STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(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 The survey team entered the facility on 2/18/24 to conduct a recertification and complaint investigation survey and exited on 2/21/24. Additional information was obtained on 3/1/24. Therefore, the exit date was changed to 3/1/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5TNV11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 2/18/24 to conduct a recertification and complaint investigation survey and exited on 2/21/24. Additional information was obtained on 3/1/24. Therefore, the exit date was changed to 3/1/24. Event ID# 5TNV11. The following intakes were investigated: NC00201496, NC00201777, NC00207052, NC00207276, NC00209698, and NC00213249. One (1) of the 15 complaint allegations resulted in a deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		3/27/24

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

Electronically Signed | 03/18/2024

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F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, Nurse Practitioner (NP), resident and staff interviews the facility failed to notify the NP when a resident experienced pain and the acetaminophen order	F 580	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth	

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F 580	Continued From page 2 expired for 1 of 2 (Residents #43) residents sampled for change in condition. The findings included: Resident #43 was admitted to the facility on 1/15/24 from the hospital with diagnoses that included chronic first vertebra of the lumbar spine (L1) compression fracture. Hospital discharge summary revealed Resident #43 was admitted to the hospital on 1/8/24 with acute chronic lower back pain and inability to walk. Magnetic Resonance Imaging (MRI) of the spine revealed chronic first vertebra of the lumbar spine (L1) compression fracture. On 1/9/24, while a patient at the hospital, Resident # 43 had a stroke. Resident #43 was admitted to the facility on 1/15/24 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, wedge compression fracture of first lumbar vertebra, fall from bed, and repeated falls. When Resident #43 was discharged from the hospital she had an order to continue taking acetaminophen 1 tablet (500 mg total) by mouth every six hours as needed. Review of physician orders revealed on 1/15/24 an order for acetaminophen 1 tablet (500 mg) by mouth every 6 hours as needed for pain for 14 days. The admission Minimum Data Set (MDS) dated 1/22/24 revealed the Resident #43 had intact cognition and was coded for almost constantly being in pain. Review of pain assessments revealed Resident #43 was assessed for having no pain on 2/1/24, 2/2/24, 2/3/24, 2/4/24, 2/5/24, 2/6/24, 2/7/24, 2/8/24, 2/9/24, 2/10/24, 2/11/24, 2/12/24, 2/13/24,	F 580	in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. 580 Notice of Changes 1. Facility failed to notify medical provider of a change in condition in resident #43 2. All current residents are at risk. 3. The Director of Nursing educated current licensed nursing staff regarding reporting changes in condition. Training included what to report related to resident accident involving injury, physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in both life-threatening conditions changes in physical condition, a need to alter medications being used for treatment, including alteration in treatment. Licensed nursing staff not receiving education will not be allowed to work until education received. New licensed nursing staff will receive education within the orientation process by the Staff Development Coordinator or designee 4. Director of Nursing or designee will audit 5 Medication Orders & Notes for Communications w medical provider weekly x 4 weeks, then 3 Medication Orders & Notes for Communications with medical provider weekly x 4 weeks then 5 Medication Orders & Notes for Communication with medical provider weekly x 1 month.	

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F 580	Continued From page 3 2/14/24, 2/15/24, 2/16/24, 2/17/24, 2/18/24, and 2/19/24. An interview on 2/19/24 at 8:59 AM with Resident #43 revealed she was in chronic back pain due to a motor vehicle accident several years ago. A second interview on 2/19/24 at 11:00 AM with Resident #43 revealed she was in pain. She indicated a nurse had recently been in her room and gave her something for pain. Resident #43 indicated she didn't know what the nurse gave her, but she thought might have been acetaminophen. She further revealed, when she was at home, she took stronger medication, but she didn't think they could give it to her because it was a "controlled substance." An interview on 2/20/24 at 11:09 AM with Nurse #2 revealed she was aware that Resident #43 was in pain. Resident #43 told Nurse #2 she was in pain and she gave her regular strength acetaminophen that she had a prn order for. Interview further revealed Resident #43 received acetaminophen at 10:45 AM. Nurse #2 assessed Resident #43 for pain and her pain level was at a 10 on the pain scale. Nurse #2 revealed that she had written notes in the provider book several times about Resident #43 being in pain and she didn't know why Resident #43 didn't have any regularly scheduled pain medication. An interview on 2/20/24 at 11:34 AM with NP #1 revealed there was no communication to her about Resident #43 being in pain. NP checked provider book and past text messages and there were no notes regarding Resident #43 complaints of pain. NP indicated she saw Resident #43 on 2/16/24 and she indicated she was in pain from	F 580	5. Results of these audits will be reviewed at Quarterly QA meeting x1 for further problem resolution if needed. 6. Date of completion: 03-27-2024	

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F 580	Continued From page 4	F 580		

sitting in the chair. NP #1 offered her Advil and Resident #43 declined as she thought her pain would lessen if she got back in the bed. NP#1 further revealed that she would go visit with Resident #43 today.

