #48 was notified on 11/21/23 by the Business Office Manager of the incorrect issuing of NOMNC. Any resident currently in house that required a NOMNC or ABN in the last 14 days were reviewed by the Business Office Manager on 12/19/23. Any resident who should have received this notice and did not, was corrected on 12/20/23 by the Business Office Manager The Business Officer Manager and Administrator were in-serviced on issuing the NOMNC or ABN as required. This in-service was conducted on 12/20/23 by the Administrator. The business office	

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F 582	Continued From page 18 skilled services was to end 10/27/23 and the resident would remain in the facility. A review of the medical record revealed a CMS-10055 SNF ABN (ABN) was not provided to the resident or responsible party until 11/21/23. 2b. Resident #105 was admitted to the facility under part A Medicare services on 8/1/23. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was signed by Resident #105 on 10/3/23. The notice indicated that Medicare coverage for skilled services was to end 8/24/23 and the resident would remain in the facility. A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident or responsible party. An interview was conducted with the Billing Office Manager on 11/30/23 at 3:15 PM and she revealed that Residents # 48 and #105 did not receive the NOMNC and ABN forms as required but that she and the Administrator were working on addressing this issue. An interview was conducted with the Administrator on 11/30/23 at 3:19 PM revealed the residents who got discharged from Medicare Part A services but remained at the facility should be issued both notices 48 hours prior to the coverage end date and she just talked to the Business Office Manager about this issue.	F 582	manager will be primarily responsible for delivery of the NOMNC or ABN with the Administrator, Social Worker, or concierge as a back up for delivery. The Administrator or designee will audit up to 3 resident charts weekly for NOMNC or ABN notice, and delivery requirements x 12 weeks. The Administrator will be responsible for bringing the NOMNC/ABN notice audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		1/1/24

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F 584	Continued From page 19 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable	F 584		

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F 584	Continued From page 20 sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with resident and staff, the facility failed to maintain a dresser drawer in good repair for 1 of 2 residents reviewed for a safe comfortable, homelike environment (Resident #98). The findings included: Resident #98 was admitted to the facility on 7/19/23. Review of the quarterly Minimum Data Set on 10/26/23 revealed Resident #98 was cognitively impaired and required extensive assistance with dressing. During an observation and interview on 11/27/23 at 12:45 PM, Resident #98 was seen sitting on her wheelchair beside a dresser which did not have the front face of the first two drawers and had visible exposed broken wood with rough edges. Resident #98 indicated the dresser had been broken for a long time and she was not able to use it for her belongings. During a follow up observation of Resident #98's room on 11/29/23 at 7:46 AM the dresser drawer was observed to be in the same condition of disrepair. During an interview on 11/29/23 at 7:52 AM, Nurse Aide (NA) #8 stated she started working in July 2023 and the dresser in Resident #98's room had been broken since she started working the assignment. She further revealed the Maintenance Director had been made aware	F 584	Resident #98 dresser was replaced on 11/29/23 by Maintenance Director. All facility rooms were audited by the Director of Plant Ops on 12/21/23 for broken dressers. Any dresser found to be broken was replaced by Maintenance Director 12/21/23. All department managers (Business office manager, concierge, dietary manager, housekeeping manager, medical records, maintenance, Director of Nursing, Unit managers, Staff development coordinator, Human resources, activities, Social work, Therapy Director, central supply, scheduler) and all floor staff to include licensed nurses, certified nursing assistants, housekeepers, laundry, dietary aides, cooks, activities assistant, maintenance assistant were in-serviced on reporting broken dressers to maintenance and/or Administrator on 12/19/23. The Administrator or designee will audit 10 resident dressers weekly x 4 weeks, then 5 resident dressers biweekly x 4 weeks then 1 resident dresser x 1 month. The Maintenance Director will be responsible for bringing the broken dresser audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	

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F 584	Continued From page 21 verbally but could not recall when the notification occurred. During an interview on 11/29/23 at 4:00 PM, the Maintenance Director indicated he was not aware of the broken dresser in Resident #98's room and broken items are usually found during rounds, but he has had problems with his current assistant and was unable to provide paperwork for documentation of the rounds. During an interview on 11/30/23 at 12:03 PM, the Administrator indicated that she had completed a full check on the building for any repair needs and made the Maintenance Director aware of any broken items in need of repair. She did not recall if the dresser was on her list and was unable to provide a list of identified items in need of repair or pending repairs. She further revealed she was not sure why this furniture had not been replaced but all residents should have access to working furniture in good repair.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the	F 585		1/1/24

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F 585	Continued From page 22 facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING ______ B. WING ______	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT HILLS CENTER FOR NURSING AND REHAB	**109 S HOLDEN RD GREENSBORO, NC 27407**

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F 585	Continued From page 23 example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585		

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F 585

Continued From page 24

This REQUIREMENT is not met as evidenced by:

Based on record review, resident, and staff interviews the facility failed to investigate and resolve grievances for Residents #12, #419, #267 and maintain evidence demonstrating the result of the grievances for Residents #80, #29, #68. This was for 6 of 17 residents reviewed for grievances.

The findings included:

An interview was conducted on 11/30/23 12:30 PM with Social Worker #1. She revealed that when she was made aware of a grievance, she would initiate the grievance form and give it to the appropriate department head to investigate. She further revealed that she had pending grievances that had not been investigated for Residents #12, #419 and #267. The Social Worker indicated that the lack of follow-up on these grievances was due to frequent turnover in the social work department.

1a.Resident #12 was admitted on 9/22/22.

A review of Resident #12's grievance dated 1/31/23 was conducted and revealed no documented investigation or follow up noted on the grievance form.

An interview was conducted with Resident #12 on 12/1/2023 at 1:45 PM and she revealed she had shared a grievance regarding dietary and not getting her trays concern a long time ago and never received a response.

b. Resident # 419 was admitted on 10/26/23.

F 585

Resident #12, #419, #267 were interviewed by the Social Services Director on 12/14/23. New grievances were written by the Social Services Director on 12/14/23, however there were none to report. The Administrator investigated the grievance and reported results to the resident on 12/15/23. The Administrator spoke with residents #80, #29, and #68 to follow up on previous grievance for follow up. Documentation of follow up was completed. Residents did not want a copy of the resolution.
Grievances filed over the last 30 days were reviewed by the Administrator on 12/12/23 & 12/26/23 for complete investigation and documentation of the result of the grievance. Any grievance not investigated or documentation of result, this was completed by Administrator and Social Worker on 12/15/23.
The Administrator was in-serviced by Administrator Mentor on 12/20/23 for the grievance process to include investigation and documentation of result of grievance.
The Administrator in-serviced the Director of Social Services, Director of Nursing, Dietary Manager, Housekeeping Manager, Unit Managers, Staff Development Coordinator, Business office Manager, medical records manager, and concierge on investigating grievances and documentation of the result of the grievance on 12/21/23.
The Administrator will audit all grievances x 12 weeks for investigation and documentation of results.

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F 585	Continued From page 25 A review of Resident #419's grievance dated 11/6/23 was conducted and revealed no documented investigation or follow up noted on the grievance form. An interview was conducted with Resident #419 on 12/1/23 at 1:58 PM. She revealed that she recalled voicing a grievance regarding nursing staff leaving her wet, but she did not receive any follow up to her grievance. c. Resident # 267 was admitted on 10/18/23. A review of Resident #267's grievance dated 10/28/23 was conducted and revealed no documented investigation or follow up noted on the form. An interview was conducted with Resident #267 on12/01/23 02:20 PM and she revealed that she recalled submitted the grievance and had not had anyone follow with her on this complaint. An interview was conducted on 12/1/23 at 1:55 PM with Administrator #1. She revealed that she was not aware that there were pending grievances for Residents #12, Resident #419, and Resident # 267 and that per policy the social worker should have forwarded the grievance onto the appropriate department head and to the administrator. A review of the facility grievance log was conducted from May 2022 to November of 2023. The review revealed logged grievances for Resident #80 dated 1/23/23, a grievance for Resident # 29 dated 7/7/23 and a grievance for Resident #68 dated 8/29/23. No copies of these three grievances were provided by the facility.	F 585	The Administrator will be responsible for bringing the Grievance audit to the Quality Assurance Performance Improvement Committee x 3 consecutive months. The Quality Assurance Committee will be responsible for determining the need for further monitoring. Date of Compliance: 1/1/2024	

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F 585	Continued From page 26 An interview was conducted on 12/1/23 at 2:42 PM with Administrator # 1. She revealed that she was not sure why a copy of the grievances for Residents #80, #29, and #68 were not kept on file and that grievances should have been kept on file for three years.	F 585		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to prevent misappropriation of property when an unknown person used a resident's bank card information and made an unauthorized purchase. This occurred for 1 of 7 residents (Resident #267) reviewed for abuse. The findings included: Resident #267 was admitted to the facility on 10/18/2023. A review of the admission Minimum Data Set (MDS) dated 10/26/2023 indicated Resident #267 was cognitively intact. An interview was conducted on 11/30/2023 at	F 602	An initial investigation report for alleged misappropriation was filed by the Administrator on 11/30/23. The investigation and 5 day follow up was completed on 12/2/23 by the Administrator. All alert and oriented residents were interviewed on 12/27/23 by for reports of missing bank cards or fraudulent charges to bank card. No other residents were identified to have any concerns. The Social Worker was educated on 11-27-2023 by the Administrator that all reports of misappropriation were to be reported immediately. All staff were in-serviced on reported allegations of misappropriation to the Administrator immediately, regardless of time of day,	1/1/24

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F 602	Continued From page 27 12:30 p.m. with the Social Worker (SW) and she revealed she had started working at the facility in late October 2023. She added when she started, the residents had several concerns and grievances that needed to be addressed. The SW added she received a grievance from Resident #267 on 11/27/2023 around midday. Resident #267 had reported that someone had made a fraudulent charge to her bank card, in the amount of $192.00, and the bank reported to the Resident the charge was made at the facility location. The SW did not explain how it was known the purchase was made from the facility. The SW revealed she had not reported this to the Administrator. She stated she received education on misappropriation of property upon hire and in the case of missing property or abuse it must be reported to the Administrator as soon as possible. She added she had not reported this because the State Agency was on site, and she thought she would wait until after they were finished with the onsite visit to report to the Administrator. An interview was conducted with Resident #267 on 11/30/2023 at 3:52 p.m. and she revealed on 11/25/2023 she tried to make a purchase with her bank card and the purchase was rejected. She stated she contacted the bank, and they reported her bank card had been placed on hold due to a charge of $192.00 to pay for a telephone bill. The telephone bill was not the company used by Resident #267 in the past and the bank placed a hold on the card. She added the bank had been able to track the purchase based on the Internet Protocol (ip) address used for the purchase. The ip address matched the facility location. She stated she reported this to a nursing assistant on 11/25/2023 but could not remember her name. She then reported this to the SW on 11/27/2023	F 602	day of the week, or who was in the facility. This education was added to the new hire orientation by the Director of Nursing on 11-27-23. The Administrator or designee will conduct 5 resident interviews for report of misappropriation weekly x 4 weeks, then 2 residents weekly x 4 weeks then 1 resident x 1 month. The Administrator will be responsible for bringing the misappropriation audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance 1/1/2024	

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F 602	Continued From page 28 in the afternoon. She added no one had come to interview her regarding the missing funds until 11/30/2023 at 2:00 p.m. An interview was conducted with the Administrator on 11/30/2023 at 1:02 p.m. and she revealed she had not been made aware Resident #267 reported that someone from the facility had used her bank card and charged $192.00. She stated she would look into the situation.	F 602		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		1/1/24

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F 607	Continued From page 29 §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to implement their abuse policy for immediately notifying the Administrator of allegations when they 1) failed to notify the Administrator of an allegation of abuse (Resident #116) and 2) failed to notify the Administrator of misappropriation of resident property (Resident #267). This deficient practice occurred for 2 of 7 residents reviewed for abuse. Findings included: A review of the Review of the facility policy titled: " Abuse, Neglect and Exploitation" dated February 2023 Revision read as follows: "A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 1) Review of facility's 24-hour Initial Allegation Report to the state agency revealed that the	F 607	Nursing Assistant #12 was educated on 9-28-23 by the Administrator on reporting allegation immediately. This allegations was reported on 9-28-23 to required reporting agencies by the Administrator upon notification by NA#12. Social Worker was educated on 11-30-23 by the Administrator on immediately reporting any reports of misappropriation and not to wait. The allegation was reported by the Administrator on 11-30-23 to all required agencies. Resident #267 was interviewed by the Administrator on 11-30-23. All residents have the potential to be affected by this deficient practice. Interviews were conducted for residents by the Director of Nursing, Unit Managers, Staff Development Coordinator and Administrator on 11/30/23 for any allegations of abuse including misappropriation. No other concerns were identified. The Administrator initiated an in-service for all staff on reporting on abuse to include immediate reporting and to who to report to. This in-service was initiated on 11/30/23. Any staff who did not get the in-service by 12/30/23 will not be allowed to work until this has been completed. This in-service was added to the new hire orientation by the Director of Nursing on 11-30-23.	

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F 607	Continued From page 30 Administrator was made aware of an allegation of abuse on 9/28/23. The allegation was NA #11 grabbed Resident #116 by the wrist and squeezed during activities of daily care (ADL). Resident #116 was admitted to the facility on 7/27/23 with diagnoses that included encephalopathy and Alzheimer's disease. Resident #116 later expired at the facility on 10/12/23. An interview was attempted with the reporting staff member, NA # 12, but attempts to interview were not successful. An interview was conducted with the alleged perpetrator NA #11 on 11/29/23 at 1:02 PM. She revealed she was reported by NA # 12 1 to 2 weeks after the alleged incident, but the allegation was not substantiated. An interview was conducted with Administrator #3 on 11/29/23 at 1:27 PM. She stated that she was made aware of the allegation on 9/28/23 that an incident occurred 1 to 2 weeks earlier and she immediately initiated the investigation, and the allegation was not substantiated. During an interview with Administrator #1 on 11/30/23 1:05 PM, she indicated that all staff members need to follow the facility abuse protocols and that the Administrator and the director of nursing should be notified immediately when there is an allegation of abuse. 2) Resident #267 was admitted to the facility on 10/18/2023.	F 607	The Administrator or designee will interview 10 residents and/or staff weekly x 4 weeks for allegations or reports of abuse including misappropriation, then 5 residents and/or staff weekly x 4 weeks then 1 resident or staff monthly x 1 month. The Administrator will be responsible for bringing the reporting abuse audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance 1/1/2024	

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F 607	Continued From page 31	F 607		

A review of the admission Minimum Data Set (MDS) dated 10/26/2023 indicated Resident #267 was cognitively intact.

An interview was conducted on 11/30/2023 at 12:30 p.m. with the Social Worker (SW) revealed she received a grievance from Resident #267 on 11/27/2023 around midday. Resident #267 had reported that someone had made a fraudulent charge to her bank card, in the amount of $192.00, and the bank reported to the Resident the charge was made at the facility location. The SW revealed she had not reported this to the Administrator. She stated she received education on misappropriation of property upon hire and in the case of missing property or abuse it must be reported to the Administrator as soon as possible. She added she had not reported this because the State Agency was on site, and she thought she would wait until after they were finished with the onsite visit to report to the Administrator. The SW was encouraged to report this to the Administrator immediately and stated she was going to take a thirty-minute break and then would speak to the Administrator.

An interview was conducted with the Administrator on 11/30/2023 at 1:02 p.m. and she revealed she had not been made aware Resident #267 reported that someone from the facility had used her bank card and charged $192.00. She stated she would look into the situation.

An interview was conducted with Resident #267 on 11/30/2023 at 3:52 p.m. and she revealed on 11/25/2023 she tried to make a purchase with her bank card and the purchase was rejected. She stated she contacted the bank, and they reported

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F 607	Continued From page 32 her bank card had been placed on hold due to a charge of $192.00 to pay for a telephone bill. The telephone bill was not the company used by Resident #267 in the past and the bank placed a hold on the card. She added the bank had been able to track the purchase based on the Internet Protocol (ip) address used for the purchase. The ip address matched the facility location. She stated she reported this to a nursing assistant on 11/25/2023 but could not remember her name. She then reported this to the SW on 11/27/2023 in the afternoon. She added no one had come to interview her regarding the missing funds until 11/30/2023 at 2:00 p.m.	F 607		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636		1/1/24

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F 636	Continued From page 33 (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 636	Residents #99, 20, 79, 105, 102, 38, 68,	

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

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facility failed to complete 3 admission comprehensive Minimum Data Set (MDS) assessments within 14 days of Admission and failed to complete comprehensive Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD), [which was the last day of the assessment period] for 8 out of 9 sampled residents. (Resident #99, Resident #20, Resident #79, Resident #105, Resident #102, Resident #38, Resident #68, and Resident #106)

Findings included:

a. Resident #99 was admitted to the facility on 4/20/23.

