STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/5/24 through 2/9/24. Additional information was obtained on 2/12/24 and 2/13/24. Therefore, the exit date was changed to 2/13/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #01NN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/5/24 through 2/9/24. Additional information was obtained on 2/12/24 and 2/13/24. Therefore, the exit date was changed to 2/13/24. Event ID#01NN11. The following intakes were investigated: NC00213107, NC00212259, NC00212174, NC00209761, NC00209644, NC00209168, NC00207570, NC00203893, NC00203516 and NC00203467. Intake NC00212259 resulted in immediate jeopardy. 16 of the 30 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.45 at tag F760 at a scope and severity (J) The tag F760 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		3/11/24

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

Electronically Signed | 02/26/2024

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F 550	Continued From page 1	F 550		

§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.

§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

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F 550	Continued From page 2 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide a dignified dining experience when Nurse Aide (NA) #4 stood at Resident #7's bedside while feeding Resident #7. This was for 1 of 2 residents reviewed for dignity. A reasonable person might feel a lack of dignity when NA #4 stood while feeding them. Findings included: Resident #7 was admitted to the facility on 7/20/23 with a diagnosis of dementia. A review of Resident #7's current comprehensive care plan revealed a focus area initiated on 7/21/23 for activities of daily living. The goal, last revised on 11/7/23, was for Resident #7's care to be completed with staff support. An intervention was dependent for eating. A review of Resident #7's quarterly Minimum Data Set (MDS) assessment dated 1/20/24 revealed she was severely cognitively impaired. She had functional limitation of range of motion of both upper extremities. She was dependent for eating. On 2/5/24 starting at 12:54 PM a continuous observation of Resident #7's lunch meal was conducted in her room. NA #4 was observed to feed Resident #7 while standing beside Resident #7's bed. A chair was available in Resident #7's room. At 1:06 PM NA #4 was observed still standing while feeding Resident #7. At 1:09 PM, after Resident #7 indicated she was finished	F 550	F550 Resident Rights/Exercise of Rights On 2/5/2024, Nurse Aide #4 (NA) was verbally educated by the Assistant Director of Nursing regarding Dignity and Respect with emphasis sitting at resident eye level and not standing when providing feeding assistance to a resident. Resident # 7 no longer resides at the facility. On 2/22/2024, the Minimum Data Set (MDS) Nurse initiated an audit of all residents requiring feeding assistance. This audit is to ensure all residents were treated with dignity and respect during meals with emphasis on staff sitting at resident eye level when providing feeding assistance and not standing. The RN MDS Nurse will address all concerns identified during the audit to include education of staff. On 2/22/24, the Assistant Director of Nursing initiated an in-service with all nurses and nursing assistants (NA) to include NA #4 regarding Resident Rights/Dignity and Respect with emphasis on treating resident with dignity and respect by sitting at resident eye level when providing feeding assistance. In-service will be completed by 3/11/24. After 3/11/24, any nurse or nursing assistants (NA) who has not received the in-service will complete it upon next	

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F 550	Continued From page 3 eating, NA #4 was observed to conclude the feeding activity and remove Resident #7's lunch meal from the room. An interview with NA #4 at that time indicated she was familiar with Resident #7 and frequently fed her meals. NA #4 stated she always stood beside Resident #7's bed when she fed her. She stated she always stood when feeding residents as she preferred this. She went on to say she had worked at the facility for 9 years and she had never been instructed to sit beside residents when feeding. On 2/8/24 at 9:57 AM an interview with the Director of Nursing indicated standing while feeding residents was a dignity issue. She stated NA #4 should have been seated and at eye level with Resident #7 while she was feeding her. She went on to say NA #4 should have known this. She further indicated in-service training had begun for all NAs regarding this issue. On 2/9/24 at 11:39 AM an interview with the Administrator indicated NAs should be seated at eye level with residents while feeding them.	F 550	scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Resident Rights. The Nurse Supervisors and ADON will complete 10 resident care observations to include all mealtimes weekly x 4 weeks then monthly x 1 month utilizing the Resident Rights Audit Tool. This audit is to ensure staff treat residents with dignity and respect during mealtime by sitting at resident eye level when providing feeding assistance. The Nurse Supervisor, ADON and or Unit Managers will address all concerns identified during the audit to include retraining of staff. The Director of Nursing (DON) will review the Resident Rights Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the Resident Rights Audit Tool to the Quality Assurance Performance Improvement Committee monthly x 2 months to review the Resident Rights Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 553		3/11/24

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F 553	Continued From page 4 (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Responsible Party (RP) and staff, the facility failed to facilitate the inclusion of a cognitively intact resident and her RP in the care planning process for 1 of 1 resident reviewed for the care planning process (Resident #287). The findings included:	F 553	F 553 Right to Participate in Care Planning Resident #287 no longer resides in the facility. On 2/22/24, the Director of Nursing initiated an audit of all residents most recent care plan meeting. This audit is to	

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F 553	Continued From page 5 Resident #287 was admitted to the facility on 1/24/23. The quarterly Minimum Data Set (MDS) dated 12/26/23 indicated Resident #287 was cognitively intact. A review of the care plan for Resident #287 revealed it was last revised on 2/28/23. A record review for Resident #287 revealed there were no care plan meetings documented nor was there documentation of attempts to contact or conversations with the RP. On 2/10/24 at 1:10 PM an interview with Resident #287's RP revealed she and the Resident were not invited to care plan meetings until a few days before the Resident's passing on 10/30/23. An interview with Social Worker #1 on 2/7/24 at 12:21 PM revealed she held care plan meetings upon admission, approximately every three months in conjunction with the MDS assessment schedule and in the event of a significant change in the Resident's health. These meetings were documented in the care plan notes section of the medical record and noted everyone who attended and what was discussed. She further stated any contact or attempt to contact the Resident or their RP regarding care plan meetings should be documented. Social Worker #1 was unable to explain why there were no notes for Resident #287 about care plan meetings. On 2/8/24 at 2:30 PM an interview with the Administrator revealed Care Plan meetings were held quarterly and annually and were to be documented, including all who attended, and the	F 553	ensure that a care plan meeting was scheduled and completed per facility guidelines and that the resident and/or resident representative were provided a written invitation to the care plan meeting with documentation in the electronic record. The Medical Records Director, Assistant Director of Nursing (ADON) and/or Director of Nursing (DON) will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting for any resident or resident representative who was not provided a written invitation per facility protocol or have written documentation of attending/declining to attend care plan meeting. The audit will be completed by 3/11/24. On 2/22/2024, the Nurse Consultant initiated an in-service with the administrator, director of nursing (DON), Minimum Data Set (MDS) nurses, Admission Nurse and social worker regarding Resident Care Plan Process with emphasis on (1) resident right to participate in the planning process (2) timely scheduling of care plan meetings following admission, with changes in plan of care and/or quarterly and (3) providing the resident and/or resident representative a written invitation to care plan meeting with documentation in the electronic record. The in-service will be completed by 3/11/24. The MDS nurses will audit 10% of newly held care plan meetings to include newly admitted/re-admitted residents and/or	

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F 553	Continued From page 6 topics discussed. Any contact with the Resident or RP would have been documented in the care plan section of the electronic record. The Administrator further stated she knew there was a lack of documentation about care plan meetings, and scheduling of care plan meetings had been an issue.	F 553	scheduled quarterly reviews weekly x 4 weeks then monthly x 1 month to ensure a care plan meeting was scheduled and completed per facility guidelines and that the resident and/or resident representative were provided a written invitation to the care plan meeting with documentation in the electronic record. The MDS nurses, Social Worker, and/or Medical Records Director will address all concerns identified during the audit to include but not limited to scheduling a care plan meeting per facility guidelines, providing a written invitation to the resident and/or resident representative with documentation in the electronic record and/or re-education of staff. The Administrator will review the care plan audit weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Quality Assurance nurse will forward the results of the Care Plan Audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		3/11/24

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F 584	Continued From page 7 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain walls in good repair for 1	F 584	F584 Safe/Clean/Comfortable/Homelike Environment	

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F 584	Continued From page 8 of 23 rooms reviewed for the provision of a safe, clean, homelike environment (room 210). Findings included: On 2/5/24 at 2:56 PM an observation revealed approximately 12 linear indented lines on the wall behind the resident's bed that revealed the plaster. On 2/7/24 at 2:50 PM a second observation of the wall with the Maintenance Director revealed approximately 12 linear indented lines on the wall clearly visible on the right side directly behind the resident's head of bed that revealed the plaster. In interview at that time the Maintenance Director indicated the lines were approximately 12 inches long, 1/8 inch deep, and revealed the plaster. He stated he did monthly room checks of the call system and the emergency lights in the bathroom in every room. He went on to say he did not recall when he last checked room 210. He further indicated he did not keep a log of his monthly room checks. He went on to say there was a computer reporting system where staff could make reports of maintenance issues that needed attention. He further indicated staff would also sometimes tell him in person. The Maintenance Director stated he had not been aware of the gashes in the wall in room 210 before now. On 2/8/24 at 9:27 AM a follow-up interview with the Maintenance Director indicated he had last been in room 210 about a week or two ago working on the resident's wheelchair. He stated he had not noticed the gashes in the wall at that time. On 2/7/24 at 3:15 PM an interview with NA #3 indicated she was assigned to the resident in room 210. She stated she had regularly been	F 584	On 2/8/2024, a work order was entered into TELs for repairs room 210 to include repair of linear scratches to the wall plaster. The repair to the wall was completed on 2/19/2024. On 2/22/2024, the Housekeeping Supervisor initiated an audit of all resident rooms. This audit is to identify any room that needs repair to include but not limited to holes in the walls, scratched walls, peeling paint, or areas in need of painting to maintain a safe and homelike environment. The Administrator and Maintenance Director will address all concerns identified during the audit to include but not limited to repairing damaged walls when indicated. The maintenance staff will review with the Administrator a timeline for completing identified concerns. Audit will be completed by 3/11/24. On 2/22/2024, the Administrator completed an in-service with the Maintenance Director and maintenance staff regarding Maintaining a Homelike Environment with emphasis on timely repair of facility and resident rooms to maintain a safe and homelike environment. The in-service also included notification of the Administrator for any concerns that cannot be addressed timely for additional recommendations/interventions. All newly hired maintenance staff will be educated during orientation regarding Maintaining a Homelike Environment.	

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F 584	Continued From page 9 assigned to work with the resident in room 210 since his admission to the facility about 2 weeks ago and the scratches had been in the wall since the resident came. She went on to say she thought they were from the movement of the bed up and down. She further indicated she had not notified the Maintenance Director of the scratches because he should have noticed them when he did his rounds. On 2/7/24 at 3:36 PM an interview with the Administrator indicated the facility had a process in place where rooms were inspected after a resident was discharged before a new resident was admitted to the room. She stated she felt the reason the wall in room 210 had not been fixed before the current resident was admitted to it was the Maintenance Director had been fixing another room at the time. She further indicated the facility was looking into purchasing bumpers for the beds that would prevent the issue.	F 584	On 2/23/2024, the Assistant Director of Nursing initiated an in-service with all nurses, nursing assistants, therapy staff, housekeeping staff, maintenance staff, accounts payable, accounts receivable, social worker, administrator, activity staff, receptionist, scheduler, and medical records director regarding Safe and Homelike Environments. Emphasis is the process for prompt reporting of any area in the facility in need of repair to include but not limited to holes in the walls, scratched walls, peeling paint, or areas in need of painting in resident rooms to maintain a safe and homelike environment. In-service also included how to report concern. In-service will be completed by 3/11/24. After 3/11/24, any staff who has not received the training will complete the in-service on the next scheduled work shift. All newly hired nurses, nursing assistants, therapy staff, housekeeping staff, maintenance staff, accounts payable, accounts receivable, social worker, administrator, activity staff, receptionist, scheduler, and medical records director will be in-serviced during orientation regarding Safe and Homelike Environment. The Housekeeping Supervisor will complete facility rounds to include all resident rooms weekly x 4 weeks then monthly x 1 month. This audit is to identify any new areas in the facility in need of repair to include but not limited to holes in the walls, scratched walls, peeling paint, or areas in need of painting to maintain a	

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F 584	Continued From page 10	F 584	safe and homelike environment. The Housekeeping Supervisor will notify the maintenance director, nurse supervisor and/or Administrator for all identified areas of concern. The Maintenance Director will address all work orders submitted for concerns identified to include but not limited to repairing and painting damaged drywall when indicated. The Administrator will review the environmental rounds audit weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will present the findings of the Environmental Rounds Audit to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months to review the environmental rounds audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		3/11/24

