STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345566	A. BUILDING _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An onsite recertification and complaint investigation survey were conducted from 2/5/24 through 2/8/24. An extended survey was conducted on 2/16/24. Therefore, the exit date was changed to 2/16/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9U2E11.	E 000		
F 000	INITIAL COMMENTS An onsite recertification and complaint investigation survey were conducted from 2/5/24 through 2/8/24. An extended survey was conducted on 2/16/24. Therefore, the exit date was changed to 2/16/2024. Event ID# 9U2E11. The following intakes were investigated: NC00213083, NC00212793, NC00212734, NC00196947, NC00198776, NC00198838, NC00200273, NC00201279, NC00201351, NC00201445, NC00202645, NC00205850, NC00210189, NC00210182, NC00210380, NC00210749, NC00211555, NC00211928, NC00211916, NC00212734, NC00198116, NC00201089, NC00212632, NC00199744. 45 of the 88 complaint allegations resulted in deficiency. Substandard Quality of Care was identified at: CFR483.10 at tag F550 at a scope and severity (H). The tag F550 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 550 SS=H	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 | 03/05/2024

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§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 exercise of his or her rights as required under this

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F 550	Continued From page 2 subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family member, and staff interviews, the facility failed to protect residents' dignity when residents were left soiled in feces and saturated in urine for 4 of 17 residents reviewed for dignity issues (Resident #192, Resident #34, Resident #48, and Resident #69), and failed to provide a dignity cover over a urinary catheter drainage bag for 1 of 4 residents reviewed for urinary catheters (Resident #390). Resident #192, Resident #34, Resident #48, and Resident #69 reported they felt upset, angry, mad, and like they did not matter at all when they were not provided incontinence care. Resident #390 felt upset that "everyone could see my urine." The reasonable person concept was applied for Resident #48 due to her inability to express her feelings and a reasonable person would feel humiliated and degraded having to holler for assistance. The findings included: 1. Resident #192 was admitted to the facility on 2/1/2024 with diagnoses including respiratory failure and hypertension. The admission Minimum Data Set (MDS) dated 2/8/204 assessed Resident #192 to be cognitively intact. The remainder of the MDS was in progress and incomplete. The admission nursing assessment dated 2/1/2024 documented Resident #192 was incontinent of urine and feces. A care plan dated 2/1/2024 addressed Resident #192's potential for skin breakdown related to incontinence. The MDS	F 550	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #192 is no longer a resident in the facility. Resident #34 is no longer a resident in the facility Resident #48 is no longer a resident in the facility. Resident #390 is no longer a resident in the facility Resident #69 Resident #69 remains in the center and is provided timely incontinence care. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. Current residents with BIMS of 12 or greater and resident #69 will be interviewed by the Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC) Social Worker (SW), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) regarding dignity and respect using resident	

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vision assessment was not completed, however, Resident #192 read from her phone, and was able to read the name badge of the surveyor.

Resident #192 was interviewed on 2/5/2024 at 11:17 AM. Resident #192 reported that on Sunday 2/4/2024 she was left saturated in urine, and she waited for care from 8:30 AM until 12:30 PM. Resident #192 described that her bed linens were wet with urine, her nightgown was wet with urine, and her incontinence brief was saturated with urine. Resident #192 explained that she had very little control of her bladder and she required an incontinence brief all the time. Resident #192 reported the incident made her feel sad and bad about herself, "Like I didn't matter at all," and she was cold and uncomfortable. When asked how she knew she waited for 4 hours for incontinence care, Resident #192 explained she pressed her call light at 8:30 AM and the nurse told her he would be in to help her when he finished with his medication pass. Resident #192 reported she tracked the time on her cell phone.

An interview was conducted with Nurse #10 on 2/6/2024 at 3:45 PM. Nurse #10 reported on Sunday 2/4/2024 the hall had one nursing assistant (NA) and him working. Nurse #10 reported that he had to administer medications before he was able to help the NA with incontinence care on residents. Nurse #10 reported Resident #192 was "very wet" when he provided her with incontinence care after he had administered medication, but she did not mention she was upset.

NA #1 was interviewed on 2/8/2024 at 10:12 AM. NA #1 reported she was the only NA scheduled to work the short-term unit and it was her and Nurse

questionnaire by 3/11/24. Residents with BIMS score less than 12 will have the clinical nursing management team physically check the resident brief to ensure the resident is clean and dry. If the resident is not clean and dry, incontinence care will be provided immediately. This will be completed by 3/11/24.
Current residents with indwelling catheters will have catheter drainage bag viewed by the Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC) Social Worker (SW), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) to ensure each drainage collection bag has a privacy cover and urine is not able to be viewed by other residents or staff. This will be completed by 3/11/2024.

3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.

The Director of Health Services, Clinical Competency Coordinator, RN Supervisors, and/or designee will provide education to current nursing staff regarding resident rights and dignity and examples of not protecting resident□s rights/dignity including being in soiled brief for an extended period and drainage bags not having a privacy cover by 3/11/2024. After 3/11/2024, any staff that has not worked and received the education will complete upon their next scheduled shift. All newly hired nursing staff will receive

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F 550	Continued From page 4 #10 on the hall on 2/4/2024. NA reported she started at one side of the short-term hall and started providing care to residents one-by-one. NA #1 explained that several residents were soiled and saturated in urine, and she was not certain how long it took to provide care to all the residents. NA #1 reported she had provided care to Resident #192 on Saturday 2/3/2024 and she was aware that Resident #192 was incontinent of urine. NA#1 reported she did not know when Resident #192 received incontinence care on Sunday 2/4/2024 because Nurse #10 provided that care. The Director of Nursing (DON) #1 was interviewed on 2/8/2024 at 4:09 PM. DON #1 explained she was not certain why staffing was so low on 2/4/2024 and she would need to review the staffing sheets. DON #1 reported she expected incontinence care to be provided to residents in a timely manner. 2. Resident #34 was admitted to the facility on 1/3/2024 with diagnoses to include stroke and diabetes. The admission MDS dated 1/8/2024 assessed Resident #34 to be cognitively intact. The MDS documented Resident #192 was occasionally incontinent of urine and always continent of bowels. Resident #34 was interviewed on 2/5/2024 at 12:02 PM. Resident #34 reported during the past weekend (he was not certain if it was 2/3/2024 or 2/4/2024) he was left soiled in feces and his bed linens were wet with urine. Resident #34 reported he used the call bell for assistance, but it was a significant amount of time before he was provided incontinence care. Resident #34 reported he did not track the time; he only knew	F 550	the same education during general facility orientation. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC) Social Worker (SW), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will interview 10% of residents using questionnaire. Additionally, 10% of residents will be audited by the clinical nursing management team by physically checking the resident brief to ensure the resident is clean and dry. If the resident is not, assistance will be provided immediately, to ensure residents are receiving incontinence care timely. Audits will occur 2 times a week x 4 weeks, weekly x 4 weeks, and then monthly x 1 month. Residents with indwelling catheters will have drainage bag viewed 2 times a week x 4 weeks, weekly x4 weeks, and then monthly x1 to ensure privacy cover is in place. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via the Dignity Audit Tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly.	

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he was wet and soiled and upset. Resident #34 reported he felt horrible to be left wet and soiled and he was very upset.

NA #1 was interviewed on 2/8/2024 at 10:12 AM. NA #1 reported she was the only NA scheduled to work the short-term unit and it was her and Nurse #10 on the hall on 2/4/2024. NA #1 explained that several residents were soiled and saturated in urine, and she was not certain how long it took to provide care to all the residents. NA recounted Resident #34 was soiled with feces and his bed linens and incontinence brief was saturated with urine. NA #1 reported Resident #34 was very angry and upset when she was able to provide care to him.

The Director of Nursing (DON) #1 was interviewed on 2/8/2024 at 4:09 PM. DON #1 explained she was not certain why staffing was so low on 2/4/2024 and she would need to review the staffing sheets. DON #1 reported she expected incontinence care to be provided to residents in a timely manner.

3. Resident #48 was admitted to the facility on 4/22/22 and readmitted on 12/11/23 with diagnoses that included chronic diastolic (congestive) heart failure, vascular dementia with behavioral disturbance, pulmonary hypertension, urinary incontinence, chronic pain syndrome, hemiplegia with hemiparesis following cerebral infarction affecting left non-dominant side, and erosive (osteo) arthritis.

Review of Resident #48's quarterly Minimum Date Set (MDS) dated 12/21/23 revealed Resident #48 was moderately cognitively impaired. She was able to communicate her

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needs to staff and required extensive assistance to total dependence with all her activities of daily living. Resident #48 was always incontinent of bowel and bladder.

During an observation on 02/08/24 at 8:15 am Resident #48 could be heard from the hallway hollering for help. Upon entry into Resident #48's room, a urine odor was present.

A follow-up observation was conducted on 02/08/24 at 8:50 am of Resident #48, her call light was on and she was hollering for help. An interview was attempted with Resident #48 but was unsuccessful.

On 02/08/24 at 9:00 am NA #8 was observed leaving Resident #48's room and the call light was turned off. NA #8 was interviewed at this time and reported Resident #48's brief was wet. The NA stated she was the scheduler/transportation person but was assisting on the floor that day as a nurse aide. NA #8 indicated that she would get NA #10 who was assigned to the Resident to provide incontinence care.

On 02/08/24 at 10:10 am an observation was conducted of NA #8 providing incontinence care to Resident #48. Resident#48's brief was observed to be saturated in urine and a strong smell of urine was present.

An interview with NA #10 on 02/08/24 at 10:30 am. NA #10 indicated she was the only NA on the hall to care for 26 Residents. NA #10 indicated Resident #48 had a behavior of hollering out from time to time when it took staff too long to provide care and when she was upset. NA #10 indicated

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she believed Resident #48 was upset and feeling bad because staff did not come in sooner to provide care she needed. NA #10 indicated that she tried to treat all her residents with dignity and respect.

The Director of Nursing (DON) #1 was interviewed on 2/8/24 at 4:09 PM. DON #1 explained she was not certain why staffing was so low on 2/8/24 and she would need to review the staffing sheets.

4. Resident #69 was admitted to the facility on 08/14/23, diagnosis included diabetic nephropathy, Cerebellar stroke syndrome, congestive heart failure (CHF), repeated falls, and lack of coordination.

Resident #69's quarterly Minimum Data Set (MDS) assessment dated 01/05/24 indicated his cognition was moderately impaired and he displayed no rejection of care behaviors. He was coded to exhibit disorganized thinking behavior that was present and/or fluctuated. He required maximum assistance with personal hygiene, toileting hygiene, shower/bath, and dressing. He was frequently incontinent of bowel and bladder.

Resident #69's active care plan, last revised on 01/04/2024, included the focus area of functional status activities of daily living (ADL) decline related to slurred speech and impaired mobility. The interventions included for staff to encourage Resident #69 to do as much as possible and to provide assistance as needed or requested. A focus area of bladder incontinence which included the intervention to provide Resident #69 incontinence care after each incontinent episode. He also had a focus that he was at risk for skin

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breakdown related to decline in mobility and medical diagnosis. The interventions included to keep skin clean and dry as possible and minimizing skin exposure to moisture and providing incontinence care.

An interview was conducted on 02/07/24 at 1:43 PM with Resident #69's family member. She stated she was active in Resident #69's care. She explained there have been multiple times when Resident #69 was saturated with urine through his pants and his bed would be wet. She indicated she comes to the facility daily for breakfast and dinner to ensure he eats and was changed. She also stated she had to come into the facility to make sure he was cared for. She stated she was very unhappy with the care provided.

An interview was conducted on 02/08/24 at 9:03 AM with Resident #69. He stated there had been many times where he was saturated with urine so much that his clothes and/or his bed would be soaked. He then pointed at his mattress and stated, "look at my mattress, it happened this morning, they even had to change my sheets", indicated his sheets and his incontinence brief was saturated with urine. Observation of the mattress revealed a circular area in center of mattress extending out to approximately 2 inches from each side of the mattress. The center of the large area was slightly damp, and the edges of the circular area were whitish in color. No sheets were observed on the mattress. He stated he did not receive a shower, but the Nursing Assistant wiped him up. He further commented that there was no call for it, and he hoped that he didn't get sores from the urine on him like that. He then stated it made him frustrated and mad when staff

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don't change him often enough to prevent him from soaking through his clothes and bedding.

An interview was conducted on 02/08/24 at 9:15 AM with Nursing Assistant (NA) #11. She stated Resident #69 was out of bed and dressed sitting in his wheelchair when she came on shift at 7:00 AM. The night shift NA had gotten him up. She verified there were no sheets on the bed when she entered the room. She stated normally sheets are changed if they were wet, soiled, or it was the residents shower day. She verified circular discoloration to the mattress.

