STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING _____ B. WING _____	R-C 04/13/2024

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LINCOLNTON REHABILITATION CENTER	1410 EAST GASTON STREET LINCOLNTON, NC 28092

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 04/08/24 through 04/11/24. Additional information on 04/13/24. Therefore, the exit date was changed to 04/13/24. Tags F585, F600, and F880 were corrected as of 4/13/24. Repeat tags were cited. New tags were also cited as a result of the recertification and complaint investigation survey conducted at the same time as the revisit. The facility is still out of compliance. Event ID# 4D8N12.	{F 000}		
{F 550} SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	{F 550}		

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

Electronically Signed

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{F 550}	Continued From page 1	{F 550}		

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on record review and resident and staff interviews the facility failed to treat a resident in a dignified manner by not providing incontinent care when requested for 1 of 3 residents reviewed for dignity (Resident #80). Resident #80 stated it made her upset to sit in a soiled brief and made her "feel like a third-class citizen" and she paid her bill like everyone else.

The Findings included:

Resident #80 was admitted to the facility on 07/05/22 with diagnoses of diabetes mellitus and hypertension.

The quarterly Minimum Data Set (MDS) assessment dated 01/31/24 revealed that Resident #80 was cognitively intact, required extensive assistance with toileting, and was always incontinent of bladder and bowel. No refusal of care was noted during the assessment

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reference period.

An observation conducted on 04/08/24 at 10:30 AM revealed Resident #80 yelled into the hall and notified NA #1 she had a soiled brief. NA #1 was observed entering the room.

Resident #80 was interviewed in her room on 04/08/24 at 10:45 AM. During the interview she stated she had been sitting in a soiled brief since 9:30 AM and knew this because she had been looking at the clock on the wall. She stated she had told NA #1 that she was sitting in a soiled brief and NA #1 acknowledged her and left the room. She stated she was still sitting in bowel movement and needed to be changed. During the interview Resident #80 stated, "It makes me feel like a third-class citizen, I pay my bill like everyone else". She went on to say it made her upset having to sit in a soiled brief filled with bowel movement.

On 04/08/24 at 10:50 AM the surveyor told Unit Manager #1 that Resident #80 was sitting in a soiled brief. An observation was conducted at 10:57 AM of Unit Manager #1 and Assistant Director of Nursing (ADON) providing incontinence care to Resident #80. Resident #80's top sheet, bed pad and fitted sheet were observed to be soiled with feces. Resident #80 was observed to have feces extending down onto the thighs and covering her urinary catheter. A complete bed change was observed after the nurses provided incontinence care to Resident #80.

On 04/08/24 at 9:49 AM an interview was conducted with Nurse Aide (NA)#1. During the interview she stated Resident #80 had told her

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{F 550}	Continued From page 3	{F 550}		

she needed to be changed however she had already started running water down the hall for another resident's bed bath. The interview revealed she had planned on completing the bed bath prior to changing Resident #80. NA #1 stated she did not know Resident #80 had been sitting in a soiled brief since 9:30 AM.

On 04/11/24 at 12:21 PM an interview was conducted with Unit Manager #1. Unit Manager #1 stated once you see a call light on you should provide the care or let another staff member know so the care was provided. Unit Manager #1 stated she had to complete an entire bed change for Resident #80 due to incontinence and that was not common in the facility. She stated typically the Nurse Aides were good about providing care. She stated no resident should feel upset, like a third-class citizen or have to sit in bowel movement.

On 04/11/23 at 3:24 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she did assist Resident #80 with incontinence care and had to complete a bed change due to the incontinence. The ADON stated Nurse Aides should be providing care upon resident request. The interview revealed no resident should feel upset or have to ask twice to be changed while sitting in a brief with bowel movement.

On 04/09/24 at 8:55 AM an interview was conducted with the Director of Nursing (DON). She stated NA #1 should have provided care when the resident asked. The DON stated Resident #80 should never feel like a third-class citizen or upset because staff would not change her brief.