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F 661	Continued From page 11 the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviewed, the facility failed to complete a recapitulation of stay for 1 of 1 resident reviewed for a planned discharge from the facility to home (Resident #137). Findings included: Resident #137 was admitted to the facility on 1/05/23 and discharged home on 2/17/23. The discharge Minimum Data Set dated 2/17/23 revealed Resident #137 was coded as moderately impaired cognition. Review of Resident #137's electronic health record revealed a discharge summary dated 2/17/23. Further review of the discharge summary revealed that it did not include the required elements of customary routine, cognitive patterns, communication, vision, mod and behavior	F 661	F661 483.21 Discharge Summary Resident #137 was discharged home on 2/17/23 and no longer resides in the facility. On 2/23/2024, the Director of Nursing initiated an audit of all discharges in the past 30 days to ensure an interdisciplinary recapitulation of the resident stay was completed per Centers for Medicare and Medicaid Services (CMS) guideline. The Interdisciplinary team to include dietary manager, therapy, activities, social worker, nursing, and physician will address all areas of concern identified during the audit. Audit will be completed by 3/11/24. On 2/24/2024 the Administrator initiated an in-service with Director of Nursing	

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F 661	Continued From page 12 patterns, psychosocial well-being, physical functioning and structural problems, continence, disease diagnoses and health conditions, dental and nutritional status, skin condition, activity pursuit, medications, or special treatments and procedures. An interview on 2/07/24 at 11:01 AM with the Social Worker (SW) revealed she was aware of the requirement for a recapitulation summary. She stated that based on the requirements, the discharge summary for Resident #137 did not include all the required elements. She stated that she initiated the summary, and each section entered their portion. She also stated that nursing printed, reviewed, and provided a copy to the resident at discharge. The SW stated she was not employed at the facility in February 2023 and could not say why it was not completed with the required elements. An interview on 2/08/24 at 3:04 PM with the Administrator revealed that she was aware of the requirement for a recapitulation summary and did not know why Resident #137's did not contain the required elements.	F 661	(DON), Assistant DON, Unit managers, Social Workers (SW), Medical Records Director, Therapy Director, Dietary Manager, Activities Director, and Physician regarding Content of the Discharge Summary-Recapitulation of Resident Stay with emphasis on the requirements of a recapitulation. In-service will be completed by 3/11/24. All newly hired nurses, SW, Medical Records Director, Therapy Director, Dietary Manager, Activities Director, and physicians will be in-service during orientation. 10% of all residents discharged to the community will be audited by the Medical Records Director weekly x 4 weeks then monthly x 1 month to ensure the Discharge Summary, Physician Discharge Progress note, and Discharge Instructions was completed that provides a recapitulation of the stay utilizing a Recapitulation Audit Tool. The Assistant Director of Nursing (ADON) will address all areas of concern identified during the audit to include ensuring a recapitulation of stay is completed by all disciplines and/or re-training of staff. The DON will review the Recapitulation Audit Tool weekly X 4 weeks and monthly x 1 month to ensure completion and that all areas of concerns were corrected. The DON will forward the results of the Recapitulation Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months to review to determine trends	

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F 661	Continued From page 13	F 661	and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to rinse soap from a resident's skin during a dependent resident's bed bath and to provide nail care for 1 of 9 residents reviewed for activities of daily living (Resident #57). Findings included: Resident #57 was admitted to the facility on 11/27/23 with diagnoses which included Diabetes Mellitus. The quarterly Minimum Data Set 1/10/24 revealed Resident #57 was coded as cognitively intact. He was also coded to be dependent on staff for all activities of daily living (ADL). He was coded for rejection of care 1-3 days. Review of Resident #57's care plan revised 1/16/24 included an ADL focus with a shower/bath of two person assist as needed. During an observation on 2/08/24 at 9:49 AM, Nursing Assistants (NA) #1 and #2 were	F 677	F677 ADL Care Provided for Dependent Residents On 2/23/2024, resident #57 was provided a full bed bath by the assigned nursing assistant (NA) with oversight of the Treatment Nurse to ensure staff utilized appropriate technique to include but not limited to rinsing soap from resident skin and that nail care was provided per resident preference. On 2/13/2024, the treatment nurse completed a skin check on resident #57 with no skin irritation noted. On 2/23/2024, the Activity Director initiated an audit of nail care (fingernails and toenails) for all residents to include resident #57. This audit is to ensure all residents were provided nail care/cleaning/trimming per resident preference. The hall nurse, treatment nurse, and Unit Managers provided nail care for all identified concerns during the audit. The audit will be completed by	3/11/24

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F 677	Continued From page 14 observed to provide a bed bath for Resident #57. NA #2 gathered bathing supplies which included a basin of warm water, washcloths, towel, body oil, bottle of body wash, deodorant, and premoistened wipes pack. NA #2 squirted the body wash into the basin of warm water, washed Resident #57's face, arms, upper body, legs, and feet and dried all areas. NA #2 did not rinse the body wash off the resident. NA#2 continued the bed bath by placing the premoistened wipes into the basin of warm soapy water and washed the resident's perineal area. NA #2 dried the perineal area and did not rinse the body wash off the perineal area. NA #2 placed the premoistened wipes into the basin of warm soapy water and wiped the urinary catheter. NA #2 did not rinse the body wash off the urinary catheter. A clean gown and brief were placed on the resident. The lift transfer sling was placed under the resident, and he was transferred to a chair. NA #1 and NA #2 gathered the used linen, emptied the basin, and put all toiletries away. During the bed bath observation, NA #1 provided Resident #57 positioning assistance. During the bed bath observation (2/08/24 at 9:49 AM), the resident was observed to have ¼ inch to ½ inch long yellow fingernails which had brown debris under several of them on his left hand. His toenails were observed to be pale yellow, thick, misshaped with dry patches of skin around them. An interview on 2/08/24 at 10:40 AM with NA #1 and NA #2 revealed that they were unaware that the body wash required rinsing. NA #2 went to Resident #57's room and returned to the interview with the body wash bottle. She confirmed that the bottle of body wash read to rinse thoroughly. She	F 677	3/11/24. On 2/23/2024, the Treatment Nurse initiated resident care observations with return demonstration on Resident Care Audit- Activities of Daily Living (ADL) with all nursing assistants (NA) to include NA # 1 and NA #2 . This was to ensure staff (1) provide a bath using appropriate technique to include rinsing soap from resident skin (2) the resident was provided nail care, oral care, and hair care per resident preference and (3) the NA notified the nurse of all refusals of ADL care. Return demonstrations will be completed by 3/11/24. After 3/11/24, any NA who has not completed the return demonstration will complete it upon next scheduled work shift. On 2/23/2024, the Assistant Director of Nursing initiated an in-service with all nursing assistants regarding Resident ADL Care with emphasis on (1) rinsing soap from resident skin (2) cleaning and trimming nails per resident preference (3) providing hair care and (4) oral care. In-services will be completed by 3/11/24. After 3/11/24 any nursing assistant who has not worked or completed the in-service will complete on the next scheduled work shift. All newly nursing assistants will be in-service during the orientation regarding Resident ADL Care. The Unit Manager, Admission Nurse, Assistant Director of Nursing (ADON) will complete 10 resident care observations weekly x 4 weeks then monthly x 1 month	

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F 677	Continued From page 15 stated she did not rinse the body wash and had not read the bottle. She stated that she did not provide nail care for any residents. NA #2 stated that she thought the unit nurse provided nail care. NA #2 stated that she had not notified the unit nurse that Resident #57's fingernails needed to be cut. NA #2 confirmed that she had worked with Resident #57 frequently and he was on her assignment today. NA #1 stated that she provided positioning and transfer assistance for NA #2 during the resident's bed bath. An interview on 2/08/24 at 2:13 PM with Nurse #1 revealed she worked regularly with Resident #57. She stated she had tried to cut his nails in the past, but he had refused. She stated that she had not documented the attempt. She was unaware that he currently needed to have his nails cut. She stated that she cleaned his fingernails during his bath. An interview and observation on 2/08/24 at 11:45 AM with the Director of Nursing (DON) and the Corporate Nurse Consultant revealed that Resident #57 did have ¼ inch to ½ inch long yellow fingernails with brown debris under several of the nails on his left hand. She stated that they needed to be trimmed and cleaned. The DON stated that the NA should have rinsed the body wash off Resident #57. The DON stated that nurses cut diabetic resident nails and she did not know why Resident #57's fingernails were not cut. An interview with the Administrator on 2/08/24 at 2:42 PM revealed that the staff had been trained on rinsing the body wash and nail care. She did not know why it had not been done.	F 677	utilizing the Resident Care Audit- ADL. This audit is to ensure staff provided ADL care utilizing appropriate techniques to include but not limited to rinsing soap from resident skin, providing oral and hair care and/or cleaning/trimming nails per resident preference. Any areas of identified concern will be addressed by the Unit Manager, Admission Nurse, Assistant Director of Nursing (ADON) to include rinsing soap from resident skin, providing nail care, hair care, oral care per resident preference and/or additional staff training. The DON will review the Resident Care Audit Tool-ADL weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The DON will forward the results of the Resident Care Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 684 SS=D	Quality of Care	F 684		3/11/24

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F 684	Continued From page 16 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to obtain daily weights as ordered by the physician for 1 of 6 residents (Resident #30) reviewed for respiratory care. Findings included: Resident #30 was admitted to the facility on 5/22/23 a diagnoses of congestive heart failure (CHF). A review of Resident #30's quarterly Minimum Data Set (MDS) assessment dated 1/29/24 revealed he was cognitively intact. He was taking a diuretic (water pill). On 2/5/24 a review of the current active physician's orders for Resident #30 revealed a physician's order dated 6/3/23 for daily weights one time a day for CHF to be done before 7:00 AM. A review of Resident #30's Medication Administration Record for February 2024 revealed in part the physician's order for daily weights at 6:30 AM. There was no documentation	F 684	F684 Quality of Care Resident On 2/25/2024, the nurse obtained a weight per physician order. On 2/26/24, The physician was notified of resident current weight along with resident refusals for daily weight monitoring with new order to discontinue daily weights and begin weekly weight monitoring. The resident care plan was updated for resident refusals for daily weight monitoring. On 2/23/2024, the MDS Nurse initiated an audit of all residents with orders for daily weight monitoring. This audit is to ensure resident weights were obtained per physician orders and the physician notified when weight exceeds parameters or the resident refuses daily weight monitoring. The MDS Nurse will address all concerns identified during the audit to include but not limited to assessment of the resident, obtaining weight per physician orders, notification of the physician for weight outside desired parameters/resident refusals, updating	

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F 684	Continued From page 17	F 684		

that a weight was obtained on 2/3/24 or 2/5/24. Additionally, there was no documentation of a refusal.

A review of Resident #30's progress notes for 2/3/24 and 2/5/24 revealed no documentation he refused his daily weight on those dates.

On 2/7/24 at 9:35 AM an interview with Nurse Aide (NA) #5 indicated she was assigned to care for Resident #30 on 2/3/24 and 2/5/24 at 6:30 AM. She stated she was new to Resident #30's hall and recalled asking Resident #30's nurse about him at the beginning of her first shift on 2/3/24. She went on to say the nurse did not ever mention anything to her about Resident #30 needing a daily weight and she had not attempted to get one.

On 2/7/24 at 9:44 AM an interview with Nurse #3 indicated she was assigned to Resident #30 on 2/3/24 and 2/5/24 at 6:30 AM. She stated she recalled letting Resident #30's NA know that he needed a daily weight on those days. She went on to say she had not followed up to ensure they were done because she had gotten behind on her medication pass on those mornings.

On 2/8/24 at 9:38 AM an interview with the Director of Nursing (DON) indicated the nurse assigned to Resident #30 on the days when his daily weight needed to be done should be following up with the NA to ensure it was done.

On 2/8/24 at 3:45 PM an interview with Physician #2 indicated the daily weights were initiated for Resident #30 to monitor his CHF status. He stated Resident #30 had been stable and managed clinically for his CHF. He went on to say

care plan for resident refusals and/or education of staff. The audit will be completed by 3/11/24.

On 2/24/2024, the Assistant Director of Nursing initiated an in-service with all nurse and nursing assistants regarding Daily Weight Monitoring with emphasis on (1) obtaining weight per physician orders (2) notification of the physician if weight exceeds weight parameters for further recommendations and (3) notification of refusals for weight monitoring. The in-service will be completed by 3/11/24. After 3/11/24 any nurse or nursing assistant who has not received the in-service will complete it at the next scheduled work shift. All newly hired nurses and nursing assistants will be educated during orientation regarding Daily Weight Monitoring.