An interview was conducted on 02/08/24 at 9:20 AM with Nursing Assistant (NA) #4. She verified the circular discoloration area on the mattress was present. She indicated she did not know what was on the mattress, but it appeared to be urine. She further stated she cleaned the area prior to applying the clean sheets.

An interview was conducted on 02/07/24 at 10:05 AM with Director of Nursing (DON) #1. She stated Resident #69 was to receive incontinence as needed and should be checked for incontinence needs often. No residents' clothing or bed linens should be wet with urine.

Multiple phone calls were made to the Nursing Assistant (NA) #12 from 02/07/24 through 02/08/24 with no answer. She was assigned to Resident #69 on 02/07/24 from 7:00 PM-7:00 AM.

5. Resident #390 was admitted to the facility on 1/29/24 with diagnoses that included retention of urine.

A care plan, dated 1/29/24, was in place for a

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urinary catheter related to diagnosis of urinary retention.

On 2/5/24 at 10:50 AM, Resident #390 was observed walking in the hallway with Physical Therapy (PT). He was noted to have an indwelling urinary catheter with the drainage bag attached to the walker. The drainage bag did not have a privacy cover and contained yellow urine which was visible to other residents and staff in the hallway.

On 2/5/24 at 12:00 PM, Resident #390 was observed walking in the therapy gym. He was noted to have a urinary catheter with the drainage bag attached to the walker. The drainage bag did not have a privacy cover and urine was visible to the other residents and staff in the gym.

An interview and observation occurred with Resident #390 on 2/6/24 at 9:18 AM. He was observed to be sitting on the side of the bed with the urinary drainage bag attached to a walker. The drainage bag did not have a privacy cover, had yellow urine in the drainage bag and could be seen from the hallway. Resident #390 commented, "I don't think everyone should see my urine."

An interview occurred with Nurse #13 on 2/6/24 at 9:20 AM and she stated all residents with urinary catheters should have a privacy cover on the drainage bags and indicated she would make sure one was provided for Resident #390.

On 2/6/24 at 2:18 PM, Resident #390 was observed sitting up in a recliner chair watching TV. The urinary drainage bag was hanging to the left side of the chair, yellow urine in the drainage

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F 550	Continued From page 11 bag and was visible from the hallway. There was no privacy cover in place. Another interview occurred with Nurse #13 on 2/6/24 at 4:13 PM and she stated she spoke with the Central Supply Clerk and was told there were no dignity covers available. Nurse #13 added she instructed the nurse aides to cover the drainage bag with a pillowcase. On 2/7/24 at 11:08 AM, Resident #390 was observed sitting up in a chair in his room with a walker in front of him. The urinary drainage bag was attached to the walker with a pillowcase partially wrapped around it. Yellow urine was still visible from the hallway and there was no dignity cover in place. The Central Supply Clerk was interviewed on 2/7/24 at 11:45 AM. She explained the facility had urinary drainage bags with a dignity cover in place. The Central Supply Clerk was able to show that multiple urinary drainage bags with a dignity cover were present in the supply closet on the hallway where Resident #390 resided. She added the nurses were responsible for making sure the residents with urinary catheters had a urinary drainage bag with a dignity cover. Director of Nursing #1 was interviewed on 2/8/24 at 9:54 AM and stated it was her expectation for the nursing staff to use a privacy cover for urinary drainage bags to protect the resident's dignity and was unable to state why Resident #390's drainage bag was not covered.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		3/11/24

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	345566	A. BUILDING _____ B. WING _____	C 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 554	Continued From page 12 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview the facility failed to assess a resident's ability to self-administer medications for 2 of 2 residents reviewed for medications at bedside (Resident #440 and Resident #194). The findings included: 1. Resident #440 was admitted to the facility on 01/23/24 with diagnoses that included chronic congestive heart failure, chronic kidney disease, type 2 diabetes mellitus, anxiety disorder, and atrial fibrillation. Review of the admission Minimum Data Set (MDS) assessment dated 01/29/24 revealed that Resident #440 was cognitively intact. Review of Resident #440's medical record revealed no documentation that Resident #440 had been assessed to self-administer medications at bedside. Further review of Resident #440's medical record revealed no care plan for self-administration of medications. An observation and interview were conducted with Resident #440 on 02/06/24 at 9:13 AM. Resident #440 was sitting in his wheelchair beside his bedside table. He was noted to have over-the-counter medications, fluticasone propionate nasal spray (used for sneezing and a	F 554	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #440 is no longer a resident in the facility. Resident #194 is no longer a resident in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of 100% of resident□s rooms to ensure no medications are available at the resident□s bedside unless the resident had been assessed, deemed clinically appropriate for self-administration of medications, and physician order obtained to self-administer medications. The Director of Health Services (DHS), Assistant Director	

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F 554	Continued From page 13	F 554		

runny nose) and refresh tear eye drops (relief of eye irritation), on his bedside table. A further observation revealed a table in the corner of his room that contained personal items which included over-the-counter medications, a bottle of MiraLAX (for constipation) and AREDS 2 eye vitamins (a supplement).

Review of Resident #440's physician orders sheet dated January 2024 revealed no physician orders for the refresh tear eye drops, MiraLAX, and AREDS 2, however it was noted an order dated 01/23/24 for Flonase Allergy Relief (fluticasone propionate) spray, suspension; 50 micrograms (mcg)/actuation: 2 sprays; nasal once a day.

An interview was conducted with Resident #440 on 02/06/24 at 9:20 am and he indicated the medications observed were his medications and he had used the medications on his bedside table that morning.

Nurse #13 was interviewed on 02/06/24 at 9:32 AM. She indicated she had administered Resident #440's morning medications this morning. She stated, "he took his medicines from me, and I don't give any of these medications." Nurse #13 indicated she was not aware of the medications in Resident's room as he was sitting close to the door in his wheelchair, and she did not see the medications when she administered his medications. She stated she had talked to Resident's family members before because they had brought medications in before. Nurse #13 indicated Resident #440 had not been assessed for self-administration and did not have an order for self-administration of medications.

Director of Nursing (DON) #1 was interviewed on

of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024.

3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.

The Director of Health Services, Clinical Competency Coordinator, RN Supervisors, and/or designee will provide education to 100% of licensed nurses noting mediations should be administered per physician order and no medication should be left at the bedside of a resident unless they have been assessed, noted to be clinically appropriate for self-administration of medications, and a physician order obtained to do so. This will include medication bought in by the family. Education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired licensed nurses will receive the same education during general facility orientation.

The Director of Health Services, Clinical Competency Coordinator, RN Supervisors, and/or designee will audit 100% of resident rooms to ensure medications are not found at the

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F 554	Continued From page 14 02/06/24 at 4:09 PM and she indicated sometimes family members would bring in medications and would not tell the nursing staff. She indicated they needed to be better at checking and educating residents/families. 2. Resident #194 was admitted to the facility 2/1/2024 with diagnoses to include dry eye syndrome and ocular hypertension. The admissionMinimum Data Set (MDS) assessment dated 2/8/2024 assessed Resident #194 to be cognitively intact. The remainder of the MDS was in progress and not completed. Resident #194's medical records were reviewed and there was no order for Resident #194 to self-administer his medications. There was no care plan developed for self-administering medications for Resident #194, and no assessment of his ability to self-administer medications. Orders for Resident #194 included an order dated 2/1/2024 for brimonidine/timolol eye drops to be administered every 12 hours. Review of the medication administration record indicated Resident #194 received this medication as evidenced by nursing initials. An order dated 2/5/2024 for dorzolamide eye drops to be administered every 8 hours. The medication administration record indicated this was administered on 2/6/2024. During an interview with Resident #194 on 2/5/2023 at 2:30 PM, he mentioned his wife brought in the eye drops for him to administer	F 554	resident□s beside unless the resident has been assessed, deemed clinically appropriate to self-administer medications, and has physician order to self-administer medications. Audits will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via the Self Administration of Medications Audit Tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	

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F 554	Continued From page 15	F 554		

until the facility was able to get his prescription eye drops.

Resident #194 opened his nightstand drawer to reveal the 2 bottles of eye drops, brimonidine/timolol and dorzolamide. When asked if the nursing staff knew that he had the eye drops in his room, Resident #194 reported he had told a nurse (he was uncertain who) he had his own eye drops.

Resident #194 was interviewed again on 2/6/2023 and he reported the facility had obtained both of his prescription eye drops and his wife took his bottles home.

Nurse #13 was interviewed on 2/6/2024 at 3:37 PM. Nurse #13 reported she was not aware Resident #194 had eye drops in his room. Nurse #13 reported she asked about home medications when she completed the admission assessment but did not complete Resident #194's admission assessment.

Nurse #10 was interviewed on 2/6/2024 at 3:45 PM. Nurse #10 reported that he was not aware Resident #194 had eye drops in his nightstand drawer and was self-administering the eye drops.

The facility physician was interviewed on 2/8/2024 at 3:03 PM. The physician reported that eye drops in a closed nightstand drawer would not pose a danger to other residents, but an assessment for self-administration of medications should have been completed for Resident #194.

The Director of Nursing (DON) #1 was interviewed on 2/8/2024 at 4:09 PM. DON #1 explained that sometimes residents will bring in

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F 554	Continued From page 16 medications and not tell staff. DON #1 reported she would expect if a resident brought in medication from home, a medication self-administration assessment was completed.	F 554		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		3/11/24

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(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the

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F 623	Continued From page 18 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff and Responsible Party (RP) interviews, the facility failed to notify a Residents RP in writing of a hospital transfer. This was for 2 of 3 residents reviewed for hospitalization(Resident #16 and Resident #19). The findings included: 1. Resident #16 was admitted on 4/2/21. Resident #16's quarterly Minimum Data Set (MDS) dated 10/3/23 indicated Resident #16 had severe cognitive impairment. Review of her electronic medical record read she was transferred to the hospital on 1/2/24. She	F 623	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #16 remains in the facility and the resident and/or responsible party was provided written notification of hospital transfer that occurred on 1/2/24 on 3/6/24. Resident #19 remains in the facility and the resident and/or responsible party was provided written notification of hospital transfer that occurred on 3/24/23 on 3/6/24.	

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F 623	Continued From page 19 was readmitted on 1/5/24. There was no documented evidence that her RP was notified in writing the reason for her hospital transfer. A telephone interview was completed on 2/8/24 at 12:08 PM with Resident #16's RP. He stated he did not receive anything in writing about Resident#16's transfer to the hospital or the reason for her hospital transfer on 1/2/24 but stated the nurse did call him to let him know. An interview was completed on 2/8/24 at 8:50 AM with the Clinical Reimbursement Coordinator. She stated the floor nurses wrote up the reason for the hospital transfer and gave it to the Business Office Manager to mail out. Another interview was completed on 2/8/24 at 9:40 AM, with the Clinical Reimbursement Coordinator. She stated the facility was not mailing out or providing a copy to the Notice Of Involuntary Transfer form to the resident if applicable or the RP. An interview was completed on 2/8/24 at 11:00 AM with the Business Office Manager. She stated she was not aware that she was supposed to mailing a copy of the Notice Of Involuntary Transfer form for hospital transfers. 2. Resident #19 was admitted 6/25/18. Resident #19's quarterly Minimum Data Set dated 10/25/23 indicated she was cognativel intact. Review of her electronic medical record read she was transferred to the hospital on 3/21/23. She was readmitted on 3/24/23. There was no documented evidence that her RP was notified in	F 623	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of last 30 days of hospital transfers to ensure written notification of transfer was provided to the resident□s responsible party. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The Director of Health Services, Clinical Competency Coordinator, RN Supervisors, and/or designee will provide education to 100% of licensed nurses noting the resident and/or responsible party must be notified via phone and in writing of all hospital transfers.	