An interview with Resident #43 on 2/20/24 at 12:37 PM revealed that she saw NP #1 and told NP #1 that she was constantly in pain. NP #1 ordered her medication to help with pain. A follow-up interview was conducted with NP #1 on 2/20/24 at 12:45 PM. She revealed that after speaking with Resident #43 and assessing her pain, she ordered hydrocodone-acetaminophen oral tablet 5-325mg once daily.

An interview with Nurse Aide #7 on 2/21/24 at 8:34 AM revealed that Resident #43 had told her that she was in pain, especially when she transferred her from side to side. Nurse Aide #7 further revealed that when Resident #43 was in pain she would let the nurse know so they could give her some pain medication.

A phone interview with Director of Nursing (DON) on 3/1/24 at 2:49 PM revealed she didn't see any orders for pain medication after the acetaminophen ended on 1/29/24 until 2/20/24 when the hydrocodone-acetaminophen was ordered. She was recently hired and wasn't employed at the facility in January 2024.

A phone interview with Rehab Director on 3/1/24 at 3:03 PM revealed Resident #43 participated in occupational, physical and speech therapy since her admission and had not missed any sessions. She indicated that Resident #43 would sometimes complain about her chronic back pain during therapy but was easily redirected by

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F 580	Continued From page 5 working on breathing techniques. Rehab Director further indicated the nurses would address her pain, and she didn't think her pain impeded her therapy participation. A phone interview with the Medical Director on 3/1/24 at 4:00 PM revealed he wasn't very familiar with Resident #43, NP #1 saw Resident #43 often. He indicated they typically follow the hospital orders. He wasn't sure why the acetaminophen was changed to 14 days. He further revealed that NP #1 saw Resident #43 frequently and surveyor would have to ask her about the change with acetaminophen. NP #1 was unavailable on 3/1/24.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		3/27/24

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F 609	Continued From page 6 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to submit an initial report of an abuse allegation to the State Agency within the required 2- hour time frame for 1 of 3 residents (Resident #32) reviewed for abuse. The findings included: A review of the facility's Administrative Policies and Procedures included Policy #703 (Effective Date 10/17/23) entitled, "Abuse/Neglect/Misappropriation/Crime: Reporting Requirements/Investigations." The policy stated, "The Administrator will ensure the timely reporting, investigating, and follow up reporting of incidents of alleged/suspected patient abuse, neglect, mistreatment, exploitation, or crime against a patient to the State Agency and any other appropriate authorities." The procedures for this policy read, in part: "Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the	F 609	F609 Failure to report Abuse Allegation within 2 hours 1. Facility allegedly failed to report abuse allegation in a timely manner of resident #32 2. All current residents are at risk 3. The Regional Director of Clinical Services conducted education with the Administrator regarding prompt reporting of any type of resident abuse and providing a safe environment for all residents. Education also included that any allegation of abuse would need to be reported to the state agency within 2 hours of receiving the allegation. Education provided to administrator on 3/15/2024. Current staff received education included what to do if abuse is suspected, who to notify for an abuse allegation, timely reporting of abuse concerns, and protecting residents from abuse with immediate action. Education included that any allegation that involved abuse must be reported to the state agency within 2 hours of receiving the allegation. Education provided by Staff Development Coordinator on	

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F 609	Continued From page 7 events that caused the allegation do not involve abuse and do not result in serious bodily injury." Resident #32 was admitted to the facility from a hospital on 4/14/23 with cumulative diagnoses which included a history of multiple vertebral fractures, repeated falls, and bipolar disorder. The resident's most recent Minimum Data Set (MDS) assessment was a quarterly assessment dated 12/9/23. This MDS revealed Resident #32 had intact cognition. The resident was assessed as being independent with eating, toileting, rolling left to right, walking 10 feet, and transitioning from sit to stand and from chair to bed or bed to chair. The resident required set-up or clean-up assistance with dressing and personal hygiene; and she needed supervision or touching assistance for bathing. Review of a Facility Reported Incident involving Resident #32 alleged that Nurse Aide (NA) #1 hurt the resident's arm during care by pulling the sheet from underneath her too aggressively during her rounds. The alleged incident occurred on 2/5/24. The facility reported becoming aware of the alleged incident on 2/6/24 at 11:55 AM. The facility's Administrator completed the Initial Allegation Report which indicated the allegation/incident type was resident abuse. A Transmission Verification Report from the fax of the Initial Allegation Report sent to notify the State Agency of the abuse allegation was dated and timed as 2/7/24 at 8:59 AM (indicative of more than 21 hours after the facility became aware of the abuse allegation). An interview was conducted on 2/21/24 at 10:57 AM with the facility's Administrator and in the	F 609	Abuse/Neglect/Misappropriation/Crimes and initial reporting guidelines. Education provided on 03/19/2024. Any staff member not receiving education will not be allowed to work until education received. Any new employees will receive education in the orientation process by Staff Development coordinator or designee. 4. Regional Vice President or designee will audit 5 abuse reports for timely reporting within 2 hours of receiving allegation if available/warranted weekly x 4 weeks, then 5 abuse reports if available/ warranted biweekly x 8 weeks, then 5 abuse reports if available/ warranted monthly x 1 month. 5. Results of these audits will be reviewed at Quarterly QA meeting x1 for further problem resolution if needed. 6. Date of completion: 03-27-2024	