The MDS Nurse will review all residents with orders for daily weight monitoring 3 times a week x 2 weeks, weekly x 2 weeks then monthly x 1 month utilizing the Daily Weight Monitoring Audit Tool. This audit is to ensure resident weights were obtained per physician orders, the physician is notified when weight exceeds parameters or the resident refuses daily weight monitoring for further recommendations and that the care plan is updated for refusals with daily weight monitoring. The Director of Nursing will address all areas of concern identified during the audit to include but not limited to assessment of the resident, notification of the physician if weight exceeds

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F 684	Continued From page 18 he could probably discontinue Resident #30's daily weights. Physician #2 stated if a resident had a physician's order for daily weights, they should be obtained.	F 684	parameters/resident refuses weight monitoring for further recommendations, updating care plan if indicated and/or re-training of staff. The Director of Nursing will review the Daily Weight Monitoring Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the Daily Weight Monitoring Audit Tool to the Quality Assurance Performance Improvement Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		3/11/24

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F 690	Continued From page 19 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 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and physician interviews, the facility failed to: 1) obtain a written physician's order for the use of a urinary catheter (Resident #30 and #57) and 2) ensure the consulting physician's recommendation for the urinary catheter changes were entered into the medical record (Resident #30). This was for 2 of 4 residents reviewed for urinary catheter. Findings included: 1. Resident #30 was admitted to the facility on 5/22/23. A review of a hospital discharge summary for Resident #30 dated 12/21/23 revealed in part he was admitted to the hospital on 12/15/23 for penile cellulitis (skin infection) and balanitis (inflammation of the foreskin and head of penis). It further revealed an indwelling urinary catheter	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI On 2/23/24, the Director of Nursing clarified with the physician the need for an indwelling foley catheter for resident #30 to include supporting diagnosis for use, size of catheter, and parameters for changing the catheter per Urologist consult visit on 1/10/24. The Director of Nursing updated the order in the electronic record. On 2/26/24, the Director of Nursing clarified with the physician the need for an indwelling foley catheter for resident #57 to include supporting diagnosis for use, size of catheter, and parameters for changing the catheter if indicated. The Director of Nursing updated the order in	

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F 690	Continued From page 20 was placed. A review of a Nursing Admission/Reentry Assessment dated 12/21/23 revealed in part Resident #30 was readmitted to the facility with an indwelling urinary catheter. A review of a urology Report of Consult form for Resident #30 dated 1/10/24 revealed in part Resident #30's indwelling urinary catheter was changed. It further revealed a recommendation to exchange the indwelling urinary catheter every 4 to 5 weeks. A review of Resident #30's quarterly Minimum Data Set (MDS) assessment dated 1/29/24 revealed he was cognitively intact. He had an indwelling urinary catheter. On 2/5/24 at 12:32 PM an observation of Resident #30 revealed he had an indwelling urinary catheter. An interview with Resident #30 at that time indicated he was not having any issues with his catheter. He stated Nurse Aides (NAs) kept the area clean. On 2/7/24 a review of Resident #30's current active physician's orders did not reveal orders for an indwelling urinary catheter or exchange of the indwelling urinary catheter every 4 to 5 weeks as recommended by the urologist. On 2/9/24 at 9:03 AM an interview with the Nurse Practitioner (NP) indicated according to Resident #30's hospital discharge summary dated 12/21/23 he had an indwelling catheter placed because of a neurogenic bladder (bladder dysfunction) and balanitis. She stated Resident #30 should have a current order for this. She went on to say she	F 690	the electronic record. On 2/23/2024, the Treatment Nurse initiated an audit of all residents with indwelling catheters. This audit is to ensure all residents with an indwelling catheter has a physician order in place to include supporting diagnosis for use, catheter size, balloon size, parameters for changing catheter if indicated and that the care plan was updated for use of indwelling catheter. The DON will address all concerns identified during the audit to include but not limited to clarifying order for indwelling catheter with the physician, updating the electronic record when indicated and education of staff. The audit will be completed by 3/11/24. On 2/23/2024, the Director of Nursing initiated an audit of all Urology consults regarding indwelling catheters for the past 30 days. This audit is to ensure all recommendations to include use of indwelling catheter, parameters for changing catheter when indicated, recommendations for voiding trials are transcribed to the electronic record per physician□s order. The Director of Nursing will address all concerns identified during the audit to include verifying orders when indicated, updating electronic record and/or education of staff. The audit will be completed by 3/11/24. On 2/24/2024, the Assistant Director of Nursing initiated an in-service with all nurses regarding (1) Indwelling Catheters with emphasis on ensuring residents with	

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F 690	Continued From page 21 previously reviewed the Consult Report recommendations from the urologist dated 1/10/24 and had agreed with the recommendations as evidenced by her initials on the document. The NP stated the facility should have a process in place where the order for the indwelling urinary catheter was entered by nursing when he came back to the facility with it and where nursing entered the urology recommendation order. On 2/9/24 at 9:14 AM an interview with NA #3 indicated she was assigned to Resident #30 that day. She stated she had been assigned to care for him frequently and was very familiar with him. She stated Resident #30 had an indwelling urinary catheter since he last came back from the hospital a couple of months ago. She went on to say she emptied the urine from the catheter bag and cleaned the area each shift. She further indicated Resident #30 was not having any issues with his urinary catheter, had not complained of anything, and his urine was clear. On 2/9/24 at 9:18 AM an interview with Nurse #9 indicated she was assigned to care for Resident #30 that day and was familiar with him. She stated Resident #30 had an indwelling urinary catheter. She went on to say he had this in place since she began caring for him on 1/15/24. She further indicated Resident #30 was not having any issues with his catheter. On 2/9/24 at 9:25 AM an interview with the Director of Nursing indicated she was aware of the urology recommendation dated 1/10/24 for Resident #30 to have his indwelling urinary catheter exchanged every 4 to 5 weeks. She stated she reviewed all consulting physician's	F 690	indwelling urinary catheters have a physician order in place to include supporting diagnosis for use, size of catheter, size of balloon and parameters for changing the catheters when indicated or attempting voiding trials as directed (2) Transcribing Physician Orders with emphasis on ensuring all recommendations are transcribed accurately or the nurse notifying the physician for further recommendations when a consult visit form is not received. The in-services will be completed by 3/11/24. After 3/11/24, any nurse who has not worked or received the in-services will complete upon next scheduled work shift. All newly hired nurses will be in-service during orientation. The ADON or Admission Nurse will review all newly admitted residents with indwelling catheters weekly x 4 weeks then monthly x 1 month utilizing the Catheter Audit Tool to ensure residents with indwelling catheters have a current physician□s order to include supporting diagnoses for use, size of catheter, size of balloon, parameters for changing the catheters when indicated, that the orders are transcribed correctly to the medication administration record (MAR), care plan is updated for use of indwelling catheter, dignity bags are present and anchors utilized. The ADON or Admission nurse will address all concerns identified during the audit to include but not limited to clarifying order with the physician and updating the electronic record, updating care plan when indicated and/or	

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F 690	Continued From page 22 recommendations and entered these orders herself. She further indicated she recalled entering this order for Resident #30, but she did not see it now. She stated she did not know what had happened to it. On 2/9/24 at 9:46 AM an interview with Nurse #4 indicated he was the facility's Admissions Nurse. He stated he recalled receiving report from the hospital when Resident #30 was admitted back into the facility. He went on to say he had been aware that Resident #30 had an indwelling urinary catheter at that time. He further indicated he recalled putting the order for the catheter into the computer system but did not see it now. He stated he did not know what happened to it. On 2/9/24 at 11:39 AM an interview with the Administrator indicated Resident #30 should have a current active order for his indwelling urinary catheter. She went on to say he should also have a current active order for the consulting urologists recommendation. 2. Resident #57 was admitted to the facility on 11/27/23 with diagnoses which included obstructive uropathy. The quarterly Minimum Data Set 1/10/24 revealed Resident #57 was coded as cognitively intact. He was also coded to have an indwelling urinary catheter. Resident #57's care plan last revised 1/16/24 revealed a focus for altered pattern of urinary elimination with indwelling catheter.	F 690	re-training of staff. The Director of Nursing will review the Catheter Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Assistant Director of Nursing (ADON) will review all urology consult visits related to indwelling catheters weekly x 4 weeks then monthly x 1 month utilizing the Consult Audit Tool. This audit is to ensure all recommendations are transcribed accurately to the electronic record to include but not limited to parameters for changing catheter or voiding trials when indicated and/or the nurse clarified recommendations with the provider if no consult visit form received. The ADON will address all concerns identified during the audit to include clarifying orders, updating electronic records or re-training of staff. The DON will review the consult audit tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the Catheter Audit Tool and the Consult Audit Tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 690	Continued From page 23 An observation on 2/05/24 at 12:42 PM revealed Resident #57 lying in bed with a urinary catheter bag hanging on the side of his bed. Review of Resident #57's electronic health record physician's orders revealed no order for a urinary catheter. An interview 2/08/24 at 11:26 AM with the Director of Nursing (DON) revealed that Resident #57 did not have an order for a urinary catheter. The DON stated she did not know why he did not have a physician's order for a urinary catheter. An interview with the Administrator on 2/09/24 at 10:47 AM revealed that she did not know why Resident #57 did not have an order for a urinary catheter.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral	F 693		3/11/24

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F 693	Continued From page 24 means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to change a tube feeding syringe daily or store a tube feeding syringe with the plunger separated from the barrel for 1 of 1 resident reviewed for enteral feeding management (Resident #57). Findings included: Resident #57 was admitted to the facility on 11/27/23. The quarterly Minimum Data Set 1/10/24 revealed Resident #57 was coded as cognitively intact. He was also coded to have a feeding tube. An observation on 2/05/24 at 12:42 PM revealed that the tube feeding syringe plunger and barrel were stored together in a bag hanging on the infusion pump stand at the bedside. The outside of the bag was dated 2/05/24. An observation on 2/06/24 at 7:48 AM revealed that the tube feeding syringe plunger and barrel were stored together in a bag hanging on the infusion pump stand at the bedside. The outside of the bag had 2/05/24 written on it with a '6' written over the '5'. An observation on 2/07/24 at 1:35 PM revealed that the tube feeding syringe plunger and barrel	F 693	F693 Tube Feeding Management/Restore Eating Skills On 2/8/24, the Director of Nursing discarded the tube feeding syringe for resident #57 and a new tube feeding syringe placed at bedside. On 2/23/2024, the Scheduler initiated an audit of all residents who receive nutrition, hydration or medications via enteral feeding tubes. This audit is to ensure the tube feeding syringe is changed daily and dated with date opened and that the syringe and plunger are stored separately after use. The Director of Nursing will address all concerns identified during the audit to include replacing tube feeding syringe when indicated and education of staff. The audit will be completed by 3/11/24. On 2/23/2024 the Assistant Director of Nursing initiated an in-service with all nurses regarding Tube Feeding Syringes with emphasis on changing syringes daily, dating syringe with open date and storing the syringe/plunger separately following use. The in-service will be completed by 3/11/24. After 3/11/24 any nurse who has not received the in-service or worked will	

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F 693	Continued From page 25 were stored together in a bag hanging on the infusion pump stand at the bedside. The outside of the bag was dated with the same 2/05/24 with '6' written over the '5'. An observation on 2/08/24 at 10:00 AM revealed that the tube feeding syringe plunger and barrel were stored together in a bag hanging on the infusion pump stand at the bedside. The outside of the bag was dated with the same 2/05/24 with '6' written over the '5'. An observation and interview 2/08/24 at 11:45 AM with the Director of Nursing (DON) revealed that Resident #57's tube feeding syringe were stored together in a bag hanging on the infusion pump stand at the bedside. The outside of the bag was dated 2/05/24 with '6' written over the '5'. The DON stated the tube feeding syringes should be changed every 24 hours and it was night shift's responsibility to change them. She also stated that the plunger and barrel should be stored separately and did not know why they were not. An interview on 2/08/24 at 2:21 PM with Nurse #2 revealed that Resident #57 received tube feeding flushes three times per day. She stated that today she used the tube feeding syringe hanging on the infusion pump stand in his room for his morning tube flush. She stated that she had not noted the date on the syringe bag. She stated she was taught to wash the tube feeding syringe plunger and barrel, let them dry, and then place them back together in the bag for storage which is what she had done. An interview with the Administrator on 2/09/24 at 2:52 PM revealed that she did not know why Resident #57 tube feeding syringe had not been	F 693	complete the in-service upon next scheduled work shift. All newly hired nurses will be educated during orientation. The Activities staff, Admission staff and/or Social Workers will audit all residents who receive nutrition, hydration or medications enteral feeding tubes 5 times a week x 4 weeks then weekly x 1 month utilizing the Tube Feeding Syringe Audit Tool to ensure the tube feeding syringe is changed daily, dated with an open and that the syringe and plunger are stored separately after use. The Unit Managers, Admission Nurse, Assistant Director of Nursing will address all concerns identified during the audit to include replacing tube feeding syringe when indicated and re-education of staff. The Director of Nursing will review the Tube Feeding Syringe Audit Tool 5 times weekly x 4 weeks then weekly x 1 month to ensure all concerns are addressed. The DON will forward the results of the Tube Feeding Syringe Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months to review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 693	Continued From page 26 changed daily or the plunger and barrel stored separately.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, Nurse Practitioner (NP) and Physician interviews the facility failed to obtain a physician's order for the use of supplemental oxygen (Residents #68 and #37), assess a resident receiving respiratory medications via nebulizer (Resident #8), change oxygen tubing and humidification bottles in accordance with the manufacturer's instructions (Residents #68 and #37), and administer oxygen in accordance with the Physician's order (Resident #30) for 4 of 5 residents reviewed for respiratory care. The findings included: 1. Resident #8 was admitted to the facility on 12/2/20 with diagnoses that included chronic congestive heart failure and dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated 1/11/24 revealed Resident #8 was moderately cognitively impaired.	F 695	F 695 Respiratory/ Tracheostomy Care and Suctioning On 2/7/24, the Director of Nursing clarified the physician□s order for the use of supplemental oxygen for resident # 37 and updated the electronic record. Resident #8 completed order for schedule nebulizer treatments on 2/7/24. The Charge Nurse completed a respiratory assessment on 2/26/24 to include oxygen saturation, lung sounds and respiratory effort on resident #8 with no concerns identified. On 2/8/24, the Director of Nursing clarified the physician order for the use of supplemental oxygen for resident #30. The order for oxygen was discontinued per physician order.	3/11/24