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F 623	Continued From page 20 writing the reason for her hospital transfer. A telephone interview was completed on 2/7/24 at 3:58 PM with Resident #19's RP. He stated he did not receive anything in writing about Resident#19's transfer to the hospital or the reason for her hospitalization on 3/21/23 but stated the nurse did call him to let him know. An interview was completed on 2/8/24 at 8:50 AM with the Clinical Reimbursement Coordinator. She stated the floor nurses wrote up the reason for the hospital transfer and gave it to the Business Office Manager to mail out. Another interview was completed on 2/8/24 at 9:40 AM, with the Clinical Reimbursement Coordinator. She stated the facility was not mailing out or providing a copy to the Notice Of Involuntary Transfer to the resident if applicable or the RP. An interview was completed on 2/8/24 at 11:00 AM with the Business Office Manager. She stated she was not aware that she was supposed to mail a copy of the Notice Of Involuntary Transfer form for hospital transfers.	F 623	Documentation in the electronic health record should reflect the written transfer documents being provided to the resident and/or responsible party. Education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired nursing staff will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, RN Supervisors, and/or designee will audit all documentation in electronic health record for each hospital transfer to ensure written notification of hospital transfer were provided to the resident and/or responsible party. Audits will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via the Hospital Transfer Notification Audit Tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	
F 640 SS=B	Encoding/Transmitting Resident Assessments	F 640		3/11/24

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F 640	Continued From page 21 CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review.	F 640		

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F 640	Continued From page 22 (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete residents Minimum Data Set (MDS) assessments within the required time. This was for 4 of 34 active residents reviewed for MDS completion (Residents #16, #19, #8, and #18). The findings included: 1. Resident #16 was admitted on 4/2/21 and was admitted to hospice services on 1/8/24. Review of the significant change in status Minimum Data Set (MDS) dated 1/10/24 revealed it was still in progress, and the mood section had not been completed. An interview was completed on 2/8/24 at 1:30 PM with the Clinical Reimbursement Consultant. She stated the two MDS Coordinators started six months ago, and they were still learning, and there was one part-time MDS person also assisting. She indicated she was aware of the completion and transmission problems, and they were working to get caught up. 2. Resident #19 was admitted on 6/16/17 and	F 640	Corrective Action for the Resident Affected Resident # 8□s MDS assessment with Assessment Reference Date (ARD) 1/05/2024 was completed and submitted to Internal Quality Improvement and Evaluation System (IQIES) with accepted date of 2/9/2024. Resident # 16□s MDS assessment with Assessment Reference Date (ARD) 1/10/2024 was completed and submitted to Internal Quality Improvement and Evaluation System (IQIES) with accepted date of 2/9/2024. Resident # 18□s MDS assessment with Assessment Reference Date (ARD) 1/19/2024 was completed and submitted to Internal Quality Improvement and Evaluation System (IQIES) with accepted date of 2/20/2024. Resident # 19□s MDS assessment with Assessment Reference Date (ARD)	

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F 640	Continued From page 23 admitted to hospice services on 1/6/24. Review of the significant change in status Minimum Data Set (MDS) dated 1/9/24 revealed it was still in progress and the only areas completed were the identification information, cognition, and preferences and customary activities. An interview was completed on 2/8/24 at 1:30 PM with the Clinical Reimbursement Consultant. She stated the two MDS Coordinators started six months ago, and they were still learning, and there was one part-time MDS person also assisting. She indicated she was aware of the completion and transmission problems, and they were working to get caught up. 3. Resident #8 was admitted 6/25/18. Review of the quarterly Minimum Data Set (MDS) dated 1/5/24 revealed it was still in progress and the mood section had not been completed. An interview was completed on 2/8/24 at 1:30 PM with the Clinical Reimbursement Consultant. She stated the two MDS Coordinators started six months ago, and they were still learning, and there was one part-time MDS person also assisting. She indicated she was aware of the completion and transmission problems, and they were working to get caught up. 4. Resident #18 was admitted to the facility on 09/04/23 and was admitted to hospice services on 01/19/24. Review of Resident #18's most recent Minimum Dat Set (MDS) assessment was dated 01/19/24	F 640	2/9/2024 was completed and submitted to Internal Quality Improvement and Evaluation System (IQIES) with accepted date of 2/9/2024. Action for the Residents Potentially Affected On 2/28/2024, the Case Mix Director or Designee ran an assessment status Report to identify any outstanding MDS that is in progress status or in need of transmission to the Internal Quality Improvement and Evaluation System (IQIES). Eight assessments were identified as being in progress. No assessment identified needing to be transmitted to the IQIES. The eight identified outstanding MDS will be prioritized for prompt completion and transmission to the IQIES. Completion date 2/29/2024 Systemic Changes On 02/29/2024, the two MDS nurses received education related to the Encoding/transmitting Resident Assessments per RAI guidelines by the Clinical Reimbursement Coordinator. Transmission will be done at least once a week. This education will be provided to all newly hired Case Mix Directors and/or Case Mix Coordinators during general orientation. The Case Mix Director will run the MDS status due report to identify assessments that are outstanding or in progress for completion and transmission. This report	

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F 640	Continued From page 24 and was coded as a significant change in status assessment. The assessment had not been completed and there was no indication the assessment had been transmitted. An interview was conducted on 02/08/24 at 1:30 PM with the Clinical Reimbursement Consultant. She stated the two MDS Coordinators started six months ago, and they were still learning, and there was one part-time MDS person also assisting. She indicated she was aware of the completion and transmission problems, and they were working to get caught up.	F 640	will be pulled weekly for 4 weeks, then monthly for 4 months. The Case Mix Director will maintain a log of all identified outstanding assessments for completion and transmission. Quality Assurance The Case Mix Director will present the analysis of the transmission timing assessments to the Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is maintained and then quarterly thereafter, to ensure ongoing compliance. Date of compliance: 3/11/2024	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		3/11/24

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F 657	Continued From page 25	F 657		

medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews and record review, the facility failed to revise a care plan for falls to include a new intervention on 12/27/23 for anti-tippers to a wheelchair. This was for 1 of 6 residents reviewed for accidents (Resident #16).

The findings included:

Resident #16 was admitted on 4/2/21 with cumulative diagnoses of metabolic encephalopathy, peripheral vascular disease with a left above the knee amputation (AKA).

Resident #16's quarterly Minimum Data Set (MDS) dated 10/3/23 indicated Resident #16 had severe cognitive impairment, impairment to one lower extremity and substantial/maximum assistant with transfers from sit to stand and transfers from bed to wheelchair and wheelchair to bed. She was coded for one fall with minor injury.

Review of a nursing note dated 12/23/23 at 5:36 PM read Resident #16 was sitting in her wheelchair in the dining room. She had eaten her

Corrective Action for the Resident Affected

On 2/08/2024, resident #16□s care plan was updated to reflect anti-tippers added to her wheelchair by therapy.

Action for the Residents Potentially Affected

On 2/29/2024, the Case Mix Director (CMD) reviewed residents□ charts fall related therapy interventions. Of sixty resident in-house, four have fall-related therapy interventions. The CMD reviewed the residents care plans to ensure that if they had a therapy intervention that it is reflected in the care plan. Of the four care plans reviewed, four residents with a fall related therapy interventions was addressed appropriately.

Systemic Changes

On 2/29/2024, the Clinical Reimbursement Consultant in-serviced

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F 657	Continued From page 26 evening meal and apparently had locked her wheelchair brakes. As she attempted to push her wheelchair back away from the table, her wheelchair tipped backwards resulting in Resident #16 striking her head on the hearth of the stone fireplace behind where she was seated. There was bleeding noted with an open area to the back of her head. She was sent to the emergency room for an evaluation. Review of a physical therapy note dated 12/27/23 read anti-tippers were added to her wheelchair. Review of Resident #16's fall risk care plan dated initiated on 12/19/23 last revised on 12/29/23 included a new intervention dated 12/23/23 for staff to give her verbal reminder not to ambulate/transfer without assistance, staff to visually monitor frequently and to observe Resident #16 frequently and place her in a supervised area when she was out of the bed. There was another new intervention dated 12/28/23 which read to analyze her falls to determine a pattern/trend and the last new intervention was dated 12/29/23 read for Resident #16 to wear a new brace due to spinal fractures. There was not any documentation on the care plan regarding the new intervention of anti-tippers added to her wheelchair on 12/27/23. An interview was completed on 2/8/24 at 1:30 PM with the Clinical Reimbursement Consultant. She stated she had oversight of the regional MDS departments. She stated the two MDS Coordinators started six months ago, and they were still learning. She also said there was one part-time MDS person also assisting. She stated she had discussed care plans with the previous Administrator and she was to write up a formal	F 657	the in-service the Interdisciplinary Team (IDT) to include the MDS nurses, Administrator, Director of Health Services (DHS), Social Worker, Activity Director, Nurse Managers, Facility Educator, Therapy Director, on the timing and revision of the resident care plans utilizing the Resident Assessment Instrument (RAI) and company policy. The Administrator and or the DHS will review three resident□s care plans, weekly times four weeks and then two resident□s care plans monthly times three months to ensure timing revision of the care plan for, utilizing the QA Monitoring Tool for comprehensive care plans. Quality Assurance The results of these reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator and or Director of Health Services for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 3/11/2024	

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F 657	Continued From page 27 performance improvement plan but she apparently did not do so. She stated she had a spread sheet of all the residents whose care plan was revised and that Resident #16's fall care plan was revised on 12/29/23. The Clinical Reimbursement Coordinator stated the new intervention of the wheelchair anti-tippers must have been an oversight and it should have been added to her care plan when it was last revised.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews of residents, family member, and staff, the facility failed to provide incontinence care for dependent residents (Resident #192, Resident #34, Resident #69, Resident #48, and Resident #339), and failed to provide bathing for a dependent resident (Resident #339) for 5 of 16 residents reviewed for activities of daily living. The findings included: 1. Resident #192 was admitted to the facility on 2/1/2024 with diagnoses including respiratory failure and hypertension. The admission Minimum Data Set (MDS) dated 2/8/204 assessed Resident #192 to be cognitively intact. The remainder of the MDS was in progress and incomplete.	F 677	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #192 is no longer a resident in the facility. Resident #34 is no longer a resident in the facility. Resident #48 is no longer a resident in the facility. Resident #339 is no longer a resident in the facility. Resident #69 remains in the center and is provided incontinence care when requested and as needed.	3/11/24

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F 677	Continued From page 28 The MDS vision assessment was not completed, however, Resident #192 read from her phone, and was able to read the name badge of the surveyor. The admission nursing assessment dated 2/1/2024 documented Resident #192 was incontinent of urine and feces. A care plan dated 2/1/2024 addressed Resident #192's potential for skin breakdown related to incontinence. Resident #192 was interviewed on 2/5/2024 at 11:17 AM. Resident #192 reported that on Sunday 2/4/2024 she was left saturated in urine, and she waited for care from 8:30 AM until 12:30 PM. Resident #192 described that her bed linens were wet with urine, her nightgown was wet with urine, and her incontinence brief was saturated with urine. Resident #192 explained that she had very little control of her bladder and she required an incontinence brief all the time. When asked how she knew she waited for 4 hours for incontinence care, Resident #192 explained she pressed her call light at 8:30 AM and the nurse told her he would be in to help her when he finished with his medication pass. Resident #192 reported she tracked the time on her cell phone. An interview was conducted with Nurse #10 on 2/6/2024 at 3:45 PM. Nurse #10 reported on Sunday 2/4/2024 the hall had one nursing assistant (NA) and him working. Nurse #10 reported that he had to administer medications before he was able to help the NA with incontinence care on residents. Nurse #10 reported Resident #192 was "very wet" when he provided her with incontinence care after he had administered medication.	F 677	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current Residents have the potential to be affected. Current residents with BIMS of 12 and greater and resident # 69 will be interviewed by the Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC) Social Worker (SW), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) ensuring incontinence care and bathing assistance is being provided when requested and as needed by 3-11-2024. Residents with BIMS less than 12 will have the clinical nursing management team physically check the resident brief to ensure the resident is clean and dry. If the resident is not clean and dry, incontinence care and/or bathing assistance will be provided immediately. This will be completed by 3-11-2024. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The Director of Health Services and/or Clinical Competency Coordinator, RN Supervisors, and/or designee will provide education to current nursing staff noting residents should receive incontinence and bathing assistance when requested and as needed. If residents are unable to	

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NA #1 was interviewed on 2/8/2024 at 10:12 AM. NA #1 reported she was the only NA scheduled to work the short-term unit and it was her and Nurse #10 on the hall on 2/4/2024. NA reported she started at one side of the short-term hall and started providing care to residents one-by-one. NA #1 explained that several residents were soiled and saturated in urine, and she was not certain how long it took to provide care to all the residents. NA #1 reported she had provided care to Resident #192 on Saturday 2/3/2024 and she was aware that Resident #192 was incontinent of urine. NA#1 reported she did not know when Resident #192 received incontinence care on Sunday 2/4/2024 because Nurse #10 provided that care.

The Director of Nursing (DON) was interviewed on 2/8/2024 at 4:09 PM. The DON explained she was not certain why staffing was so low on 2/4/2024 and she would need to review the staffing sheets. The DON reported she expected incontinence care to be provided to residents in a timely manner.