A review of Resident #99 admission MDS assessment with an ARD of 4/27/23 was signed as completed on 7/14/23.

b. Resident #20 was admitted to the facility on 7/17/22.

A review of Resident #20 annual MDS assessment with an ARD of 7/16/23 was signed as completed on 8/14/23.

c. Resident #79 was admitted to the facility on 4/15/23.

A review of Resident #79 admission MDS assessment with an ARD of 4/21/23 was signed as completed on 7/5/23.

d. Resident #105 was admitted to the facility on 7/3/23.

A review of Resident #105 admission MDS

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and 106 Minimum Data Set (MDS) were completed late and are unable to be corrected due to Resident Assessment Instrument Manual Instructions.
On 12/26/2023, an Minimum Data Set (MDS) completion audit was conducted on comprehensive Minimum Data Set (MDS) assessments by the Regional Minimum Data Set (MDS) nurse that were flagging as late to determine immediate action for compliance. Comprehensive late assessments were completed by 12/29/2023 by Minimum Data Set (MDS) nurse.
The Regional Clinical Reimbursement Consultant educated the Minimum Data Set (MDS) nurse on Minimum Data Set (MDS) completion and submission requirements. This education was completed by 12/29/2023, no MDS nurse will be allowed to work until they have completed education.
The Regional Clinical Reimbursement Consultant will conduct weekly audits starting the week of 1/2/2024 to ensure the timeliness of Comprehensive Minimum Data Set (MDS) assessments for 4 weeks, then 2 times a month for 2 months then monthly for 1 month. If an assessment is found to be late immediate action will be taken to ensure assessment is completed within 48 hours and determine the reason it was not completed timely.
The Administrator will be responsible for bringing the Comprehensive Minimum Data Set (MDS) timeliness audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3

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F 636	Continued From page 35 assessment with an ARD of 7/21/23 was signed as completed on 7/30/23. e. Resident #102 was admitted to the facility on 5/5/23. A review of Resident #102 admission MDS assessment with an ARD of 5/11/23 was signed as completed on 7/20/23. f. Resident #38 was admitted to the facility on 4/27/23. A review of Resident #38 admission MDS assessment with an ARD of 5/3/23 was signed as completed on 7/17/23. g. Resident #68 was admitted to the facility on 9/1/21. A review of Resident #68 annual MDS assessment with an ARD of 7/13/23 was signed as completed on 8/14/23. h. Resident #106 was admitted to the facility on 7/16/23. A review of Resident #99 admission MDS assessment with an ARD of 7/23/23 was signed as completed on 8/1/23. An interview with the Regional MDS Nurse Coordinator on 11/29/23 at 2:20pm, revealed that assessments were completed late because the facility did not have an MDS Nurse coordinator. She further indicated the facility had multiple individuals completing MDS assessments remotely.	F 636	consecutive months. At this time, the QAPI committee will determine the need to continue the MDS timeliness audits Date of Compliance 1/1/24	

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F 636	Continued From page 36 An Interview with MDS #1 on 11/30/23 at 3:05pm, indicated that she worked remotely to assist the facility with completing MDS assessments. She further indicated the MDS assessments were late because the previous MDS nurse could not get caught up. An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated she required MDS assessments to be completed in a timely manner, but sometimes that was not possible because things happened, and the assessments would be late. On 12/1/23 at 11:30am an interview was conducted with the Administrator. The Administrator indicated that she would require MDS assessments to be completed in a timely manner. She further indicated that the facility did not have a full time MDS nurse coordinator but had individuals working remotely to get MDS assessments completed.	F 636		
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD), [which was the last day of the assessment period] for 8 out of 9 sampled residents. (Resident #21, Resident	F 638	Residents #21, 89, 37, 25, 86, 55, 54, 28 Quarterly Minimum Data Set (MDS)were completed late are unable to be corrected due to Resident Assessment Instrument Manual Instructions. On 12/26/2023, an Minimum Data Set	1/1/24

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F 638	Continued From page 37 #89, Resident #37, Resident #25, Resident #86, Resident #55, Resident #54, and Resident #28) Findings included: a. Resident #21 was admitted to the facility on 2/28/23. A review of Resident #21 quarterly MDS assessment with an ARD of 7/28/23 was signed as completed on 8/15/23. b. Resident #89 was admitted to the facility on 1/20/23. A review of Resident #89 quarterly MDS assessment with an ARD of 10/9/23 was signed as completed on 10/29/23. c. Resident #37 was admitted to the facility on 12/13/21. A review of Resident #37 quarterly MDS assessment with an ARD of 5/2/23 was signed as completed on 7/11/23. d. Resident #25 was admitted to the facility on 9/21/22. A review of Resident #25 quarterly MDS assessment with an ARD of 5/2/23 was signed as completed on 7/14/23. e. Resident #86 was admitted to the facility on 10/26/22. A review of Resident #86 quarterly MDS assessment with an ARD of 7/22/23 was signed as completed on 8/14/23. f. Resident #55 was admitted to the facility on 2/28/20. A review of Resident #55 quarterly MDS assessment with an ARD of 7/7/23 was signed as	F 638	(MDS) completion audit was conducted on quarterly Minimum Data Set (MDS) assessments by the Regional Minimum Data Set (MDS) nurse that were flagging as late to determine immediate action for compliance. Quarterly late assessments will be completed by 12/29/2023. The Regional Clinical Reimbursement Consultant educated the MDS nurse on MDS completion and submission requirements. This education was completed by 12/29/2023 no MDS nurse will be allowed to work until they have completed education. The Regional Clinical Reimbursement Consultant will conduct weekly audits starting the week of 1/2/2024 to ensure the timeliness of Quarterly MDS assessments for 4 weeks, then 2 times a month for 2 months then monthly for 1 month. If any assessment is found to be late immediate action will be taken to ensure assessment is completed within 48 hours and determine the reason it was not completed in a timely manner. The Administrator will be responsible for bringing the Quarterly Minimum Data Set (MDS) timeliness audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the Minimum Data Set (MDS) timeliness audits. Date of Compliance 1/1/24	

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completed on 8/14/23.

g. Resident #54 was admitted to the facility on 3/29/23.
A review of Resident #54 quarterly MDS assessment with an ARD of 7/5/23 was signed as completed on 8/14/23.

h. Resident #28 was admitted to the facility on 1/27/22.
A review of Resident #28 quarterly MDS assessment with an ARD of 7/28/23 was signed as completed on 8/15/23.

An interview with the Regional MDS Nurse Coordinator on 11/29/23 at 2:20pm, revealed that assessments were completed late because the facility did not have an MDS Nurse coordinator. She further indicated the facility had multiple individuals completing MDS assessments remotely.

An Interview with MDS #1 on 11/30/23 at 3:05pm, indicated that she worked remotely to assist facility with completing MDS assessments. She further indicated that the MDS assessments were late because the previous MDS nurse could not get caught up.

An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated she required MDS assessments to be completed in a timely manner, but sometimes that was not possible because things happened, and the assessments would be late.

On 12/1/23 at 11:30am an interview was conducted with the Administrator. The Administrator indicated that she would require

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F 638	Continued From page 39 MDS assessments to be completed in a timely manner. She further indicated the facility did not have a full time MDS nurse coordinator but had individuals working remotely to get MDS assessments completed.	F 638		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 6 of 6 residents reviewed for MDS accuracy. (Resident #99, Resident #11, Resident 102, Resident #518, Resident #80 and Resident #51). Findings included: 1a. Resident #99 was admitted to the facility on 4/20/23. Review of physician order initiated on 4/20/23 revealed Resident #99 had an order for Risperidone (antipsychotic) 1milligram(mg) tablet, give one tablet by mouth one time a day for schizophrenia. Review of physician order initiated on 7/11/23 revealed Resident #99 had an order for Sertraline HCL (antidepressant) 25mg tablet, give one table by mouth one time a day for depression. Review of the Medication Administration Record (MAR) revealed Resident #99 received Risperidone (antipsychotic) 1mg tablet, every day	F 641	Residents #99 MDS with an ARD of 7/20/2023 was modified by 12/27/2023 by Regional MDS Nurse to accurately reflect antipsychotics and antidepressants during the look back period, resident #99 MDS with an ARD of 4/27/2023 the BIMS and PHQ are unable to be corrected per the RAI Manual, resident #11 MDS with an ARD of 7/16/2023 was modified by 12/27/2023 by the Regional MDS Nurse to accurately reflect the Nystatin cream applied during the look back period, resident #102 MDS with an ARD 5/11/2023 was modified by 12/27/2023 by the Regional MDS Nurse to accurately reflect antidepressants during the look back period, resident #51 MDS does not have an MDS with an ARD of 2/26/23, resident #80 MDS with an ARD 9/2/2023 was modified by 12/27/2023 by the Regional MDS Nurse to accurately reflect the range of motion during the look back period, resident # 518 MDS with ARD 11/24/2023 was modified to accurately reflect the Pain Interview conducted	1/1/24

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F 641	Continued From page 40 starting 7/1/23 through 7/31/23. Review of the MAR revealed Resident #99 received Sertraline HCL (antidepressant) 25mg tablet, every day starting 7/12/23 through 7/24/23. A review of Resident #99 quarterly MDS assessment dated 7/20/23 indicated the resident did not receive any antipsychotic and antidepressant medication. b. A review of Resident #99 admission MDS assessment dated 4/27/23 indicated the resident did not have a brief interview for Mental status (BIMS) interview and a resident mood interview conducted. An interview with the Regional MDS Nurse Coordinator on 11/29/23 at 2:20pm, revealed that Resident #99 had received 7 days of Risperidone and 7 days of Sertraline HCL medications each day of the 7 day lookback for the 7/20/23 assessment. She further indicated the BIMS and mood interviews were not conducted because the facility did not have a social worker to conduct the interviews and complete those sections at the time of the MDS assessment. An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated she required MDS assessments to be documented accurately. She further indicated the BIMS and mood interviews should be attempted for all residents assessments. On 12/1/23 at 11:30am an interview was conducted with the Administrator. The administrator indicated she would require interviews for MDS assessments.	F 641	during the look back period by 12/27/2023 by the Regional MDS Nurse. On 12/28/2023, an MDS accuracy audit for residents for receiving Antipsychotic medication, Antidepressant medication on their most recent MDS. An MDS accuracy audit for application of ointment/ medication other than to feet, residents' Pain interviews and with obvious or likely cavity or broken natural teeth with an ARD between 10/1/2023-12/26/2023 was conducted. Residents who had inaccurate coding in these areas were modified by MDS Nurse by 12/29/2023. The Regional Clinical Reimbursement Consultant educated the MDS nurse on proper coding on the MDS. This education was completed on 12/28/2023. No MDS nurse will be allowed to work until they have completed education. The Regional Clinical Reimbursement Consultant will conduct 10 MDS audits for MDS accuracy related to administration of Antipsychotic medication, administration of Antidepressant medication, Application of ointment/medication other than feet, completed pain interviews, and observations for obvious or likely cavity or broken natural teeth weekly x 4 weeks, then 5 MDS audits weekly x 4 weeks then 1 MDS audit weekly x 2 weeks. The Administrator will be responsible for bringing the MDS accuracy audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months. At this time, the QAPI committee will determine the need to continue the MDS accuracy audits. Date of Completion 1/1/2024	

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2. Resident #11 was admitted to the facility on 6/21/22.

Review of physician order initiated 2/5/23 revealed Resident #11 had an order for Nystatin External Powder (topical antifungal medication) 100,000 unit/gram (GM) applied to abdominal fold topically every day shift for wound care.

Review of the MAR revealed Resident #11 received Nystatin External Powder (topical antifungal medication) 100,000 unit/gram (GM) applied to abdominal fold topically every day shift from 7/1/23 through 7/31/23.

A review of Resident #11 quarterly MDS assessment with an ARD of 7/16/23 indicated that the resident did not receive any application of ointments/medication other than to feet during the last 7 days from the Assessment Reference Date (ARD).

An interview with the Regional MDS Nurse Coordinator on 11/29/23 at 2:20pm, revealed Resident #11 had received 7 days of Nystatin External Powder 100,000 unit/gram (GM) to abdominal fold within the last 7 days of the ARD.

An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated she required MDS assessments to be documented accurately.

On 12/1/23 at 11:30am an interview was conducted with the Administrator. The administrator indicated that she would require MDS assessments to be documented accurately.

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3. Resident #102 was admitted to the facility on 5/5/23.

Review of physician orders from 5/5/23 to 5/11/23 revealed Resident #102 had no physician order for any antidepressant medication.

Review of the May MAR revealed Resident #518 had not received any antidepressant medication from 5/5/23 to 5/11/23.

A review of Resident #102 admission MDS assessment with an ARD of 5/11/23 indicated the resident was documented as receiving an antidepressant for 7 days during the assessment period.

An interview with the Regional MDS Nurse Coordinator on 11/29/23 at 2:20pm, revealed Resident #102 had not received antidepressant medication and the assessment was documented inaccurately.

An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated she required MDS assessments to be documented accurately.

On 12/1/23 at 11:30am an interview was conducted with the Administrator. The Administrator indicated that she would require MDS assessments to be documented accurately.

4. Resident #518 was admitted to the facility on 11/7/23.

Record review of Resident #518 Nurse Practitioner (NP) progress note dated 11/20/23 indicated Resident #518 was not sleeping well

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due to pain.

Review of Medical Director's progress note for Resident #518 dated 11/22/23 indicated "resident has pain and numbness in bilateral arms and legs."

Review of physical therapy treatment encounter note for Resident #518 dated 11/22/23 indicated "resident reported pain all over body and limiting resident's ability to scoot."

Review of occupational therapy treatment encounter notes for Resident #518 dated 11/22/23 indicated that "resident reporting ongoing pain and discomfort "all over."

A review of Resident #518 admission MDS assessment with an ARD of 11/24/23 indicated Resident #518 did not have pain and did not have trouble sleeping.

An Interview with MDS Nurse #1 on 11/30/23 at 3:05pm, indicated she worked remotely to assist the facility with completing the MDS assessments and she did not conduct a pain interview with the resident.

An interview with the Regional MDS Nurse Coordinator on 11/29/23 at 2:20pm, revealed Resident #518 had not had a pain interview completed and the pain assessment was documented inaccurately.

An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated she required MDS assessments to be documented accurately. She further indicated pain interviews should be attempted with all

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residents for their assessments.

On 12/1/23 at 11:30am an interview was conducted with the Administrator. The Administrator indicated that she would require pain interviews to be attempted with all residents for their assessments.

5. Resident #80 was admitted to the facility on 4/28/22. Diagnoses included, in part, severe dementia, muscle weakness, and bilateral extremity contractures.

The annual MDS assessment dated 9/2/23 was marked as Resident #80 having no impairment on upper or lower extremities.

Observation on 11/27/23 at 10:30 am revealed Resident #80 to be severely contracted in all four extremities.

During an interview with corporate MDS Nurse on 11/29/23 at 11:30 AM, she stated that the facility does not currently have a full-time MDS nurse and she was assisting the completion of the assessments that were due. She stated that the MDS nurse should have not relied on what was written in the chart and should have been performing a visual assessment on each resident. She stated that Resident #80's contractures should have been documented on her MDS.

6. Resident #51 was admitted to the facility on 2/23/23.

Review of Resident 51's admission minimum

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data set assessment (MDS) dated 2/26/23 revealed she was cognitively intact. The area for obvious or likely cavity or broken natural teeth was not marked.

During an interview on 11/27/23 at 10:35 AM with Resident #51 she was observed to have brown, missing, and broken upper and lower teeth. Some teeth were broken and brown at the gum line. She denied pain during the interview. She shook her head indicating she had not had a dental assessment since her admission.

During an interview on 11/29/23 at 9:57 AM with Resident #51 she was observed to have brown, missing, and broken upper and lower teeth with some broken at the gum line. During the interview she shook her head indicating she had not had a dental assessment since admission.

On 11/29/23 at 9:57 AM, during an interview with the Corporate MDS nurse, she stated the facility MDS Nurse worked part time and remotely. An observation of Resident #51 during the interview and the Corporate MDS nurse stated the MDS should have been marked for broken natural teeth and added it to the care plan. She added she would modify Resident #51's MDS to reflect broken natural teeth.

In an interview conducted on 12/01/23 at 3:48 PM with the Administrator and Director of Nursing (DON)revealed they were unaware Resident #51 had not been accurately assessed for broken, missing teeth. The Administrator further stated going forward assessments should be done in person and marked correctly. The DON added an accurate assessment could be completed without physically assessing the resident in person.