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F 695	Continued From page 27 A physician's order dated 2/2/24 for Resident #8 indicated a time limited order for respiratory medication to be administered via nebulizer every 6 hours through 2/6/24. Resident #8 was observed receiving medication via the nebulizer for a respiratory treatment on 2/5/24 at 1:45 PM. During an interview with Resident #8 on 2/5/24 at 1:47 PM she stated she had a cough/cold for a few days. Review of the Medication Administration Record (MAR) revealed that nebulizer treatments were documented as given to Resident #8 every 6 hours 2/2/24 through 2/6/24 as ordered. The Resident's vital signs record revealed oxygen saturation levels (O2 sats) were documented as completed on 2/5/24 at 5:17 PM. There were no other O2 sats documented for the period of 2/2/24 through 2/6/24. A review of Resident #8's progress notes dated 2/2/24 through 2/6/24 revealed that respiratory assessments such as lung sounds and response to nebulizer treatments were not documented at any time during the prescribed respiratory medication use. An interview with Nurse #4 on 2/9/24 at 8:36 AM revealed assessments of O2 sats and lung sounds should be documented on Resident #8 before and after a nebulizer treatment along with a progress note once a shift. If the nebulizer treatment was not effective, he would contact the Physician or NP. He did not have to contact them	F 695	On 2/15/24, the Director of Nursing clarified the physician□s order for the use of supplemental oxygen for resident #68 and updated the electronic record. On 2/23/2024, the Central Supply Clerk changed and dated the oxygen tubing and humidification bottle for resident #68 per manufacturer□s instructions and facility guidelines. On 2/23/2024, the Central Supply Clerk changed and dated the oxygen tubing and humidification bottle for resident #37 per manufacturer□s instructions and facility guidelines. On 2/23/2024, the Director of Nursing initiated an audit of all residents with supplemental oxygen orders or residents utilizing supplemental oxygen. This audit is to ensure all residents utilizing oxygen had a current order indicating flow rate and monitoring parameters, oxygen was administered per physician order and the oxygen tubing and humidification bottle were changed per manufacturers and facility guidelines. The Director of Nursing addressed all concerns identified during the audit to include but not limited to clarification with the physician resident need for supplemental oxygen to include flow rate and monitoring parameters, changing/dating oxygen tubing/humidification bottle when indicated and/or education of staff. The audit will be completed by 3/11/24.	

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F 695	Continued From page 28 as treatments had been effective. He was unable to say why he did not document an assessment or progress note on 2/5/24 after nebulizer treatments except that he may have been overwhelmed as he was the Admissions Nurse and did not regularly work on the floor. An interview with Nurse #5 on 2/9/24 at 8:27 AM revealed assessments of O2 sats and lung sounds should be documented on Resident #8 before and after a nebulizer treatment along with a progress note once a shift. If the nebulizer treatment was not effective, she would contact the Physician or NP. She further stated that all treatments she had provided were effective. She was unable to say why she did not document an assessment or progress note after nebulizer treatments on 2/6/24. In an interview with the Director of Nursing (DON) on 2/9/24 at 9:05 AM she stated Nursing should complete O2 sats and lung sounds both before and after a nebulizer treatment and document in the resident's chart along with a progress note after each treatment. She further indicated if a treatment was not effective, they should contact the Physician or Nurse Practitioner. She was not aware assessments were not being documented on Resident #8 during the 5 days she was prescribed the medication for cough/congestion. An interview with the NP on 2/9/24 at 10:15 AM revealed Nursing would assess a resident before and after receiving a nebulizer treatment. She further stated the assessment would include lung sounds, O2 sats and effectiveness and would be documented in the chart after each treatment including a progress note each shift. The NP indicated she used the Nursing progress notes as	F 695	On 2/23/2024, the Assistant Director of Nursing initiated an in-service with all nurses regarding (1) Administration of Oxygen with emphasis on (a) ensuring resident utilizing supplement oxygen have a current physician order to include flow rate and monitoring parameters (b) oxygen is administered per physician orders and (c) oxygen tubing and humidification bottles are changed/dated per manufacturers and facility guidelines (2) Assessment following Respiratory Treatment with emphasis on completing a respiratory assessment prior to and following nebulizer treatments to include oxygen saturation, lung sounds and respiratory effort and notification of the physician for any concerns identified for further recommendations. The in-service will be completed by 3/11/24. After 3/11/24 any nurse who has not worked or completed the in-service will complete it at the next scheduled work shift. All newly hired nurses will be in-service during orientation. The Admission Nurse, Nurse Supervisors and Assistant Director of Nursing will review 10% of residents receiving supplement oxygen and residents receiving nebulizer treatments weekly x 4 weeks then monthly x 1 month utilizing Respiratory Audit Tool. This audit is to ensure all residents utilizing oxygen had a current order indicating flow rate and monitoring parameters, oxygen was administered per physician order and the oxygen tubing and humidification bottle were changed per manufacturers/ facility	

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F 695	Continued From page 29 updates on a resident's illness and treatment effectiveness. She was not aware assessments were not being documented on Resident #8 during the 5 days she was prescribed the medication for cough/congestion. 2. Resident #37 was admitted to the facility on 5/29/23 with diagnoses that included pneumonia, acute respiratory failure, and chronic obstructive pulmonary disease (COPD) A review of the quarterly Minimum Data Set (MDS) assessment dated 11/23/23 revealed Resident #37 was cognitively intact, had shortness of breath, and received oxygen therapy. A review of Resident #37's care plan dated 1/18/24 indicated a focus of potential for ineffective breathing pattern related to Congestive Heart Failure and Chronic Obstructive Pulmonary disease with a goal that the resident's airway would be maintained through next review. Interventions included oxygen therapy as ordered. A review of Resident #37's Physician orders revealed there was no order for oxygen use. An observation of Resident #37 on 2/5/24 at 3:27 PM revealed she was using portable supplemental oxygen via nasal cannula in her wheelchair in the common area. Upon further observation it was noted the cannula was not dated as to when it was changed last. An observation of Resident #37's bedroom on 2/5/24 at 3:45 PM revealed an oxygen concentrator with a nasal cannula and	F 695	guidelines and that any resident receiving nebulizer treatment was assessed by the nurse prior to and following the treatment with notification of the physician of any abnormal findings for further recommendations. The Director of Nursing will address all concerns identified during the audit to include clarifying orders when indicated, administering oxygen per physician orders, changing/dating oxygen tubing or humidification bottles per manufacturers and facility guidelines, assessment of the resident when indicated and/or re-training of staff. The Director of Nursing (DON) will review the Respiratory Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the Respiratory Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months for review to determine issues and trend to include continued monitoring frequency.	

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F 695	Continued From page 30	F 695		

humidification bottle attached. Upon further observation it was noted the cannula was not dated as to when it was changed last. An observation of the humidification bottle for the oxygen concentrator in her room revealed a date of 12/28/23 was connected for use and was empty.

A review of the manufacturer's recommendations on 2/8/24 at 1:45 PM revealed oxygen tubing and humidification bottles should be changed every 7 days.

During an interview with the Central Supply Manager on 2/8/24 at 1:30 PM, he indicated he restocked the medication storage rooms for Nursing staff to have access to nasal cannulas and humidification bottles. He further stated they could access the central supply room after hours if needed.

In an interview with Nurse #10 on 2/7/24 at 6:11 AM on third shift she stated she did not know who was responsible for changing oxygen tubing and humidification bottles as it was not indicated anywhere that she had seen. Nurse #10 stated the only way she knew if someone was on oxygen was if the resident had an order in the Medication Administration Record (MAR). She further stated she did not know who was responsible for transcribing orders into the MAR or overseeing the process.

In an interview with a nurse familiar with Resident #37, Nurse #4, on 2/9/24 at 8:36 AM he revealed he did not know who was responsible for changing oxygen tubing or humidification bottles. He further stated he would expect it to be in the MAR on the day and shift it was due. Nurse #4

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F 695	Continued From page 31	F 695		

revealed the only way he knew if a resident was on oxygen was if they had an order in the MAR or if it was reported to him at shift change. He further stated she did not know who was responsible for transcribing orders into the MAR or overseeing the process.

During an interview with the Director of Nursing (DON) on 2/6/24 at 1:07 PM she stated night shift was responsible for changing oxygen tubing and humidification bottles once a week on Sundays and should be labeled with the date by the Nurse. She further stated they were to be changed weekly "as that is standard practice". The DON was not aware it was not being done and was unaware there was no schedule for changing the tubing and humidification bottles that Nursing could refer to. She further stated she did not have a policy regarding the care of oxygen equipment. The DON was unaware that Resident #37 did not have an order for the use of oxygen. She further stated that a Nurse would have entered the order for oxygen when it was received from the Physician or NP. When asked how nurses would know when to change the oxygen tubing and humidification bottles, she stated, "They should just know."

An interview with Physician #2 on 2/7/24 at 11:30 AM revealed he was unaware Resident #37 did not have an order for oxygen. He further stated Resident #37 should have an order for oxygen and that the order must not have been transcribed by Nursing. He further stated oxygen tubing and humidification bottles should be changed per manufacturer recommendations or per facility policy.

3. Resident #68 was admitted to the facility on

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12/9/22 with diagnoses that included chronic obstructive pulmonary disease (COPD) and acute respiratory failure.

A review of Resident #68's care plan dated 10/3/23 indicated a focus of Potential for Ineffective Breathing Pattern related to Chronic Obstructive Pulmonary disease and Pulmonary Edema with a goal that the resident's airway would be maintained through next review. Interventions included oxygen therapy as ordered.

Review of the quarterly Minimum Data Set (MDS) assessment dated 1/16/24 revealed Resident #68 was cognitively intact, had shortness of breath and was coded as receiving oxygen therapy.

A review of Resident #68's Physician orders indicated there was no order for oxygen use.

An observation of Resident #68 on 2/5/24 at 11:33 AM revealed he was using portable supplemental oxygen via nasal cannula while in his wheelchair. Upon further observation it was noted the cannula was not dated as to when it was changed last.

An observation of Resident #68's bedroom on 2/5/24 at 11:45 AM revealed an oxygen concentrator with a nasal cannula and humidification bottle attached. Upon further observation it was noted neither the cannula nor the humidification bottle were dated as to when they were changed last.

A review of the manufacturer's recommendations on 2/8/24 at 1:45 PM revealed oxygen tubing and humidification bottles should be changed every 7

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days.

During an interview with the Central Supply Manager on 2/8/24 at 1:30 PM, he indicated he restocked the medication stock rooms for Nursing staff to have access to nasal cannulas and humidification bottles. He further stated they could access the central supply room after hours if needed.

In an interview with Nurse #10 on 2/7/24 at 6:11 AM on third shift she stated she did not know who was responsible for changing oxygen tubing and humidification bottles as it was not indicated anywhere that she has seen. She further stated she was unaware of who was responsible for transcribing oxygen orders into the MAR.

An interview with Nurse #4 on 2/9/24 at 8:36 AM revealed he did not know who was responsible for changing oxygen tubing or humidification bottles. He further stated he would expect it to be in the MAR on the day and shift it was due. He further stated he was unaware of who was responsible for monitoring and entering oxygen orders into the MAR.

During an interview with the Director of Nursing (DON) on 2/6/24 at 1:07 PM she stated night shift was responsible for changing oxygen tubing and humidification bottles once a week on Sundays and should be labeled with the date by the Nurse. She further stated they were to be changed weekly "as that is standard practice". The DON was not aware it was not being done and was unaware there was no schedule for changing the tubing and humidification bottles that Nursing could refer to. She further stated she did not have a policy regarding the care of oxygen equipment.

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The DON was unaware that Resident #68 did not have an order for the use of oxygen. When asked how nurses would know when to change the oxygen tubing and humidification bottles she stated, "They should just know."

An interview with Physician #1 on 2/8/24 at 1:15 PM revealed he was unaware Resident #68 did not have an order for oxygen. He further stated Resident #68 should have an order for oxygen. He further stated oxygen tubing and humidification bottles should be changed per manufacturer recommendations or per facility policy.

4. Resident #30 was admitted to the facility on 5/22/23 with diagnoses including chronic respiratory failure, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea and congestive heart failure.

A review of the current comprehensive care plan for Resident #30 revealed a focus area initiated on 5/22/23 for ineffective breathing pattern. The goal, last revised on 12/15/23, was for Resident #30 to demonstrate an effective respiratory pattern with an appropriate oxygen (O2) saturation level through the next review. An intervention was O2 therapy as ordered.

A review of the physician's orders for Resident #30 revealed a current active physician's order initiated on 5/23/23 of oxygen 3 liters (l) by nasal cannula (NC) every day and night shift for COPD.

A review of Resident #30's quarterly Minimum Data Set (MDS) assessment dated 1/29/24 revealed he was cognitively intact. He did not use oxygen therapy or BiPap (Bilevel positive airway pressure).