2. Resident #34 was admitted to the facility on 1/3/2024 with diagnoses to include stroke and diabetes. The admission MDS dated 1/8/2024 assessed Resident #34 to be cognitively intact. The MDS documented Resident #192 was occasionally incontinent of urine and always continent of bowels.

Resident #34 was interviewed on 2/5/2024 at 12:02 PM. Resident #34 reported during the past weekend (he was not certain if it was 2/3 or 2/4/2024) he was left soiled in feces and his bed linens were wet with urine. Resident #34 reported he used the call bell for assistance, but it

communicate the need for bathing or incontinence are, the resident should be checked and changed several times during the shift for incontinence and bathing care. Education will be completed by 3-11-2024. After 3-11-2024, all nursing staff that have not worked and received the education will complete upon their next scheduled shift. The Clinical Competency Coordinator will include the same education in general orientation for all newly hired nursing staff.

The Director of Health Services, Clinical Care Coordinator, RN Supervisors, and/or designee will interview 5 residents dependent for ADL care with a BIMS of 12 or higher to ensure incontinence care is being provided when requested and as needed. Additionally, 5 residents with BIMS less than 12 will be audited by the clinical nursing management team by physically checking the resident□s brief to ensure the resident is clean and dry. Audits will be conducted 2 times a week x 4 weeks, weekly x 4 weeks, and then monthly x 1 month.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Health Services will track and trend the results via the Incontinence and Bathing Care audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and

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was a significant amount of time before he was provided incontinence care. Resident #34 reported he did not track the time; he only knew he was wet and soiled.

NA #1 was interviewed on 2/8/2024 at 10:12 AM. NA #1 reported she was the only NA scheduled to work the short-term unit and it was her and Nurse #10 on the hall on 2/4/2024. NA #1 explained that several residents were soiled and saturated in urine, and she was not certain how long it took to provide care to all the residents. NA recounted when she provided incontinence care to Resident #34, he was soiled with feces and his bed linens and incontinence brief were saturated with urine.

The Director of Nursing (DON) was interviewed on 2/8/2024 at 4:09 PM. The DON explained she was not certain why staffing was so low on 2/4/2024 and she would need to review the staffing sheets. The DON reported she expected incontinence care to be provided to residents in a timely manner.

3. Resident #69 was admitted to the facility on 08/14/23, diagnosis included diabetic nephropathy, Cerebellar stroke syndrome, congestive heart failure (CHF), repeated falls, and lack of coordination.

Resident #69's quarterly Minimum Data Set (MDS) assessment dated 01/05/24 indicated his cognition was moderately impaired and he displayed no rejection of care behaviors. He was coded to exhibit disorganized thinking behavior that was present and/or fluctuated. He required maximum assistance with eating, personal hygiene, toileting hygiene, shower/bath, dressing, and bed mobility. He was frequently incontinent of

then quarterly.

Compliance date: 3-11-2024

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bowel and bladder.

Resident #69's active care plan, last revised on 01/04/2024, included the focus area of functional status activities of daily living (ADL) decline related to slurred speech and impaired mobility. The interventions included for staff to encourage Resident #69 to do as much as possible and to provide assistance as needed or requested. A focus area of bladder incontinence which included the intervention to provide Resident #69 incontinence care after each incontinent episode. He also had a focus that he was at risk for skin breakdown related to decline in mobility and medical diagnosis. The interventions included to keep skin clean and dry as possible and minimizing skin exposure to moisture and providing incontinence care.

Nursing notes reviewed from 12/31/23 through 02/06/24 no refusals of incontinence care were noted.

An interview was conducted on 02/07/24 at 1:43 PM with Resident #69's family member. She stated she was active in Resident #69's care. She explained there have been multiple times when Resident #69 was saturated with urine through his pants and his bed would be wet. She indicated she comes to the facility daily for breakfast and dinner to ensure he eats and was changed. She also stated she had to come into the facility to make sure they are cared for. She stated she was very unhappy with the care provided.

An interview was conducted on 02/08/24 at 9:03 AM with Resident #69. He stated there had been many times where he was saturated with urine so

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much that his clothes and/or his bed would be soaked. He then pointed at his mattress and stated, "look at my mattress, it happened this morning, they even had to change my sheets". Observation of the mattress revealed a circular area in center of mattress extending out to approximately 2 inches from each side of the mattress. The center of the large area was slightly damp, and the edges of the circular area were whitish in color. No sheets were observed on the mattress. He stated he did not receive a shower, but the Nursing Assistant wiped him up. He further commented that there was no call for it, and he hoped that he didn't get sores from the urine on him like that. He then stated it made him frustrated and mad when staff don't change him often enough to prevent him from soaking through his clothes and bedding.

An interview was conducted on 02/08/24 at 9:15 AM with Nursing Assistant (NA) #11. She stated Resident #69 was out of bed and dressed sitting in his wheelchair when she came on shift at 7:00 AM. The night shift NA had gotten him up. She verified there were no sheets on the bed when she entered the room. She stated normally sheets are changed if they were wet, soiled, or it was the residents shower day. She verified circular discoloration to the mattress.

An interview was conducted on 02/08/24 at 9:20 AM with Nursing Assistant (NA) #4. She verified the circular discoloration area on the mattress was present. She stated the only time sheets are normally changed is if they were wet, soiled, or it was the residents shower day. She indicated she did not know what was on the mattress, but it appeared to be urine. She further stated she cleaned the area prior to applying the clean

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PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

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sheets.

The shower schedule on 02/08/24 at 10:43 AM revealed Resident #69's shower days were Tuesdays and Fridays on day shift.

An interview was conducted on 02/07/24 at 10:05 AM with the Director of Nursing (DON). She stated Resident #69 was to receive incontinence as needed and should be checked for incontinence needs often. No residents' clothing or bed linens should be wet with urine.

Multiple phone calls were made to the Nursing Assistant (NA) #12 from 02/07/24 through 02/08/24 with no answer. She was assigned to Resident #69 on 02/07/24 from 7:00 PM-7:00 AM.

4. Resident #48 was admitted to the facility on 04/22/22 and readmitted on 12/11/23 with diagnoses that included chronic diastolic (congestive) heart failure, vascular dementia with behavioral disturbance, pulmonary hypertension, urinary incontinence, chronic pain syndrome, hemiplegia with hemiparesis following cerebral infarction affecting left non-dominant side, and erosive (osteo) arthritis.

Review of Resident #48's quarterly Minimum Date Set (MDS) dated 12/21/23 revealed Resident #48 was moderately cognitively impaired. She was able to communicate her needs to staff and required extensive assistance to total dependence with all her activities of daily living. Resident #48 was always incontinent of bowel and bladder.

A review of Resident #48's care plan revised on 12/23/23 indicated that Resident was resistive to

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care due to dementia and she would refuse activities of daily living (ADL) care. Resident #48 was also care plan that she needed extensive to total care of one to two plus staff for most of her ADL care.

During an observation on 02/08/24 at 8:15 am Resident #48 could be heard from the hallway hollering for help. The Resident's call light was not on. Upon entry into Resident #48 room, a urine odor was present in the room.

On 02/08/24 a continuous observation of the hall where Resident #48 resided was conducted starting at 8:15 am until 8:47 am and no nurse aide (NA) was observed on the hall during this timeframe. Resident #48 continued to holler for help during the continuous observation.

On 02/08/24 at 8:50 am NA#8 and another unidentified person were observed in the sitting area on the unit. Resident #48 continued to holler out for help. Resident #48's call light was on.

On 02/08/24 at 8:55 am Resident #48 continued to holler out. NA #8 asked Resident #48 what she wanted, and Resident #48 was observed moving her hands up and down in front of her brief.

On 02/08/24 at 9:05 am an interview was conducted with NA #8, and she indicated that she was the scheduler/transporter but was assisting on the floor today as a nurse aide. NA #8 indicated that she would get NA #10 who was assigned to this Resident. NA #8 confirmed that Resident #48 was wet. NA #8 explained that Resident #48 used her hands to communicate she was wet by moving them up and down.

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An observation was conducted on 2/8/24 at 10:10 am of NA #8 performing incontinence care on Resident #48. NA#8 removed the old brief, and it was observed to be saturated with urine and noted to have a strong urine smell. The resident's skin was intact. NA #8 confirmed she smelled the urine smell. NA #8 applied a new brief on Resident #48 after applying barrier cream.

An interview was conducted with NA #10 on 02/08/24 at 10:30 am. The NA revealed she performed her round after breakfast, and she had to help with feeding on another hall. She stated that Resident #48 did not communicate at 8:00 am that she was wet and incontinence care was not provided. NA #10 indicated that she was the only NA on the hall to care for 26 residents on 02/08/24 until 7pm.

NA #22 was identified by DON #1 as the nurse aide assigned to Resident #48 on 02/07/24 during third shift (11:00 pm until 7:00 am).

On 02/08/24 at 12:45 pm NA #22 was interviewed and stated she had not worked in the facility since Monday, 02/05/24 and did not recall working with Resident #48.

Attempts were made to contact Resident #48's nurse on duty for the evening of 02/07/24 but the nurse was unable to be reached for an interview.

The Director of Nursing (DON) #1 was interviewed on 2/8/24 at 4:09 PM. DON #1 explained she was not certain why staffing was so low on 2/8/24 and she would need to review the staffing sheets. DON #1 reported she expected incontinence care to be provided to residents in a timely manner.

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During an interview with the DON and Administrator on 02/08/24 at 4:50 pm the Administrator indicated that his start date with the facility was 02/05/24 and the DON indicated she had been in the facility for two weeks.

5. Resident #339 was admitted to the facility on 12/19/22 with the diagnosis of a stroke and dementia.

Resident #339's quarterly Minimum Data Set dated 2/17/23 documented he had a severe cognitive deficient. The resident was dependent for bathing and an extensive assist of 2 staff for personal hygiene. The resident was always incontinent of bowel and had a urinary catheter. Active diagnoses were neurogenic bladder and stroke.

Resident #339 had a care plan dated 2/17/23 for activities of daily living (ADL) deficit set up with assistance as needed.

The resident was no longer at the facility

a. On 02/06/24 at 11:16 am an interview was conducted with Resident #339's family member. The family member stated the resident was dependent on staff for all his care. The family member visited frequently and found the resident had stool that dried to his buttocks and there was a concern the resident was not cleaned for hours. The family member stated she had brought her concerns to the attention of the Director of Nursing and the care had not improved. The family member stated the care concerns continued from February 2023 until July 2023 when the resident expired.

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A review of Resident #339's activity of daily living record for February 2023 documented he was incontinent of stool almost every day, 1 to 3 times a day. Personal hygiene for incontinence care was not documented as being completed during February 2023 on dates 2/10/23, 2/19/23, 2/22/23, 2/24/23, 2/28/23. There was no documentation in the system for any type of care on 2/28/23. Nursing Assistant (NA) #8 was assigned to the resident frequently during February 2023.

On 2/7/24 at 2:03 pm an interview was conducted with NA #8. NA #8 stated she had worked at the facility for 5 years. She had worked in January, February, and March 2023 when there were only 3 NAs on the 3:00 pm to 7:00 pm schedule responsible for 90 residents until staff arrived at 7:00 pm and other day shifts she had 20 residents (8 hours). NA #8 stated resident care could not be completed and when care was completed it was delayed. The residents would be very soiled when staff was able to provide care. The resident's ADL documentation was not completed because the care was not provided.

b. On 02/06/24 at 11:16 am an interview was conducted with Resident #339's family member. The family member stated the resident was dependent on staff for all his care. The family member visited frequently and found the resident had body odor and dirty looking hair. The family member stated she had brought her concerns to the attention of the Director of Nursing and the resident received a bath that day, but it was not consistent. The family member stated the care concerns continued from February 2023 until July 2023 when the resident expired.

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F 677	Continued From page 38 A review of Resident #339's ADL bathing records for February 2023 documented the resident received 7 baths out of 28 days in the month. The 4 times bathing was completed, 2 were partial bed baths and 1 bath was documented as other. The resident was incontinent of stool almost every day, 1 to 3 times a day. On 2/7/24 at 2:03 pm an interview was conducted with Nursing Assistant (NA) #8. NA #8 stated she had worked at the facility for 5 years. She had worked in January, February, and March 2023 when there were only 3 NAs on the 3:00 pm to 7:00 pm schedule responsible for 90 residents until staff arrived at 7:00 pm and other day shifts she had 20 residents (8 hours). NA #8 stated resident care bathing could not be completed. The resident's ADL documentation was not completed because the care was not provided. On 2/8/24 at 4:10 pm an interview was conducted with the Director of Nursing. The DON stated she was not aware resident care was not being completed and had no further comments.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		3/11/24

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by:
Based on record review, staff and medical director interviews, the facility failed to obtain daily weights as ordered for a resident with heart failure and prescribed a diuretic (Resident #70). This was for 1 of 8 residents reviewed for nutrition.