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F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to certify the accuracy of pain interview responses relative to the resident's condition for 1 of 1 resident reviewed for pain. (Resident #518) Findings included:	F 642	Resident # 518 Admission Minimum Data Set(MDS) with an ARD 11/24/2023 item J0200 was modified to reflect a 01 “Yes” per the Resident Assessment Instrument Manual to accurately reflect the Pain Interview should have been conducted during the look back period but it was not. This was corrected by 12/29/2023 by the	1/1/24

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Continued From page 47

Resident #518 was admitted to the facility on 11/7/23.

Record review of Resident #518's Nurse Practitioner (NP) progress note dated 11/20/23 indicated Resident #518 was not sleeping well due to pain.

Review of occupational therapy treatment encounter notes for Resident #518 dated 11/20/23 indicated "Resident reported 10/10 global pain affecting function."

Review of Medical Director's progress note for Resident #518 dated 11/22/23 indicated "Resident has pain and numbness in bilateral arms and legs."

Review of physical therapy treatment encounter note for Resident #518 dated 11/22/23 indicated "Resident reported pain all over body and limiting resident's ability to scoot."

Review of occupational therapy treatment encounter notes for Resident #518 dated 11/22/23 indicated "Resident reporting ongoing pain and discomfort "all over."

A review of Resident #518 admission MDS assessment with an ARD of 11/24/23 indicated Resident #518 did not have pain and did not have trouble sleeping.

An interview with MDS Nurse #1 on 11/30/23 at 3:05pm, indicated she worked remotely to assist the facility with completing the MDS assessments and she did not conduct a pain interview with Resident #518. MDS Nurse #1 also indicated no one in the facility had completed the pain

F 642

Regional MDS Nurse.
On 12/26/2023, an Minimum Data Set accuracy audit for pain interviews was conducted for in-house residents with an Assessment Reference Date(ARD) between 10/1/2023-12/26/2023.
Residents who had inaccurate coding in these areas were modified by MDS Nurse by 12/27/2023.
The Regional Clinical Reimbursement Consultant educated the Minimum Data Set(MDS) nurse on proper pain interview coding on the Minimum Data Set(MDS).
This education was completed by 12/29/2023 no MDS nurse will be allowed to work until they have completed education.
The Regional Clinical Reimbursement Consultant will conduct audits starting the week of 1/2/2024 for 10 Minimum Data Set (MDS) audits for accuracy related to completed resident pain interviews x 4 weeks, then 5 audits weekly x 4 weeks then 1 MDS audit weekly x 2 weeks.
The Administrator will be responsible for bringing the Minimum Data Set (MDS) accuracy audit results to the Quality Assurance Performance Improvement (QAPI)meeting x 3 consecutive months.
At this time, the QAPI committee will determine the need to continue the Minimum Data Set (MDS) accuracy audits.
Date of Compliance 1/1/24

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F 642	Continued From page 48 interview for Resident #518. MDS Nurse #1 indicated she falsely documented that she conducted a pain interview, and she should have not documented something that she did not do. MDS Nurse #1 indicated she had never assessed or met with Resident #518 in person because and used the medical record to gather information. An interview with the Regional MDS Nurse Coordinator on 11/29/23 at 2:20pm, revealed that Resident #518 had not received a pain interview and the pain assessment was documented inaccurately. An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated she required MDS assessments to be documented accurately. She further indicated pain interviews should be attempted with all residents in person at the facility and not remotely. On 12/1/23 at 11:30am an interview was conducted with the Administrator. The Administrator indicated that she would require pain interviews to be attempted with all resident assessments in person.	F 642		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		1/1/24

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F 657	Continued From page 49 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to develop a resident specific care plan for 1) discharge planning and this occurred for 1 of 5 residents (Resident # 568) reviewed for discharge planning and 2) urinary catheter status and this occurred for 1 of 2 residents (Resident #106) reviewed for urinary catheter care. The findings included: 1)Resident #568 was admitted to the facility on 10/31/2023 with diagnoses that included severe burns to 10-19% of the body surface. A review of the electronic medical record revealed Resident #568 was her own legal representative. A review of the admission Minimum Data Set	F 657	The facility failed to develop a resident specific care plan for discharge planning and the facility failed to update a resident specific care plan for urinary status. On 12/28/2023 resident #568's guardian was contacted regarding resident #568 discharge Administrator. On 12/28/2023 resident # 568's care plan was updated to reflect residents discharge plan by Administrator or designee. On 12/28/2023 resident # 106's urinary catheter status care plan was resolved by Director of Nursing or designee. On 12/28/2023 resident # 106's care plan was updated to reflect incontinent of bladder status by Director of Nursing or designee. On 12/28/2023 a 100% audit of all resident's care plans for discharge plans and urinary status was completed by	

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F 657	Continued From page 50 (MDS) dated 11/07/2023 revealed Resident #568 had not been willing to participate in the mental assessment and had verbal behaviors of yelling out 1 to 3 days during the lookback period. The assessment did not assess the Resident preference to return to the community. A review of the care plan dated 11/2/2023 did not include the discharge preferences of the Resident. An observation was conducted on 11/27/2023 at 11:10 a.m. and the Resident was in her room, yelling that she wanted to go home. She yelled that she wanted to be discharged from the facility. An interview was conducted on 11/27/2023 at 11:18 a.m. with Resident #568 and she revealed she thinks she was being discharged today. She stated she had informed staff she desired to go home and wanted out of this place. She added she was only supposed to be at the facility a short while. An observation was conducted on 11/27/2023 at 2:23 p.m. of a male staff member as he reported to the Social Worker that Resident #568 desired to be discharged against medical advice. An observation was conducted on 11/28/2023 at 2:02 p.m. of Resident #568 yelling that she wanted to please go home. An interview was conducted on 11/30/2023 at 10:00 a.m. with the Social Worker (SW) and she revealed the SW was responsible for completing the discharge plan portion of the care plan and to conduct discharges. She added she became aware Resident #568 had desired to be	F 657	Administrator. On 12/28/2023 the Director of Nursing, Staff Development Coordinator, and Unit Managers were educated on developing resident specific care plans for discharge planning for all residents upon admission and updating resident specific care plans for discharge planning upon request by resident by Regional MDS Coordinator On 12/28/2023 the Director of Nursing, Staff Development Coordinator and Unit Managers were educated on updating resident specific care plans with changes in urinary status by Regional MDS Coordinator. The Regional MDS Coordinator or designee will audit new admissions, readmissions, quarterly and annual assessment care plans for accuracy of discharge planning and urinary status weekly x 12 weeks. All audits will be brought to the Quality Assurance Plan Improvement Committee monthly by the Regional MDS Coordinator or designee for review. Any further action needed will be implemented by the committee as required. Date of Compliance 1/1/24	

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F 657	Continued From page 51	F 657		

discharged on 11/27/2023 when the Unit Manager reported the Resident desired to be discharged. She added because the Unit Manager had concerns that it would not be a safe discharge she did not begin the steps to discharge the Resident. She added she had not conducted the SW portion of the care plan and the Resident remains her own RP.

An interview was conducted with the Regional MDS Nurse consultant on 11/30/2023 at 10:56 a.m. and she revealed the current care plan for Resident #568 should reflect the discharge plans of a resident. She added a concern with care plans had been identified the week before and a correction plan had been started but the SW had not caught up at that point.

An interview was conducted on 11/30/2023 at 12:02 p.m. with the Administrator and she revealed due to the unsafe discharge concerns of the clinical staff a guardianship hearing was requested and the Resident received the necessary legal paperwork on Tuesday, 11/28/2023. She added the desire of the Resident to return to the community should be reflected in the care plan.

2. Resident #106 was admitted to the facility on 07/16/23 with diagnosis that included urinary retention with urinary catheter in place and benign prostatic hyperplasia (BPH).

Resident #106's active care plan, last reviewed on 11/10/23, revealed a focus that read resident had an indwelling catheter due to neurogenic bladder. Date Initiated: 08/01/2023.

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F 657	Continued From page 52	F 657		

Nursing progress note dated 08/03/23 revealed Resident #106 returned from a urology appointment with the recommendation to do a voiding trial early in the am (08/04/23). If the resident did not void the urinary catheter was to be replaced.

Resident #106's active care plan, last reviewed on 11/10/23, revealed a focus that read, resident had an indwelling catheter due to neurogenic bladder.

Observation of Resident #106 on 11/27/23 at 3:32 PM was conducted. He was walking up and down 1 East & 2 East hallways continuously. He also was noted at the front desk. No urinary catheter was observed.

Observation of Resident #106 on 11/28/23 at 4:23 PM was conducted. He was again walking up and down 1 East and 2 East hallways continuously. No urinary catheter was observed.

An interview with Nurse #1 was conducted on 11/29/23 at 2:15 PM. She stated she recalled the orders for Resident #106 on 08/03/23. She then stated she reported the instructions to the oncoming shift and that when she returned to work at 7:00 AM on 08/04/23 the urinary catheter had been removed and Resident #106 had no difficulty voided. The urinary catheter remained out.

An interview with the Director of Nursing (DON) was conducted on 11/30/23 at 4:25 PM. She stated the facility did not currently have a full time Minimum Data Set (MDS) Nurse. The past MDS Nurse ' s changed to as needed on 11/17/23 and

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F 657	Continued From page 53 that she only works remotely. She then stated had been assisting with the Minimum Data Set (MDS) duty of updating care plans. She verified Resident #106 ' s care plan still had a focus with interventions for a urinary catheter and that it should have been revised after the urinary catheter had been removed. An interview was conducted on 12/01/23 at 12:35 PM with the Administrator. She stated care plans should be resident centered and updated and revised as needed. She was unaware the care plan had not been updated for Resident #106. Unsuccessfully attempted to contact the Minimum Data Set (MDS) Nurse three times.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined	F 660		1/1/24

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F 660	Continued From page 54 by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient	F 660		

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F 660	Continued From page 55 assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, Responsible Party, and staff interviews the facility failed to have a discharge planning process in place for a resident with a discharge goal of transferring to an alternate facility for 1 of 1 sampled resident for discharge planning (Resident #98). Findings Included: Resident #98 was admitted to the facility on 7/19/23 with a diagnosis that included altered mental status. A review of the quarterly Minimum Data Set dated 10/26/23 revealed Resident #98 was cognitively impaired. A telephone interview was conducted with the Responsible Party on 11/28/23 at 10:03 PM. She indicated that she made a request on 11/1/23 for assistance with transferring the resident to another skilled nursing facility and still had not received a response.	F 660	FL2 for resident #98 was updated on 11/30/23 by the Social Services Director. The FL2 was sent to the facility of daughters choice on 11/30/23. All in house residents who are alert and oriented were interviewed by the Administrator for desire to remain in the facility, change facility or return to community. Residents who were not able to interview, the Administrator contacted the responsible party to interview for desire to remain in facility, change facility or return to community. If the desire was to change facility or return to community, discharge planning was initiated by the Administrator on 12/28/23. The Administrator provided education to the Social Services Director on 12/19/23 on the process for discharge planning when a resident or responsible party expresses desire to discharge from facility. This education will be added to the new hire of Social Services on 12/28/23	

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F 660	Continued From page 56 An interview was conducted on 11/29/23 at 10:30 AM with the Admissions/Concierge Director and she revealed that she was notified on 11/1/23 via email by Resident #98's Responsible Party of the request for discharge planning assistance to another skilled nursing facility and forwarded the request to Social Worker #1 to assist with discharge planning. An interview was conducted on 11/29/23 at 10:28 AM with Social Worker #1. She revealed Resident #98's responsible party made the request for discharge planning assistance on 11/1/23 but due to a back log in discharge planning she had not assisted with getting an updated FL-2 form (North Carolina's form that describes a patient's medical condition and the amount of care they need when placed in a facility) sent to other skilled nursing facilities of interest and no other discharge planning efforts had been made to date. An interview was conducted on 11/30/23 at 12:05 PM with Administrator #1 and she revealed that it was the social worker's responsibility to assist residents with discharge planning and was not aware that Resident #98 had been waiting for a month for social work assistance.	F 660	by the Administrator. The Administrator or designee will audit the discharge planning assessment with each Minimum Data Set due for the resident x 3 months. The Administrator will be responsible bringing the discharge planning assessment audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		1/1/24

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Based on observation, record review, resident and staff interviews, the facility failed to provide oral hygiene to a resident (Resident #69) dependent on staff for activities of daily living (ADL). This occurred for 1 of 10 residents reviewed for ADL.

Resident #69 was admitted to the facility on 9/28/2021 with diagnoses that included hemiplegia and a history of a cerebral infarction.

A review of the quarterly Minimum Data Set (MDS) dated 9/20/2023 identified Resident #69 was cognitively intact, had adequate vision and hearing, required extensive assistance of one staff member with personal hygiene, and did not refuse care.

A review of the care plan dated 9/20/2023 included a focused area that Resident #69 had an ADL self-care performance deficit related to a history of decreased mobility. The interventions identified the Resident required 1 to 2 person staff assistance with personal hygiene and oral care.

An observation of Resident #69 was conducted on 11/27/2023 at 10:25 a.m. and the Resident had only two teeth on the top and multiple teeth on the bottom covered in a thick white substance, and yellow and grey discoloration.

An interview was conducted with Resident #69 on 11/27/2023 at 10:25 a.m. and he revealed he had not received oral care in weeks. He added he had asked the Nursing Assistant the week before for a toothbrush on several occasions and they exited the room and returned to inform him one was not available at the facility.

F 677

Resident #69 received oral care on 11-30-23 by the floor certified nursing assistant.
All inhouse residents were assessed by the Director of Nursing, Unit Managers, and Staff Development Coordinator for oral hygiene. Any resident who was dependent and unable to provide themselves oral care was offered oral care by certified nursing assistants on 12/22/23. .
The Director of Nursing and staff development coordinator initiated an in-service on 12/22/23 to all licensed nurses, and certified nursing assistants that residents who are dependent on staff for activities of daily living and are unable to provide their own oral hygiene have the right to be offered the oral hygiene services. Any licensed nurse or certified nursing assistant who do not complete the education by January 1, 2024, will not be allowed to work until the in-service has been completed. The education was added to the new hire orientation by the Director of Nursing on 12/27/23.
The Director of Nursing or designee will audit 20 dependent residents weekly x 4 weeks, 10 dependent residents x 4 weeks then 5 dependent residents x 4 weeks for oral hygiene provided.
The Director of Nursing will be responsible for bringing the oral hygiene audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring
Date of Compliance: 1/1/2024

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F 677	Continued From page 58	F 677		

An observation was conducted on 11/30/2023 at 4:35 p.m. Nursing Assistant # 7 was observed to exit the room. The Resident was lying in bed and had a thick white substance and yellow/grey discoloration on his teeth.
An interview was conducted on 11/30/2023 at 4:35 p.m. with Resident # 69 and he revealed he had not had his teeth brushed the entire week. He stated he had informed staff he did not have a toothbrush and one had not been provided.

An observation was conducted of the supply storage area on the second floor of the facility, on 11/30/2023 at 4:38 p.m. and toothbrushes were included in the supplies available.

An interview was conducted on 11/30/2023 at 4:43 p.m. with NA # 7 and she revealed she had been assigned to Resident #69 on 11/29/2023 for second shift and 11/30/2023 for second shift. She was asked if she had completed ADL care for the Resident. She stated, yes, she had checked on the Resident and was finished with his ADL care for that round. She stated she had checked on the Resident to see if incontinence care was required and provided fresh water. When asked if she provided oral hygiene, she stated the oral care should be done by the first shift NA. She added she had not provided or offered oral care the entire second shift on 11/29/2023 and had not offered it during her first round on 11/30/2023. She checked the Resident's room and was unable to locate a toothbrush.