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On 2/5/24 at 12:32 PM an observation of Resident #30 revealed he was in bed. He was not observed to be receiving oxygen. He was wearing a BiPap machine. An interview with Resident #30 at that time indicated he did not use oxygen. He stated he kept his BiPap on all the time except when he was out of the bed. He went on to say he could put this on and take it off by himself. He stated he was using his home BiPap machine in the facility. He further indicated he was not experiencing any breathing issues or feeling short of breath.

On 2/6/24 at 12:11 PM an observation of Resident #30 revealed he was in bed. He was not observed to be receiving oxygen. An interview with Resident #30 at that time indicated he was not having any breathing difficulties.

On 2/7/24 at 8:23 AM an observation of Resident #30 indicated he was not observed to be receiving oxygen. He did not appear to be having any breathing issues or be short of breath.

On 2/7/24 at 8:24 AM an interview with Nurse Aide (NA) #3 indicated she was very familiar with Resident #30. She stated she was caring for him today and cared for him every day this week on the day shift. She went on to say she cared for him regularly. She further indicated Resident #30 did not use oxygen. NA #3 stated Resident #30's had not been having any difficulties breathing.

On 2/7/24 at 7:24 PM a telephone interview with Nurse #3 indicated she was caring for Resident #30 at that time. She stated she was familiar with him and had cared for him before. She went on to say she documented on Resident #30's

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Medication Administration Record (MAR) on 2/2/24, 2/3/24 and 2/4/24 that he was receiving O2 3L per NC continuously because she misunderstood the order. She stated Resident #30 wore his BiPap continuously and she thought that meant he was receiving oxygen through it. She stated she had just spoken with Resident #30 and observed his BiPap machine, and he was not receiving any oxygen. On 2/8/24 at 9:18 AM a follow up interview with Nurse #3 indicated she put an O2 concentrator in Resident #30's room last night and placed his O2 at 3L per NC under his BiPap. She stated Resident #30 had not had an O2 concentrator in his room prior to that and had not been receiving O2.

On 2/8/24 a review of a nursing progress note for Resident #30 written by Nurse #3 dated 2/8/24 at 4:15 AM revealed Resident #30's oxygen was placed in his nose via nasal cannula at 3 liters at the beginning of shift. Nurse #3 continued to have to tell Resident #30 to keep oxygen in nose. When Nurse #3 went into the room to give Resident #30 medication, Resident #30 had taken the O2 out of his nose. Nurse #3 educated to resident that he needed to keep O2 on per the physician's order, but Resident stated, "NO".

On 2/8/24 at 9:38 AM in an interview the Director of Nursing stated Resident #30 had a current active physician's order for O2 at 3L per NC continuously and he should be receiving this in accordance with the physician's order. She went on to say if there was a question about a physician's order, the nurse caring for Resident #30 should clarify with the physician.

On 2/8/24 at 3:45 PM a telephone interview with Physician #3 indicated if a resident had a

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F 695	Continued From page 37 physician's order for the administration of O2, the order should be followed. On 2/9/24 at 11:39 AM an interview with the Administrator indicated physician's orders for O2 should be followed. She went on to say if Resident #30 had a physician's order for O2, he should be receiving it. She further indicated if Resident #30 had been doing fine without O2 or had been refusing it, the physician should have been contacted to have the order clarified or discontinued.	F 695		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff, Physician, and resident interviews the facility failed to prevent a significant medication error when Nurse #1 administered Resident #63 medications prescribed to Resident #340 to include carvedilol (a medication classified as a beta blocker used to lower the heart rate and high blood pressure) 25 milligram (mg), losartan (a medication to treat high blood pressure) 25 mg, hydralazine (a medication to treat high blood pressure) 100 mg, and apixaban (a medication to thin the blood) 5 mg on 01/14/24. Resident #63 had previously received her own prescribed carvedilol 25 mg and losartan 100 mg that morning prior to receiving Resident #340's medication which resulted in duplicate medication. Resident #63 was transported by Emergency Medical Services to the hospital	F 760	Past noncompliance: no plan of correction required.	

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emergency department (ED) where she required intravenous (IV) (directly into the vein) administration of norepinephrine (a medication used to treat life threatening hypotension) to increase her blood pressure, 2 liters of IV fluids, and was admitted to critical care management for treatment to prevent life-threatening conditions of shock and toxidrome (a syndrome caused by dangerous levels for toxins in the body, often the consequence of a drug overdose). This deficient practice affected 1 of 5 residents reviewed for significant medication errors.

Findings included:

Resident #63 was admitted to the facility on 12/24/23 with a diagnosis that included hypertension, heart failure, cirrhosis of the liver, and renal failure.

The Admission Minimum Data Set (MDS) dated 12/30/23 revealed Resident #63 was cognitively intact and received an antiplatelet (medication to prevent blood cells called platelets from clumping together to form a clot).

Review of the January 2024 physician orders for Resident #63 revealed orders for carvedilol 25 mg and losartan 100 mg. Resident #63 had no orders for hydralazine 100 mg or apixaban 5 mg.

Review of the January 2024 Medication Administration Record (MAR) revealed that on 01/14/24 at 8:00 am Resident #63 received all her scheduled medications as ordered to include, carvedilol 25 mg and losartan 100 mg, as evidenced by nursing initials for Nurse #1 and a checkmark on the MAR.

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Resident #340 was admitted to the facility on 12/29/23.

Resident #340's physician orders included carvedilol 25 milligram (mg), losartan 25 mg, hydralazine 100 mg, and apixaban 5 mg.

In a record review of a medication error incident report completed by the Assistant Director of Nursing (ADON) dated 01/14/24 at 10:45 am it was revealed that a medication error had occurred for Resident #63 when the medication nurse (Nurse #1) scanned medication for administration prescribed to Resident # 340 (who had the same first name as Resident #63) and instead administered the medication to Resident #63. The review further revealed that the medication nurse (Nurse #1) identified Resident #63 by her first name only. Resident #63 received medications not prescribed to her that included: losartan 25 mg, carvedilol 25 mg, and apixaban 5 mg.

A record review of a Facility Witness Statement dated 01/14/24 written by Nurse #1 revealed that Nurse #1 administered medication intended for another resident to Resident #63. It further revealed that she entered Resident #63's room and called her by her first name, and Resident #63 answered. Nurse #1 then administered the medication [intended for Resident #340] to Resident #63. As she was exiting Resident #1's room she realized she administered the medication to the wrong resident. The review further revealed that Nurse #1 immediately notified the DON who informed her to notify the Physician and she then paged Physician #2 and he responded and informed Nurse #1 to send Resident #63 to the hospital. She indicated she

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called EMS and then assessed the resident until EMS arrived. She then notified the family of the medication error, and that Resident #1 was sent to the hospital for monitoring. The completion of this document was signed as witnessed by the DON and the Assistant Director of Nursing (ADON).

Review of a nursing progress note written by Nurse #1 dated 01/14/24 at 3:36 pm revealed Resident #63 received her medications 8:00 am. She remained in bed and stated she was feeling better. At 11:00 am, Nurse #1 scanned and prepared another resident's [Resident # 640] medications, walked into Resident #63's room and identified her by first name. Resident #63 received duplicates of carvedilol and losartan as well as a single dose of apixaban. On exiting the room Nurse #1 became aware of the mistake. She checked Resident #63's B/P with results of 159/86 (increased blood pressure) and rechecked 30 min. later with results of 110/68 (decreased blood pressure). Notified the on-call Physician #2. Orders were received from Physician #2 to send Resident #63 to the emergency department. The family member was notified. EMS arrived and transported Resident #63 to the hospital on 01/14/24 at 12:15 pm.

Review of a nursing progress note written by Nurse #1 dated 01/14/24 at 4:02 pm revealed that this note was an addition to Nurse #1's note dated 1/14/24 at 3:36 pm. The documentation indicated that Resident #63 remained alert and oriented, awake and answering questions appropriately. Respirations remained unlabored, at a rate of 16 when emergency medical services arrived. Resident #63's skin was documented as warm, dry, and pale. She denied pain and stated,

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"I'm just really tired". Resident #63 sat up and moved to the gurney with the assistance of the emergency medical technician. An NA remained with Resident #63 until she was transported.

In a phone interview with Nurse #1 on 02/08/24 at 11:24 am it was revealed that she was the weekend supervisor on 01/14/24 and had been assigned to Resident #63's unit that day after another nurse did not show up for her shift. She further stated that she was not typically assigned to a medication cart and was unfamiliar with the resident and unit. Nurse #1 stated she had given Resident #63 her prescribed medications around 8:00 am on 01/14/24. She further stated that around noon on 1/14/24 she prepared medications prescribed for Resident #340, who had the same first name as Resident #63. Resident #340 resided in the room next to Resident #63. Nurse #1 stated she entered Resident #63's room with the medications she had prepared for Resident #340 in error. She stated she only looked at the first name on the room door name plate and called Resident #63 by her first name and that Resident #63 responded yes. She further added that she did not verify Resident #63's last name or date of birth and did not compare the picture on the MAR like she should have. Nurse #1 indicated that she then gave the medication that she had prepared for Resident #340 to Resident #63 and by the time she got back to the medication cart she realized that she had given the wrong medication to Resident #63. She stated that she immediately called the DON and then called Physician #2 and was instructed to send Resident #63 to the hospital for further evaluation and monitoring. The interview further revealed Nurse #1 had checked Resident #63's blood pressure right after

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she realized she gave Resident #63 the wrong medications and re-checked her blood pressure again 20 minutes later and she noted that Resident #63's blood pressure was lower the second time. She stated she called Emergency Medical Services (EMS) and the resident was sent to the hospital for further evaluation and monitoring. She then notified the family. Nurse #1 stated that she was stressed on 01/14/24 because she wasn't familiar with that unit. She further added that the call bell system was not working, and residents were given handbells to call for assistance and she was trying to assist in answering the handbell calls. She added she was behind on administering medications and other residents had come to the medication cart and asked for their medication. She further added that family members of other residents came to her to ask questions, and this caused her to be rushed and she just didn't verify the identity of Resident #63 like she should have.

Review of progress note written by Physician #2, the Medical Director, on 01/14/24 at 12:04 pm revealed that he was contacted by a nurse that a resident had a medication error and was given another resident's medications. The note further revealed that Resident #63 had received her own carvedilol 25 mg and losartan 100 mg and in addition received another carvedilol 25 mg, another losartan 100 mg, and received hydralazine 100 mg. In addition, she is quite anemic with a hemoglobin of 7.5 and she received apixaban. The review indicated that Resident #63 could not be monitored safely in the facility and should be monitored on telemetry (continuous heart monitoring), so she was sent to the hospital to be closely monitored.

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Review of the EMS report dated 01/14/24 revealed EMS responded to a call to the facility because staff gave Resident #63 someone else's medication. The primary impression on the report was documented as poisoning/drug ingestion. Blood pressures monitored during EMS transport to the hospital emergency department indicated blood pressures of, at 12:22 pm 130/54; at 12:34 pm 103/57; at 12:40 pm 108/60; at 12:46 108/63; and at 12:51 95/50. An IV catheter was inserted at 12:48 pm and a saline lock (a short section of tubing attached to the end of an IV catheter that is filled with normal saline solution and then capped to close off the tubing until medications are ready to be administered). The record review further revealed that staff reported to EMS that they had given Resident #63 her prescribed medication and 30 minutes later gave her someone else's medication. It was reported to EMS that Resident #63 was given an extra 25 mg of carvedilol, and extra 100 mg of losartan and was given 2 other medications, that included, apixaban 5 mg and hydralazine 100 mg, not prescribed to her. EMS personnel assessed and monitored the resident continuously while enroute to the hospital.

Review of hospital ED records dated 1/14/24 revealed Resident #63 was received in the ED on 01/14/24 from EMS for a chief complaint of hypotension. The original ED assessment and plan outlined and included the following (as written):
1. Unintentional drug administration
2. Hypotension
a. Patient normally takes Coreg 25 mg and losartan 100 mg.
b. Given additional doses of coreg [carvedilol] 25, losartan 100, hydralazine 100, and Eliquis

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[apibaxan] 5 by mistake at her facility.
c. Monitor vitals.
d. Given a 2-liter bolus [IV fluid administered at a rapid rate to improve cardiac output, correct low blood pressure and ensure sufficient renal blood flow] in ER and will continue IV fluid hydration.
e. Start peripheral levophed [norepinephrine] and keep MAP [mean arterial pressure] greater than 65 and decrease if able.
3. Hypertension
a. Hold home meds.