The findings included:

Resident #70 was admitted to the facility on 10/16/23 with diagnoses that included heart failure. He was discharged to the hospital on 10/18/23 and did not return to the facility.

A review of Resident #70's physician orders included the following:
- An order dated 10/16/23 for Torsemide (a diuretic medication) 20 milligrams (mg) one tablet by mouth once a day.
- An order dated 10/17/23 to obtain daily weights and to notify the provider if weight gain of greater than three pounds was present.

The admission Minimum Data Set (MDS) assessment dated 10/23/23 indicated Resident #70 was cognitively intact.

A review of the October 2023 Medication Administration Record (MAR) revealed daily weights were not documented as obtained or refused by Resident #70 on 10/20/23.

A review of the November 2023 MAR revealed the daily weight was not documented as obtained or refused by Resident #70 on 11/3/23, and 11/17/23.

A review of the December 2023 MAR revealed

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

Resident # 70 is no longer a resident in the facility.

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

Current residents have the potential to be affected.

The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of 100% of resident□s electronic health record to identify any resident with heart failure and prescribed a diuretic to ensure resident is having weights obtained as ordered. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Registered Nurse Supervisors (RNS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024.

3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not

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F 684	Continued From page 40 the daily weight was not documented as obtained or refused by Resident #70 on 12/1/23, 12/2/23, 12/3/23, 12/9/23 and 12/10/23. A phone interview was completed with Nurse #1 on 2/7/24 at 2:36 PM. She was assigned to Resident #70 on the 7:00 PM to 7:00 AM shift on 10/20/23. She could not recall Resident #70 or explain why the daily weight was documented as obtained or refused. Nurse #1 stated a list of was provided to the Nurse Aides for weights to be obtained at 6:00 AM. She stated if the weight wasn't documented then it must not have been obtained. On 2/7/24 at 3:30 PM, a phone interview occurred with Nurse #5. She was assigned to Resident #70 on the 7:00 PM to 7:00 AM shift on 12/2/23 and could not recall Resident #70 or why there was no daily weight value. She added if the weight wasn't documented then it most likely wasn't obtained. Nurse #9 was interviewed by phone on 2/7/24 at 3:38 PM. She was assigned to Resident #70 on the 7:00 PM to 7:00 AM shift on 12/10/23 and could not recall why the daily weight was not documented with a value or as refused and most likely wasn't obtained. A phone interview occurred with Nurse #8 on 2/7/24 at 4:23 PM. She was assigned to Resident #70 on the 7:00 PM to 7:00 AM shift on 12/9/23 and could not recall why the daily weight was documented with a value or as refused. She added if the weight wasn't documented then it wasn't obtained on that day. An interview was completed with Director of	F 684	recur. The Director of Health Services, Clinical Competency Coordinator, RN Supervisors, and/or designee will provide education to 100% of current nursing staff noting weights are to be obtained as ordered for residents with a heart failure who are prescribed a diuretic. Education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired nursing staff will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, RN Supervisors, and/or designee will audit current residents with heart failure prescribed a diuretic with weight orders to ensure weights are being obtained as ordered. Audits will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via the Weekly Weights Audit Tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly.	

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F 684	Continued From page 41 Nursing #1 on 2/8/24 at 9:54 AM and stated that she expected daily weights to be obtained as ordered and documented with the value or if the resident refused. An interview occurred with the Medical Director on 2/8/24 at 2:49 PM and explained that when a resident had a diagnosis of heart failure and was on a diuretic, daily weights were important in order to monitor and adjust the medications as needed. Multiple phone calls were made to Nurse #2 from 2/6/24 to 2/8/24 without an answer. She was assigned to Resident #70 on 11/3/23, 11/17/23 and 12/1/23.	F 684	Compliance date: 3-11-2024	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff, Nurse Practitioner, (NP) #1 and Medical Director (MD) interviews, observations and record review, the facility failed to supervise Resident #16 who was cognitively impaired and impulsive. The resident was eating in a dining room without any staff present in the room and with the back of her wheelchair positioned in front of a stone hearth. While passing trays on the 300 hall, NA #8 observed Resident #16 aggressively	F 689	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #16 remains in the facility and is provided with supervision when out of bed in the dining room during mealtime.	3/11/24

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F 689	Continued From page 42 bounce her wheelchair and suddenly flip her wheelchair backwards hitting her head on the stone fireplace. This accident resulted in acute cervical 6, cervical 7 and thoracic 1 fractures. The fall on 12/23/23 resulted in pain at a level of 6 out of 10 and the use of a hard cervical collar. This was for 1 of 6 residents reviewed for accidents (Resident #16). The findings included: Resident #16 was admitted on 4/2/21 with cumulative diagnoses of metabolic encephalopathy, peripheral vascular disease with a left above the knee amputation (AKA) and a history of falls. Resident #16 was care planned on 5/13/23 for cognitive loss and a memory recall problem. An intervention read to provide verbal and visual reminders. An Interdisciplinary Team note (IDT) evaluation note following a 7/20/23 fall determined Resident #16 was impulsive, poor safety awareness and attempted to transfer without assistance. The intervention added to the care plan was to remind her to call for assistance with transferring. A care plan intervention initiated on 7/27/23 was for increased supervision. Resident #16's quarterly Minimum Data Set (MDS) dated 10/3/23 indicated Resident #16 had severe cognitive impairment, impairment to one lower extremity and substantial/maximum assistance with transfers from sit to stand and transfers from bed to wheelchair and wheelchair to bed. She was coded for one fall with minor	F 689	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of current residents with cognitive impairment to ensure adequate supervision is being provided during mealtime in dining area. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will provide education to 100% of current nursing staff noting adequate supervision is to be provided to cognitively impaired residents in the dining area during mealtimes. Education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who	

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F 689	Continued From page 43 injury. Review of a nursing note dated 12/23/23 at 5:36 PM read Resident #16 was sitting in her wheelchair in the dining room. She had eaten her evening meal and apparently had locked her wheelchair brakes. As she attempted to push her wheelchair back away from the table, her wheelchair tipped backwards resulting in Resident #16 striking her head on the hearth of the stone fireplace behind where she was seated. There was bleeding noted with an open area to the back of her head. She was sent to the emergency room for an evaluation. This note was written by Nurse #18. Review of an event report completed by Nurse #18 dated 12/23/23 at 5:41 PM read Resident #16 was eating her dinner in the dining room. The report did not include any further details. There were no IDT evaluation notes and the report read not applicable (NA)-event still open:" An interview was completed on 2/7/24 at 2:19 PM with Nurse #18. She stated she was assigned Resident #16 on the 500 hall on 12/23/23 when she fell and hit her head on the stone fireplace hearth. Nurse #18 stated she was down the hall passing medications. Resident #16 was in the dining room eating dinner. She was not aware if any staff were in the dining room at the time of the fall but the aides yelled and she went to the dining room to assess Resident #16. She stated there was a lot of blood from a laceration on the back of her head and she complained of neck pain. Nurse #18 stated she immediately called the previous Director of Nursing (DON) and emergency medical services (EMS) for a hospital transfer. She stated that was all she knew about it	F 689	have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired nursing staff will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, and or Nurse Supervisors will audit supervision being provided during mealtime in dining area 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via the Supervision During Mealtime in Dining Area audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	

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PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

(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 689	Continued From page 44	F 689		

until the next day when she learned about the cervical and thoracic fractures.

An interview was completed on 2/7/24 at 3:00 PM with NA #9 who worked 12/23/23 7:00 AM to 7:00 PM and was assigned Resident #16. She recalled assisting Resident #16 to the dining room but did not recall locking her brakes and Resident #16 was known to do that herself. She stated she was passing trays on the hall because Resident #16 could feed herself. NA #9 stated it was Christmas weekend and they were working short. She stated normally one person was assigned to observe and assist in the dining room, but she did not think there was an aide in the dining room when Resident #16's fall happened because her peers were also passing trays and feeding residents in their rooms. NA #9 stated the dining room was right across from the nurses station and anyone could observe the residents while passing the dining room.

A telephone interview was completed on 2/8/24 at 10:13 AM with NA #8. She recalled working on 12/23/23 at the time of Resident #16's fall in the dining room. She stated she was passing trays on the 300 hall which was across from the dining room, and she saw Resident #16 aggressively bouncing her wheelchair but NA #8 stated she did not notice that Resident #16's wheelchair brakes were locked when she suddenly flipped her wheelchair backwards and hit her head on the stone fireplace.

A telephone interview was completed on 2/8/24 at 10:39 AM with NA #10. She recalled Resident #16's fall on 12/23/23. She stated there were only three aides working at the time of the fall. She stated she and her peers were either passing

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F 689	Continued From page 45	F 689		

trays or feeding residents in their rooms. NA #10 stated there was no staff normally assigned to the dining room and there was approximately 8-10 residents eating there. She stated the residents she observed in the dining room on 12/23/23 were independent or set up assistance only. NA #10 stated she was walking by the dining room when she saw Resident #16's wheelchair in midair and before she could react, she fell backwards striking her head on the stone fireplace. NA #10 stated apparently Resident #16's wheelchair brakes were locked and she complained of pain immediately.

An interview was completed on 2/8/24 at 10:20 AM with Nurse #11. She stated she was working on 12/23/23 but she was assigned the 300 and 400 halls. She stated Resident #16 had a lot of falls from her wheelchair and thought Resident #16 overestimated her abilities. Nurse #11 stated she had seen Resident #16 eating in the dining room at a table with her back to the stone fireplace. She stated apparently Resident #16 was attempting to leave her table when she flipped her wheelchair striking her head on the fireplace hearth. She stated there were no anti-tippers on her wheelchair at the time of the fall.

Review of a nursing note dated 12/24/23 at 11:55 AM read Resident #16 arrived back to the facility with multiple fractures throughout her spine and her thoracic spine. The noted read there was no surgical intervention recommended and orders were for her to wear a hard collar neck brace for 4-6 weeks until she could follow up with a neurologist. The note also read that it was recommended she be prescribed opiates, muscle relaxers and nonsteroidal anti-inflammatory

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F 689	Continued From page 46 (NSAIDS) medication as needed for pain control. This note was written by Nurse #6. Review of the December Physician orders read a new order dated 12/25/23 for hydrocodone-a acetaminophen 5mg-325mg every 6 hours as needed. She received the pain medication once on 12/25/23 and 12/26/23. She received Ibuprofen once on 12/28/23. New orders were given on 12/28/23 for scheduled hydrophone-acetaminophen four times daily which she received as ordered. An observation was completed on 2/5/24 at 11:00 AM. Resident #16 sitting up in her wheelchair with her brakes unlocked. There was a padded cushion to the seat of the wheelchair. A telephone call was completed on 2/8/24 at 11:59 AM with former NP. She stated up until about 2 weeks ago, she was working at the facility and recalled Resident #16's fall on 12/23/23. NP #1 stated she was familiar with Resident #16. She stated she was impulsive and required close supervision. An interview was completed on 2/8/24 at 2:40 PM with the MD. He stated Resident#16 was known to be impulsive. He stated there should be closer supervision of the residents eating in the dining room and it sounded like a plan should be implemented to prevent additional unsupervised falls.	F 689		
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	F 690		3/11/24

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F 690	Continued From page 47 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interview of facility staff, the facility failed to follow the physician's order to obtain a urine sample for urinalysis and culture and sensitivity (to evaluate for a urinary tract infection) for 1 of 5 residents reviewed for	F 690	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 690	Continued From page 48 urinary catheter/urinary tract infection (Resident #343). Findings included: Resident #343 was admitted to the facility on 1/24/24 with the diagnosis of urinary retention. Resident #343's admission Minimum Data Set (MDS) dated 1/30/24 documented the resident was admitted with a urinary catheter and had the diagnosis of urinary retention. Physician order dated 1/29/24 documented Resident #343 had her urinary catheter removed for a voiding trial. Resident #343's nurses' note dated 2/2/24 documented the resident had delusions. Resident was noted sitting in her wheelchair at the bedside talking incoherently to herself. The resident's abdomen was distended, and the resident complained of discomfort. The physician was notified, and a bladder scan was completed which revealed 867 milliliters of urine in the resident's bladder. The physician was notified of urine retention and an order was received to insert a urinary catheter and to obtain urine for a urinalysis and culture & sensitivity, documented by Nurse #12. A physician order dated 2/2/24 for Resident #343 was to place a urinary catheter and obtain urine for a urinalysis and culture and sensitivity. Physician note dated 2/2/24 documented nursing reported Resident #343 had urine retention and Flomax (medication to improve urine flow) was started, a urinary catheter was placed, and a urinalysis and culture & sensitivity was ordered.	F 690	Resident #343 remains in the center. Urine sample was obtained per physician order on 2/12/24. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of the last 30 days of active lab orders for urinalysis and culture and sensitivity to ensure samples were obtained. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will provide education to 100% of licensed nursing noting physician orders are to be followed	