An interview was conducted on 12/01/2023 at 11:18 a.m. with the Director of Nursing (DON) and she revealed a resident should receive oral hygiene care during the morning rounds and on

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F 677	Continued From page 59 second shift, prior to bed. She added the staff document the care in the point of care system. She stated she expected all residents to be provided oral hygiene assistance as needed.	F 677		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		1/1/24

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F 690	Continued From page 60 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview and staff interviews the facility failed to maintain a resident's continence status for 1 of 2 residents who were continent to both bowel and bladder (Resident #518). Findings included: Resident #518 was admitted to the facility on 11/17/23, with diagnosis that included chronic pain syndrome, disorder of thyroid, adult failure to thrive, bipolar disorder, constipation, anorexia, hypothyroidism, and spondylosis. Review of Resident #518 admission assessment progress note by Nurse #3, dated 11/17/23, revealed the resident was continent of both bowel and bladder. An interview with Nurse #3 was conducted on 11/29/23 at 3:19pm. Nurse #3 admitted resident on 11/17/23 and indicated upon her assessment, Resident #518 was continent of both bowel and bladder. Nurse #3 indicated that resident required the nurse aide to offer a bed pan for toileting. Nurse #3 was not aware that Resident #518 was asked to wear a brief by staff. An admission Minimum Data Set (MDS) assessment dated 11/24/23 revealed Resident #518 was cognitively intact with no behaviors or rejection of care and frequently incontinent of both bowel and bladder.	F 690	Resident #518, was interviewed for use of brief on 11/30/23 by the Unit Manager. Resident preference is to use a brief and not get up to bathroom or use a bedpan All inhouse residents were assessed by the Director of Nursing, Unit Managers, and Staff Development Coordinator for continence, inability to walk to the bathroom and offering of bedpan or bedside commode. Any resident who was continent, and unable to walk to the bathroom was offered a bedpan or bedside commode on 12/19/23 by Unit Managers. The Director of Nursing and staff development coordinator initiated an in-service to all licensed nurses, and certified nursing assistants that residents who are continent and unable to walk to the bathrooms have the right to be offered the use a bed pan or bedside commode for toileting needs, not placed in a brief unless this was the resident preference. Any licensed nurse or certified nursing assistant who do not complete the education by January 1, 2024, will not be allowed to work until the in-service has been completed. The education was added to the new hire orientation by the Director of Nursing on 12/26/23. The Director of Nursing or designee will audit 10 continent residents weekly x 4 weeks, 5 continent residents x 4 weeks then 1 continent resident x 4 weeks for	

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F 690	Continued From page 61 An interview with MDS Nurse #1 on 11/30/23 at 3:05pm, indicated that she worked remotely to assist the facility with completing the MDS assessments. MDS Nurse #1 indicated she had never assessed or met with Resident #518 in person because she worked remotely and used the medical record to gather information. Resident #518's care plan initiated 11/21/23 did not address the resident's incontinence. On 11/29/23 at 5:13am, an observation of incontinence care was made with Resident #518 and NA #3. Resident #518 was noted to be wearing a brief that was soaking wet of urine. Resident #518 did not have a bedpan in the bathroom or room. Resident #518 was interviewed on 11/29/23 at 5:49am. Resident #518 indicated she was continent of both bowel and bladder but was asked by staff to wear a brief since admission (11/17/23) because she could not walk to the bathroom and use the restroom. Resident #518 indicated she used her call light to ask for toileting assistance, but staff would not respond, and she would go on herself. Resident #518 indicated she was able to tell when she needed to be toileted. Resident #518 indicated the facility did not offer her a bed pan to use while in bed and just placed her in briefs. Resident #518 indicated she had used a bed pan and bedside commode while at an acute care hospital prior to being admitted to facility. On 11/29/23 at 3:34pm, an interview was conducted with Nurse #1. Nurse #1 indicated Resident #518 was continent to both bowel and bladder but not able to transfer safely or walk to the bathroom. Nurse #1 further indicated	F 690	use or offering of bedpan or bedside commode, and not use of brief if not a resident preference. The Director of Nursing will be responsible for bringing the offering of bedpan or bedside commode to continent residents who could not walk to the bathroom to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	

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F 690	Continued From page 62 Resident #518 required the nurse aide to offer a bed pan for toileting. Nurse #1 was not aware that Resident #518 was asked to use brief by staff. An interview was conducted on 11/30/23 at 10:07am while NA #5 provided incontinence care to Resident #518. NA #5 indicated she worked with Resident #518 regularly, and she had never offered a bed pan to Resident #518 because the resident was wearing a brief since admission (11/17/23), and she assumed Resident #518 was incontinent. On 11/30/23 at 10:54am, an interview was conducted with Certified Occupational Therapist Assistant (COTA). The COTA indicated Resident #518 was not able to use the bathroom commode or bedside commode for toileting because she was not safe with transfers, but she was able to use a bed pan, because her bed mobility was decent. COTA was not aware that Resident #518 was not offered a bed pan. An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated if a resident was admitted and continent of both bowel and bladder, but they were not able to walk to the bathroom, she would require staff to offer the resident a bedpan for toileting. DON was not aware that Resident #518 was not offered bed pan. On 12/1/23 at 11:30am an interview was conducted with the Administrator. The administrator indicated if a resident was admitted as being continent of both bowel and bladder and could not safely transfer, she would require staff to maintain continence by offering the resident a bed pan while in bed for toileting. Administrator	F 690		

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F 690	Continued From page 63 was not aware that Resident #518 was not offered bed pan.	F 690		
F 697 SS=J	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview, staff interviews, Nurse Practitioner (NP) interview and Medical Director interview, the facility staff failed to implement a pain management program that included pharmacological and non-pharmacological approaches for Resident #518 who was admitted with chronic pain syndrome. Resident #518 was not thoroughly assessed for pain, a plan for pain management was not initiated, pain medication was not ordered, care continued to be delivered to Resident #518 in the presence of pain described at 9 out of 10. Pain interfered with sleep, mobility, and provision of activities of daily living. Resident #518 exhibited verbal and nonverbal cues of pain that included facial grimacing, groaning, and holding tightly onto the grab bars during incontinence care and bed mobility. A diagnostic x-ray was not implemented stat (rush) as ordered. Resident #518 was diagnosed with osteoarthritis following the results of the x-ray. This deficient practice occurred for 1 of 1 resident reviewed for pain management (Resident #518).	F 697	Resident was assessed for pain immediately after the surveyor issued the template on 11/30/23 by the Director of Nursing. Resident reported her pain was a 7/10 and that the Tylenol she received earlier was helping. The nurse offered to call for more pain medication and the resident voiced that she would only take Tylenol. The nurse administered 2-500mg tablets of Tylenol as ordered. Also, Voltaren was applied to the right shoulder. Resident expressed "some relief." The X-ray company was notified and completed the order at 7:00 pm. The x-ray results showed no fracture but did show mild osteoarthritis acromioclavicular and glenohumeral joints. Pain assessment has been added to Resident MAR for monitoring every shift. Tylenol has been scheduled three times a day, Voltaren gel has been scheduled three times a day and Meloxicam has been scheduled to assist with controlling resident's pain. Pain will continue to be assessed by the nurse and documented	1/1/24

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F 697

Continued From page 64

Immediate jeopardy began on 11/20/2023 when Resident #518 experienced pain at a 10 out of 10 level according to the occupational therapy treatment encounter notes, indicated to the Nurse Practitioner (NP) she was not sleeping well due to the pain and had no orders for pain management. The immediate jeopardy was removed on 12/1/23 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to pain management.

Findings included:

Resident #518's Medication Administration Record (MAR) from the Hospital, indicated the resident was hospitalized on 11/5/23. Resident #518's hospital MAR indicated she received Cymbalta DR (antidepressant) 30 milligram (mg) capsule two times a day by mouth starting 11/6/23 to 11/13/23, Lamictal 200mg 1 tablet by mouth a day starting 11/6/23 to end 11/6/23 and Lamictal 25mg 1 tablet by mouth daily starting 11/13/23 to 11/17/23.

Resident #518 was admitted to the facility on 11/17/23, with diagnosis that included chronic pain syndrome, disorder of thyroid, adult failure to thrive, bipolar disorder, constipation, anorexia, hypothyroidism, and spondylosis.
Resident #518 physician order dated 11/18/23 revealed resident was to receive Lamictal (mood stabilizer) 25 milligram (mg) one tablet, by mouth one time a day.

F 697

on the MAR. Tylenol has been scheduled three times a day to help with pain management and relief during therapy sessions.
Care plan updated to reflect a goal of normal activities will not be interrupted secondary to pain. Interventions include anticipating the resident's need for pain relief and respond immediately to any complaint of pain. Care plan was reviewed and updated by the Regional Nurse Consultant on 11/30/23. The non-pharmaceutical intervention of repositioning was added for pain relief and comfort. The direct care staff were informed on 11/30/23 by the Unit Managers and Staff Development Coordinator to respond to the resident's complaint of pain timely and encourage the use of her ordered pain medications.
The Regional Clinical Nurses and the Director of Nursing conducted a full-house pain interview and assessment by using verbal and non-verbal signs. This was completed on 11-30-23. The total of in-house residents is 108. Notification was given to the hall nurse for any resident who reported pain at that time and an intervention was put into place, or the pain was treated on 11-30-23.
Education on identifying and reporting pain to staff (to include licensed nurses, certified nursing assistants, medication aides, all department heads, housekeeping, dietary, laundry and therapy) was initiated on 11-30-23 and conducted by the Unit Managers, wound nurse, and Staff Development Coordinator. The education included

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F 697	Continued From page 65 Occupational therapy treatment encounter notes for Resident #518 dated 11/20/23 indicated that "resident reported 10/10 global pain affecting function." NP progress notes dated 11/20/23, revealed that "resident underwent psychiatry evaluation, and it was determined that resident's decreased appetite is due to hypothyroidism and not a psychiatric issue. Resident states today that she is in the rehabilitation facility because she is unable to move secondary to bilateral arm and leg pain and numbness. Resident states she is not sleeping well due to the pain." On 11/30/23 at 1:07 pm, a telephone interview was conducted with the NP. The NP progress notes for 11/20/23 were reviewed with NP where she indicated Resident #518 had chronic pain and had undergone psychiatric evaluation. A continued review of the NP progress notes further indicated Resident #518 had bilateral arm and leg pain and numbness, and complained she could not sleep because of pain. The NP indicated, after reviewing her notes, that she did not address Resident #518's pain on 11/20/23 because Resident #518 had a diagnosis of bipolar disorder and she wanted Resident #518 to take her medication (Lamictal) first, before the NP would be able to do anything about the resident's pain. The NP further indicated the medication needed time to "kick in" before she could address the pain. Resident #518's care plan initiated 11/21/23 did not address resident's pain and did not have any care plan in reference to behaviors or refusal of medication.	F 697	identifying pain through verbal and nonverbal cues (grimacing, screaming, guarding, etc.) then reporting to the resident's nurse or Director of Nursing. The nurse is to then complete an assessment of the resident's pain and put the proper intervention in to place. Nurses were educated on completing a pain assessment and documenting on the medical record. Any staff who did not receive this in service by 11-30-23 were not allowed to work until this was completed. The Director of Nursing and Staff Development Coordinator are responsible for maintaining records of staff who need the in-service prior to their next shift. All licensed nurses were educated in following up on x-ray orders. This education was initiated on 11-30-23 by the Unit Managers, wound nurse, and Staff Development Coordinator. Any licensed nurse who did not receive this education by 11-30-23 was not allowed to work until completed. The Director of Nursing and Staff Development Coordinator are responsible for maintaining records of all licensed staff who need the in-service prior to their next shift. This education was added to the new hire orientation by the Director of Nursing on 11-30-23. Facility alleges removal of the immediate Jeopardy as 12-1-23. The Director of Nursing or designee will audit 10 pain assessments weekly x 4 weeks, then 5 pain assessments weekly x 4 weeks and then 1 pain assessment weekly x 1 month.	

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F 697	Continued From page 66 Medical Director's progress notes for Resident #518 dated 11/22/23 indicated that "resident has pain and numbness in bilateral arms and legs." An in-person interview was conducted on 11/30/23 at 4:04 pm with the Medical Director (MD). The MD indicated Resident #518 did not complain of pain. The MD indicated the review of systems in his progress notes was from the history and physical and Resident #518 did not have anything acute. The MD indicated the resident was on Lamictal (a medication used to treat epilepsy and bipolar disorder.) which would usually take at least 4 to 6 weeks to be therapeutic, but he would not expect for a medical provider to wait 4 to 6 weeks or to wait until a medication was therapeutic to address any resident's pain and he would have initiated a pain medication such as Tylenol, or an anti-inflammatory medication such as aspirin. The MD further indicated pain was not dependent on a resident's psychiatric status, especially when dealing with a resident who did not have any dependency concerns with pain medication. Physical therapy treatment encounter notes for Resident #518 dated 11/22/23 indicated that "resident reported pain all over body and limiting resident's ability to scoot." Occupational therapy treatment encounter notes for Resident #518 dated 11/22/23 indicated that "resident reporting ongoing pain and discomfort "all over." An admission Minimum Data Set (MDS) assessment dated 11/24/23 revealed Resident #518 was cognitively intact with no behaviors or rejection of care and no pain and required	F 697	The Director of Nursing will be responsible for bringing the pain assessment audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	

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F 697	Continued From page 67	F 697		

Continued From page 67
moderate assistance with bed mobility and was dependent on toileting hygiene.

Physical therapy treatment encounter notes dated 11/27/23 indicated that "resident with reports of pain "all over," facial grimacing and groaning."

An interview was conducted with NA #5 on 11/29/23 at 3:12 pm. NA #5 indicated that she worked with Resident #518 on 11/27/23 during the day shift (7:00 am to 3:00 pm shift). NA #5 indicated that Resident #518 did complain of shoulder pain (could not validate which shoulder) during care on 11/27/23, and she notified Nurse #3 and Medication Aide (MA) #2.

On 11/29/23 at 3:19 pm, an interview was conducted with Nurse #3. Nurse #3 indicated that the NA #5 did not notify her on 11/27/23 that Resident #518 was complaining of pain.

Interview with Medication Aide (MA)#2 was conducted on 11/30/23 at 10:04 am. MA#2 indicated that on 11/28/23 she was working day shift (7:00 am to 3:00 pm) and was in training. MA #2 stated she went to provide Resident #518 her medication in her room, and during medication administration, Resident #518 made groaning noises while she was moving in bed. MA #2 indicated she did not ask Resident #518 about her pain and stated Resident #518 did not state she was in pain. MA #2 indicated she did not report this to the nurse.

Physical therapy treatment encounter notes dated 11/28/23 indicated that "physical therapy assistant requested patient to be provided pain medication prior to session to prevent pain limiting progression. Resident refused her medication

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and pain pills and reported pain all over her body. Physical therapist assistant talked with Director of rehabilitation about patients increase pain levels and limitation."

Resident #518 Medication Administration Record starting 11/17/23 through 11/29/23, revealed that resident had not refused to take any medication.

Physician orders starting 11/17/23 through 11/29/23, revealed that resident had no pain medications ordered.
Resident #518 MAR starting 11/17/23 through 11/29/23, revealed that resident had no pain medication order.
Resident #518 did not have any standing orders.

An interview with the Director of Nursing on 11/30/23 at 4:15 pm revealed Resident #518 did not have any standing orders. DON further indicated that standing orders are usually on a case-to-case basis.

Review of Resident #518 occupational therapy treatment encounter notes dated 11/28/23 indicated that "resident with increase pain today."

Resident #518's Medication Administration Record (MAR) revealed no pain medication physician orders from 11/17/2023. There was also no refusal of medication by Resident #518.

On 11/30/23 at 10:54 am, an interview was conducted with Certified Occupational Therapist Assistant (COTA). The COTA indicated that Resident #518 had limited mobility due to pain that was getting worse. The COTA indicated she had communicated multiple times to nursing staff about Resident #518's pain for more than a week.

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F 697	Continued From page 69 The COTA indicated the resident had complained about her shoulder pain for about a week. The COTA indicated Resident #518 could not lift her arm during shoulder flexion due to shoulder pain. The COTA indicated she had asked nursing to administer pain medications to Resident #518 prior to rehabilitation treatment on 11/27/23 and 11/28/23. At 11:17 am, on 11/30/23 the COTA further indicated Resident #518 was clearly in pain and Resident #518 had been indicating her shoulder hurts. The COTA indicated she was seeing more signs of pain with Resident #518 that progressed. The COTA indicated Resident #518 had received therapy on 11/28/23, during which time, the nurse (unknown) was asked to medicate Resident #518 with pain medication after lunch, prior to her rehabilitation therapy treatment. The nurse (unknown) indicated to therapy the resident had refused to take her medication and refused to take her pain medication on 11/28/23. The COTA indicated the facility did have a diathermy machine (a medical device that uses high-frequency electric current to produce heat deep inside a targeted tissue through the skin to the area that is causing pain) that was used as a non-medication pain regime, but it was not used on the resident, because she did not go to the therapy room for treatment. On 11/29/23 at 5:13 am, an observation of incontinence care was made with Resident #518 and NA #3. As NA #3 was moving resident, Resident #518 complained of right shoulder pain. NA #3 continued to proceed with providing incontinence care. Resident #518 was observed holding onto both her grab bars, making nonverbal signs of pain (facial grimacing,	F 697		

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F 697	Continued From page 70 groaning) while NA #3 was providing incontinence care. Resident #518 also verbalized pain while NA #3 was providing incontinence by saying "that hurts" and NA #3 continued to provide incontinence care. NA #3 stated to Resident #518 that her perineal area was red and appeared to be irritated and infected. The observation revealed that the resident's perineal area was reddened. NA #3 turned the resident over to her right side to continue incontinence care. Resident #518 verbally complained of pain and indicated her right shoulder was in pain. NA #3 continued to provide incontinence care.NA # 3 completed incontinence care and indicated to Resident #518 that she was going to get another aide to assist her with moving Resident #518 up in her bed. NA #3 returned to the room a few minutes later with NA #4 to assist resident with bed mobility. NA #3 asked Resident #518 to cross both her arms on her chest. Resident #518 indicated to both NA #3 and NA #4 that her right shoulder was hurting. NA #3 and NA #4 continued to assist Resident #518 with bed mobility by moving her up in the bed even after Resident #518 indicated that she was having right shoulder pain. NA #3 and NA #4 used the draw pad/linen protector to move the resident up in the bed with their hands positioned in the mid chest area of the resident. An interview was conducted with NA #3 on 11/29/23 at 5:40 am. NA #3 indicated her shift started on 11/28/23 at 3:00 pm, and she was doing a double shift(3:00 pm to 7:00 am), which would end on 11/29/23 at 7:00 am. NA #3 indicated she notified Nurse #1 at about 3:30 pm on 11/28/23 , after she had completed her first round of incontinence care on Resident #518, that the resident was complaining of pain in her perineal area and all over. NA #3 indicated that	F 697		

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she did not stop providing perineal care, because she wanted to clean the area first.