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{F 580} SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, 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).	{F 580}		

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{F 580}	Continued From page 5 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, resident, Infusion Center Nurse, Nurse Practitioner, Medical Director, and staff interviews the facility failed to notify the physician of a facility-initiated discharge for 1 of 3 residents (Resident #1) reviewed for notification. On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Findings included: Resident #1 was admitted into the facility on 08/26/23 with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness. Review of Resident #1's admission Minimum Data Set (MDS) dated 8/28/23 revealed the resident was alert and oriented. The MDS further revealed Resident #1 had a tracheostomy. Interview conducted with the Respiratory Therapist (RT) revealed on 04/11/24 at 11:05 AM revealed Resident #1 was assessed on 08/27/23. She indicated he had a cuffed tracheostomy and	{F 580}		

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{F 580}	Continued From page 6	{F 580}		

recommended it be changed to an uncuffed tracheostomy due to nursing staff not being familiar with caring for a resident with a cuffed tracheostomy with a different cannula. The RT further revealed he was unable to change the tracheostomy due to the facility not having the supplies needed. The RT indicated Resident #1 was not in distress and could have waited to have his trach change when supplies were obtained.

Review of progress note completed by Nurse #1 dated 8/28/23 revealed Resident #1 was sent to the Emergency Room (ED).

A phone interview conducted with Resident #1 on 04/11/24 at 6:10 PM revealed on 08/28/23 he was advised and aware he was going to an infusion appointment. Resident #1 further revealed while he was waiting on the transporter at the front of the facility a staff member (unable to recall specific staff member) dropped a bag in his lap with all his belongings and reported he was going to the Emergency Department (ED) after his appointment with no other information. Resident #1 further revealed he contacted a family member to pick him up and take him home from his infusion appointment because he had nowhere else to go.

A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the Infusion Center received a message that Resident #1 needed to be sent to the ED after his infusion appointment. She indicated she was contacted the Admissions Director because Resident #1 did not have any orders and the Infusion Center did not feel comfortable sending the resident to the ED. It was reported to the Infusion Center Nurse #1 from the facility

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{F 580}	Continued From page 7	{F 580}		

Admissions Director the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement. It was indicated Infusion Center Nurse #1 indicated Resident #1 had a bag packed with his belongings.

A phone interview with the prior Admissions Director on 04/09/24 at 6:00 PM revealed she recalled having a conversation with the infusion care center staff and it was an "ugly conversation" but could not recall anything that was discussed. It was further revealed the Admissions Director could not recall any part of Resident #1 being discharged on 08/28/23.

Interview conducted with the Director of Nursing (DON) on 04/10/24 at 3:35 PM revealed the Respiratory Therapist (RT) assessed Resident #1 on 08/27/24 and recommended Resident #1 have his tracheostomy changed from a cuffed to an uncuffed tracheostomy. The DON further revealed Resident #1 had an appointment to the infusion center on 08/28/24 and she decided for the Resident #1 to have his tracheostomy changed at the Emergency Department (ED) afterwards since the facility did not have the supplies to do so at the facility. The DON stated she could not recall why she did not notify the Nurse Practitioner (NP) or the Medical Director (MD) to obtain orders for ED transfer and tracheostomy change. The DON stated she had planned for Resident #1 to come back to the facility in the evening of 08/28/23 and was not aware the resident had taken his belongings with him. The DON stated she was not aware the facility Admissions Director had reported to the infusion center that Resident #1could not return to the facility.

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{F 580}	Continued From page 8 Interview with the Nurse Practitioner (NP) on 04/11/24 at 10:35 AM revealed she had not assessed Resident #1 during his stay in the facility and did not recall any conversation with the facility that Resident #1 was being sent out to have their trach changed. The NP indicated she could not recall who notified her that Resident #1 had left against medical advice (AMA) but someone from the facility had reported it to her. Interview with the Medical Director (MD) on 04/10/24 at 4:55 PM revealed he had not assessed Resident #1 during his stay in the facility. The MD further revealed he was not notified that the resident had been sent out to the emergency room to have his tracheostomy changed. The MD further revealed he was unable to recall who notified the MD Resident #1 had left AMA and was not returning to the facility on 08/30/23.	{F 580}		
{F 624} SS=G	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review and resident, Resident Representative,staff, Infusion Center staff, Nurse Practitioner, and Medical Director interviews the facility failed to provide a safe and orderly	{F 624}		

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discharge for 1 of 3 residents (Resident #1). On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Resident #1 was not provided with discharge paperwork or discharge instructions and did not understand what was happening. The discharge location was not verified, home health services were not ordered at the time of discharge, and the resident was not followed up with to ensure his needs were met. This resulted in Resident #1 feeling like he was being thrown out, abandoned, and was mad.