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F 690	Continued From page 49 The resident was confused. Nurses' note documented on 2/5/24 at 12:14 pm documented the resident had a urinary catheter placed to collect a urine sample for confusion on 2/2/24. The diagnosis was repeat urinary retention and an order for urinalysis and culture and sensitivity was obtained, documented by Nurse #12. On 2/7/24 at 2:30 pm an interview was attempted with Nurse #12, but she was unable to be reached. The Director of Nursing was unavailable for information during the survey and information was obtained from the Corporate MDS Nurse as directed. On 2/6/24 at 3:30 pm an interview was conducted with the Corporate MDS Nurse (Director of Nursing was unavailable). She stated the urinalysis and culture & sensitivity ordered for Resident #343 was missed, not obtained on 2/2/24 and she would notify the physician. On 2/7/24 a new order for urinalysis and culture & sensitivity was obtained from the physician for Resident #343. On 2/8/24 at 4:10 pm an interview was conducted with the Director of Nursing (DON). The DON stated she was not aware the lab for Resident #343 was missed. The DON had no other comments.	F 690	and urine samples are to be obtained for all ordered urinalysis and culture and sensitivity laboratory orders. Education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired licensed nurses will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will audit lab orders for urinalysis and culture and sensitivities to ensure physician orders were followed and urine sample was obtained. This audit will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via the Urinalysis and Culture and Sensitivity audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		3/11/24

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F 695	Continued From page 50 § 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 record review, observations and staff interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 1 resident reviewed for respiratory care (Resident #18). The findings included: Resident #18 was admitted to the facility on 09/04/23 with diagnoses that included congestive heart failure and chronic obstructive pulmonary disease (COPD). A review of the active physician orders revealed an order dated 12/06/23, for oxygen (O2) at 2 liters per minute via nasal cannula to keep O2 Sats at 92% or above. A quarterly Minimum Data Set (MDS) assessment dated 12/08/23 indicated Resident #18 was cognitively intact. She was coded as receiving intermittent oxygen therapy. A review of Resident #18's active care plan, last reviewed 02/02/24, included a focus area that read Resident #18 required oxygen therapy related to oxygen desaturation and shortness of breath. One of the approaches was to provide oxygen as ordered via nasal cannula.	F 695	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #18 remains in the center and oxygen is being administered at the prescribed rate of 2Lpm. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of current residents receiving oxygen therapy to ensure oxygen is being administered at the prescribed rate. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency	

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F 695	Continued From page 51 Medication Administration Record (MAR) revealed oxygen was signed off as being administered at 2 liters per minute from 02/01/24 through 02/06/24. On 02/05/24 at 1:52 PM, an observation was made of Resident #18 while she was lying in bed. The oxygen (O2) regulator on the concentrator was set at 4 liters per minute when viewed horizontally, at eye level. On 02/06/24 at 8:51 AM, an observation was made of Resident #18 while she was lying in bed. The oxygen (O2) regulator on the concentrator was set at 4 liters per minute when viewed horizontally, at eye level. An observation and interview were conducted on 02/07/24 at 9:40 AM of Resident #18, which revealed the oxygen regulator on the concentrator was set at 4 liters per minute by nasal cannula when viewed horizontally at eye level. Resident #18 stated she did not know what the oxygen was set on, all she knew was that she needed the oxygen because it made it easier to breathe. An interview was conducted on 02/07/24 at 9:52 AM with Nurse #11. She was not the nurse assigned to Resident #18 but stated she did have residents that required oxygen therapy. She stated the nurse was responsible for checking the oxygen (O2) saturations and verifying the O2 concentrators were set per the physician orders. On 02/07/24 at 10:05 AM, an observation of Resident #18 was completed with Director of Nursing (DON) #1 in conjunction with an interview with DON #1. DON #1 was assisting a new nurse	F 695	Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will provide education to 100% of licensed nurses, noting residents are to receive oxygen therapy at prescribed rate. Education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired licensed nurses will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will audit residents receiving oxygen therapy to ensure oxygen is being administered at the prescribed rate. This audit will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track	

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F 695	Continued From page 52 that was working the 500 hall which included Resident #18. She verified Resident #18 ' s oxygen (O2) concentrator was set to 4 liters per minute when viewed horizontally at eye level. She stated the nurse was responsible for verifying the O2 concentrators were set per order every shift. She then verified Resident #18's O2 order read oxygen was to be delivered at 2L. She then stated Resident #18's oxygen should be delivered at the prescribed rate.	F 695	and trend the results via the Oxygen audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	
F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		3/11/24

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F 725	Continued From page 53 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff, resident, Nurse Practitioner, and Medical Director interviews, the facility failed to provide sufficient nursing staff which resulted in residents being treated in an undignified manner when left incontinent of urine or stool (Resident #192, #34, #48, and #69) and when a urinary catheter bag was left uncovered (Resident #390). These residents reported feeling upset, angry, mad and unimportant. The facility failed to provide sufficient nursing staff to assist with activities of daily living (ADL) care for dependent residents (Resident #192, #34, #69, #48, and #339). The facility failed to supervise a resident who was at high-risk for falls which resulted in acute cervical 6, cervical 7 and 1 thoracic fractures due to a fall (Resident #16). This affected 9 of 86 residents reviewed for sufficient nursing staff. The findings include: This tag is crossed referenced to F 550: Based on record reviews and staff interviews, the facility failed to protect residents' dignity when residents were left soiled in stool and saturated in urine for 4 of 17 residents reviewed for dignity issues (Resident #192, Resident #34, Resident #48, and Resident #69), and failed to provide a dignity cover over a urinary catheter drainage bag for 1 of 4 residents reviewed for urinary catheters (Resident #390). Resident #192, Resident #34, Resident #48, and Resident #69 reported they felt upset, angry, mad, and like they did not matter at all when they were not provided incontinence	F 725	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #192, #34, #48, #390, and #339 are no longer residents in the facility. Resident #69 remains in the center and is provided timely incontinence care. Resident #16 remains in the facility and is provided with supervision when out of bed in the dining room during mealtime. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The Director of Health Services (DHS) will provide education to the Nursing Staff Scheduler noting immediate notification to the DHS is required when staffing data indicates insufficient nursing staffing. In the event staffing numbers are not deemed sufficient, the DHS or designee will adjust staffing in house by unit, use	

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F 725	Continued From page 54 care. Resident #390 felt upset that "everyone could see my urine." The reasonable person concept was applied for Resident #48 due to her inability to express her feelings and a reasonable person would feel humiliated and degraded having to holler for assistance. This tag is crossed referenced to F 677: Based on observations, record reviews and interviews of residents, family member, and staff, the facility failed to provide incontinence care for dependent residents (Resident #192, Resident #34, Resident #69, Resident #48, and Resident #339), and failed to provide bathing for a dependent resident (Resident #339) for 5 of 16 residents reviewed for activities of daily living. This tag is crossed referenced to F689: Based on staff, Nurse Practitioner, (NP) #1 and Medical Director (MD) interviews, observations and record review, the facility failed to supervise Resident #16 who was cognitively impaired and impulsive. The resident was eating in a dining room without any staff present in the room and with the back of her wheelchair positioned in front of a stone hearth. While passing trays on the 300 hall, NA #8 observed Resident #16 aggressively bounce her wheelchair and suddenly flip her wheelchair backwards hitting her head on the stone fireplace. This accident resulted in acute cervical 6, cervical 7 and thoracic 1 fractures. The fall on 12/23/23 resulted in pain at a level of 6 out of 10 and the use of a hard cervical collar. This was for 1 of 6 residents reviewed for accidents (Resident #16).	F 725	ancillary staff that are certified, use non-ancillary staff to assist within their scope, and activate the call list and offer incentive bonuses as needed to cover open shifts. All newly hired Nursing Staff Scheduler will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, RN Supervisors, and/or designee will audit supervision being provided during mealtime in dining area, interview 5 of residents using questionnaire to ensure incontinence care is being provided timely 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. The Area Vice President of Operations/ Regional Nurse Consultant will also conduct weekly reviews of planned nursing staffing for subsequent 7 days weekly x 4 weeks, then monthly x2 months. Ongoing, the center currently has an active recruitment and retention plan. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via the Nursing Staff Audit Tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	

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PRUITTHEALTH-UNION POINTE	3510 WEST HIGHWAY 74 MONROE, NC 28110

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F 725	Continued From page 55	F 725		

On 2/7/24 at 2:03 pm an interview was conducted with Nursing Assistant (NA) #8. NA #8 stated, this past Saturday (2/4/24), she worked on the long-term care hall (Halls 400 and 500) with 1 other NA and 48 residents on day shift. NA #8 stated, yesterday (2/6/24), from 3:00 pm to 5:30 pm I was the only NA on the long-term care hall with 87 residents. NA #8 stated she texted the Director of Nursing (DON) #1 multiple times and informed her. The residents residing on Hall 500 had not received any care or had call lights answered by me during this time. NA #8 stated she had spoken with the Corporate Floating DON and informed her the care was not completed and showed her that Resident #339 was soaked through to the bed flooded with urine and had not received care for hours. NA #8 stated the Corporate Float DON informed her to "do her best and answer call lights." NA #8 stated some resident call lights were answered after 30 minutes. NA #8 stated she had not observed licensed nursing staff provide incontinence or personal care to the residents during this time. NA #8 stated that the staffing problem had become unsafe for staff and residents and currently the staffing was the worst she had seen in the 5 years she had been employed at the facility.

A review of the nursing staffing for 2/6/24 revealed there was 1 NA scheduled from 3:00 to 7:00 pm on the long-term care Hall (400 and 500) due to call outs. The census for the facility (4 halls 100 - 400) was 78.

On 2/7/24 at 2:03 pm an interview was conducted with NA #8. She stated on 2/3/24 and 2/6/24 there were approximately 40 residents to care for on Halls 400 and 500.

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F 725	Continued From page 56 The Infection Preventionist Nurse (IP) was interviewed on 2/7/24 at 11:55 am. The IP stated she was frequently pulled to cover licensed nursing call outs for a hall assignment to pass medication. The IP stated she was on the floor assignment during the 3:00 pm to 7:00 pm block of time when there were few NAs. She was aware that there were only 3 NAs during this time for 80 to 90 residents. The prior Administration had 8 hours shifts for NAs and the facility was moving to 12 hours shifts for the NAs which caused the occasional low staff gap from 3:00 pm to 7:00 pm NA schedule. On 2/8/24 at 4:10 pm an interview was conducted with the Director of Nursing #1 (DON). The DON stated she was scheduling nursing staff and not aware of a NA staffing shortage/coverage and she would need to review the staffing sheets. The DON had no further comments.	F 725		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		3/11/24

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F 761	Continued From page 57 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview of facility staff, the facility failed to label/date an opened vial of tuberculin (injectable solution to test for tuberculosis) and failed to discard an opened expired vial of tuberculin for 2 of 2 medication storage refrigerators observed on the short-term hall and long-term hall respectively. Findings included: The manufacturer's instructions for tuberculin read "initial and date the tuberculin vial when opened" and to "discard the tuberculin vial 30 days after opening." On 2/8/24 at 11:04 am the short-term hall medication storage refrigerator observation revealed that a tuberculin vial was opened and not dated. The Infection Preventionist (IP) was present for observation and stated the tuberculin should have been dated when opened and discarded the vial. On 2/8/24 at 11:04 am an interview was conducted with the IP during medication storage	F 761	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of the medication preparation rooms and storage areas to ensure any open vials of tuberculin and other required drugs are labeled/dated and/or discarded if expired. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical	

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F 761	Continued From page 58 observation. The IP stated that nursing staff was required to date all medication when opened and to check for expired medication during their shift to discard. On 2/8/24 at 11:29 am the long-term hall medication storage refrigerator observation revealed that a tuberculin vial had a date tag which was written opened on 1/6/24. The vial had expired 30 days after opening, 2/6/24. The vial was discarded by Nurse #15. Concurrent interview with Nurse #15 stated she did not know how long an open Tuberculin vial could be used before expiring. She further commented that she worked on the short-term hall and the vials were used before they expired. On 2/8/24 at 4:10 pm an interview was conducted with the Director of Nursing (DON). The DON was not aware of the findings for the medication storage of tuberculin. The DON had no further comments.	F 761	Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will provide education to 100% of licensed nurses, noting tuberculin vials are to be dated when opened and discarded 30 days after the open date. Also, other medications are to be labeled /dated with open dates as required and discarded when expired. Education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired licensed nurses will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will audit medication storage rooms and areas to ensure tuberculin vials and other drugs/medications are labeled/dated as required and that all expired medications have been discarded. This audit will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1.	