Resident #518 was interviewed on 11/29/23 at 5:49 am. Resident #518 indicated that she notified a nurse (Unknown) a couple of days prior, about her perineal area pain and irritation, and her right shoulder pain upon moving. Resident #518 indicated that the Nurse (unknown) came back to her room and applied A and D ointment (skin protectant) to her perineal area and did not offer anything to relieve her right shoulder pain. Resident #518 indicated that she would take Tylenol (analgesic) medication when she was home and did not use any opioid medication.

On 11/29/23 at 3:34 pm, an interview was conducted with Nurse #1. Nurse #1 confirmed that she worked with Resident #518 on 11/27/23 and 11/28/23. Nurse #1 indicated she did not work with the resident often and stated that the resident never reported pain to her. Nurse #1 indicated that she did not recall NA #3 reporting Resident #518 having right shoulder pain.

At 5:57 am on 11/29/23, an interview was done with Nurse #2. Nurse #2 confirmed that she was the regular night shift nurse for Resident #518 and stated the resident did not report pain to her. Nurse #2 indicated NA # 3 and NA #4 never notified her about Resident #518's pain and that she would go and assess Resident #518.

A follow up interview was done with Nurse #2 at 6:15 am on 11/29/23, and she indicated upon assessment of Resident #518, the resident complained of right shoulder pain. Nurse #2 indicated that she would notify the medical provider of Resident #518's right shoulder pain.

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On 11/29/23 at 3:19 pm, an interview was conducted with Nurse #3. Nurse #3 indicated that the outgoing nurse on 11/29/23 (11:00 pm to 7:00 am), Nurse #2 reported to her during shift report, that Resident #518 was assessed to have right shoulder pain. Nurse #3 further indicated that she notified the NP who was in the facility. Nurse #3 indicated the NP did not initiate anything for Resident #518's pain.

An observation of incontinence care was made on 11/30/23 at 10:07 am with NA #5 and Resident #518. Resident #518 complained of right shoulder pain and was observed holding tightly on her grab bars and having facial grimacing while NA #5 continued to provide incontinence care. NA #5 asked Resident #518 to turn to her right side, and Resident #518 informed NA #5 that her right shoulder and perineal area were in pain.

An interview with Resident #518 was conducted on 11/30/2023 at 10:09 am while she received perineal care from NA #5. Resident #518 was asked to rate her pain related to her right should and perineal area, on a scale of 1 to 10 and the resident indicated that her pain was 9 out of 10 during perineal care and moving.

An interview with NA #5 was conducted on 11/30/23 at 10:10 am. NA #5 indicated she could not stop providing care but would notify the nurse of Resident #518's right shoulder pain, after she had completed incontinence care.

On 11/30/23 at 10:11 am an interview was conducted with Nurse #1. The Surveyor informed Nurse #1 that Resident #518 complained of right shoulder pain during observation of incontinence

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care, and Resident #518 held tightly to her grab bars, with facial grimacing during perineal care and bed mobility. Nurse #1 indicated she would assess the resident.

At 10:15 am on 11/30/23, Nurse #1 indicated that she would notify the medical provider about Resident #518's right shoulder pain of 9 out of 10 and she would recommend an X-ray to rule out fracture. Nurse #1 indicated that Resident #518 had a history of falls prior to admission to the facility, and the pain could be related to that. Nurse #1 indicated that Resident #518 did not have any medication for pain.

An interview was conducted on 11/30/23 at 10:47 am. Nurse #1 indicated that she had received a new physician order for Resident #518 to start Tylenol (non-opioid analgesic) 500milligrams two tablets by mouth twice a day and Voltaren gel (dermatological anti-inflammatory analgesic) 2 grams for right shoulder. She also indicated the medical provider ordered for a right shoulder X ray to rule out fracture.

The physician order dated 11/30/23 revealed a STAT order for a right shoulder X ray to rule out fracture.

The physician's order dated 11/30/23 revealed an order for Tylenol 500mg two tablets by mouth twice a day for right shoulder pain.

On 11/30/23 at 1:07 pm, a telephone interview was conducted with the NP. The NP indicated she assessed Resident #518 on 11/29/23 while in the facility. The NP indicated Resident #518 did not complain of pain upon her assessment on 11/29/23. The NP indicated that nursing staff did

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notify her on 11/29/23 of Resident #518's right shoulder pain but she had not addressed the pain due to Resident #518's psychiatric issues and she wanted to "make sure the pain was real."

Interview was conducted with Nurse #1 on 11/30/23 at 3:52 pm. Nurse #1 indicated that the STAT Xray ordered for Resident #518 at 10:30 am on 11/30/23 had not been initiated. Nurse #1 did not know why the Xray had not been initiated.

At 4:15 pm on 11/30/23 an interview was conducted with the Director of Nursing (DON). DON indicated STAT x-rays had not been implemented because the company that was contracted to provide diagnostic testing, did not consider STAT physician orders to be within 4 hours, but could be done in a day or two or later. DON indicated that if a resident verbalized pain or had any nonverbal signs of pain during peri care, she would require the nursing assistants to complete providing peri care first, and tell the residents "Sorry it hurts", but they would need to complete care and after completion of care, the nurse aide would notify the nurse. DON further indicated that if resident verbalizes pain or has any nonverbal signs of pain noted before or during bed mobility, she would require the nursing assistants to stop moving the resident and notify the nurse.

Resident #518's Xray to right shoulder was completed after the surveyor's intervention 11/30/23. The result of Xray revealed no fracture but showed mild osteoarthritis.

The administrator was notified in person of the immediate jeopardy on 11/30/23 at 5:40 pm.

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On 12/2/23 on the facility provided the following IJ removal plan:
"   Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.
Resident was admitted to facility on 11-17-23 status post hospitalization with chronic pain syndrome. Resident was witnessed experiencing pain on 11-30-23 in the presence of staff. Interviews identified the resident had been experiencing pain for greater than one week with facility staff aware of the situation. During these periods of pain, the facility failed to identify the pain, properly assess for location and severity, and put proper interventions in to place to manage the pain.
The CNA that was providing care was educated on 11/30/23 by the Regional Nurse Consultant regarding identifying pain and immediately ceasing care being provided to notify nurse of the pain.
The Regional Clinical Nurses and the Director of Nursing conducted a full-house pain interview and assessment by using verbal and non-verbal signs. This was completed on 11-30-23. The total of in-house residents is 108. Notification was given to the hall nurse for any resident who reported pain at that time and an intervention was put into place.
o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

Resident was assessed for pain immediately after the surveyor issued the template on 11/30/23 by the Director of Nursing. Resident reported her pain was a 7/10 and that the Tylenol she received

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F 697	Continued From page 76 earlier was helping. The nurse offered to call for more pain medication and the resident voiced that she would only take Tylenol. The nurse administered 2-500mg tablets of Tylenol as ordered. Also, Voltaren was applied to the right shoulder. Resident expressed "some relief." The X-ray company was notified and completed the order at 7:00 pm. The x-ray results showed no fracture but did show mild osteoarthritis acromioclavicular and glenohumeral joints. Pain assessment has been added to Resident MAR for monitoring every shift. Tylenol has been scheduled three times a day, Voltaren gel has been scheduled three times a day and Meloxicam has been scheduled to assist with controlling resident's pain. Pain will continue to be assessed by the nurse and documented on the MAR. Tylenol has been scheduled three times a day to help with pain management and relief during therapy sessions. Care plan updated to reflect a goal of normal activities will not be interrupted secondary to pain. Interventions include anticipating the resident's need for pain relief and respond immediately to any complaint of pain. Care plan was reviewed and updated by the Regional Nurse Consultant on 11/30/23. The non-pharmaceutical intervention of repositioning was added for pain relief and comfort. The direct care staff were informed on 11/30/23 by the Unit Managers and Staff Development Coordinator to respond to the resident's complaint of pain timely and encourage the use of her ordered pain medications. Education on identifying and reporting pain to staff (to include licensed nurses, certified nursing assistants, medication aides, all department heads, housekeeping, dietary, laundry and therapy) was initiated on 11-30-23 and conducted by the Unit Managers, wound nurse, and Staff	F 697		

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Development Coordinator. The education included identifying pain through verbal and nonverbal cues (grimacing, screaming, guarding, etc.) then reporting to the resident's nurse or Director of Nursing. The nurse is to then complete an assessment of the resident's pain and put the proper intervention in to place. Nurses were educated on completing a pain assessment and documenting on the medical record. Any staff who did not receive this in service by 11-30-23 were not allowed to work until this was completed. The Director of Nursing and Staff Development Coordinator are responsible for maintaining records of staff who need the in-service prior to their next shift. All licensed nurses were educated in following up on x-ray orders. This education was initiated on 11-30-23 by the Unit Managers, wound nurse, and Staff Development Coordinator. Any licensed nurse who did not receive this education by 11-30-23 was not allowed to work until completed. The Director of Nursing and Staff Development Coordinator are responsible for maintaining records of all licensed staff who need the in-service prior to their next shift. This education was added to the new hire orientation by the Director of Nursing on 11-30-23.

Facility alleges removal of the immediate Jeopardy as 12-1-23.

Validation of the immediate jeopardy removal plan was conducted in the facility on 12/4/23. The facility's initial plan audit was verified and signature sheet for education reviewed with no concerns. Facility nurses were interviewed and were aware of the pain management protocol, how and when to assess pain, and how to appropriately respond to a resident's request or

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F 697	Continued From page 78 nonverbal signs of pain. Facility medication aides, nurse aides, dietary staff, housekeeping staff and rehabilitation staff were also aware of the pain protocol and how to observe for nonverbal signs of pain and how to respond to resident's request or nonverbal signs of pain. The facility's immediate jeopardy removal date of 12/1/23 was validated.	F 697		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours a day for 22 out of 120 days reviewed for staffing. The failure to have RN coverage for the facility had a high likelihood of impacting every resident in the facility. The findings included:	F 727	Staff schedules were adjusted on 12/20/23 bythe staffing scheduler to ensure proper RN coverage is in place. Current residents are affected by this current deficiency. Regional Nurse Consultant educated the Director of Nursing and Administrator on 11/29/23 on providing a Registered Nurse in the facility for 8 consecutive hours for a day, 7 days a week.	1/1/24

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F 727	Continued From page 79 Review of the PBJ Staffing Data Report CASPER Report 1705D/FY Quarter 3 2023 (April 1 - June 30) compared to the Staff Schedule/Assignment Sheets, and RN timecard reports revealed that there was no RN coverage for eight consecutive hours for 4/2/23, 4/9/23, 5/6/23, 5/7/23, 5/13/23, 5/14/23, 5/15/23, 5/20/23, 6/3/23, 6/4/23, 6/10/23, 6/11/23, 6/18/23. Further review of the Posted Nurse Staffing as compared to the Staff Schedule/Assignment Sheets, and RN timecard reports revealed there was no RN coverage for eight consecutive hours for 11/4/23, 11/5/23, 11/6/23, 11/7/23, 11/9/23, 11/20/23, 11/11/23, 11/15/23, 11/18/23. An interview was conducted on 11/30/23 at 10:08 AM with the facility scheduler. She stated she had been in her position for 2 months. She stated that the facility had only 3 RNs on staff and had to rely on agency employees to help staff the facility. She further stated if the agencies did not have an RN available at that time, then they didn't have RN coverage and had to rely on the licensed practical nurses. An interview was conducted on 12/1/23 at 1:35 PM with the facility Nurse Consultant who stated she was unaware that the facility had so many days of no RN coverage at the facility. She did state that the new administrator and new director of nursing (DON) were in the process of actively hiring more staff which will include registered nurses. She also stated that she is aware of the regulation that stated the facility had to provide RN coverage for at least 8 consecutive hours a day.	F 727	The Director of Nursing and/or designee will audit schedule to ensure a Registered Nurse is in the facility for 8 consecutive hours for a day, 7 days a week weekly x 8 weeks. The Director of Nursing will be responsible for bringing the Registered Nurse audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine if further auditing will be required. Date of Compliance: 1/1/2024	
F 732 SS=C	Posted Nurse Staffing Information	F 732		1/1/24

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CFR(s): 483.35(g)(1)-(4)

§483.35(g) Nurse Staffing Information.
§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

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	345116	A. BUILDING ______ B. WING ______	C 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT HILLS CENTER FOR NURSING AND REHAB	109 S HOLDEN RD GREENSBORO, NC 27407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 81	F 732		

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to display accurate Posted Nurse Staffing Information as compared to the Staff Schedule/Assignment Sheets for 30 out of 31 days reviewed for staffing.

The findings included:

A review of the Staff Schedule/Assignment Sheets and timecard reports compared to the daily Posted Nurse Staffing Information sheets from 10/30/23 through 11/30/23 revealed discrepancies in the areas of actual hours worked and actual nursing staff who worked including the licensed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs), and the unlicensed Medication Aides (MAs), and Nursing Assistants (NAs).

The number of unlicensed and licensed staff and actual hours worked on 1st, 2nd, and 3rd shift were incorrect for the following days: 10/29/23, 10/30/23, 10/31/23, 11/1/23, 11/3/23, 11/4/23, 11/5/23, 11/6/23, 11/7/23, 11/8/23, 11/9/23, 11/10/23, 11/11/23, 11/12/23, 11/13/23, 11/14/23, 11/15/23, 11/16/23, 11/18/23, 11/19/23, 11/20/23, 11/21/23, 11/22/23, 11/23/23, 11/24/23, 11/25/23, 11/26/23, 11/27/23, 11/28/23, 11/29/23, and 11/30/23.

The facility was unable to provide staffing sheets for 11/2/23 and 11/17/23.

An interview on 11/30/23 at 10:08 AM was conducted with the facility scheduler. She had been in her role for 2 months. She stated she was responsible for completing the daily Posted Nurse

Provider's Plan of Correction:

The scheduled reviewed and corrected the daily postings from period 10/29/23 to 11/30/23 on 12/23/23. The staffing sheets for 11/2/23-11/17/23 were identified and corrected by the scheduler on 12/23/23.
All residents have the potential to be affected by incorrect or missing daily postings of staff.
The Administrator, Director of Nursing and scheduler were in-serviced by Chief Nursing Officer_ on 12/1/2 for the requirement of accuracy of daily posting, correcting the posting as schedules change and maintaining the daily postings for 18 months. This education was added to the new hire orientation for schedulers by the Director of Nursing on 12/26/23.
The Administrator or designee will complete an audit of the daily postings and compare to time cards to the posting 5 x week x 4 weeks, then 3x a week x 4 weeks then weekly x 4 weeks.
The Administrator will be responsible for bringing the daily posting audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring.
Date of Compliance 1/1/2024

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F 732	Continued From page 82 Staffing Information sheet based on the actual working assignment sheet for the day and posting them in a viewable area. The scheduler confirmed that when any nursing staff called out for the day, she was unaware she had to adjust the posting sheet. She stated that the unit manager on each shift was responsible for completing staffing sheets and alerting her of any call outs for the day but that is not being done on a consistent basis. She stated that the inconsistencies between the schedule she provided to the units vs the staffing sheets she gets in return are persistent problems. An interview on 12/1/23 at 1:03 PM was conducted with facility Nurse Consultant who confirmed that the daily Posted Nurse Staffing Information sheets were inaccurate, and she was unable to provide the missing sheets, as well. She indicated the daily Posted Nurse Staffing Information sheets did not reflect the correct actual working hours or the correct number of staff for the days reviewed.	F 732		
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.	F 756		1/1/24

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F 756	Continued From page 83 (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. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Consultant Pharmacist, and the Medical Director (MD), the Pharmacy Consultant failed to identify drug irregularities for the use of a psychotropic medication (any drug that affects brain activities associated with mental processes and behavior). This was for 1 of 8 residents reviewed for unnecessary medications (Resident #106). The findings included: Resident #106 was admitted to the facility on	F 756	Resident #106 antipsychotic medication was reviewed by pharmacy consultant and medical provider on 11/30/23. No supporting diagnosis was evident and a recommendation to D/C risperidone via taper was made by the Consultant Pharmacist on 12/24/23. All residents on antipsychotics have the potential to be affected. Lead pharmacy consultant reviewed all in house residents on antipsychotics for supporting diagnosis on 12/23/23. Any resident on	

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F 756 Continued From page 84

07/16/23 with diagnoses that included Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

Review of Resident #106's active orders revealed a physician order dated 07/16/23 for 0.5 milligrams (mg) risperidone (an antipsychotic medication) to be given as one tablet by mouth and scheduled to be administered twice daily for sleep.