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F 609	Continued From page 8 presence of the Regional Director of Clinical Services. When the Administrator was asked what the required time frame was for the initial reporting of an allegation of abuse, she stated, "It depends on what it is, either 2 hours or 24 hours." The regulations in the State Operations Manual on the time requirement for reporting abuse allegations were reviewed at that time. Upon review, the facility's Administrator reported she was not aware that all abuse allegations (with or without injury/harm) needed to be reported within 2 hours of the facility becoming aware of the allegation.	F 609		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		3/27/24

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F 636	Continued From page 9 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete an annual	F 636	F636:Comprehensive Assessments & Timing	

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F 636	Continued From page 10 comprehensive Minimum Data Set (MDS) assessment for 1 of 28 residents reviewed for MDS assessments (Resident #54). The findings included: Resident #54 was admitted to the facility on 6/13/2022 with diagnoses to include stroke and dementia. A significant change in condition MDS was completed 12/20/2022. Quarterly MDS assessments were completed on 3/15/2023, 6/15/2023, 9/15/2023, and 12/15/2023. No annual MDS had been completed for Resident #54. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 2/21/2023 at 12:12 PM. MDS Nurse #1 reported the quarterly MDS assessment dated 12/15/2023 should have been completed as a comprehensive annual assessment. MDS Nurse #2 explained that she used an Assessment Reference Date (ARD) manager to keep track of when assessments were due. MDS Nurse #2 displayed the ARD manager, and a warning was noted for Resident #54 that his annual comprehensive assessment was overdue. MDS Nurse #2 explained she missed the comprehensive annual assessment. The Administrator was interviewed on 2/21/2023 at 2:36 PM. The Administrator explained that the ARD manager was not always accurate, and she thought the missed assessment was an oversight on MDS Nurse #2's part.	F 636	1. Facility allegedly failed to complete comprehensive care plan for (Resident #54). Comprehensive Assessment opened and completed. Comprehensive care plan have been updated / revised to reflect their current status. 2. Current residents have the potential to be affected by the alleged deficient practice. All current resident□s assessment schedules will be audited for accuracy 3. Minimum Data Set Nurses were reeducated by Region of Director of Clinical Reimbursement or designee regarding the need weekly monitoring of assessment schedule. Education provided on 3/08/2024. This includes instruction on using Point Click Care scheduler and RAI schedule for all OBRA /PDPM assessments and completion time frames. Any new Minimum Data Set nurses will be educated on process during the orientation process by the Regional Director of Clinical Reimbursement. 4. Regional Director of Clinical Reimbursement or Designee will audit 5 MDS schedules weekly for 4 weeks, biweekly times two , and then monthly times two months 5. Results of these audits will be reviewed at Quarterly QA meeting x1 for further problem resolution if needed. 6. Date of completion: 03-27-2024	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		3/27/24

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F 641	Continued From page 11 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of dialysis and discharge location for 2 of 7 residents reviewed for dialysis and discharge (Resident #79 and Resident #80). The findings included: 1. Resident #79 was admitted to the facility on 9/19/23 from a hospital. Her cumulative diagnoses included diabetes and end stage renal disease with dependence on dialysis. A review of Resident #79's electronic medical record (EMR) included a physician's order dated 9/19/23 for dialysis to be provided three times weekly on Tuesdays, Thursdays, and Saturdays at a dialysis center. Further review of the resident's EMR revealed her care plan included an area of focus which read, "Community Dialysis: The resident is at increased risk for complications secondary to requiring hemodialysis secondary to ESRD [End Stage Renal Disease]" Created on 9/19/23. Resident #79's most recent Minimum Data Set (MDS) was a significant change in status assessment dated 11/29/23. The "Special Treatments, Procedures, and Programs" section of this MDS assessment did not indicate Resident #79 received dialysis while residing in the facility.	F 641	F641 Accuracy of Assessments F641: 1 (Resident #79 and Resident #80) Residents Minimum Data Set assessment and Comprehensive care plan have been updated / revised to reflect their current status. 2 Current residents have the potential to be affected by the alleged deficient practice. 3 Current resident Minimum Data Set assessments have been audited for Dialysis coding and Discharge locations Audited to reflect all current Minimum Data Set assessments are correct. 4 Minimum Data Set nurses were reeducated by Region of Director of Clinical Reimbursement or designee regarding daily falls risk meetings with updates to care plans for falls/ behaviors interventions. Education was completed on 3/15/2024. Any new Minimum Data Set Nurse will be educated by the Regional Director of Clinical Reimbursement during the orientation process. Regional Director of Clinical Reimbursement or Designee will audit 5 MDS schedules weekly for 4 weeks, biweekly times two, and then monthly times two months 5. Results of these audits will be reviewed	