Findings included:

Review of the hospital discharge summary dated 08/26/23 revealed Resident #1 was admitted to the hospital on 08/07/23 due to Resident #1 having generalized body weakness and the family had also taken him to the hospital for placement. Resident #1 was admitted with throat cancer and a tracheostomy and was diagnosed with adult failure to thrive and increased general weakness. Resident #1 was discharged from the hospital on 08/26/23 and referred to the facility for skilled services.

Resident #1 was admitted to the facility on 08/26/23 with diagnoses which included cancer, malnutrition, respiratory failure, and muscle weakness.

Review of Resident #1's admission Minimum Data Set (MDS) dated 8/28/23 revealed the resident was alert and oriented. The MDS further revealed Resident #1 had a tracheostomy.

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A phone interview conducted with the Respiratory Therapist (RT) revealed on 04/11/24 at 11:05 AM revealed Resident #1 was assessed on 08/27/23 and revealed Resident #1 had a cuffed tracheostomy and recommended it be changed to an uncuffed tracheostomy because uncuffed tubes allow airway clearance but provide no protection from aspiration and cuffed tracheostomy tubes allow secretion clearance and offer some protection from aspiration. The RT revealed nursing staff was not familiar with caring for a resident with a cuff tracheostomy. The RT further revealed he was unable to change the tracheostomy due to the facility not having the supplies needed. The RT indicated he did not write physician orders and that the Nurse Practitioner (NP) or Medical Director (MD) would have to be notified to obtain the order to change the tracheostomy type. The RT indicated Resident #1 was not in distress and could have waited to have his trach changed when supplies were obtained but the Director of Nursing (DON) made the RT aware the decision was made to send Resident #1 to the ED after the infusion appointment on 08/28/23.

Review of a progress note completed by Nurse #1 dated 8/28/23 revealed Resident #1 was at the Emergency Room (ED).

A phone interview conducted with Resident #1 on 04/11/24 at 6:10 PM revealed on 08/28/23 he was advised and aware he was going to an infusion appointment. Resident #1 further revealed while he was waiting on the transporter at the front of the facility and a staff member (unable to recall specific staff member) dropped a bag in his lap with all his belongings and reported he was going to the Emergency Department (ED) after his

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appointment with no other information. Resident #1 indicated once he arrived at the infusion appointment with his bag the infusion staff nurse revealed to Resident #1 they had received a message from the facility to send the resident to the ED after his appointment. The infusion staff nurse explained to him that they could not send him to the ED because Resident #1 did not have an order. Resident #1 stated at this time he felt he was being discharged without knowledge and he felt like he was being thrown out, abandoned and was mad. Resident #1 revealed the Infusion Nurse contacted the facility Admissions Director and was told Resident #1 could not return to the facility. Resident #1 further revealed he contacted a family member to pick him up and take him home from his infusion appointment because he had nowhere else to go. Resident #1 indicated the facility had his personal phone number and did not attempt to contact his Resident Representative (RR) until 08/30/23 after Resident #1's primary care office reached out to the facility. Resident #1 stated the facility did not provide any discharge information, discharge services, medicines, or supplies once he left the facility. Resident #1 indicated he was able to perform self trach care and had medications and tube feeding formula when he returned home.

A phone interview conducted with Infusion Center Nurse #1 on 04/10/24 at 1:20 PM revealed on 08/28/23 the infusion center received a message that Resident #1 needed to be sent to the ED after his infusion appointment. It was further revealed Infusion Center Nurse #1 contacted the Admissions Director because Resident #1 did not have any orders and the infusion center did not feel comfortable sending the resident to the ED. It was reported by the facility Admission Director

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that the facility was unable to care for Resident #1 and the resident needed to go to the ED to help find placement. It was observed by Infusion Center Nurse #1 that Resident #1 had a bag packed with his belongings and Resident #1 was observed to be frustrated and was confused on being discharged without notice. Infusion Center Nurse #1 stated Resident #1 contacted his RR to pick him up and Infusion Center Nurse #2 retrieved a small bag of supplies to send home with him.

A phone interview with Infusion Center Nurse #2 on 04/10/24 at 9:45 AM revealed Resident #1 arrived at the infusion center upset, with his belongings with him, and reported he believed was being discharged without notice. It was further revealed Infusion Center Nurse #1 contacted the facility and it was reported Resident #1 could not return to the facility and had to be sent to the ED after his appointment. Infusion Center Nurse #2 indicated the infusion center staff did not feel comfortable sending the resident to the ED without orders and the resident did not observe to be in medical distress. Infusion Center Nurse #2 stated Resident #1 called his RR to come get him from the infusion center. Infusion Center Nurse #2 stated she felt like the facility had "dumped" Resident #1 and she was very upset for Resident #1.