Review of quarterly Minimum Data Set (MDS) assessment, dated 10/13/23, revealed Resident #106 ' s cognition was severely impaired, and he had no behaviors.

The consultant pharmacist's Medication Regimen Reviews (MRR) dated 07/26/23, 08/30/23, 09/27/23 and 10/30/23 included the following statement: Medical record reviewed including orders, available labs, progress notes. See consultant pharmacist report for consultation if any irregularities and/or recommendations. Consultant pharmacist reports dated 07/26/23, 08/30/23, 09/27/23 and 10/30/23 included the following statement: no irregularities noted.

An interview was conducted on 11/30/23 at 4:14 PM with the Medical Director. He stated Resident #106 was admitted to the facility with the order for Risperidone and had been on it for a while. He verified the resident does not have a supporting diagnosis for an antipsychotic medication. He verified Resident #106 did not have any psychotic behaviors ' and that he was receiving it for sleep. He further stated the pharmacy consultant should have made a recommendation as well.

A phone interview was conducted on 11/30/23 at

F 756

antipsychotics who did not have a supporting diagnosis was reviewed by the medical provider and the medication was discontinued or a supporting medical diagnosis was provided on 12/30/23.
The lead pharmacy consultant in-serviced the pharmacy consultant on review of antipsychotics to include reviewing for supporting diagnosis or pharmacy recommendation on 12/23/23. The medical provider was in-service by the Administrator on 12/21/23 the need of supporting diagnosis when prescribing an antipsychotic and review of medications on admission and monthly.
The Director of Nursing or designee will pull report for residents in house monthly on antipsychotics and audit the medication review from the pharmacy consultant monthly x 3 months. The Director of Nursing will review all new admissions x 3 months for antipsychotic medication and supporting documentation. The Director of Nursing will meet monthly with the medical provider to audit medication review of pharmacy consultant report and supporting diagnosis of any resident on a antipsychotic x 3 months.
The Director of Nursing will be responsible for bringing admission and monthly antipsychotic medication and supporting diagnosis audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring
Date of Compliance: 1/1/2024

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F 756	Continued From page 85 6:00 PM with the facility Pharmacy Consultant. She stated she was aware of the guidelines for needing a supporting diagnosis for prescribed antipsychotics. She indicated it was an oversight that she did not address and alert the Medical Director or the Director of Nursing (DON) of Resident #106 ' s order for Risperidone for sleep. She did not realize he did not have a supporting diagnosis for the antipsychotic. An interview was conducted on 12/01/23 at 12:35 PM with the Administrator. She stated a resident should not be on an antipsychotic medication without a supporting diagnosis and Resident #106 should not be prescribed an antipsychotic medication for sleep. She indicated the Pharmacy Consultant, and the medical director should review the medications on admission and monthly to ensure there are no irregularities or concerns with the medications.	F 756		
F 758 SS=D	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 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	F 758		1/1/24

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F 758	Continued From page 86 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. §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, staff interviews and the Medical Director interview, the facility failed to provide a diagnosis for the use of risperidone (a psychotropic medication which is any drug that affects brain activities associated with mental processes and behavior). This was for 1 of 8	F 758	Resident #106 antipsychotic medication was reviewed by pharmacy consultant and medical provider on 11/30/23. No supporting diagnosis was evident. Medical provider ordered psychiatric services for assessment of resident on	

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F 758	Continued From page 87 residents (Resident #106) reviewed for unnecessary medications. The findings included: Resident #106 was admitted to the facility on 07/16/23 with diagnoses that included Dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of quarterly Minimum Data Set (MDS) assessment, dated 10/13/23, revealed Resident #106 ' s cognition was severely impaired, and he had no behaviors. Resident #106's active care plan, last reviewed on 11/10/23, revealed a focus that read resident used psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) related to diagnosis (no diagnosis listed). Date Initiated: 08/01/2023. The interventions included administering psychotropic medications as ordered by physician. Monitor for side effects and effectiveness every shift, to consult with pharmacy, Medical Director (MD) to consider dosage reduction when clinically appropriate at least quarterly and to monitor/document/report as needed any adverse reactions of psychotropic medications. Review of Resident #106's active orders as of 11-27-22 revealed a physician order dated 07/16/23 for 0.5 milligrams (mg) risperidone (an antipsychotic medication) to be given as one tablet by mouth and scheduled to be administered twice daily for sleep. An interview was conducted on 11/30/23 at 4:14 PM with the Medical Director. He stated Resident	F 758	12/18/23. Psychiatric assessment was ordered on 12/18/23. Telehealth visit to be conducted on 12/28/23. Medical provider added diagnosis to medication on 12/28/23. All residents on antipsychotics have the potential to be affected. Lead pharmacy consultant reviewed all in house residents on antipsychotics for supporting diagnosis on 12/23/23. Any resident on antipsychotics who did not have a supporting diagnosis was reviewed by the medical provider, psychiatric services ordered for review and the medication was discontinued or a supporting medical diagnosis was provided on 12/30/23. The lead pharmacy consultant in-serviced the pharmacy consultant on review of antipsychotics to include reviewing for supporting diagnosis or pharmacy recommendation on 12/20/23. The medical provider was in-serviced by the Administrator on 12/21/23 the need of supporting diagnosis when prescribing an antipsychotic and review of medications on admission and monthly. The Director of Nursing or designee will pull report for residents in house monthly on antipsychotics and audit the medication review from the pharmacy consultant monthly x 3 months. The Director of Nursing will review all new admissions x 3 months for antipsychotic medication and supporting documentation. The Director of Nursing will meet monthly with the medical provider to audit medication review of pharmacy consultant report and supporting diagnosis of any resident on a	

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F 758	Continued From page 88 #106 was admitted to the facility with the order for Risperidone and had been on it for a while. He verified the resident does not have a supporting diagnosis for an antipsychotic medication. He further stated he should have been referred to psych services for antipsychotic use. He indicated he would refer him to psych services prior to discontinuing the Risperidone. He verified Resident #106 did not have any psychotic behaviors ' and that he was receiving it for sleep. He further stated the pharmacy consultant should have made a recommendation as well. An interview was conducted on 12/01/23 at 12:35 PM with the Administrator. She stated a resident should not be on an antipsychotic medication without a supporting diagnosis and Resident #106 should not be prescribed an antipsychotic medication for sleep. She indicated the Pharmacy Consultant, and the medical director should review the medications on admission and monthly to ensure there are no irregularities or concerns with the medications.	F 758	antipsychotic x 3 months. The Director of Nursing will be responsible for bringing admission and monthly antipsychotic medication and supporting diagnosis audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring Date of Compliance: 1/1/2024	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		1/1/24

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F 761	Continued From page 89 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure medicated treatment supplies left in an unattended treatment cart for 1 of 2 treatment carts (the upper-level treatment cart). In addition, the facility failed to secure resident medications left in an unattended medication cart for 1 of 2 medication carts (second floor- east side medication cart). The findings included: 1. During hall tour observation on 11/27/23 12:05 PM, the treatment cart #1 on the upper level beside the nurse's station was observed to be unlocked during a continuous observation from 12:05 PM to 12:17 PM. The cart lock button was not pushed in indicating the drawers, which contained the supplies in the cart, were in an unlocked position. On 11/27/23 at 12:17 PM, residents were observed ambulating around the upper-level nurse's station near the unlocked cart without any staff members present.	F 761	On 11-30-23, all medications carts were noted to be locked. Nurse #6, Medication Aide# 4, were in-serviced on 12/1/23 by Director of Nursing for locking medication cart when not in use and at the cart. All residents have the potential to be affected by this deficient practice. The Director of Nursing initiated an in-service on 12/22/23 to all licensed nurses and medication aides on locking the medication and treatment cart when not in use and at the cart. For any licensed nurse or medication aide who did not receive this in-service by 12/27/23 was not allowed to work. This in-service was added to the new hire orientation of licensed nurses and medication aides by the Director of Nursing on 12/20/23. The Director of Nursing or designee will audit for unattended medication and treatment carts. This audit will review locking of unattended carts 10 x weekly x 4 weeks, then 5x weekly x 4 weeks then 1x weekly x 4 weeks.	

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F 761	Continued From page 90 Observation of Treatment Cart #1 with the unit manager on 11/27/23 at 12:20 PM revealed the top drawer to contain topical ointments. The second drawer contained medicated dressings and bandages. Both the top and bottom drawers contained resident prescribed medicated creams for both wings of the upper level. During an interview conducted with the Unit Manager on 11/27/23 at 12:20 PM he stated the treatment nurse went downstairs and must have inadvertently left the treatment cart unlocked. He stated it should be locked when there wasn't a staff member present. On 11/27/23 at 12:40 PM an interview was conducted with the treatment nurse who stated she was made aware she had left the treatment cart unlocked by the unit manager and would make sure it didn't happen again. During an interview on 11/30/23 at 2:34 PM with the nurse consultant, she stated both the treatment carts and the medication carts should be locked at all times when not in use. 2. An observation of the second floor was conducted on 11/29/23 at 5:04 AM which revealed the medication cart for the east side of the unit was observed with the lock not engaged as evidenced by the red dot on the lock being visible. There was no staff member at the medication cart. Several staff members were observed walking past the medication cart. On 11/29/23 Medication Aide #4 was observed approaching the medication cart at 5:10 AM. An interview was completed at that time. Medication Aide #4 stated she went to use the restroom and	F 761	The Director of Nursing will be responsible for bringing locked medication and treatment cart audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	

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F 761	Continued From page 91 forgot to lock the medication cart. Medication Aide #4 explained she should have locked the medication cart prior to leaving. Medication Aide #4 revealed the contents of the unlocked medication cart which included resident medications, creams, eye drops, and over the counter medications. The narcotic drawer was observed to be locked. An interview with Nurse #6 was completed on 11/29/23 at 6:15 AM who stated his medication aides should lock the medication cart when they step away. He stated he spoke with the medication aide, and she explained she forgot to lock the medication cart due to having to use the restroom. During an interview on 11/30/23 at 2:34 PM with the nurse consultant, she stated both the treatment carts, and the medication carts should be locked at all times when not in use.	F 761		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	F 791		1/1/24

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F 791

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§483.55(b)(2) Must, if necessary or if requested, assist the resident-
(i) In making appointments; and
(ii) By arranging for transportation to and from the dental services locations;

§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;

§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident and staff interviews the facility failed to follow a Dental provider's recommendations to assist a resident in obtaining dentures. This occurred for 1 of 2 residents (Resident #46) reviewed for dental services.

The findings included:

Resident #46 was admitted to the facility

F 791

Resident #46 was scheduled for dental exam on 12/28/23. Exam to be conducted on 2/5/23 by Aria Health.
All residents who are edentulous and have the desire to have dentures have the potential to be affected. Alert and oriented residents in house who are edentulous were interviewed on 12/26/23 by Director of Nursing, Staff Development Coordinator and Unit Managers for desire

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F 791

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9/14/2018 with diagnoses that included left hemiparesis, dysphagia, and edentulous.
A review of Resident #46's orders revealed a regular texture diet.

A review of the quarterly Minimum Data Set (MDS) dated 10/24/2023 revealed Resident #46 was cognitively intact and had no rejection of care. The MDS documented the resident had no complaints or difficulty with swallowing, no coughing or choking during meals, and had not experienced weight loss.

A review of the care plan revised 10/24/2023 included a focused area that was initiated 12/28/2018, that read; Resident #46 has an oral/dental health problem related to missing his teeth. The interventions included coordinating arrangements for dental care and transportation as needed or as ordered.

A review of the dental provider documentation for Resident #46 revealed:

1) 12/12/2022 Resident was seen at the bedside and seems to be eating food well and maintaining weight at the time of the exam. Resident was edentulous and had no removable dentures. Resident desired to have dentures made at that time. Resident #46 can accommodate wearing dentures. Recommendations for follow up for impressions for the new maxillary (upper jaw) and mandibular (lower jaw) dentures to be completed.

2) 5/15/2023 Resident was seen and wants dentures. The Dental provider documented the resident was a good candidate for dentures. The recommendations for follow up included impressions for the upper and lower dentures.

F 791

of dentures. Any resident who is unable to make needs know, the responsible party was interviewed for desire of dentures. Any resident or responsible party of the resident verbalizes the desire for dentures, a consultation was submitted by 12/28/23.
The Director of Nursing initiated an in-service to all staff that if a resident or responsible party of the resident verbalizes a desire to have dentures, this will be reported to the Director of Social Services and the consultation for such will be made. This in-service was initiated on 12/22/23. Any staff who did not receive this in-service by 12/27/23 will not be allowed to work until the in-service is completed. The Director of Nursing added this to staff new hire orientation on 12/27/23.
The Director of Social Services or designee will audit all new edentulous admissions for desire of dentures x 3 months.
The Director of Social Services or designee will be responsible for bringing the edentulous audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring.
Date of Compliance: 1/1/2024

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F 791	Continued From page 94	F 791		

An interview was conducted with Resident #46 on 11/28/2023 at 10:07 a.m. and the Resident revealed he does not have teeth. He stated he had dentures 5 years ago and claimed the facility misplaced or lost his dentures. He added he had been trying to obtain a new pair of dentures since then and was informed by the dentist a mold would be made to begin the process, but this had not occurred.

An observation was conducted of Resident #46 on 11/28/2023 at 1:26 p.m. during lunch and no difficulties with eating were noted.

An interview was conducted with the Corporate Nurse Consultant #2 on 12/01/2023 at 12:15 p.m. and she revealed she had contacted the Dental Provider to receive all visit summaries and reviewed the medical record. She added she did not locate any visits that were scheduled to obtain dental impressions or to obtain a new set of dentures. She added a care plan meeting was conducted in October 2023 and the Resident had made the administrative team aware of his desire to obtain dentures. She was not able to locate a dental visit scheduled since the care plan meeting.

An interview was conducted on 12/01/2023 at 12:39 p.m. with Nursing Assistant (NA) #2 and she revealed she had been assigned to Resident #46 often and the Resident had expressed to her that his dentures had been missing for years. She stated she had not reported the missing dentures to anyone and was unaware if he wanted to replace them.