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	345419	A. BUILDING _____ B. WING _____	C 03/01/2024

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F 641	Continued From page 12 An interview was conducted on 2/21/24 at 2:06 PM with MDS Nurse #1 and MDS Nurse #2. Upon review of Resident #79's EMR, MDS Nurse #1 confirmed the resident received dialysis three days a week while she was a resident of the facility. MDS Nurse #1 reported the 11/29/23 significant change in status MDS assessment was not accurately coded to indicate Resident #79 received dialysis. She stated this error would need to be corrected. 2. Resident #80 was admitted to the facility on 10/21/2023. The discharge Minimum Data Set (MDS) assessment dated 11/26/2023 documented Resident #80 was discharged to a short-term general hospital on 11/26/2023. A physician order dated 11/26/2023 ordered Resident #80 to be discharged home with home health services. A nursing note dated 11/26/2023 documented Resident #80 discharged home on 11/26/2023. A nurse practitioner (NP) note dated 11/27/2023 documented that Resident #80 was discharged to home on 11/26/2023. An interview was conducted with MDS Nurse #1 and MDS Nurse #2 on 2/21/2023 at 12:12 PM. MDS Nurse #1 reported the discharge MDS assessment for Resident #80 should have been coded for discharge home. MDS Nurse #2 explained she made an error when documenting on the discharge MDS for Resident #80. The Administrator was interviewed on 2/21/2023 at 2:36 PM. The Administrator explained that she thought the error in coding was an oversight on	F 641	at Quarterly QA meeting x1 for further problem resolution if needed. 6. Date of completion: 03-27-2024	

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F 641	Continued From page 13 MDS Nurse #2's part.	F 641		
F 656 SS=B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		3/27/24

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F 656	Continued From page 14 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to update care plan interventions related to fall prevention (Resident #44) and behavioral interventions (Resident #54) for 2 of 28 residents reviewed for care plan accuracy. The findings included: 1. Resident #44 was admitted to the facility 2/17/2023 with diagnoses to include dementia. The Quarterly Minimum Data Set (MDS) assessment dated 12/27/2023 documented Resident #44 was severely cognitively impaired. A care plan initiated on 2/17/2023 addressed Resident #44's risk for falls and interventions included a fall mat on the floor beside the bed with a revision date of 5/29/2023. Resident #44 was observed in her bed on 2/19/2024 at 11:38 AM, 2/20/2024 at 12:09 PM, and 2/21/2024 at 1:59 PM. No fall mats were noted to be on the floor beside her bed. An interview was conducted with nursing assistant (NA) #4 on 2/20/2024 at 11:37 AM. NA	F 656	F656 Develop/Implement a Comprehensive Care Plan 1 Facility allegedly failed to ensure comprehensive care plan accuracy for (Resident #44,#54) Comprehensive care plan have been updated / revised to reflect their current status. Correcting falls mats removed from #44 care plan and #54 gloves removed from care plan interventions. 2. All current resident□s Behaviors and falls care plans have been Audited to reflect all current devices are correct. Audit was completed on 03/01/2024 by Regional Director of Clinical Reimbursement. 3. Minimum Data Set Coordinators were reeducated by Region of Director of Clinical Reimbursement or designee regarding daily falls risk meetings with updates to care plans for falls/ behaviors interventions. Education was competed on 03/08/2024. Any new Minimum Data Set Coordinator will be educated by the Regional Director of Clinical Reimbursement during the	

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F 656	Continued From page 15 #4 reported that Resident #44 did not move in bed and the fall mats were not used. NA #5 was interviewed on 2/20/2024 at 1:53 PM. NA #5 explained Resident #44 was able to move her upper body in the bed, but she was unable to roll from side to side and the fall mats were not used for her. During an interview with NA #6 on 2/20/2024 at 2:30 PM, she revealed that Resident #44 was unable to move in bed and she was kept propped on pillows. Nurse # 1 was interviewed at the time of the observation on 2/21/2023 at 1:59 PM. Nurse #1 noted Resident #44 did not have fall mats on the floor beside her bed. Nurse #1 explained Resident #44 did not independently move in bed, and the care plan should be modified to remove the fall mats. The Administrator was interviewed on 2/21/2024 at 2:36 PM and she reported it was an oversight that the care plan was not modified to remove the use of fall mats. 2. Resident #54 was admitted to the facility on 6/13/2022 with diagnoses to include stroke and dementia. A Quarterly MDS assessment dated 12/15/2023 assessed Resident #54 to be severely cognitively impaired. A care plan created on 7/14/2022 and modified on 10/26/2023 included an intervention dated 10/26/2023 to apply gloves to Resident #54 to prevent him from chewing on his fingers.	F 656	orientation process. 4. Regional Director of Clinical Reimbursement or Designee will audit 5 MDS schedules weekly for 4 weeks, biweekly times two, and then monthly times two months 5. Results of these audits will be reviewed at Quarterly QA meeting x1 for further problem resolution if needed. 6. Date of completion: 03-27-2024	