The hospital record review further revealed that Resident #63's blood pressure was 102/67 when she arrived in the hospital emergency department at 12:55 pm and entered triage at 1:04 pm. She was oriented to person, place, and time, was at high risk of morbidity, and had high complexity. She was placed in observation. At 1:10 pm Resident #63's blood pressure was trending downward, and her MAP was <65, a bolus of intravenous fluids was hung to be administered. Vital signs were monitored every 10 minutes and blood chemistry studies were done. An electrocardiogram (EKG) (a test to detect heart problems) was done and revealed a prolonged QT [an irregular heart rhythm] wave abnormality. Poison control was consulted for recommendation in the care of Resident #63 because of the overdose of medication. Poison Control recommended norepinephrine already explained in the PS and to repeat an EKG to ensure the QT prolongation had resolved. At 3:54 pm her blood pressure dropped into 80s/40s, and the physician ordered Resident #63 to be admitted to the hospital to critical care. Resident #63 was discharged from the ED observation at 3:58 pm and admitted to the hospital in critical care, she continued to receive intravenous

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norepinephrine to treat low blood pressure. A Physician progress note dated 01/14/24 at 3:59 pm indicated that critical care was necessary to treat or prevent imminent or life-threatening deterioration for the following conditions: shock and toxidrome and that critical care time was performed to assess and manage the high probability of imminent, life-threatening deterioration that could result in multi-organ failure. At 5:36 pm Resident #63's blood pressure was 117/87 and her MAP was 96. Her blood pressure was monitored every 10 minutes. The medication error that resulted in the hospitalization of Resident #63 was resolved 48 hours after admission. Resident #63 was hospitalized for a total 4 days, the later portion to of the hospitalization was related to additional gastrointestinal issues that arose after being admitted to the hospital, that was later determined to not be related to the medication error. Resident #63 was discharged from the hospital on 01/19/24 to home with home health.

In a phone interview with Resident #63 on 02/09/24 at 9:28 am she stated that she could recall that on 01/14/24 nurses (could not recall names) kept going in her room at the facility and asked how she felt. "I told them I was tired and sleepy because I didn't not get much sleep the night before". She further stated that initially she did not know why staff kept asking her how she felt and then a nurse that she had never seen before "told me she had given me my medication and another patient's blood pressure medication and blood thinner, and the doctor had recommended that I be sent to the hospital". She stated that one nurse came in and stayed with her until the rescue squad arrived indicating that she was not left alone during this timeframe.

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Resident #63 further indicated that she was feeling very sleepy and when the rescue squad arrived, she was taken to the hospital. She stated when she arrived at the hospital she was really scared, and her stomach started hurting and she "got sick" to her stomach. She stated her blood pressure then "bottomed out and they went to working on me trying to get my blood pressure back up". She described the stomach pain that she had as a 9 on a 0/10 scale used to measure intensity of pain (0 being no pain and 10 being the worst pain). Resident #63 stated she was in the emergency department all night and then was admitted to the hospital. She stated the doctor told her that her stomach pain occurred because her blood pressure "bottomed out". She further added that she was in the intensive care step down unit and had monitors on her that checked her heart, she received fluids and medications intravenously through an IV, and they had to call poison control. Resident #63 stated that when the nurse at the facility brought her Resident #340's medications that she didn't question it because they always brought her medication throughout the day, and she trusted that it was her medication. She stated that they usually asked her for her full name and birthdate but didn't think Nurse #1 asked her that day and just "said my first name".

In a phone interview with Physician #2 (the Medical Director) on 02/06/24 at 12:15 pm it was revealed that Nurse #1 notified him by phone of a medication error in which she administered another resident's medication to Resident #63. She told him that she had already administered Resident #63 her own prescribed medications on the morning of 1/14/24. Physician #2 recalled that she had given Resident #63 blood pressure

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reducing medications and a blood thinner not prescribed to her. He further added that she received her own prescribed carvedilol and losartan and then received duplicate doses of carvedilol (beta blocker) and losartan, as well as apixaban (a blood thinner). Physician #2 stated that when Nurse #1 called him Resident #63's vital signs were not concerning to him at that time, but he anticipated what the outcome could be, and he felt that she would need monitoring at the hospital because of the medication error so he called the hospital emergency department himself to give them report on Resident #63. He added he was concerned that she could go into heart block and her pulse rate would decrease down into the 30's and her blood pressure could decrease, and she would become unconscious and all of the medications that she received would cause her blood pressure to decrease. He stated if the blood pressure became too low that it could cause kidney function problems. He further stated that she had cirrhosis of the liver and that caused concerns of bleeding because of the blood thinner. He stated it could take a few days for the beta blocker to clear her system. He stated the resident was at risk for harm and required monitoring, stating if her blood pressure became too low that she would require care in the Intensive Care Unit at the hospital. Physician #2 stated that he felt the situation was handled appropriately by the facility and he was contacted immediately.

In a review of an Investigational Summary completed by the facility dated 01/14/24 addressed to the Quality Assurance Committee revealed that a Medication Error occurred on 01/14/24 and that a dayshift nurse had administered the wrong medication to Resident

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#63 in error. Resident #63 was sent to the emergency department for monitoring related to Resident #63 received increased dosage of blood pressure medication and a blood thinner. The investigational summary revealed there were 3 residents with the same first name on the same unit and the nurse entered Resident #63's room and called the resident by her first name. She then gave Resident #63 the wrong medication.

In an interview with the Director of Nursing (DON) on 02/8/24 at 11:05 am it was revealed that she was aware of a medication error that occurred on 01/14/24 by Nurse #1. The DON stated that Nurse #1 called her right away on 01/14/24 to report that she had made a medication error and gave Resident #340's medication to Resident #63 in error and that Resident #63 had already received her own prescribed medication, which caused her to receive duplicate blood pressure medication. The DON further added that the medication error could cause Resident #63 to become hypotensive and could have caused cardiac issues in a resident with a cardiac diagnosis. She stated the resident was sent to hospital for routine monitoring. She stated that Nurse #1 was a supervisor and was not usually assigned to a medication cart. Another nurse had called out on 01/14/24 and Nurse #1 was assigned to the medication cart. The DON stated that Nurse #1 should have verified the resident using full name first and last, picture on the electronic medication administration record (e-MAR) and if she was still unsure, she should have asked someone that was familiar with the resident. The interview further revealed that the normal protocol for medication training for nurses was that they received medication administration training for 3 days with another nurse before they

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are assigned to a medication cart, and if they are not comfortable the training is extended until they are comfortable. They learn to use e-MAR and how to scan meds. Nurses also received computer-based on-line training that included the five rights of medication administration and how to identify a resident. To identify a resident the nurse should compare the picture on the e-MAR to the resident, knock on door and ask the resident their full name. If the resident is not alert and oriented and cannot tell you who they are then the nurse should compare the picture on the e-MAR to the resident and ask a staff member that is familiar with that resident. The DON stated that Nurse #1 received the required medication administration training. Nurse #1 was re-educated but was not disciplined because she resigned from her position right away.

Review of medication administration training transcript for Nurse #1 revealed that she had completed computer-based learning modules titled Medication Administration Safety on 08/30/23 and Medication Scanning on 01/10/24. In an interview with the Administrator on 02/06/24 at 12:37 pm it was revealed that she was aware of the medication error regarding Resident #63 and that the nurse immediately notified the DON and the Medical Director, and they decided that due to the type of monitoring required that the resident would be sent to the hospital for further evaluation and treatment. She stated she felt that the medication error occurred because the nurse had distractions of a family member repeatedly coming to the med cart to ask questions and Nurse #1 got distracted and should have just put her medication cart up for the time being. This was the first time this nurse had made any medication errors. The interview further revealed

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Nurse #1 was very upset that it had occurred and told her that she had other residents with the same first name as Resident #63 and she gave Resident #340's medication to Resident #63 because they had the same first name. She stated after the error occurred the facility did a 100 percent audit for all residents with like names and assessed other resident to make sure they got their meds accordingly, she stated they did some medication pass audits with nurses. The interview further revealed that a Performance Improvement Plan was done and the plan was still in progress. The Administrator stated Nurse #1 should have done the 6 rights of medication administration to include asking the resident her name, first and last name and verifying it with the e-MAR and the picture on e-MAR.

The Administrator was notified of Immediate Jeopardy on 02/06/24 at 3:10 pm.

The Administrator provided the following corrective action plan with a compliance date of 01/18/24.

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

On 01/14/24, Nurse #1 prepared Resident #340's medication at the medication cart. She entered the room of Resident #63, who has the same first name as Resident #340. She called the resident's first name, and the resident responded. The nurse then administered Resident #340's medications to Resident #63 in error. While exiting the room, the nurse realized she had given the resident the wrong medication. The nurse immediately assessed the resident and

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obtained vital signs. Blood pressure 159/78, heart rate 77, respiratory rate, 16-18, the resident remained alert and oriented, and able to answer all questions appropriately. The nurse notified the Director of Nursing (DON) and the physician of the medication error, and the resident was sent to the emergency room for monitoring per the physician's recommendations. The resident was admitted to the hospital for monitoring of medications administered in error and was treated with medication for low blood pressure, which was resolved within 24 hours.

On 01/16/24, a root cause analysis was completed by the Administrator and Director of Nursing. The root cause of the medication error was determined to be Nurse #1 administered medication to Resident #63 without appropriately confirming the resident's complete name and utilizing the resident's picture in the electronic medical record as an identifier.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
On 01/16/2024, the Assistant Director of Nursing (ADON) and Unit Manager initiated an audit of all residents for signs and symptoms of acute changes in condition to investigate the cause of the change and ensure the change was not related to significant medication errors. There were no areas of concern identified during the audit. The audit was completed by 01/17/2024.

On 01/16/2024, an audit of all progress notes for the past 14 days was initiated by the DON. This audit was to identify any documentation related to a resident with an acute change from a significant medication error to ensure the resident was

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assessed, interventions were initiated, and the physician was notified for further recommendations. There were no areas of concern identified during the audit. The audit was completed by 01/17/2024.

On 01/17/2024, the ADON and Unit Manager initiated Medication Pass Audits with all nurses and medication aides including agency. This audit was to ensure (1) the nurses and/or medication aides administer medications per the physician's order (2) staff utilize the rights of medication administration to include the right medication and to the right resident by asking the resident their full name and using the picture in the electronic medication administration record as an identifier and (3) staff demonstrated what to do if resident, family or staff interrupt during medication administration to avoid errors. This includes restarting the 6 rights of medication administration prior to administering the medication to a resident. The ADON and Unit Manager addressed all concerns identified during the audit including reeducation of staff if indicated. There were no other significant medication errors identified during the audit. The audit was completed by 01/17/2024. After 01/17/2024, any nurse or medication aide including agency who has not worked or completed the medication pass audit completed it upon the next scheduled work shift.

On 01/16/2024, the ADON initiated an audit of all residents with "like" names and proximity of room locations. Name alerts were placed on the medication administration record (MAR) for residents with similar names and rooms within close proximity of each other. The ADON addressed all concerns identified during the audit,

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including posting "name alerts "in the medical record. The audit was completed by 01/17/2024.

On 01/16/2024, the DON completed an audit of all incident reports for the past 30 days to identify any medication administration concerns resulting in medication errors. No additional concerns were identified during the audit.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
On 01/14/2024, ADON initiated an in-service with all nurses and medication aides to include agency regarding the?Rights of Medication Administration. The education emphasized (1) administering medications per physician order, (2) the rights of medication administration including but not limited to the right medication to the right resident, and (3) disposing of medications if not administered immediately (4) how to identify residents with emphasis on asking resident to state full name and utilizing electronic record photo to verify residents prior to administering medications (5) what to do if you are still not sure of the resident's identity i.e. ask a staff member familiar with the resident to verify their identity and (6) what to do if residents, family or staff interrupt during medication administration to avoid errors which includes restarting the 6 rights of medication administration prior to administering the medication to a resident. The in-service was completed by 01/17/2024. After 01/17/2024, any nurse or medication aide including agency who had not worked or completed the education completed it prior to the next scheduled shift.?

All newly hired nurses and medication aides

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including agency will be educated by the Director of Nursing or Nurse Supervisor during orientation, prior to performing medication administration, regarding the?Rights of Medication Administration including (1) administering medications per physician order, (2) the rights of medication administration including but not limited to the right medication to the right resident, and (3) disposing of medications if not administered immediately (4) how to identify residents with emphasis on asking resident to state full name and utilizing electronic record photo to verify residents prior to administering medications (5) what to do if you are still not sure of the resident's identity i.e. ask a staff member familiar with the resident to verify their identity and (6) what to do if residents, family or staff interrupt during medication administration to avoid errors which includes restarting the 6 rights of medication administration prior to administering the medication to a resident. The Administrator will track to ensure the education is completed by utilizing the staff new hire and/or agency orientation checklist.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The decision to monitor the system for prevention of significant medication errors was made on 1/16/24 by the Administrator and Director of Nursing and presented to the Quality Assurance Committee on 1/16/24.

The ADON and Unit Manager will complete 5?Medication Pass Audits?across all shifts with nurses and medication aides weekly x 6 weeks then monthly x 2 months. This audit is to ensure (1) the nurses and/or medication aides administers medications per the physician's order

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(2) staff utilizes the rights of medication administration to include the right medication and to the right resident (3) the staff utilizes the appropriate technique when identifying residents and (4) staff demonstrates what to do if resident, family or staff interrupt during medication administration to avoid errors. The ADON and Unit Manager will address all concerns identified during the?Medication Pass Audits, including re-training of the nurse and/or medication aide. The Administrator will review the Medication Pass Audits weekly x 4 weeks to ensure all concerns are addressed.