A follow up interview was conducted on 12/01/2023 at 12:41 p.m. with Resident #46 and

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F 791	Continued From page 95 he revealed he had requested dentures so often that he had forgotten how many times. He stated not having the dentures he had requested makes him feel like the administration of the facility had neglected to honor his request and he felt like he does not matter because they do not care about him. An interview was conducted with the Administrator on 12/01/2023 at 2:15 p.m. and she revealed she had recently taken on the role at the facility and had been unaware of the Resident's desire to obtain dentures or the dental providers recommendations for dentures. She all staff should follow up on provider recommendations and resident request.	F 791		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility failed to honor food preferences for 1 of 7 residents reviewed for preferences (Resident #71). Findings included:	F 806	On 12/20/23, resident #71 preferences were o btained by the DIeatry Manager and entered into the medical record tray system. On 12/20/23, dietary preferences were updated for all residents in the medical record tray system by the dietary	1/1/24

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F 806	Continued From page 96 Resident #71 was admitted to the facility on 10/06/2021. Review of the dietary progress note dated 10/13/2022 indicated Resident #71 requested a diabetic diet with yogurt at every meal. Resident #71's quarterly Minimum Data Set (MDS) dated 09/05/2023 revealed Resident #71 was cognitively intact. Review of the care plan dated 10/03/2023 revealed Resident #71 had a potential nutritional problem. The interventions included determining Resident #71's food preferences, providing them at mealtime and providing a controlled carbohydrate diet per Resident #71's request. During an interview on 11/27/2023 at 10:13 A.M Resident #71 stated she was not receiving yogurt with her meals. Resident #71 indicated she requested yogurt with every meal due to wanting more protein and it was listed on her meal tickets. During an observation on 11/27/2023 at 1:40 P.M. Resident #71 received pot roast with gravy, rice pilaf, sugar cookie, milk and iced tea. Resident #71 did not receive yogurt. Review of the meal ticket dated 11/27/2023 revealed Resident #71 was to receive a container of yogurt. During an observation on 11/28/2023 at 8:50 A.M. Resident #71 received french toast, oatmeal, cranberry juice, milk and a container of yogurt. Further review of the container of yogurt revealed an expiration date of 11/19/2023. Resident #71 was observed not eating the yogurt due to the expiration date.	F 806	manager. On 12/1/23, the contract for dietary service was terminated and all dietary staff were converted to facility staff on 12/2/23. All current residents have the potential to be affected by this current deficiency. Education was provided to the Dietary Manager on 12/22/2023 by the Regional Dietary Manager on obtaining food preferences & tray card accuracy. The Regional Dietary Manager initiated an in-service to all Dietary staff to include cooks and aides on tray card accuracy on 12/22/2023. Any dietary staff who did not receive this education by 12/22/2023 are not allowed to work until this in-service has been completed. The Regional Dietary Manager and/or designee will conduct 10 resident interviews weekly x 12 week for updated preferences. The Dietary Manager or designee will be responsible for bringing the preference audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	

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F 806	Continued From page 97	F 806		

During an observation and interview on 11/28/2023 at 2:50 P.M. Resident #71 stated she received everything listed on her meal ticket for lunch but did not receive yogurt. Review of the meal ticket dated 11/28/2023 revealed Resident #71 was to receive southern fried chicken, macaroni and cheese, chopped spinach, dinner roll, pear crisp, yogurt, milk, and unsweetened tea.

During an observation on 11/29/2023 at 8:48 A.M. Resident #71 received biscuits with sausage gravy, oatmeal, cranberry juice and milk. Resident #71 did not receive yogurt. Review of the meal ticket dated 11/29/2023 revealed yogurt was crossed out with a black line.

An interview was conducted on 11/30/2023 at 12:54 P.M. with Nursing Assistant (NA) #6 who revealed she was not aware that Resident #71 was to receive yogurt with every meal. NA #6 stated when a resident reported to her something was missing from their meal tray, she would go to the kitchen and request the missing item. NA #6 further stated if the missing item was not available then she requested a substitute.

An interview conducted on 11/30/2023 at 3:26 P.M. with the Dietary Manager who revealed she was not familiar with Resident #71. The Dietary Manager stated when a resident had a dietary request, a preference sheet was filled out and the resident's meal ticket was updated to reflect their food preferences. She was unable to locate a preference sheet for Resident #71. The Dietary Manager indicated the kitchen ran out of yogurt on 11/27/2023 and she purchased more from a local store. She stated she was not made aware that the yogurt she purchased was expired until

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F 806	Continued From page 98 11/28/2023 after it had been sent to Resident #71. The Dietary Manager indicated the nursing staff notified the kitchen when a resident was missing something from their meal tray and dietary staff would bring the missing item to the resident. She stated if a missing item was not available a substitute would be offered. The Dietary Manager further stated unavailable items were not to be crossed off on the resident's meal ticket and dietary staff should review the meal tickets for accuracy prior to the meal tray leaving the kitchen.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure the	F 812	On 11/28/23, a meal delivery cart was ordered to replace the open food cart. On	1/1/24

F 812

Continued From page 99

sanitizing solution (chlorine) was maintained at the required concentration of 50 ppm (parts per million) during the final rinse cycle according to manufacturer's instructions in the low temperature dish machine. And failed to ensure the ceiling in the kitchen, meal delivery carts, and venting units were clean, free from debris, and/or in good working condition; and pots and pans stacked for use were clean and dry on the storage rack. The facility also failed to ensure the personal food items stored in the nourishment refrigerator/freezer in 1 of 2 residents' nourishment rooms (the first-floor nourishment room) were labeled and dated. These practices had the potential to affect food served to all residents.

Findings included:

1. During the initial tour of the kitchen on 11/27/23 at 10:15 a.m., the operation of the low temperature dishwasher of the soiled breakfast dishes by dietary staff #1 and dietary staff #2 was observed. The sanitizing solution (chlorine) for the low temperature dishwasher did not register on the chlorine testing strips provided by the dietary staff. Dietary Aide (DA#1) stated that earlier that morning the chlorine strip read 50 ppm, which it should be. However, the dietary aides continued operating the dishwasher. After retesting the concentration of the chlorine solution in the dishwasher with the same results, the DM directed the 2-dietary staff to discontinue using the dishwasher and a service repairman was notified.

2a. On 11/27/23 at 10:52 a.m. a large

F 812

12/4/23, the hole in the ceiling was covered with plastic to prevent debris falling into food. On 12/4/23, the vent for the AC unit was cleaned. On 12/4/23, the doors on one of the meal delivery carts were replaced. On 12/20/23, meal tray cart doors were replaced. On 12/21/23, a meal delivery cart was ordered for over-flow trays stored on top of carts. On 12/1/23, the contract for dietary service was terminated and all dietary staff were converted to facility staff on 12/2/23
All current residents have the potential to be affected by this current deficiency.
Education was provided to the Dietary Manager on 12/22/2023by the Regional Dietary Manger on Dish Machine Operation & Log Maintenance, including proper storage; Nourishment Room Refrigerator & Freezer Policy; The Regional Dietary Manager initiated an in-service to all Dietary staff to include cooks and aides on Dish Machine Operation & Log Maintenance & Nourishment Room Refrigerator & Freezer Policy on 12/4/2023. Any dietary staff who did not receive this education by 1/1/2024 are not allowed to work until this in-service has been completed.
The Regional Dietary Manager or designee will conduct a Dish Machine audit 5x a week x 8 weeks. The Regional Dietary Manager or designee will conduct a Nourishment Room Refrigerator audit 5x a week x 8 weeks.
The Dietary manager will be responsible for bringin the dish machine and nourishment room audit to the Quality Assurance Performance Improvement

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F 812	Continued From page 100 (approximately 12 inches by 12 inches) square hole with an exposed black pipe was observed in the ceiling in the kitchen between the dishwashing area and the food preparation area. Three large vent panels in one of the lower walls in the kitchen were filled with thick, dark gray/black lint. During an interview on 11/27/23 at 10:53 a.m., the DM revealed there was a continuous leaking problem from the pipes in the ceiling and the facility's maintenance department had been working to repair the leaks for approximately two weeks. The DM acknowledged the large hole in the ceiling with the exposed pipe in the kitchen was not covered during these two weeks. 2b. During a dining observation on 11/27/23 at 1:06 p.m., meal trays for the residents on the 100-east hall were delivered in a semi-closed meal delivery cart. One side of the double-hinged door of the delivery cart was missing. Also, 5-meal trays were on top of the delivery cart and 2-meal trays had broken and cracked edges. An interview with the DM on 11/27/23 at 1:15 p.m. revealed one of double doors to the delivery cart has been missing since she began working at the facility in October 2023. She stated the maintenance staff was aware and was working on getting a replacement door for the delivery cart. The DM also revealed she had placed a request to administration for more meal delivery carts due to the lack of carts for the number of residents served. She stated the dietary department currently had four delivery carts of which two needed some repair. 2c. On 11/30/23 at 8:40 a.m., a follow-up kitchen	F 812	Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	

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F 812	Continued From page 101	F 812		

observation revealed the large hole in the ceiling with the exposed pipe continued to be uncovered. The three large wall panel vents remained full of dark gray/black lint. The four removable vent panels on the ice machine were also observed covered with dark gray lint.

During an interview on 11/30/23 at 8:42 a.m., the DM stated the maintenance department was responsible for cleaning the wall vents in the kitchen but was unsure when last cleaned. The DM added she had observed the maintenance staff clean the vents in the ice machine but was unsure the last date the vents in the ice machine were cleaned.

3. On 11/30/23 at 8:50 a.m., an observation of the stainless-steel pots and pans stacked on the storage racks in the kitchen was conducted with the Regional Dietary Consultant. The following pans were observed stacked wet: 1-large sheet pan and 1-(1/4 sized) 6"deep pan. The following pans stacked with dried stains/debris: 6-large muffin pans; 1-6"deep pan; 1-(1/2sized) 6"deep pan; 1-(1/3sized) 4"deep pan. There was also 1-#8 scoop covered with a white substance in a stack of cleaned serving utensils on the storage rack. The Regional Dietary Consultant acknowledged the wet and dirty conditions of the pans and serving scoop and transferred these items to the dishwashing area to be rewashed.

4. On 11/30/23 at 10:10 a.m., one of two of the facility's nourishment rooms (first- floor nourishment room) was observed with the Regional Dietary Consultant. There were three unopened bags of precooked entrees with a

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F 812	Continued From page 102 handwritten date of 10/31 in the freezer. There was no resident's name and no resident's room number on any of the frozen bags. The Regional Dietary Consultant confirmed the three frozen bags of food did not consist of a resident's name and room number as required. He discarded the three frozen bags of food into the trash bin in the nourishment room.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		1/1/24

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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.

§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;

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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 (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

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F 867	Continued From page 105 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor intervention the committee put in place following a focus infection control survey conducted on 2/05/21. This was evident for seven deficiencies that were cited in the areas of Environment (homelike), Activities of daily living for dependent Resident, Comprehensive Resident Centered Care Plan (Discharged planning process)Bowel/Bladder incontinence ,Resident Allergies, Preferences and Substitutes and Food Procurement, Store/Prepare/Serve-Sanitary and on the current recertification and complaint survey conducted on 12/04/23. The facility's Quality Assessment and Assurance (QAA) Committee also failed to maintain implemented procedures and monitor intervention the committee put in place following an annual recertification and complaint survey conducted on 12/13/21. This was evident for six deficiencies that was cited in the areas of Environment (homelike), Resident Assessment (Accuracy of Assessment), bowel/bladder incontinence, catheter, Registered Nurse coverage, Posted Nursing Staffing and Free from unnecessary psychotropic medications and on the current recertification and complaint survey on 12/04/23. The QAA additionally failed to maintain implemented procedures and monitor interventions the committee put in place following recertification and complaint survey conducted on	F 867	The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor intervention the committee put in place following a focus infection control survey conducted on 2/05/21. This was evident for seven deficiencies that were cited in the areas of Environment (homelike), Activities of daily living for dependent Resident, Comprehensive Resident Centered Care Plan (Discharge planning process) Bowel/Bladder incontinence, Resident Allergies, Preferences and Substitutes and Food Procurement, Store/Prepare/Serve Sanitary and on the current recertification and complaint survey conducted on 12/04/23. The facility's Quality Assessment and Assurance (QAA) Committee also failed to maintain implemented procedures and monitor intervention the committee put in place following an annual recertification and complaint survey conducted on 12/13/21. This was evident for six deficiencies that was cited in the areas of Environment (homelike), Resident Assessment (Accuracy of Assessment), bowel/bladder incontinence, catheter, Registered Nurse coverage, Posted Nursing Staffing and Free from unnecessary psychotropic medications and on the current recertification and complaint survey on	

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F 867	Continued From page 106 08/19/22. This was evident for six deficiencies that were cited in the areas of Resident Assessment (Accuracy of Assessment), Registered Nurse coverage, Drug Regimen Review and Food Procurement, Store/Prepare/Serve-Sanitary and on the current recertification and complaint survey conducted on 12/04/23. The duplicate citations during four federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Findings included: F 580: Based on record review, observations, resident interview, staff interviews, and Medical Director interview, the facility staff failed to notify medical provider of resident's complaint of right shoulder pain, and genitalia for 1 of 1 resident reviewed. (Resident #518). During the recertification and complaint survey conducted on 12/13/21 the facility failed to inform the nurse practitioners that wound care was not completed as ordered. The facility additionally failed to notify the urologist that Resident #19 ' s recommendations were not implemented. This was evident for 3 of 3 residents reviewed for notification of change. F584Based on observation, record review and interviews with resident and staff, the facility failed to maintain a dresser drawer in good repair for 1 of 2 residents reviewed for a safe comfortable, homelike environment (Resident #98). During the recertification and complain survey conducted on 12/4/21 the facility failed to maintain an odor free living environment for	F 867	12/04/23. The QAA additionally failed to maintain implemented procedures and monitor interventions the committee put in place following recertification and complaint survey conducted on 08/19/22. This was evident for six deficiencies that were cited in the areas of Resident Assessment (Accuracy of Assessment), Registered Nurse coverage, Drug Regimen Review and Food Procurement, Store/Prepare/Serve-Sanitary and on the current recertification and complaint survey conducted on 12/04/23. The duplicate citations during four federal surveys of record s A plan of correction was put into place at the time of the deficiency cited. The plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined period of time. Monitoring of the plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated an in-service to all administrative staff on 12/4/2023 regarding Quality Assurance Performance Improvement (QAPI) process including identifying and prioritizing quality deficiencies, systemically analyzing causes of quality deficiencies, developing, and implementing corrective action or performance improvement activities. This in-service included accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the	

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rooms 205, 213, 218, 223, 224, 226 and in the facility common areas on the 200 hall. The facility additionally failed to maintain clean furniture, bathrooms floors and toilets in rooms 205,220, 222 and 223. This was evident for 9 of 34 rooms observed on the 200 hall.

During the complaint and infection control survey conducted on 02/05/21 the facility failed to (1) maintain flooring, an overbed table, and shower room clean. (2) failed to maintain an odor free environment. (3) failed to maintain privacy curtain hooks and tracks, toilets, and water faucets in good repair This was evident in 1 of 2 resident floors. (2nd floor).

F 607: Based on record review, resident and staff interviews, the facility failed to implement their abuse policy for immediately notifying the Administrator of allegations when they 1) failed to notify the Administrator of an allegation of abuse (Resident #116) and 2) failed to notify the Administrator of misappropriation of resident property (Resident #267). This deficient practice occurred for 2 of 7 residents reviewed for abuse.

During the recertification and complaint survey conducted on 08/19/22 the facility failed to report the allegation of mistreatment within the specified timeframe of 2 hours. This was evident for 1 of 3 alleged abuse investigations completed by the facility (Resident #3).

F 641 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 6 of 6 residents reviewed for MDS accuracy. (Resident #99, Resident #11, Resident 102, Resident #518,

F 867

effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff worked util they received appropriate education.
The QAPI committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance.
The Administrator will be responsible for the plan of correction.
Date of Compliance: 1/1/2024

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Resident #80, and Resident #51).

During the recertification and complaint survey conducted on 08/19/22 the facility failed to accurately code a discharge and a quarterly Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for facility discharge for 1 of 1 resident reviewed for behaviors.

During the recertification and complaint survey conducted on 12/13/21 the facility failed to accurately code the Minimum Data Set (MDS) for opiate medication for 1 of 24 residents reviewed for MDS.

F 660: Based on record review, Responsible Party, and staff interviews the facility failed to have a discharge planning process in place for a resident with a discharge goal of transferring to an alternate facility for 1 of 1 sampled resident for discharge planning (Resident #98).

During the complaint and focus infection complain survey conducted on 02/05/21 the facility failed to implement an effective discharge plan for a resident who required home health services, foot care, physical therapy and occupational therapy when discharged from the facility for 1 of 3 residents who were discharged from the facility to home.

F 677 Based on observation, record review, resident and staff interviews, the facility failed to provide oral hygiene to a resident (Resident #69) dependent on staff for activities of daily living (ADL). This occurred for 1 of 10 residents reviewed for ADL.

During the complaint and focus infection control

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survey conducted on 02/05/21 the facility failed to provide incontinence care to keep residents clean for 1 of 3 sampled residents who were dependent on staff for activities of daily living.

F 690 Based on record review, observations, resident interview, and staff interviews the facility failed to maintain a resident's continence status for 2 of 2 residents who were continent to both bowel and bladder. (Resident #518 and Resident #167)

During the recertification and complaint survey conducted on 12/13/21 the facility failed to obtain a physician order for the use of an indwelling urinary catheter and failed to follow a urologist order for a voiding trial for one of one resident reviewed for indwelling urinary catheter use.

During the complaint and focus survey conducted on 02/05/21 the facility failed to keep the indwelling urinary catheter stabilized and the urinary drainage bag and tubing from looping, touching, and dragging on the floor. This was evident in 1 of 3 residents reviewed for urinary catheters.

F 727 Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours a day for 22 out of 120 days reviewed for staffing. The failure to have RN coverage for the facility had a high likelihood of impacting every resident in the facility.

During the recertification and complaint survey conducted on 08/19/22 the facility failed to have a Registered Nurse scheduled for 8 consecutive hours a day for 1 (07/25/22) of 30 days reviewed.