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F 656	Continued From page 16	F 656		

Resident #54 was observed on 2/18/2024 at 10:44 AM. Resident #54 did not have gloves on his hands.
Resident #54 was observed again on 2/18/2024 at 12:31 PM and he did not have gloves on.

A final observation of Resident #54 was conducted on 2/19/2024 before lunch and he was not wearing gloves.

An interview was conducted with NA #5 on 2/20/2024 at 1:54 PM. NA #5 explained that Resident #54 liked to chew on things, and they usually gave him a soft blanket that he would bite and suck on. NA #5 did not know Resident #54 had gloves to prevent him from biting on his fingers.

NA #6 was interviewed on 2/20/2024 at 2:30 PM. NA #6 reported she gave Resident #54 a soft blanket to chew on. NA #6 reported she was not aware Resident #54 had gloves to prevent him from biting his fingers.

An interview was conducted with Unit Manager (UM) #2 on 2/21/2024 at 10:25 AM. UM #2 explained that Resident #54 did not have the gloves applied every day and the care plan should be modified to read "apply gloves as needed". UM #2 explained that Resident #54 was not chewing through the fibers on the towel or blanket, he was mostly chewing and sucking, but when he chewed on his fingers, he caused them to bleed and that is why the gloves were added.

The Administrator was interviewed on 2/21/2024 at 2:36 PM and she reported it was an oversight that the care plan was not modified to read to

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F 656	Continued From page 17 apply the gloves as needed for Resident #54.	F 656		
F 657 SS=B	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 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 staff interviews and facility and hospital record reviews, the facility failed to review and revise the comprehensive care plan related to a medication that was discontinued after the resident underwent bilateral above knee	F 657	F657 Care Plan Timing and Revision Facility allegedly failed to ensure comprehensive care plan as it related to discontinuance of medication after a	3/27/24

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F 657	Continued From page 18 amputations (AKA). This occurred for 1 of 28 residents (Resident #79) whose care plans were reviewed. The findings included: Resident #79 was admitted to the facility from a hospital on 9/19/23. Her cumulative diagnosis included diabetes, severe peripheral vascular disease, and status post a bilateral (left and right) transmetatarsal amputation (a surgery to remove part of the foot due to poor blood flow or a severe infection). The resident's admission orders dated 9/19/23 included 5 milligrams (mg) apixaban (an anticoagulant) to be given as one tablet by mouth twice daily related to peripheral vascular disease. Resident #79's comprehensive care plan included the following area of focus, in part: Anticoagulant: The resident is at risk for bleeding, hemorrhage, excessive bruising and complications related to anticoagulant use secondary to severe peripheral vascular disease (PVD), recent amputation of toes (Created on 9/19/23). Resident #79 was discharged back to the hospital on 9/28/23 and re-entered the facility on 10/13/23. The Hospitalist Discharge Summary dated 10/13/23 reported the resident was status post bilateral above knee amputations. The hospital Discharge Summary and facility's medication orders dated 10/13/23 indicated the resident's apixaban was held (not ordered for administration). A review of Resident #79's electronic medical	F 657	discharge from the hospital to the facility for(Resident #79). Resident d/c. Unable to update this care plan. All current resident□s care plans will be audited for accuracy in relation Current comprehensive assessments in regards to surgical wounds and anticoagulant use. Audit completed by Regional Director of Clinical Reimbursement on 3/15/2024. 2. All current residents at risk. 3. Minimum Data Set Coordinator and Care plan team was educated by Region of Director of Clinical Reimbursement or designee regarding the need for updating and completion of the comprehensive care plan to reflect the resident□s current status with the most recent Comprehensive MDS. Education completed on 3/08/2024. Any new Minimum Data Set Coordinator will be educated by the Regional Director of Clinical Reimbursement during the orientation process. 4. Regional Director of Clinical Reimbursement or Designee will audit 5 comprehensive assessments and care plan accuracy weekly for 4 weeks, biweekly for 2 weeks, and then monthly for two months. 5. Results of these audits will be reviewed at Quarterly QA meeting x1 for further problem resolution if needed. 6. Date of completion: 03-27-2024	