The Interdisciplinary Team, including, the DON, ADON, Minimum Data Set (MDS) nurse, and Nurse Supervisor will review progress notes 5 x week x 6 weeks then monthly x 2 months. This audit is to identify any documentation related to a resident with an acute change from a significant medication error to ensure the resident was assessed, interventions were initiated, and the physician was notified for further recommendations. The Director of Nursing will immediately address all areas of concerns identified during the audit, including resident assessment, notification of the physician for further recommendations with documentation in the electronic record, and staff re-training. The Administrator will review the progress note audit weekly x 6 weeks then monthly x 2 months to ensure all concerns were addressed.

The Interdisciplinary Team, including, the DON, ADON, Minimum Data Set (MDS) nurse, and Nurse Supervisor will review incident reports weekly x 6 weeks then monthly x 2 months. This audit is to identify any medication administration concerns resulting in medication errors to ensure

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appropriate interventions were initiated, the physician notified, and the resident assessed as indicated. The Director of Nursing will immediately address concerns identified during the audit, including resident assessment, notification of the physician for further recommendations with documentation in the electronic record, and staff re-training. The Administrator will review the incident report audit weekly x 6 weeks then monthly x 2 months to ensure all concerns are addressed.

The Administrator/DON will forward the results of the Medication Pass Audits, Progress Note Reviews, and Incident Report review to the Quality Assurance Performance Improvement (QAPI) Committee including the Medical Director, DON, Administrator, Social Worker, Dietary Manager, ADON, Therapy Director, and Activity Director, monthly x 4 months. The QAPI Committee will meet monthly x 4 months and review the Medication Pass Audits, Progress Note Reviews, and Incident Report review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.

Alleged Compliance Date: 01/18/24

Validation of the corrective action was completed on 02/8/24. This included staff interviews with nurses regarding the 6 rights of medication administration to include resident identification prior to administration of medication as well as observations of medication passes to ensure the 6 rights of medication administration were followed. All of the audits were verified and there were no concerns identified. The facility's

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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 760	Continued From page 57 alleged compliance date of 01/18/24 was validated.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to don a clean pair of disposable gloves prior to the start of tray line, failed to ensure dietary staff had their hair restrained during food production and failed to serve a food item within safe temperature range. These practices had the potential to affect food served to residents. Findings included: 1. During a food temperature observation on	F 812	F812 Food Procurement, Store/Prepare/Serve- Sanitary On 2/7/24, the dietary manager verbally educated the cook regarding use of gloves, changing gloves/washing hands following contact with soiled items and before handling/serving food items. On 2/7/24, the dietary manager verbally educated all dietary staff currently working to include dietary aide #1 and dietary aide	3/11/24

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	345569	A. BUILDING _____ B. WING _____	C 02/13/2024

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F 812	Continued From page 58 2/07/24 at 11:42 AM the Cook was observed wearing disposable gloves. While wearing the same pair of disposable gloves, he was observed to take a container of food from the stove, open the meal cart door using the handle, close the meal cart door, and pick up a large pot of mashed potatoes from the stove and place it on the counter. While wearing the same disposable gloves, the Cook then picked up a serving spoon with one hand and a small plastic bowl with the other hand. While picking up the small plastic bowl, he placed two gloved fingers inside the bowl to aid in picking up the bowl. He was then observed to put a scoop of mashed potatoes inside the bowl. The Cook was observed to fill several bowls by placing two gloved fingers inside the bowl to aid in picking up the bowl. An interview on 2/07/24 at 1:50 PM with the Cook revealed that he had not changed his disposable gloves after handling other objects such as the stove handle, meal tray carts and food containers prior to plating the mashed potatoes. He also revealed that he had placed his gloved fingers into the bowls prior to putting the mashed potatoes in them. He stated he did this out of the stress of the day and the rush to get the food out to the residents. The Cook revealed that he had food safety training and was also serve safe certified. An interview on 2/07/24 at 2:10 PM with the Dietary Manager revealed he did not know why the Cook had not changed his disposable gloves prior to plating the mashed potatoes. An interview with the Administrator on 2/08/24 at 2:36 PM revealed that she did not know why the Cook had not changed his disposable gloves	F 812	#2 regarding proper use of hair nets when in food prep areas. On 2/26/2024, the Housekeeping Supervisor completed an audit of dietary staff to ensure staff (1) appropriately wore hair nets to keep hair restrained when in food prep areas and (2) staff don/doff gloves and washed hands following contact with soiled items and before handling/serving food items. The Administrator will address all concerns identified during the audit to include education of staff. The audit will be completed by 3/11/24. On 2/26/2024, the Dietary Manager under the oversight of the Administrator initiated temperature audits of meal trays to include all three meals. This audit was to ensure food was served at appropriate temperatures to maintain food safety. The Dietary Manager and Administrator will address all concerns identified during the audit to include removing any food item that was found below appropriate temperature range and education of staff. The audit will be completed by 3/11/24. On 2/7/2024, the Dietary Manager initiated an in-service with all dietary staff regarding Food Safety with emphasis on (1) use of hair nets to keep hair restrained in food prep areas (2) use of gloves and handwashing between contact with contaminated items and before handling/serving food items and (3) required temperature ranges when serving food to maintain food safety. The	

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F 812	Continued From page 59 prior to plating the mashed potatoes. 2. During a food temperature observation on 2/07/24 at 11:42 AM Dietary Aide #1 and Dietary Aide #2 were observed to be wearing hair nets that covered the front portion of their hair but did not cover the back of their hair. Dietary Aide #1 had shoulder length hair which was approximately 6 inches unrestrained below her hair net. Dietary Aide #2 had chin length hair which was approximately 3 inches unrestrained below her hair net. Both Dietary Aides were in the food preparation area with Dietary Aide #2 observed to be slicing tomatoes. An interview on 2/07/24 at 1:57 PM with Dietary Aide #2 revealed that she did not know that her hair was not under the hair net on the back of her head. She stated that she had her hair in the hair net that morning and it must have just fallen out. She stated that she had received training and knew her hair was supposed to be secured under a hair net while in the food preparation area. An interview on 2/07/24 at 2:05 PM with Dietary Aide #2 revealed that she did not know her hair was not under a hair net. She stated that she usually used 2 hair nets to secure her hair and 1 of them must have fallen off. She stated that she had received training and knew her hair was supposed to be secured under a hair net while in the food preparation area. An interview on 2/07/24 at 2:10 PM with the Dietary Manager revealed that Dietary Aides #1 and #2's hair nets must have just 'come undone'. An interview with the Administrator on 2/08/24 at 2:36 PM revealed that she did not know why the	F 812	in-service will be completed by 3/11/24. After 3/11/24 any dietary staff who has not completed the in-service will complete it at the next scheduled work shift. All newly hired dietary staff will be in service during orientation. The Housekeeping Supervisor will complete an audit of dietary staff weekly x 4 weeks then monthly x 1 month utilizing the Dietary Audit Tool. This audit is to ensure staff (1) appropriately wore hair nets to keep hair restrained when in food prep areas and (2) staff don/doff gloves and washed hands following contact with soiled items and before handling/serving food items. The Administrator will address all concerns identified during the audit to include re-education of staff. The Administrator will review the Dietary Audit Tool 3 times a week x 4 weeks then weekly x 1 month to ensure all concerns are addressed. The Housekeeping Supervisor and Manager on Duty will complete temperature audits of meal trays to include all three meals and weekends twice weekly x 4 weeks and then monthly x 1 month utilizing the Food Temperature Audit Tool. This audit is to ensure food was served at appropriate temperatures to maintain food safety. The Housekeeping Supervisor and/or Manager on Duty will address all concerns identified during the audit to include removing any food item that was found below appropriate temperature range and education of staff. The Administrator will	

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F 812	Continued From page 60 Dietary Aides hair had not been secured in hair nets. 3. An observation of food temperatures in the steam table at a satellite kitchen on 2/7/24 at 12:22 PM revealed creamed corn that was measured 87 degrees Fahrenheit (F) by Dietary Aide #1 with a dial thermometer. The temperatures were done at the start of the tray line. On 2/7/24 at 12:25 PM an observation of the lunch meal in the satellite kitchen revealed Dietary Aide #1 proceeded to plate the corn for a Resident and a Nursing Assistant (NA) #2 took it to the Resident before the error was brought to their attention. The NA removed the plate from the Resident. Dietary Aide #1 had an NA take the remaining corn to the kitchen to be reheated. An observation of the temperature of the reheated creamed corn on 2/7/24 at 12:40 PM revealed a temperature of 140 degrees F measured by Dietary Aide #1 with a dial thermometer. An interview with Dietary Aide #1 on 2/7/24 at 12:30 PM revealed she was aware food on the steam table was to be held at a minimum of 135 degrees F. She further stated she did not know that the creamed corn had to be held at a minimum of 135 degrees F. Dietary Aide #1 stated she had training about the steam table when she was first hired 4 months ago which included infection control, proper temperatures and their part in potential for foodborne illness. In an interview with the Dietary Manager (DM) on 2/8/24 at 8:45 AM he stated he trained new employees in proper food distribution when they	F 812	review the Food Temperature Audit Tool twice weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will present the findings of the Dietary Audit Tool and the Food Temperature Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 812	Continued From page 61 were first hired and when an issue came up. The new employee was then teamed up with a more experienced employee for further training. He further stated he held monthly staff meetings and did in-services at that time as well He was able to state that the minimum temperature for food on the steam table was 135 degrees F and if a temperature was below that, the food must be taken back to the kitchen to be reheated and not served to Residents due to the risk of food borne pathogens. In an interview with the Administrator on 2/8/24 at 2:30 PM she stated that she was not aware of any hot food temperatures below 135 degrees F on the steam table recently. She further stated she was unaware the creamed corn that had a temperature of 87 degrees F was served to a Resident. The Administrator believed that a high turnover rate in kitchen staff led to lack of education leading to the creamed corn being served below safe temperatures.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a dumpster that was in good condition and free of leaks and to maintain the dumpster area free of debris for 1 of 1 dumpster. This practice had the potential to attract pests and rodents. Findings included:	F 814	F814 Dispose Garbage and Refuse Properly On 2/9/2024, the Maintenance Director removed a broom, dustpan, shovel, wood boards, bags of topsoil and a 10ft x 8ft rusted metal frame from inside the dumpster area fence.	3/11/24

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F 814	Continued From page 62 Observation of the facility's dumpster area on 2/07/24 at 1:30 PM with the Regional Nutrition Consultant revealed an area of a black substance around the dumpster which extended about 10 feet toward the road. This area of black substance had a strong odor of refuse. The area observed under the dumpster had approximately 3 inches of black debris which had a strong odor of refuse. The area behind the dumpster and the recycle container but inside the dumpster area fence had several items. These items included a broom, dustpan, shovel, 3 2x4 wood boards, 1 full bag labeled topsoil, 1 partial bag labeled topsoil, and 1 approximately sized 10 feet by 8 feet rusted, gray metal frame with 6 open areas. During an interview on 2/07/24 at 2:10 PM with the Dietary Manager he stated that the dumpster had been leaking for months. He also stated that he was unaware of the items behind the dumpster and did not know why they were there. During an observation and interview with the Administrator on 2/07/24 at 1:45 PM she stated that the dumpster had been leaking for a week and they were working to get a new dumpster. She stated she was unaware of the items behind the dumpster and did not know why they were there.	F 814	On 2/9/2024, the dumpster was removed, black debris cleaned from dumpster area and a new dumpster placed. On 2/23/2024 the Administrator in-serviced the dietary staff, housekeeping staff and maintenance staff regarding Dumpster Area with emphasis on (1) not storing items within or around the dumpster area/fence (2) keeping area clean of debris or refuse and (3) immediately reporting to the Administrator any concerns related to leakage from the dumpster. All newly hired dietary managers or maintenance staff will be in-service during orientation. The admission staff will complete observation of dumpster area two times a week x 4 weeks then monthly x 1 month utilizing the Dumpster Observation Audit Tool to ensure the dumpster area is free of leakage or refuse and items are not stored within or around dumpster area/fence. The admission staff will address all areas of concern identified during the audit to include cleaning items around dumpster area, reporting concerns related to leakage from dumpster and or re-training of staff. The Administrator will review the audit tools weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will present the findings of the Dumpster Observation Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review to determine	

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F 814	Continued From page 63	F 814	trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		3/11/24

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F 842	Continued From page 64 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to maintain accurate documentation of the administration of oxygen (O2) (Resident #30) and the completion of wound treatments (Resident	F 842	F842 Resident Records-Identifiable Information On 2/8/24, the Director of Nursing clarified the physician order for the use of	