A phone interview with the prior Admissions Director on 04/09/24 at 6:00 PM revealed she recalled having a conversation with the infusion care center staff and it was an "ugly conversation" but could not recall anything that was discussed. It was further revealed the Admissions Director could not recall any part of what had occurred with Resident #1 from 08/28/23 through 08/31/23.

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A phone interview conducted with Resident #1's Resident Representative (RR) on 04/11/24 at 10:15 AM revealed Resident #1 was admitted to the facility after his hospital stay due to needing more care than the family could assist with. It was further revealed on 08/28/23 the RR was not notified prior that Resident #1 was being sent out for an infusion appointment but was contacted by the facility Admissions Director that Resident #1 was on his way to an infusion appointment and would have to be sent to the ED because the facility could not care for the resident's tracheostomy. The RR stated the facility Admissions Director revealed Resident #1 could not return to the facility. The RR revealed she arrived at Resident #1's infusion appointment and the Infusion Center Nurse #1 had contacted the facility as well and had reiterated the same information that the resident could not return to the facility. It was further revealed Resident #1 had a bag with his belongings and was very mad about being discharged without notice. The RR further revealed she took Resident #1 home because she felt like the facility had dumped him and she had no other choice.

An interview conducted with the Assistant Director of Nursing (ADON) on 04/10/24 at 3:05 PM revealed she assisted in getting Resident #1 ready for his appointment on 8/28/23 and had given him a folder that had information for his appointment. The ADON indicated she did not recall the resident having a bag packed or having any concerns. The ADON stated Resident #1 was admitted with a cuffed trach that the facility did not have supplies for, and staff did not have the training to care for. The ADON stated she believed Resident #1 was admitted by accident

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because the facility normally would not accept a resident with a cuffed trach. The ADON indicated she had thought Resident #1 had been sent to the ED to have Resident #1's trach changed and was not aware until Resident #1's primary care office reached out on 08/30/23 that the resident was at home. The ADON revealed then she reached out to Resident #1's RR and it was revealed Resident #1 did not have the preferred liquid form of metformin and insulin. The ADON indicated she contacted the on-call provider on 08/30/24 and obtained orders for Resident #1's medications. The ADON was not aware that no staff from the facility had reached out to Resident #1 and was not sure why he did not return to the facility.

An interview conducted with the facility Social Worker (SW) on 04/11/24 at 9:25 AM revealed he did not become involved with Resident #1 until 08/30/23 when Resident #1's primary care office contacted the facility to let them know Resident #1 was at home. The SW further revealed at that time he completed an Adult Protective Services (APS) report to make sure Resident #1 was safe and completed referrals for in home health but did not follow up to see if Resident #1 had been accepted for services.

An interview conducted with the Director of Nursing (DON) on 04/10/24 at 3:35 PM revealed the Respiratory Therapist (RT) assessed Resident #1 on 08/27/24 and recommended Resident #1 have his tracheostomy changed from a cuffed to an uncuffed trach. The DON further revealed Resident #1 had an appointment at the infusion center on 08/28/23 and she decided for the Resident #1 to have his tracheostomy changed at the Emergency Department (ED)

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afterwards since the facility did not have the supplies to do so at the facility. The DON stated she could not recall why she did not notify the Nurse Practitioner (NP) or the Medical Director (MD) to obtain orders to do so. The DON stated she had planned for Resident #1 to come back to the facility in the evening of 08/28/23 and was not aware the resident had taken his belongings with him. The DON revealed nursing staff failed to follow up with the whereabouts of Resident #1 during second and third shift on 08/28/23 with the thought Resident #1 was still at the hospital, and no one realized he wasn't there on 8/29/23 either. The DON indicated on 08/30/23 it was found out that Resident #1 went home from his appointment on 08/28/23 when the facility received a phone call from Resident #1's primary care office. The DON indicated an APS report was completed, referrals from in home health were completed, and orders were obtained for Resident #1 to receive medicine. The DON stated she was not aware the prior Admissions Director told Resident #1 that he could not return to the facility.