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F 657	Continued From page 19 record (EMR) revealed a significant change Minimum Data Set (MDS) assessment dated 10/19/23 was completed for the resident. The assessment indicated Resident #79 had intact cognition. The medication section of the MDS indicated the resident did not receive an anticoagulant. No revision was made to Resident #79's comprehensive care plan for the area of focus related to the anticoagulant use secondary to severe PVD and recent amputation of toes (Created on 9/19/23). A review of Resident #79's EMR also indicated a significant change MDS assessment dated 11/29/23 was completed for the resident. The medication section of the MDS indicated the resident did not receive an anticoagulant. No revision was made to Resident #79's comprehensive care plan for the area of focus related to the anticoagulant use secondary to severe PVD and recent amputation of toes (Created on 9/19/23). An interview was conducted on 2/21/24 at 2:06 PM with MDS Nurse #1 and MDS Nurse #2. Upon review of Resident #79's EMR and care plan, MDS Nurse #2 reported the care plan should have been updated with the resident's most recent revision to reflect her current condition. MDS Nurse #1 further stated that a resident's care plan should be reviewed and revised after a significant change MDS was completed.	F 657		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		3/27/24

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F 812	Continued From page 20 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with the staff and Regional Director of Culinary Operations, the facility failed to seal, label/date, and discard expired food items stored in the Dietary Department's walk-in freezer, reach-in refrigerators, and 1 of 2 Nourishment Rooms observed (100 Hall Nourishment Room). The findings included: An initial tour was conducted of the Dietary Department on 2/18/24 at 10:01 AM. Neither the Dietary Manager nor the Assistant Dietary Manager were available to join the initial tour of the Department. Observations made at the time of the initial tour identified the following concerns in the walk-in freezer:	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. The facility allegedly failed to properly label refrigerated, and frozen foods stored in dietary department refrigerator/freezer (cold storage units). 2. Current residents are at risk. 3. Food items will be properly labeled and stored in proper areas of the dietary department upon arrival to the center. Current Dietary employees were educated on proper labeling techniques and proper food storage techniques within the kitchen and nourishment areas. All non-labeled food in the nourishment room was discarded. The bread items were labeled according to the current purchase order.	

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F 812	Continued From page 21 --An opened, undated box with an opened and unsealed interior plastic bag was observed to contain pancakes. The interior plastic bag was estimated to be 1/2 full. Neither the box nor the plastic bag was closed, leaving the pancakes exposed to air (not sealed). --An opened, undated box with an opened and unsealed interior plastic bag was observed to contain scrambled egg patties. The interior plastic bag was estimated to be 3/4 full. Neither the box nor the plastic bag was closed, leaving the scrambled egg patties exposed to air (not sealed). -- An opened, undated box with an opened and unsealed interior plastic bag was observed to contain Parker House dinner roll dough. The interior plastic bag was estimated to be 1/2 full. Neither the box nor the plastic bag was closed, leaving the dinner roll dough exposed to air (not sealed). --An estimated 15-20 chicken thighs were observed to be stored in a plastic bag tied shut (sealed). However, the plastic bag containing the chicken thighs was not dated as to when it had been opened. -- An opened, undated box with an opened and unsealed interior plastic bag was observed to contain carrots. The interior plastic bag was almost full. Neither the box nor the plastic bag was closed, leaving the carrots exposed to air (not sealed). --15 individual portions of biscuit dough were stored in a plastic bag tied shut (not open to air). However, the plastic bag was not dated as to when the it had been opened. Observations made during the initial tour of the Dietary Department conducted on 2/18/24 at 10:01 AM also identified the following concerns in	F 812	The high protein items were discarded. Education was provided on 2/28/2024 by the facility administrator. Education will be completed by Dietary Manager or designee. Education includes properly labeling refrigerated and frozen food items Any dietary employee not completing required education by 03/01/24 and will not be allowed to work until education is completed. Any new dietary staff will not be allowed to work until education is received. All new dietary employees will be educated by Dietary Manager or designee during the orientation process 4. Dietary manager/designee to audit all food storage and proper storage techniques in the dietary department refrigerators/freezers and in the nourishment rooms on both nursing units 5 x weekly x 4 weeks then 3 times weekly x 4 weeks, then monthly x1 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed 6. Date of compliance: 03-27-2024	

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F 812	Continued From page 22	F 812		

the department's reach-in refrigerators:
--One full-sized steam table pan (4-inch deep) of a creamy-appearing coleslaw was observed to be covered loosely with foil. A cardboard box placed on top of the covered pan appeared to have torn the foil, exposing the coleslaw to air. The coleslaw was not labeled or dated to indicate when the coleslaw had been prepared or when it needed to be discarded.
--One - 1/8 steam table pan containing 8 breaded chicken patties and covered with foil was observed to be stored in the reach-in refrigerator. However, the container of the chicken patties was not labeled or dated as to when the patties had been prepared or when they needed to be discarded.
--One - 1 gallon plastic container of a pink-red colored fruit was observed to be stored in the reach-in refrigerator. The container was not labeled or dated.
--One - 1/4 steam table pan containing potato salad was observed to be covered with plastic wrap. The plastic wrap was not labeled or dated as to when it had been prepared or when it needed to be discarded.