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F 842	Continued From page 65 #75). This was for 2 of 21 residents reviewed for accurate documentation. Findings included: 1. On 2/5/24 at 12:32 PM an observation of Resident #30 revealed he was in bed. He was not observed to be receiving oxygen. He was wearing a BiPap machine. An interview with Resident #30 at that time indicated he did not use oxygen. A review of Resident #30's February 2024 Medication Administration Record (MAR) on 2/7/24 revealed in part a physician's order with a start date of 5/23/23 for O2 3 liters (L) per nasal cannula (NC) continuously. It further revealed documentation by Nurse #3 on 2/2/24, 2/3/24 and 2/4/24 and by Nurse #4 on 2/7/24 that this was administered. On 2/7/24 at 7:24 PM a telephone interview with Nurse #3 indicated she documented on Resident #30's MAR on 2/2/24, 2/3/24 and 2/4/24 that he was receiving O2 3L per NC continuously because she misunderstood the order. She stated Resident #30 had not been receiving any oxygen. She further indicated her documentation that Resident #30 received O2 on those days had been in error. On 2/8/24 at 11:22 AM an interview with Nurse #4 indicated he documented on Resident #30's MAR on 2/7/24 that he was receiving O2 3L per NC continuously in error. He stated he had not seen Resident #30 being administered O2 via any source and had misunderstood. On 2/8/24 at 9:38 AM an interview with the Director of Nursing indicated Nurses should not	F 842	supplemental oxygen for resident #30. The order for oxygen was discontinued per physician order. On 2/24/24, the nurse supervisor completed a head-to-toe skin assessed resident #75 to include assessment of all current wounds. Treatment was provided per physician order. There were no changes noted in wound status. On 2/23/2024, the Director of Nursing initiated an audit of all residents with supplemental oxygen orders or residents utilizing supplemental oxygen. This audit is to ensure all residents utilizing oxygen had a current order indicating flow rate and monitoring parameters and oxygen was administered per physician order. The Director of Nursing addressed all concerns identified during the audit to include but not limited to clarification with the physician resident need for supplemental oxygen to include flow rate and monitoring parameters, ensuring oxygen was administered per physician orders with documentation in the electronic record. The audit will be completed by 3/11/24. On 2/26/24, the Assistant Director of Nursing (ADON) initiated an audit of all treatment administration records (TARs) for the past 7 days. This audit is to ensure that treatment was provided per physician order with documentation in the electronic record. The ADON will address all concerns identified during the audit to include assessment of the resident,	

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F 842	Continued From page 66 be documenting that Resident #30 was being administered O2 if he was not. She went on to say documentation in Resident #30's medical record should be accurate and reflect the care they were actually receiving. On 2/9/24 at 11:39 AM an interview with the Administrator indicated the documentation in resident's medical record should be accurate. 2. a. Review of physician's orders revealed an order dated 12/16/23 and discontinued on 1/17/24 for the left ischium (a bone in the hip) wound to be cleaned, patted dry, apply collagenase ointment, calcium alginate, and cover with a foam border dressing daily for wound care. Review of Resident #75's Treatment Administration Record (TAR) for January 2024 revealed there were no signatures on 1/01, 1/06, 1/07, and 1/13. b. Review of physician's orders revealed an order dated 1/17/24 and discontinued on 1/30/24 for the left ischium wound to be cleaned, patted dry, apply silver alginate, and cover with a foam border dressing daily for wound care. Review of Resident #75's Treatment Administration Record (TAR) for January 2024 revealed there were no signatures on 1/21, 1/26, 1/27, and 1/30. c. Review of physician's orders revealed an order dated 12/16/23 and discontinued on 1/30/24 for the right ischium wound to be cleaned, patted dry,	F 842	notification of the physician for further recommendations, completion of treatment per physician order with documentation in the electronic record and education of staff. The audit will be completed by 3/5/24. On 2/23/2024, the Assistant Director of Nursing initiated an in-service with all nurses regarding Administration of Oxygen with emphasis on (1) ensuring resident utilizing supplement oxygen have a current physician order to include flow rate and monitoring parameters and (2) oxygen is administered per physician orders. The in-service will be completed by 3/11/24. After 3/11/24 any nurse who has not worked or completed the in-service will complete it at the next scheduled work shift. All newly hired nurses will be in-service during orientation. On 2/24/24, the Nurse Supervisors initiated an in-service with all nurses regarding TAR Documentation with emphasis on the nurse□s role in completing treatment in the absence of a treatment nurse, documentation of the treatment on the TAR and notification of the physician when resident refuses treatments for further recommendation. The In-service will be completed by 3/5/24. After 3/5/24, any nurse who has not worked or completed the in-service will complete prior to next scheduled work shift. All newly hired nurses will be educated during orientation.	

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F 842	Continued From page 67 apply silver alginate, and cover with a foam border dressing daily for wound care. Review of Resident #75's Treatment Administration Record (TAR) for January 2024 revealed there were no signatures on 1/01, 1/06, 1/07, 1/13, 1/21, 1/26, 1/27, and 1/30. d. Review of physician's orders revealed an order dated 1/17/24 for the sacrum wound to be cleaned, patted dry, apply silver alginate, and cover with a foam border dressing every Monday, Wednesday, and Friday for wound care. Review of Resident #75's Treatment Administration Record (TAR) for January 2024 revealed there was no signatures on 1/26. An interview on 2/08/24 at 3:57 PM with Nurse #2 revealed that she was regularly assigned to Resident #75's hall. She stated that she was responsible for providing wound care if the Wound Treatment Nurse was not available. She stated that she provided the wound care on 1/01, 1/06, 1/07, 1/21, and 1/30, but had forgotten to sign off that it was completed. Interviews were attempted for hall Nurses #11 and #12 for 1/13, 1/26, and 1/27 but were unsuccessful. An interview on 2/08/24 at 3:02 PM with the Administrator revealed that she was unaware of the wound care documentation not being signed as completed.	F 842	The Admission Nurse, Nurse Supervisors and Assistant Director of Nursing will review all residents with supplement oxygen orders or residents receiving supplement oxygen weekly x 4 weeks then monthly x 1 month utilizing Oxygen Audit Tool. This audit is to ensure all residents utilizing oxygen had a current order indicating flow rate and monitoring parameters and oxygen was administered per physician order. The Admission Nurse, Nurse Supervisors and Assistant Director of Nursing will address all concerns identified during the audit to include clarifying orders when indicated, administering oxygen per physician orders and/or re-training of staff. The Director of Nursing (DON) will review the Oxygen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Interdisciplinary team to include the Nurse Supervisors, Assistant Director of Nursing, Minimum Date Set (MDS) nurse and treatment nurse will review TAR documentation 5 times a week x 4 weeks then monthly x 1 month to include weekends. This audit is to ensure that treatment was provided per physician order with documentation in the electronic record. The Nursing Supervisors, ADON and MDS nurse will address all concerns identified during the audit to include assessment of the resident, notification of the physician for further recommendations, completion of treatment per physician order with documentation in the electronic record	

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F 842	Continued From page 68	F 842	and education of staff. The Director of Nursing will review the TAR audit 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will present the findings of the Oxygen Audit Tool and TAR audits to the Quality Assurance (QA) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information	F 867		3/11/24

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F 867	Continued From page 69	F 867		

will be used to develop and monitor performance indicators.

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

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

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

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

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

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F 867	Continued From page 70 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §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	F 867		

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F 867	Continued From page 71 program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff, Nurse Practitioner (NP), and Physician interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 3/9/21 complaint survey and the 8/20/21 and 9/22/22 recertification and complaint investigation surveys. This was for 7 deficiencies in the areas of F550 Dignity, F677 Activities of Daily Living, F684 Quality of Care/Professional Standards, F693 Tube Feeding, F695 Respiratory Care, F812 Food Preparation and Storage, and F842 Accuracy of Records. These deficiencies were recited on the current recertification and complaint investigation survey of 2/13/24. The continued failure of the facility during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: F550: Based on observations, record review and staff interviews the facility failed to provide a dignified dining experience when Nurse Aide (NA)	F 867	F867 QAPI/QAA Improvement Activities On 2/23/24, the Facility Consultant initiated an audit of previous citations and action plans from 3/2021 to 2/20/24 related to F550 Dignity, F677 Activities of Daily Living, F684 Quality of Life/Professional Standards, F693 Tube Feeding, F695 Respiratory Care, F812 Food Preparation and Storage and F842 Accuracy of Records to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the Administrator for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to the education of staff. Audit will be completed by 3/5/24. On 2/23/24, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Unit Managers regarding the Quality Assurance (QA) process to include implementation of Action Plans,	

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F 867	Continued From page 72 #4 stood at Resident #7's bedside while feeding Resident #7. This was for 1 of 2 residents reviewed for dignity. A reasonable person might feel a lack of dignity when NA #4 stood while feeding them. During the 8/20/21 recertification and complaint investigation survey the facility was cited for failing to provide a dignified dining experience. During the 9/22/22 recertification and complaint investigation survey the facility was cited for failing to provide incontinence care. On 2/9/24 at 11:59 AM during an interview, the Administrator discussed the facility's QAA process. She stated she felt the reasons in each example were different. She went on to say she felt the continued difficulties were a result of changing staff. F677: Based on observations, record review and staff interviews, the facility failed to rinse soap from a resident's skin during a dependent resident's bed bath and to provide nail care for 1 of 9 residents reviewed for activities of daily living (Resident #57). During the 3/9/21 complaint investigation survey the facility was cited for failing to trim fingernails. During the 8/20/21 recertification and complaint investigation survey the facility was cited for failing to provide showers or bed baths. During the 9/22/22 recertification and complaint investigation survey the facility was cited for failing to provide incontinence care and failing to rinse soap per the manufacturer's direction during	F 867	Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include updated advance directives. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 3/5/24. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns, to include F550 Dignity, F677 Activities of Daily Living, F684 Quality of Life/Professional Standards, F693 Tube Feeding, F695 Respiratory Care, F812 Food Preparation and Storage and F842 Accuracy of Records will be taken to the Quality Assurance committee for review monthly x 2 months by the Quality Assurance Nurse. The Quality Assurance committee will review the data and determine if a plan of corrections is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the QA	

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F 867	Continued From page 73 a bath. On 2/9/24 at 11:59 AM during an interview, the Administrator discussed the facility's QAA process. She stated although staff training had been done, and audits performed to ensure correction of these issues, she felt due to the amount of agency staff the facility employed, Nurse Aides (NAs) just weren't taking their time. She went on to say although there was not a lack of staff, they were being pulled in a lot of different directions. F684: Based on record review and staff and physician interviews the facility failed to obtain daily weights as ordered by the physician for 1 of 6 residents (Resident #30) reviewed for respiratory care. During the 8/20/21 recertification and complaint investigation survey the facility was cited for failing to transcribe orders and have medications available. On 2/9/24 at 11:59 AM during an interview, the Administrator discussed the facility's QAA process. She stated she felt the repeat issues were different. She went on to say she attributed this to changing staff. F693: Based on observation, record review, and staff interviews, the facility failed to change a tube feeding syringe daily or store a tube feeding syringe with the plunger separated from the barrel for 1 of 1 resident reviewed for enteral feeding management (Resident #57). During the 9/22/22 recertification and complaint investigation survey the facility was cited for	F 867	Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include F550 Dignity, F677 Activities of Daily Living, F684 Quality of Life/Professional Standards, F693 Tube Feeding, F695 Respiratory Care, F812 Food Preparation and Storage and F842 Accuracy of Records and all current citations and that the QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and Unit Managers for any identified areas of concern. The results of all audits and consultant review will be presented to the Quality Assurance Performance Improvement Committee quarterly x 6 months for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	

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F 867	Continued From page 74	F 867		

failing to provide tube feeding as ordered.

On 2/9/24 at 11:59 AM during an interview, the Administrator discussed the facility's QAA process. She stated she felt the repeat issues were different. She went on to say she attributed this to changing staff.

F695: Based on observations, record review, resident, staff, Nurse Practitioner (NP) and Physician interviews the facility failed to obtain a physician's order for the use of supplemental oxygen (Residents #68 and #37), assess a resident receiving respiratory medications via nebulizer (Resident #8), change oxygen tubing and humidification bottles in accordance with the manufacturer's instructions (Residents #68 and #37), and administer oxygen in accordance with the Physician's order (Resident #30) for 4 of 5 residents reviewed for respiratory care.

During the 9/22/22 recertification and complaint investigation survey the facility was cited for failing to notify the physician of a pulmonary consult recommendation.

On 2/9/24 at 11:59 AM during an interview, the Administrator discussed the facility's QAA process. She stated she felt the repeat issues were different. She went on to say she attributed this to changing staff.

F812: Based on observations and staff interviews, the facility failed to don a clean pair of disposable gloves prior to the start of tray line, failed to ensure dietary staff had their hair restrained during food production and failed to serve a food item within safe temperature range. These practices had the potential to affect food

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served to residents.

During the 8/20/21 recertification and complaint investigation survey the facility was cited for failing to label food.

During the 9/22/22 recertification and complaint investigation survey the facility was cited for failing to wear hair covering and failing to dry plate covers.

On 2/9/24 at 11:59 AM during an interview, the Administrator discussed the facility's QAA process. She stated for the hair covering, although training and auditing had been done, there were changes in staff and there had been no follow-through.

F842: Based on observations, record review, and resident and staff interviews the facility failed to maintain accurate documentation of the administration of oxygen (O2) (Resident #30) and the completion of wound treatments (Resident #75). This was for 2 of 21 residents reviewed for accurate documentation.

During the 3/9/21 complaint investigation survey the facility was cited for failing to maintain accurate documentation record of meal intake and wound care.

On 2/9/24 at 11:59 AM during an interview, the Administrator discussed the facility's QAA process. She stated the last issue with documentation happened 3 years ago. She went on to say she felt the facility had been doing great with documentation so maybe they were just forgetting to document again.