An interview with the Nurse Practitioner (NP) on 04/11/24 at 10:35 AM revealed she had not assessed Resident #1 during his stay in the facility and did not recall any conversation with the facility that Resident #1 was being sent out to have their trach changed. The NP indicated she could not recall who and on what date, but she was notified Resident #1 had left against medical advice (AMA).

A phone Interview with the Medical Director (MD) on 04/10/24 at 4:55 PM revealed he had not assessed Resident #1 during his stay in the facility. The MD further revealed he could not

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{F 624}	Continued From page 16 recall who had reported that Resident #1 had left against medical advice (AMA) on 08/30/23. Interview with the Administrator on 04/11/23 at 4:00 PM revealed he was made aware by the DON on 8/28/23 that Resident #1 was being sent out to the infusion center on 8/28/23 and then heading to ED for trach change. The Administrator further revealed it was RT's recommendations and was not aware the RT could not write orders. The Administrator revealed he was unsure if Resident #1 had left with his belongings and was not aware of who was responsible for following up with Resident #1's whereabouts after he did not return from his appointment.	{F 624}		
{F 867} SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	{F 867}		

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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.

§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

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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 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

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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 reviews and resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification survey of 2/15/24. This failure was for four deficiencies originally cited in the areas of dignity and respect, notification of change, safe and orderly discharge and subsequently recited during the survey of 04/13/24. The facility's continued failure during two surveys of record showed a pattern of the facility's inability to sustain an effective QAA program.

The findings included:

This tag was cross referenced to:

F 550: Based on record review and resident and staff interviews the facility failed to treat a resident in a dignified manner by not providing incontinent care when requested for 1 of 3 residents reviewed for dignity (Resident #80). Resident #80 stated it made her upset to sit in a soiled brief and

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made her "feel like a third-class citizen" and she paid her bill like everyone else.

During the complaint investigation survey of 02/15/24 the facility failed to treat a resident in a dignified manner when a Nurse Aide (NA) was rough and pushing on her during a transfer. This made the resident feel "unsafe" during the transfer and she stated this was a dignity issue. Additionally, the facility failed to assist a resident at eye level during a meal reviewed for dignity.

An interview conducted with the Administrator who also headed QAA committee and Director of Nursing (DON) on 04/13/24 at 11:00 AM revealed the facility had discussed frequently at quarterly QAA meetings customer services and respect towards residents. The DON further revealed she did not know why these incidents had occurred.

F 580: Based on record review, resident, Infusion Center Nurse, Nurse Practitioner, Medical Director, and staff interviews the facility failed to notify the physician of a facility-initiated discharge for 1 of 3 residents (Resident #1) reviewed for notification. On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment.

During the complaint investigation survey of 02/15/24 the facility failed to notify the Physician of a resident's wound upon admission and failed to notify the Physician when the resident's wound had started to deteriorate.

An interview conducted with the Administrator who also headed QAA committee and Director of

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Nursing (DON) on 04/13/24 at 11:00 AM revealed the facility had discussed frequently at quarterly QAA meetings notification. The DON further revealed nursing staff had failed to make appropriate notification and would continue to educate and put rules in place for proper notification.

F 624: Based on record review and resident, Resident Representative,staff, Infusion Center staff, Nurse Practitioner, and Medical Director interviews the facility failed to provide a safe and orderly discharge for 1 of 3 residents (Resident #1). On 8/28/23 Resident #1 had a scheduled medical appointment and prior to the appointment the resident's belongings were packed by staff and were sent with him to the appointment. Resident #1 was not provided with discharge paperwork or discharge instructions and did not understand what was happening. The discharge location was not verified, home health services were not ordered at the time of discharge, and the resident was not followed up with to ensure his needs were met. This resulted in Resident #1 feeling like he was being thrown out, abandoned, and was mad.

During the complaint investigation survey of 02/15/24 the facility failed to meet the resident's care needs upon discharge by not communicating the physician ordered wound care treatments and ensuring the needed medical equipment was delivered for a resident reviewed for a safe and orderly discharge.

An interview conducted with the Administrator who also headed QAA committee and Director of Nursing (DON) on 04/13/24 at 11:00 AM revealed the facility had discussed frequently at quarterly

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{F 867}	Continued From page 22 QAA meetings about safe and orderly discharges. The DON further revealed she could not recall why discharges had been an issue, but steps would be put into place to guarantee residents would not be discharged unsafe in the future.	{F 867}		