On 2/18/24 at 3:25 PM, an interview and review of the concerns identified during the initial tour of the Department were conducted with the Assistant Dietary Manager. The Assistant Dietary Manager was shown the food items in both the walk-in freezer and reach-in refrigerators that had been identified with concerns. Upon inquiry, the Assistant Dietary Manager reported staff were expected to store food items in sealed containers labeled with the date the food item was opened.

An interview was conducted on 2/19/24 at 4:28 PM with the Regional Director of Culinary

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 23 Operations. During the interview, the findings of the initial tour of the kitchen were revisited. The Director reported stored food items were supposed to be checked twice daily to ensure each item was stored in a sealed package, labeled, and dated. Accompanied by the facility's Dietary Manager, an observation was made of the 100 Hall Nourishment Room on 2/21/24 at 1:28 PM. The observation revealed a 1-quart covered, plastic container (not a manufacturer's container) containing a thick, orange substance (possibly identified as a cheese sauce) was stored in the refrigerator. The container was dated 1/17/24 and labeled with a resident's name and room number. The date on the container indicated it had been stored in the refrigerator for 35 days. The Dietary Manager reported food brought in from the outside would typically be discarded after 7 days. He was observed as he discarded the container and its contents. Upon inquiry, the Dietary Manager reported all opened food items stored in either the kitchen or nourishment room refrigerators needed to be labeled and dated with both the date the item was opened and the date as to when it needed to be discarded.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		3/27/24

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F 867	Continued From page 24 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

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F 867	Continued From page 25 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility	F 867		

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F 867	Continued From page 26 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 staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee after each of the following surveys with citations that were recited on the current recertification / complaint survey of 2/21/24: 1) The annual recertification / complaint investigation survey of 1/10/22. This was evident for three recited deficiencies in the areas of Accuracy of Assessments (F641); Development and Implementation of Comprehensive Care Plans (F656); and Posted Nurse Staffing Information (F732). 2) The annual recertification /	F 867	F 867 QAPI QAPI/QAA Improvement Activities 1. The facility allegedly failed to establish to maintain implemented procedures and monitor previous interventions set in place by the Committee after each of the surveys. 2. Current residents are at risk. 3. The current Quality Assessment and Assurance Committee trained on the importance of development of systemic programs with sustained results to prevent further repeat deficient practices. As a team the committee will work on the	

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F 867	Continued From page 27 complaint investigation survey of 10/14/22. This was also evident for four recited deficiencies in the areas of Notification of Changes (F580); Development and Implementation of Comprehensive Care Plans (F656); Care Plan Timing and Revision (F657); and Food Safety Requirements (F812). The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F580: Based on record reviews, Nurse Practitioner (NP), resident and staff interviews the facility failed to notify the NP when a resident experienced pain and the acetaminophen order expired for 1 of 2 (Residents #43) residents sampled for change in condition. During the recertification / complaint investigation survey of 10/14/22, the facility was cited for failing to notify the physician or the nurse practitioner (NP) that an anti-seizure medication (lacosamide) was not available for administration for 1 of 1 resident reviewed for notification of change. The facility failed to notify the NP or the Physician that lacosamide was not available for administration on 4/30/2022, 5/1/2022, 5/4/2022, 5/8/2022, 5/24/2022, and 5/26/2022. The resident was hospitalized with cardiac issues on 5/11/2022 and with seizure activity on 5/27/2022. F641: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of dialysis and discharge location for 2 of 7	F 867	process of development of a Performance improvement plans and Ad Hoc teams' meetings development. The team is also learning how to monitor current Performance improvement plans for efficacy and the importance of modifications if or when systemic changes are no longer effective. Education will be completed by the Administrator and/ or designee by 03/15/24. Any newly hired department heads or members of the QAA/QAPI team will be educated by the Administrator/ Director of Nursing or designee during orientation week to ensure compliance in our facility. 4. Regional Director of Clinical Services to audit all Performance improvement plans related to the repeat tags weekly x 12 weeks then 3 times weekly. 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed 6. Date of compliance: 03-27-2024	

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residents reviewed for dialysis and discharge (Resident #79 and Resident #80).

During the recertification / complaint investigation survey of 1/10/22, the facility was cited for failing to accurately code the Minimum Data Set (MDS) assessments for 8 of 9 residents reviewed for MDS accuracy. Four residents were not coded for Level II Preadmission Screening and Resident Review (PASRR). Three residents were not accurately coded for discharge planning and one resident was not accurately coded for hospice services.

F656: Based on record reviews, observations, and staff interviews, the facility failed to update care plan interventions related to fall prevention (Resident #44) and behavioral interventions (Resident #54) for 2 of 28 residents reviewed for care plan accuracy.