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F 761	Continued From page 59	F 761	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via the Medication Storage audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner and staff interviews, the facility failed to obtain x-ray results for a resident with nausea and poor appetite (Resident #70). This was for 1 of 8 residents reviewed for nutrition.	F 777	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #70 is no longer a resident in the	3/11/24

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F 777	Continued From page 60 The findings included: Resident #70 was admitted to the facility on 10/16/23 with diagnoses that included hemoperitoneum requiring surgical intervention (bleeding within the peritoneal cavity, the space that contains your abdominal and pelvic organs). The admission Minimum Data Set (MDS) assessment dated 10/23/23 indicated Resident #70 was cognitively intact. A physician progress note dated 10/19/23 indicated Resident #70 reported having loose stool over the past two days, intermittently. A nursing progress note dated 10/23/23 revealed an order was received for a STAT KUB (kidney, ureter, bladder) x-ray to rule out an obstruction. A review of the physician orders for resident #70 revealed an order dated 10/23/23 for a KUB x-ray to be obtained. A physician progress note dated 10/24/23 cites Resident #70 was being seen for poor intake and reports of nausea. The note further read that a KUB order was placed on 10/23/23, resident reported this was completed, however no results were available at that time. A physician progress note dated 10/31/23 indicated Resident #70 was being seen for complaints of poor appetite and nausea. The report indicated that the KUB results from 10/23/23 were not available and nursing was to call and obtain the results for review. A physician progress note dated 11/15/23	F 777	facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of the previous 30 days of x-ray orders to ensure x-ray test were performed, results have been obtained, and results are available in the electronic health record for viewing. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will provide education to 100% of licensed nurses noting residents with x-ray orders should have those x-ray test performed, results	

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F 777	Continued From page 61 indicated the KUB results from 10/23/23 were not available. A review of Resident #70's medical record on 2/6/24 did not include the results of the KUB x-ray results from 10/23/23. On 2/6/24 at 4:45 PM, the Clinical Reimbursement Coordinator explained that the facility called the Mobile X-ray company and received the KUB x-ray results on 2/6/24 and that they were not found in Resident #70's medical record. The results of the KUB x-ray were negative for any acute findings. The Medical Records coordinator was interviewed on 2/7/24 at 1:34 PM and stated the KUB x-ray results were not part of Resident #70's medical record and were obtained on 2/6/24. She stated there were multiple fax machines in the facility that information was sent to and sometimes the information sat on the fax machine and wasn't distributed to the right areas. A phone interview occurred with Nurse #14 on 2/7/24 at 5:26 PM. She indicated there was a time that x-ray results were not being received timely at the facility but wasn't sure if it was a fax machine problem or someone was getting them off the fax and not bringing them to the correct nursing station. She indicated this has improved over the past couple of months. A phone interview was completed with the former Nurse Practitioner #1 on 2/8/24 at 11:53 AM. She explained that she was no longer at the facility as of a month ago, but never saw the results of the KUB x-ray that was completed on 10/23/23 for Resident #70. She added that x-ray results were	F 777	should be obtained from x-ray company, and results should be available for viewing in the electronic health record. Education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired licensed nurses will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will audit residents with x-ray orders to ensure tests are performed, results are obtained, and results are available for viewing in the electronic health record. This audit will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via audit the X-Ray Audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	

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F 777	Continued From page 62 difficult to obtain when she was at the facility, and she had asked the nurses to follow-up several times. The Nurse Practitioner added she provided Resident #70 with an appetite stimulant, monitored his lab work, and ensured that he was seen by the trauma surgeon for his appetite concerns. Director of Nursing #1 was interviewed on 2/8/24 at 9:54 AM and indicated it was her expectation for all x-ray results to be received and available in the resident's medical record within one to two days. She explained she began employment at the facility in January 2024 and was unaware of any concerns with receiving x-ray results.	F 777		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced	F 802		3/11/24

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F 802	Continued From page 63 by: Based on record review, and resident, family and staff interviews, the facility failed to have an effective system to ensure there was sufficient and competent dietary staff available on 12/31/23 to serve breakfast. This failure had the potential to impact all residents who received meals from the kitchen. The findings included: The facility's meal delivery times were recorded as follows: · Breakfast - 7:00 AM - 8:30 AM · Lunch - 12:00 AM - 1:30 PM · Dinner - 5:00 PM - 6:30 PM An interview was conducted on 02/07/24 at 12:25 PM with the Infection Preventionist Nurse. She stated a group email was sent out by Administrator #2 on 12/30/23 at approximately 10:00 PM requesting anyone that was available to come in and help cook in the kitchen on 12/31/23 due to no dietary staff. She responded saying she would be able to help. She arrived at 6:00 AM and upon arriving, Dietary Staff #1 was already cooking breakfast. She stated Dietary Staff #1 instructed her to set the breakfast trays up which she done. She also indicated she read the meal tickets and made sure the correct diet was provided. Pureed diets were blended to a smooth consistency. She stated that her husband came in and assisted in the kitchen as well. She verified her husband was not an employee at the facility but had some previous work experience in a kitchen. She explained she had helped in the past	F 802	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Facility has not utilized volunteer staff, not employed by PruittHealth Union Pointe in the Dietary Department since 12/31/2023. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. On 2/16/24 the Administrator educated the Dietary manager on appropriate utilization of dietary staff and not allowing personnel that are not employed by PruittHealth Union Pointe to work and/or volunteer in the kitchen. This education has been added to the general orientation of newly hired Dietary Managers. The Dietary Manager will review dietary staffing daily for 7 days then weekly for 4 weeks then monthly thereafter to ensure only employees employed with Pruitt Health Union Pointe are scheduled to work and has worked in the dietary department.	

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F 802	Continued From page 64 but had not been trained to cook in the kitchen. She did not recall what time breakfast was served on 12/31/23 but it was served late. An interview was conducted on 02/08/24 at 11:25 AM with Dietary Aide #1. She stated she was scheduled to work on 12/31/23 but she had called out due to back pain. She could not remember who took the callout. She indicated there have been mornings in the past that Nursing Assistants (NAs) have had to assist her with cooking. Breakfast on those mornings was served late but it was always served. Dietary Aide #1 stated she did not work on 12/31/23. Review of the dietary staff schedule and time clock detail report for 12/31/23 revealed Dietary Aide #1 did not work. A phone interview was conducted on 02/08/24 at 2:07 PM with Administrator #2. She indicated that she received a call on 12/30/23 from the facility stating they had a call out for the kitchen for 12/31/23 which would leave them with no staff for breakfast shift. She did not recall who notified her of the call out. She explained that she sent a group email out to the administrative staff to inquire if anyone could assist with preparing breakfast on 12/31/23. She received a response from the Infection Preventionist that she would assist and that there were extra staff scheduled and she would pull someone from the nursing area for additional help if needed. She also indicated it was her understanding the shift was covered. She further explained that she did call the Interim Dietary Manager (DM) #1 on 12/31/23 to have him come in as well to assist. An interview was conducted on 02/07/24 at 2:18	F 802	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Dietary Manager will present the analysis of the daily staffing review to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is achieved then quarterly thereafter. Compliance date 3/11/2024	

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F 802	Continued From page 65	F 802		

PM with Dietary Manager (DM) #1. He stated he was called by Administrator #2 on 12/31/23 at approximately 9:00 AM and was told no dietary staff showed up for the early shift and he needed to come in to work. He arrived at the facility at 11:00 AM. He explained at that time he was the interim DM and was working at two different buildings. He indicated a nurse, and a Nursing Assistant (NA) were asked to work in the kitchen to assist in getting breakfast out to the residents. He also stated he did not recall what time breakfast was served to the residents, but it was served later than the regularly scheduled time. He verified the nurse and NAs had not had training on working in the kitchen. He further stated additional staff were hired and this has not occurred since 01/01/24. He then indicated that now they have 2 cooks, 2 aides, 2 managers, and a supervisor during day shift.

An interview was conducted on 02/07/24 at 1:43 PM with a family member for Resident #69. She stated she comes to the facility every day for breakfast and dinner. She indicated breakfast had been late on many mornings in December. She also stated that she arrived between 7:30 AM and 8:00 AM on the morning of 12/31/23 but breakfast was not served until after 10:00 AM and that was unacceptable. She further explained her family member had a diagnosis of type 2 diabetes mellitus and although his blood sugar remained stable, he needed to eat his breakfast at approximately the same time each day. She further indicated it had been an ongoing problem but had improved lately.

An interview was conducted on 02/08/24 at 9:03 AM with Resident # 69. He stated breakfast had been late on many days in December, with the

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F 802	Continued From page 66 latest being at approximately 10:15 AM. He explained he had a diagnosis for type 2 diabetes mellitus and takes diabetic medications by mouth twice a day and insulin at bedtime. He indicated his blood sugar has been good, but it makes him nervous when he doesn't eat by 9:00 AM. He stated he was very disappointed and frustrated with the facility. An interview was conducted on 02/07/24 at 1:07 PM with Resident # 57. She stated breakfast was late on many days in December. She indicated it made her feel as if the facility did not care enough for the residents to make sure they get their meals on time. An interview was conducted on 02/07/24 at 12:05 PM with Director of Nursing (DON) #3. She indicated she received a complaint on 01/02/24 from a family member that breakfast had been served late on 12/31/23. She explained that when she investigated the concern, she found that on 12/31/23 no dietary staff showed up to the facility to work. She indicated that the Infection Preventionist came in to cook breakfast and that Nurse # 3 was pulled from the floor to assist. She verified breakfast was late but could not recall the exact time it was served.	F 802		
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	F 842		3/11/24

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F 842	Continued From page 67 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, 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-	F 842		

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F 842	Continued From page 68 (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 record review and staff interviews, the facility failed to maintain complete and accurate medical records in the area of wound care (Resident #70) for 1 of 1 resident records reviewed for surgical wound care. The findings included: Resident #70 was admitted to the facility on 10/16/23 with diagnoses that included hemoperitoneum requiring surgical intervention (bleeding within the peritoneal cavity, the space that contains your abdominal and pelvic organs). The admission Minimum Data Set (MDS) assessment dated 10/23/23 indicated Resident #70 was cognitively intact and received surgical wound care.	F 842	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #70 is no longer a resident in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal	

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F 842	Continued From page 69 The physician orders included the following orders dated 10/16/23 to 10/26/23: - Midline abdominal incisional site: cleanse with wound cleanser, cover the two proximal (nearest to the trunk of the body) sites and most distal (away from the central of the body) site with a foam gauze twice a day. - Midline abdominal incision site at the umbilicus area: cleanse with wound cleanser and apply Medi-honey, cover with gauze and secure with foam dressing every other day. - Right site open wound with Penrose drain: cleanse with wound cleanser, prep the peri-area with no sting barrier film for protection, loosely pack slightly moistened gauze into wound, cover with an absorbent dressing and secure with tape every day. A review of the October 2023 Treatment Administration Record (TAR) revealed the surgical wound care had not been documented as completed or refused by Resident #70 on the 7:00 AM to 7:00 PM shift on 10/19/23, 10/20/23 and 10/22/23. The physician orders included the following orders dated 10/26/23 to 11/18/23: - Bottom abdominal wound: clean with normal saline or wound cleanser. Apply normal saline moistened gauze to the wound bed. Cover with a dry dressing twice a day. - Top two abdominal wounds: clean with normal saline or wound cleanser. Cover with Vaseline impregnated gauze and dry dressing every day and as needed. A review of the November 2023 TAR revealed the surgical wound care had not been documented as completed or refused by Resident #70 on the	F 842	Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit current resident with wounds to ensure there are completed and accurate medical records in the area of wound care as evidenced by completion of treatment administration record (TAR). The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will provide education to 100% of licensed nurses noting all treatments are to be completed as ordered and documented as completed or refused by the resident on the treatment administration record (TAR). Education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired licensed nurses will receive the same education during general facility orientation. The Director of Health Services, Clinical	

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F 842	Continued From page 70 7:00 AM to 7:00 PM shift on 11/4/23, and 11/9/23. Review of the nursing progress notes from 10/16/23 to 11/30/23 did not reveal any refusals of wound care by Resident #70. On 2/7/24 at 10:29 AM, an interview occurred with the Wound Care Nurse. She explained that she completed wound care during the day Monday through Friday. She reviewed the TAR's showing no initial as completing the wound care or refusal by Resident #70 on 10/19/23, 10/20/23 and 11/9/23. She stated that she completed the wound care as ordered but got busy and forgot to sign the treatments off as completed. A phone interview was completed with Nurse #8 on 2/7/24 at 4:23 PM and was assigned to care for Resident #70 on the 7:00 AM to 7:00 PM shift on 10/22/23. She recalled completing the surgical wound care to Resident #70 and stated she forgot to document that it was completed. On 2/8/24 at 9:30 AM, a phone interview was conducted with Nurse #6, who was assigned to care for Resident #70 on the 7:00 AM to 7:00 PM shift on 11/4/23. She recalled he had surgical wound care and stated that she got busy and forgot to sign it off as completed. The Director of Nursing was interviewed on 2/8/24 at 9:54 AM and indicated it was her expectation for the nursing staff to complete wound care as ordered as well as to document that it was completed or refused by the resident.	F 842	Competency Coordinator, Nurse Supervisors, and/or designee will audit documentation on the TAR to ensure documentation is completed to note wound care as completed or refused by the resident. This audit will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track and trend the results via Treatment Administration Record audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		3/11/24

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F 867	Continued From page 71 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, 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.	F 867		

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F 867	Continued From page 72 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; 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.	F 867		

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F 867	Continued From page 73 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, family member, physician, nurse practitioner, and staff interviews, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and monitor the interventions that the	F 867	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected.	