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During the recertification and complaint survey conducted 12/13/21 the facility failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 7 of 31 days.

F 732: Based on record review and staff interviews, the facility failed to display accurate Posted Nurse Staffing Information as compared to the Staff Schedule/Assignment Sheets for 30 out of 31 days reviewed for staffing.

During the recertification and complaint survey conducted 12/13/21 the facility failed to ensure daily nurse staffing information was posted for two consecutive days in a prominent place readily accessible to residents and visitors.

F 756: Based on record review, staff interviews, Consultant Pharmacist, and the Medical Director (MD), the Pharmacy Consultant failed to identify drug irregularities for the use of a psychotropic medication (any drug that affects brain activities associated with mental processes and behavior). This was for 1 of 8 residents reviewed for unnecessary medications (Resident #106).

During the recertification and complaint survey conducted on 08/19/22 the facility failed to complete an evaluation of Resident #72's medication regimen that identified the need to monitor injectable and oral diabetes medications for 4 of 4 medication regimen reviews. Resident #72 received weekly injectable and daily oral diabetes medication without blood sugar testing as ordered and experienced critically high blood sugars identified at the hospital. This deficient practice occurred for 1 of 6 sampled residents

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F 867	Continued From page 111 reviewed for medication regimen review. F 758: Based on record review, staff interviews, Consultant Pharmacist, and the Medical Director (MD), the Pharmacy Consultant failed to identify drug irregularities for the use of a psychotropic medication (any drug that affects brain activities associated with mental processes and behavior). This was for 1 of 8 residents reviewed for unnecessary medications (Resident #106). During the recertification and complaint survey on 12/13/21 the facility failed to identify drug irregularities for the use of a psychotropic medication (any drug that affects brain activities associated with mental processes and behavior). This was for 1 of 8 residents reviewed for unnecessary medications. F 806: Based on observations, record review, staff, and resident interviews the facility failed to honor food preferences for 1 of 7 residents reviewed for preferences (Resident #71). During the complaint and focus infection control survey on 02/05/21 the facility failed to honor the beverage preferences for 1 of 3 residents reviewed for food palatability. F 812 Based on observations, record review and staff interviews, the facility failed to ensure the sanitizing solution (chlorine) was maintained at the required concentration of 50 ppm (parts per million) during the final rinse cycle according to manufacturer's instructions in the low temperature dish machine. And failed to ensure the ceiling in the kitchen, meal delivery carts, and venting units were clean, free from debris, and/or in good working condition; and pots and pans	F 867		

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F 867	Continued From page 112 stacked for use were clean and dry on the storage rack. The facility also failed to ensure the personal food items stored in the nourishment refrigerator/freezer in 1 of 2 residents' nourishment rooms (the first-floor nourishment room) were labeled and dated. These practices had the potential to affect food served to all residents. During the recertification and survey conducted on 08/19/22 the facility failed to label and date food, so it was used by its use-by-date or discarded. Salad dressing, pickle relish and thickened liquids were not monitored in 2 of 2 refrigerated units. During the complaint and focus survey conducted on 02/05/21 the facility failed to maintain the temperatures of hot foods being served from the kitchen's steam table at 135 degrees Fahrenheit (F.) or higher for five of five resident meals that were observed being prepared from the steam table. An interview with the Administrator was conducted on 12/04/23 at 2:30pm. She revealed that her expectation was to sustain an effective QAPI Committee to ensure the facility does not recite a previous deficient practice.	F 867		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883		1/1/24

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receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:

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F 883	Continued From page 114 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure the residents' medical record included pneumococcal immunization status to include to inform, offer, and provide education on the pneumococcal immunization. This occurred for 3 of 5 residents (Resident #54, #71, and #80) reviewed for pneumococcal immunization status. The findings included: A review of the facility policy titled; "Pneumococcal Vaccine" revised January 2023 read: upon admission nursing staff will document in the Immunization Record the resident's history of immunization with the pneumococcal vaccine. 1)Resident #54 was admitted to the facility on 3/29/2023. A review of the quarterly Minimum Data Set (MDS) dated 10/13/2023, for Resident #54, was reviewed for the immunization section. The pneumococcal vaccine question had documentation that read: the vaccine was not up to date and had not been offered. A review of Resident #54's medical record revealed there was no documentation to indicate	F 883	Resident#54, #71, and #80 medical records were updated by the Staff Development Coordinator for the pneumococcal vaccine on 12/26/23 after education provided and the residents declined the pneumocococal vaccine. An audit of all in house residents medical chart for pneumococcal vaccine status was conducted on 12/26/23 by Staff Development Coordinator. Any resident who was eligible for the pneumococcal vaccine was educated, and offered. The consent or declination was updated in the resident medical chart by the Staff Development Coordinator. The Director of Nursing initiated an in-service for the Staff Development Coordinator/Infection Preventionist on updating residents medical charts for pneumococcal vaccine status, educating, and offering on 12/21/23. The Director of Nursing or designee will audit all new admissions x 3 months for pneumococcal vaccine status in the medical chart. The Director of Nursing will be responsible for bringing the pneumococcal chart audit to the Quality Assurance Performance Improvement	

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F 883	Continued From page 115 whether the Resident received or refused a pneumococcal vaccine. An interview was conducted with the Staff Development Coordinator/facility infection preventionist (SDC/IP) on 12/1/2023 at 2:15 p.m. She revealed all resident's immunization record was to be documented in the immunization section in the electronic medical record. She added that the facility does not use a paper chart system for filing. She added that the hall nurse that completes a resident's admission was responsible for documenting the resident's immunization history. She stated the immunization documentation was up to date and current. She stated any immunization information that is not in the electronic medical record could be in storage from medical records. An interview was conducted with the Administrator on 12/1/2023 at 2:23 p.m. and she revealed the infection preventionist was responsible for the administration of immunizations. She added the Director of Nursing, or a designated staff member was responsible for obtaining consents for immunizations. She added the signed consents should be stored in the medical record for a resident and the facility does not have a paper chart. When asked about the missing consents and immunization history for Resident #54's medical record she stated they could possibly be stored in the medical records, and she would have a staff member search for the missing influenza and pneumococcal records. On 12/4/2023 the influenza information for Resident #54 was provided and no documentation for the pneumococcal status of	F 883	Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT HILLS CENTER FOR NURSING AND REHAB	109 S HOLDEN RD GREENSBORO, NC 27407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 116	F 883		

Resident #54 was provided.

2)Resident #71 was admitted to the facility on the facility on 10/6/2021.

A review of the quarterly MDS dated 9/5/2023, for Resident #71, was reviewed for the immunization section. The pneumococcal vaccine question had documentation that read: the vaccine was not up to date and had not been offered.

A review of Resident #71's medical record revealed there was no documentation to indicate whether the Resident received or refused a pneumococcal vaccine.

An interview was conducted with the Staff Development Coordinator/facility infection preventionist (SDC/IP) on 12/1/2023 at 2:15 p.m. She revealed all resident's immunization record was to be documented in the immunization section in the electronic medical record. She added that the facility does not use a paper chart system for filing. She added that the hall nurse that completes a resident's admission was responsible for documenting the resident's immunization history. She stated the immunization documentation was up to date and current. She stated any immunization information that is not in the electronic medical record could be in storage from medical records.

An interview was conducted with the Administrator on 12/1/2023 at 2:23 p.m. and she revealed the infection preventionist was responsible for the administration of immunizations. She added the Director of Nursing, or a designated staff member was responsible for obtaining consents for

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F 883	Continued From page 117	F 883		

immunizations. She added the signed consents should be stored in the medical record for a resident and the facility does not have a paper chart. When asked about the missing consents and immunization history for Resident #71's medical record she stated they could possibly be stored in the medical records, and she would have a staff member search for the missing influenza and pneumococcal records.

On 12/4/2023 the influenza information for Resident #71 was provided and no documentation for the pneumococcal status of Resident #71 was provided.

3)Resident #80 was admitted to the facility on 4/28/2022.

A review of the comprehensive MDS dated 9/2/2023, for Resident #80, was reviewed for the immunization section. The pneumococcal vaccine question had documentation that read: the vaccine was not up to date and had not been offered.

A review of Resident #80's medical record revealed there was no documentation to indicate whether the Resident received or refused a pneumococcal vaccine.

An interview was conducted with the Staff Development Coordinator/facility infection preventionist (SDC/IP) on 12/1/2023 at 2:15 p.m. She revealed all resident's immunization record was to be documented in the immunization section in the electronic medical record. She added that the facility does not use a paper chart system for filing. She added that the hall nurse that completes a resident's admission was

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F 883	Continued From page 118 responsible for documenting the resident's immunization history. She stated the immunization documentation was up to date and current. She stated any immunization information that is not in the electronic medical record could be in storage from medical records. An interview was conducted with the Administrator on 12/1/2023 at 2:23 p.m. and she revealed the infection preventionist was responsible for the administration of immunizations. She added the Director of Nursing, or a designated staff member was responsible for obtaining consents for immunizations. She added the signed consents should be stored in the medical record for a resident and the facility does not have a paper chart. When asked about the missing consents and immunization history for Resident #80's medical record she stated they could possibly be stored in the medical records, and she would have a staff member search for the missing influenza and pneumococcal records. On 12/4/2023 the influenza information for Resident #80 was provided and no documentation for the pneumococcal status of Resident #80 was provided.	F 883		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual	F 914		1/1/24

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F 914	Continued From page 119 privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to provide a privacy curtain for 1 of 1 rooms (Room 232) reviewed for privacy. The findings included: Resident #80 was admitted to the facility on 4/28/22. Her most recent annual Minimum Data Set dated 9/2/23 revealed that she was severely cognitively impaired. On 11/27/23 at 9:37 AM, an observation of Resident #80's room revealed half of the metal track on the ceiling was noticed to be missing and there was no privacy curtain hung. During an interview on 11/27/23 at 11:30 AM with Nurse Aide (NA) #6, assigned to Resident #80, she stated that she thought the curtain was removed a couple days ago because it was dirty but she was not sure. She stated that she will use the roommate's curtain to shield Resident #80 from view or she will shut the room door if the roommate is out of the room. During an interview on 11/27/23 at 12:10 PM with the unit manager, he stated that another resident wandered into Resident #80's room and pulled the curtain down along with ½ of the metal track off the ceiling. He was unsure when the incident occurred but felt like it had "been a while" He stated that staff were supposed to document on	F 914	Resident #80 metal track on the ceiling was repaired by the Maintenance Director on 11/29/23, and a privacy curtain hung on 11/29/23 by Maintenance Director. All resident rooms were audited by the Director of Plant Operations on 12/21/23 for missing metal track and missing privacy curtains. Any room that had missing metal tracks or privacy curtains were repaired and hung on 11/29/23 by Maintenance Director. The Administrator initiated an in-service to the Maintenance Director and Housekeeping Supervisor on ensuring metal tracks and privacy curtains are in working order and hung on 12/21/23. The Administrator initiated an in-service to all staff on reporting missing metal tracks and missing privacy curtains on 12/22/23. Any staff who did not receive this in-service by 12/27/23 was not allowed to work until this in-service was completed. This education was added to the new hire orientation by the Administrator on 12/22/23. The Administrator or designee will be responsible for auditing 10 resident rooms weekly for missing tracks or missing privacy curtains x 4 weeks, then 5 resident rooms weekly x 4 weeks then 1 resident room x 1 month. The Administrator will be responsible for bringing the metal track and privacy curtain audit to the Quality Assurance Performance Improvement Committee x 3	

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F 914	Continued From page 120 the clipboard at the nurse's station items that needed to be fixed by maintenance. He did not know why no one had addressed the missing curtain. During an interview on 11/28/23 at 10:30 AM, the maintenance director stated that he was waiting for the metal piece for the ceiling to come in and would fix it when it arrived. During an interview with the administrator on 11/28/23 at 3:35 PM, she stated she was unaware of Resident #80's missing privacy curtain and track and that she expected staff to communicate with maintenance about all issues that affected residents and their rooms. She stated that the curtain would be fixed that day. The administrator stated her expectation was to provide full visual privacy to residents.	F 914	consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 1/1/2024	
F 944 SS=F	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure they had provided mandatory training that outlined and informed all their staff of the elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program.	F 944	The facility was unable to correct the deficiency at the time of the survey. All residents have the potential to be affected by this deficient practice The Staff Development Coordinator initiated an in-service training for all staff on Quality Assurance Performance	1/1/24

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F 944	Continued From page 121 Findings included: During an interview with the Staff Development Coordinator (SDC) on 11/30/23 at 10:35 AM the SDC stated she had been working in her role at the facility for 2 months and had not completed any QAPI in-servicing for the staff as a part of the mandatory yearly facility training. The SDC stated she was also unable to locate any staff QAPI training completed by the previous SDC. During an interview with the facility administrator on 12/1/23 at 9:48 AM she stated the key facility staff was meeting monthly, but she was not aware of the regulation that stated all facility staff should be trained yearly on the facility QAPI program and the current goals they are working towards.	F 944	Improvement (QAPI) on 12/22/2023. The training included what current topics were being developed and tracked by the facility. Any staff who did not receive the training by 1/1/2024, was not allowed to work until this was completed. The Administrator or designee will conduct 10 random audits weekly x 4 weeks with staff on what QAPI is, then 5 random audits weekly x 4 weeks then 1 audit weekly x 1 month. The Administrator or designee will be responsible for bringing the QAPI audits to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance 1/1/2024	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		1/1/24

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F 947	Continued From page 122 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the mandatory twelve hours of annual in-servicing for 1 of 4 nursing assistants (NA) #1 reviewed for competent nursing staff. The findings included: NA #1 date of hire was 7/21/21. Review of NA #1's educational record did not include 12 hours of the annual mandatory in-servicing for 2022 or 2023. The Staff Development Coordinator was interviewed on 11/30/23 at 9:30 AM. She stated she was new to her role and had been with the facility for 2 months. She stated that the facility did not use an online in-servicing program and was currently still paper-based. She was unable to explain how NA #1's training requirements were missed and added that she was in the process of reviewing all staff members' training files. The Regional Nurse Consultant provided documentation on 12/1/23 at 11:42 AM of NA #1's completed dementia and annual mandatory in-servicing totaling 2.25 hours on 11/22/23. She stated that she was also unable to find the training record for NA #1. She stated that she was aware that all nurse aides must have the annual mandatory in-servicing.	F 947	Nursing Assistant #1 completed 12 hours of annual mandatory training on 12/28/23. The Staff Development Coordinator provided this training. All residents have the potential to be affected by this deficient practice. All current certified nursing assistant's education file was audited for the 12 hours of mandatory annual training on 12/29/23 by the staff development coordinator. Any certified nursing assistants who had not completed the 12 hours of mandatory annual training, was completed by the Staff Development coordinator or designee by 1/1/2024. The Regional Nurse Consultant educated the Staff Development Coordinator on 11/30/23 the 12-hour mandatory annual in-service requirement for certified nursing assistants. The Director of Nursing or designee will audit all certified nursing assistants within one month of hire for the next 3 months, then annually in November. The Director of Nursing will be responsible for bringing the annual training audit to the Quality Assurance Performance Improvement Committee x 3 consecutive meetings. The Quality Assurance Committee will determine the need for further education and monitoring Date of Compliance 1/1/24	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 640

Encoding/Transmitting Resident Assessments
CFR(s): 483.20(f)(1)-(4)

§483.20(f) Automated data processing requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to electronically transmit to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System, a comprehensive Minimum Data Set (MDS) assessment, within 14 days of the Completion Date for 1 of 2 resident reviewed. (Resident #102)

Findings included:

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345116	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY COMPLETE: 12/4/2023
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 1 Resident #102 was admitted to the facility on 5/5/23. A review of Resident #102 admission MDS assessment with an ARD of 5/11/23 was signed as completed on 7/20/23. The assessment was submitted to the QIES ASAP system on 8/22/23. An interview with the Regional MDS Nurse Coordinator on 11/29/23 at 2:20pm, revealed that assessments were completed and submitted late because the facility did not have an MDS Nurse coordinator. An Interview with MDS Nurse #1 on 11/30/23 at 3:05pm, indicated that she worked remotely to assist the facility with completing MDS assessments. She further indicated that the MDS assessments were late because the previous MDS nurse could not get caught up. An interview was conducted with the Director of Nursing (DON) on 12/1/23 at 10:30am. The DON indicated she required MDS assessments to be completed and submitted in a timely manner, but sometimes that was not possible because things happened, and the assessments would be late. On 12/1/23 at 11:30am an interview was conducted with the Administrator. The Administrator indicated that she would require MDS assessments to be completed and submitted in a timely manner. She further indicated the facility did not have a full time MDS nurse coordinator but had individuals working remotely to get MDS assessments completed.