During the recertification / complaint investigation survey of 1/10/22, the facility was cited for failing to develop and implement comprehensive care plans for 3 of 9 residents reviewed for care plans.

During the recertification / complaint investigation survey of 10/14/22, the facility was cited for failing to ensure a comprehensive care plan was accurate for 1 of 32 residents reviewed for comprehensive care plans.

F657: Based on staff interviews and facility and hospital record reviews, the facility failed to review and revise the comprehensive care plan related to a medication that was discontinued after the resident underwent bilateral above knee amputations (AKA). This occurred for 1 of 28 residents (Resident #79) whose care plans were

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reviewed.

During the recertification / complaint investigation survey of 10/14/22, the facility was cited for failing to review and revise comprehensive care plans for 3 of 10 residents reviewed for comprehensive care plan review and revision. The resident's care plan must be reviewed after each assessment time frame and revised based on changing goals, preferences and needs of the resident and in response to current interventions for the resident to meet resident care needs.

F732: Based on record reviews, observations, and staff interviews, the facility failed to accurately account for licensed staff on the posted daily nurse staffing sheet for 2 of 10 posted daily staffing sheets reviewed.

During the recertification / complaint investigation survey of 1/10/22, the facility was cited for failure to post accurate staffing information for licensed and unlicensed nursing staff for 6 of 6 posted nurse staffing sheets reviewed.

F812: Based on observations and interviews with the staff and Regional Director of Culinary Operations, the facility failed to seal, label/date, and discard expired food items stored in the Dietary Department's walk-in freezer, reach-in refrigerators, and 1 of 2 Nourishment Rooms observed (100 Hall Nourishment Room).

During the recertification / complaint investigation survey of 10/14/22, the facility was cited for failing to
label opened beverages, clean fluids off the bottoms of coolers, label and close frozen foods, air-dry steamer pans, and label and date resident

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food in 1 of 2 nutritional rooms observed. This had the potential to affect 86 of 87 residents in the facility.

On 2/21/24 at 4:31 PM and in the presence of the corporate Vice President of Operations, an interview was conducted with the facility's Administrator to discuss the facility's Quality Assurance and Performance Improvement (QAPI)/QAA Improvement Activities. The Administrator was relatively new to the facility with a start date of November 2023. She reported the QAA Committee would meet once a month with small ad hoc team meetings conducted as needed. The committee used trends identified from the morning clinical meeting as one resource to identify new opportunities for improvement of care areas within the facility. As a team, the committee would work on developing a Performance Improvement Plan (PIP), implementing the plan, and tracking its progress when such a care area was identified. When asked how repeat citations were handled, the Administrator reported a lead staff member would be responsible to review the facility's policy related to the citation and to conduct a root cause analysis. She stated the PIP developed would need to include a means to monitor the facility's progress and that this progress (or lack of) would be reported back to the team.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345419	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 3/1/2024

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F 732	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to accurately account for licensed staff on the posted daily nurse staffing sheet for 2 of 10 posted daily staffing sheets reviewed. The findings included: a. The schedule for 11/23/2022 was reviewed and 2 Registered Nurses (RNs) and 2 Licensed Practical Nurses (LPNs) were scheduled to work the evening shift (3:00 PM to 11:00 PM). Review of the assignment sheet for that date confirmed that 2 RNs and 2 LPNs were working assignments on 11/23/2022 for evening shift. The daily posted nurse staffing sheet indicated 1 RN provided 8 hours of care and 3 LPNs were provided 24 hours of care that shift. b. The schedule for 12/9/2023 was reviewed and 2 LPNs were scheduled to work the evening shift on that date. Review of the assignment sheet for that date confirmed that 2 RNs and 2 LPNs were working assignments on 12/9/2023 for evening shift. The daily posted nurse staffing sheet indicated 3 LPNs provided

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24 hours of care that shift.

The Scheduler was interviewed on 2/21/2024 at 1:20 PM and she reported she had been the scheduler for a few months. The Scheduler explained she adjusted the posted nurse staffing sheet each morning after she arrived for her shift. The Scheduler reported that she worked from about 8:00 AM until 5:00 PM, unless she was needed to take an assignment. The Scheduler revealed she was not aware the daily posted nurse staffing sheet should be updated as changes occurred with the schedule, and she was not updating the posted nurse staffing sheet until the following day and on Monday following the weekend. The Scheduler described how the nurses would change the schedule and assignment sheets and she used those forms to adjust the posted daily nurse staffing sheets. The Scheduler reviewed the schedule, assignments sheets, and the posted daily nurse staffing sheet and clarified she was not in the position 11/23/2022, but she had corrected the 12/9/2023 daily nurse staffing sheet and she must have miscounted the nurses.

The Administrator was interviewed on 2/21/2024 at 2:36 PM and she reported the daily posted nurse staffing sheet should be completed with each change in the schedule and she expected the posted staffing sheets to accurately reflect the staffing in the facility.