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F 867	Continued From page 74 committee put into place in following the complaint investigation of 3/12/2021 and 10/22/2021, and the recertification and complaint investigation of 6/30/2022. This was for 4 deficiencies in the areas of F677 Activities of Daily Living (ADLs), F842 Accuracy of Records, F684 Quality of Care/Professional Standards, and F883 Influenza and Pneumococcal Immunizations. These deficiencies were recited on the current recertification and complaint investigation survey of 2/16/2024. 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 QAPI program. The findings included: This tag is cross referred to: F677: Based on observations, record reviews and interviews of residents, family member, and staff, the facility failed to provide incontinence care for dependent residents (Resident #192, Resident #34, Resident #69, Resident #48, and Resident #339), and failed to provide bathing for a dependent resident (Resident #339) for 5 of 16 residents reviewed for activities of daily living. During the complaint investigation of 3/12/2021 the facility failed to provide a dependent resident with shaving assistance for 1 of 4 residents reviewed for activities of daily living (ADL). F842: Based on record review and staff interviews, the facility failed to maintain complete and accurate medical records in the areas of surgical wound care (Resident #70) for 1 of 1 resident record reviewed for surgical wound care.	F 867	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. No residents have the potential to be affected. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur. On 2-9-2024, the Regional Nurse Consultant completed an in-service with the Administrator, Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Minimum Data Set (MDS) nurses, Social Worker, Dietary Manager, Maintenance Director, and Environmental Services Manager (Interdisciplinary Team) noting the Quality Assurance and Performance Improvement policy and protocol for the facility with emphasis on continuing to monitor and evaluating prior areas cited during past surveys. All newly hired interdisciplinary team members will receive the same education during the general facility orientation from the Clinical Competency Coordinator, Administrator and/or Director of Health Services. The Area Vice President of Operations for Coastal North Division and or the Regional Nurse Consultant will attend the monthly QAPI meetings to ensure that the repeat tags are monitored, monthly times	

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F 867	Continued From page 75 During the complaint survey dated 10/22/2021, the facility failed to document the correct medication dosage on the electronic medication administration record (eMAR) for Fentanyl patch for 1 of 1 resident reviewed for accurate medical record. F684: Based on record review, staff and medical director interviews, the facility failed to obtain daily weights as ordered for a resident with heart failure on a diuretic (Resident #70). This was for 1 of 8 residents reviewed for nutrition. During the recertification and complaint survey dated 6/30/2022, the facility failed to assess, document, and treat skin tears, resulting in the resident receiving antibiotic treatment, for one of three sampled residents reviewed for wound care. F883: Based on record reviews and staff interviews, the facility failed to administer an influenza vaccine for a resident who signed a consent form to receive an influenza vaccine or document an influenza vaccine was received for 1 of 5 residents reviewed for infection control (Resident #58). During the recertification and complaint survey dated 6/30/2022, the facility failed to offer the pneumococcal vaccine and include documentation in the resident's medical record of education or vaccination status for the pneumococcal vaccination for two of five residents reviewed for the pneumococcal vaccinations. An interview was conducted with the Regional Nurse Consultant and the Clinical	F 867	6 months, then quarterly times 3 quarters, then annually. Opportunities to be corrected as identified during the QAPI process. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator to the Quality Assurance Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring. Compliance date: 3-11-2024	

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F 867	Continued From page 76 Reimbursement Consultant RN on 2/8/2024 at 11:19 AM and they revealed a mock survey had been conducted in December 2023 and multiple areas of concern were identified. The Clinical Reimbursement Consultant RN reported several plans of correction were in place as well as several performance improvement plans. The Regional Nurse Consultant explained that during the follow-up a couple weeks ago, the team found that the facility was not meeting metrics and the plans of correction were modified. The Administrator was interviewed on 2/8/2024 at 4:32 PM. The Administrator explained his first day at the facility was 2/5/2024. The Administrator reported the QAPI committee met monthly and reviewed risks and monitored areas of concern by following standard monitoring guidelines. The Administrator explained that to maintain compliance, the QAPI committee would review areas of concern and track the audit results for up to 6 months if necessary.	F 867		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883		3/11/24

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F 883	Continued From page 77	F 883		

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical

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F 883	Continued From page 78 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to administer an influenza vaccine for a resident who signed a consent form to receive an influenza vaccine or document an influenza vaccine was received for 1 of 5 residents reviewed for infection control (Resident #58). The findings included: Resident #58 was admitted to the facility on 9/9/23 and had a reentry date of 10/16/23. Resident #58's quarterly Minimum Data Set (MDS) assessment dated 10/18/23 revealed Resident #58 was cognitively intact. Review of Resident #58's medical record revealed he signed a "Resident Influenza (Flu) Vaccine Consent/Refusal" form on 10/31/23. There was a check mark on the line that read I do wish to receive the flu vaccine depending on the availability of the vaccine. There was a handwritten note at the top of the form that read, "Do not receive went to hospital." Review of Resident #58's medical record showed he was admitted into a hospital on 11/13/23 and returned to the facility on 11/28/23. Review of Resident #58's hospital records dated 11/28/23 showed no documentation Resident #58 received an influenza vaccine during his hospitalization. An interview was attempted on 2/8/24 at 9:20	F 883	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #58 is no longer a resident in the facility. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents have the potential to be affected. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will complete an audit of current residents to ensure education, consent or declination of Pneumonia and/or Influenza vaccines, and administration of consented and eligible vaccinations has been initiated. The Director of Health Services (DHS), Assistant Director of Health Services (ADHS), Nurse Supervisors (NS), Clinical Competency Coordinator (CCC), Minimal Data Set (MDS) Nurses and/or Staff Nurse(s) will address any concerns identified during the audit. The audit will be completed by 3/11/2024. 3. Address what measures will be put into place or systematic changes made to	

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	345566	A. BUILDING _____ B. WING _____	C 02/16/2024

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F 883	Continued From page 79 A.M. with Resident #58. Resident #58 was unavailable. An interview was conducted on 2/7/24 at 12:17 P.M. with the Infection Preventionist and the Director of Nursing (DON) #3. During the interview, the DON #3 explained the influenza vaccine was offered to residents annually. The DON #3 stated when a resident was out of the facility for an appointment or hospitalization, the resident should be offered the vaccine when they returned to the facility and met the criteria to receive the vaccine. DON #3 further explained the facility always had influenza vaccines available at the facility and she was unsure why Resident #58 had not been administered the influenza vaccine this season. An interview was conducted on 2/8/24 at 11:35 P.M. with DON #3. During the interview, DON #2 confirmed she had reviewed Resident #58's medical record and there was no documentation Resident #58 had received an influenza vaccine. An interview was conducted on 2/8/24 at 1:43 P.M. with the Director of Nursing (DON) #1. During the interview, the DON stated it was the responsibility of staff to follow up with Resident #58 and administer him an influenza vaccine when he returned from the hospital. The DON did not provide an answer to why Resident #58 had not received an influenza vaccine this influenza season after signing a consent to receive the influenza vaccine.	F 883	ensure that the deficient practice will not recur. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will provide education to 100% of licensed nurses noting upon admission and readmission, the admitting nurse should provide written education for Pneumonia and Influenza vaccination as appropriate, attempt to obtain consent or declination for Pneumonia vaccinations all year and complete for Influenza during the months of October through March, and document consent or declinations in the electronic health record. The Director of Health Services, Clinical Competency Coordinator/Infection Preventionist, and/or Nurse Supervisors will ensure orders are obtained and implemented for eligible residents with floor staff nurses responsible for administration and documentation of administration of ordered vaccines. Education will be completed by 3-11-2024. After 3-11-2024, any nurses who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired licensed nurses will receive the same education during general facility orientation. The Director of Health Services, Clinical Competency Coordinator, Nurse Supervisors, and/or designee will audit admissions and readmissions to ensure they have been offered the Pneumonia and influenza vaccinations as appropriate,	

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F 883	Continued From page 80	F 883	consent and declinations are documented, and administrations for consented vaccinations are completed. This audit will be conducted 3 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. Ongoing monitoring will be completed by DHS and Infection Preventionist for the facility by keeping a running audit of Pneumonia and Influenza vaccine compliance and update as needed. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services and/or Infection Preventionist will track and trend the results via the Immunization Audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management	F 947		3/11/24

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F 947	Continued From page 81 training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete mandatory twelve hours of annual in-services training for 2 of 5 Nursing Aides (NA #22, and NA #23) reviewed. The findings included: Review of the personnel file of NA #22 revealed a hire date of 7/14/21. Review of the personnel file of NA #23 revealed a hire date of 8/11/21. Review of NA #22's Educational Record for yearly training did not include 12 hours of the annual mandatory in-servicing for 2023. Review of NA #23's Educational Record for yearly training did not include 12 hours of annual mandatory in-servicing for 2023. Review of all the facility education and training documentation revealed no record of education or in-service training for NA #22 and NA #23 for the year of 2023.	F 947	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as affected. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Clinical Competency Coordinator (CCC) will complete an audit of current certified nursing assistants (CNA) education records to ensure the mandatory twelve hours of annual in-services training have been initiated. The Clinical Competency Coordinator (CCC) and or Director of Health Services (DHS) will address any concerns identified during the audit. The audit will be completed by 3/11/2024. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not	

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F 947	Continued From page 82 The Clinical Reimbursement Coordinator was interviewed on 02/07/24 at 9:30 AM. She stated the facility used an online in-service program and she was aware that all nurse aides must have the annual mandatory in-service training. The Clinical Reimbursement Coordinator indicated she was helping the facility out and reviewed the facility training records for NA #22 and NA #23 and she could not find any documented education for either NA for 2023. During an interview with the Director of Nursing on 02/08/24 at 11:30 AM, she indicated she had only been in the facility for less than 2 weeks and could not provide any information.	F 947	recur. The Director of Health Services will provide education the Clinical Competency Coordinator noting current certified nursing assistants must complete mandatory twelve hours of in-services training must be completed annually covering various topics including care of cognitively impaired residents. The Clinical Competency Coordinator will provide education to certified nursing assistants, noting they must complete a mandatory twelve hours of in-services annually. All education will be completed by 3-11-2024. After 3-11-2024, any nursing staff who have not worked or received the education will receive it prior to the next scheduled work shift. All newly hired certified nursing assistants will receive the same education during general facility orientation. The Director of Health Services and/or Clinical Competency Coordinator will audit current certified nursing assistant staff to ensure assigned in-services are being completed by the certified nursing staff. Audits will be conducted weekly x 4 weeks then monthly x 2 months. Ongoing monitoring of in-service completion will be conducted by the Clinical Competency Coordinator. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will track	

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F 947	Continued From page 83	F 947	and trend the results via Annual In-services for Certified Nursing Assistants audit tool weekly and report the findings to the Quality Assurance Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved and then quarterly. Compliance date: 3-11-2024	