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F 000	INITIAL COMMENTS A complaint investigation was conducted from 4/23/24 to 4/25/24. Event ID# IS3M11. The following intakes were investigated: NC215495 and NC00216056. One of the six complaint allegations resulted in deficiency.	F 000		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, family, and physician the facility failed to obtain an x-ray as ordered when a resident fell. This was for one (Resident # 1) of three residents reviewed for completion of diagnostic tests. The findings included: Resident # 1 was admitted to the facility on 2/21/24 with diagnoses of stroke, muscle	F 776	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2024

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F 776	Continued From page 1	F 776		

weakness, dysphagia, hypertension, chronic kidney disease, chronic obstructive pulmonary disease, hyperlipidemia, and hearing loss.

Resident # 1's admission Minimum Data Set assessment, dated 2/28/24, coded the resident as severely cognitively impaired.

On 3/11/24 at 12:33 AM Nurse # 1 documented the following information in a nursing entry. Resident # 1 had an unwitnessed fall. The physician and the responsible party had been notified.

Nurse # 1 was interviewed on 4/24/24 at 8:45 AM and reported the following. The NA (Nurse Aide) had alerted her that Resident # 1 was on the floor on 3/11/24. She had assessed the resident from head to toe. She did not appear to be in pain and had no obvious physical injuries. They checked on her frequently throughout the rest of the night, and the resident appeared to be fine.

NA # 1 was interviewed on 4/24/24 at 2:14 PM and reported the following. She had been assigned to care for Resident # 1 during the night of the fall. She had been checking on Resident # 1 prior to the fall. The resident had been in bed, The resident's room had been very close to the nursing station. She (NA #1) was at the nursing station when she heard a noise. She entered the room and found Resident # 1 on the floor. She (NA # 1) alerted the nurse who checked the resident. The resident appeared to be okay when the nurse checked her. After the fall, she (NA # 1) checked on Resident # 1 frequently throughout the night and she appeared to be fine.

On 3/11/24 the NP (Nurse Practitioner) noted the

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following. She was seeing Resident # 1 who had experienced a fall. Initially the resident had not complained of pain after the fall, but at the time of the NP's assessment, she was complaining of neck pain and limited range of motion. The resident had no further concerns. The NP noted she would order scheduled Acetaminophen and an x-ray.

On 3/11/24 an order was entered into the record for a cervical and lumbar spine x-ray.

According to the record, Resident # 1 was discharged from the skilled nursing facility on the following day (3/12/24) and admitted to the assisted living section of the facility. There was no record of the spine x-ray being completed prior to the resident's transfer to assisted living.

A review of medical records revealed on 3/12/24, Resident # 1 had a new record which was not part of her previous skilled nursing record. Therefore, the 3/11/24 x-ray order did not show up in the assisted living record.

Interview with Resident # 1's responsible party on 4/23/24 at 12:13 PM revealed that she had visited on 3/14/24. Resident # 1 was uncomfortable in her neck, and she learned the x-ray had not been completed on 3/11/24. This was mentioned to the NP, who ordered the x-ray again.

On 3/14/24 the NP noted the following information in Resident # 1's assisted living record. She saw Resident # 1 again. The resident was complaining of neck pain and was unable to rotate her neck without grimacing. The NP noted she would reorder the x-ray.

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On 3/14/24 an order was entered into Resident # 1's assisted living record for an x-ray of the neck and lumbar spine.

Review of X-ray results revealed the x-ray was completed on 3/14/24 and showed the following. The resident had subluxation (incomplete of partial dislocation) of the Cervical 3 (C3) and C4. There was also narrowing of the C4 to C5. There was moderate degenerative changes of cervical spine. There was a "reversal of the cervical lordosis consistent with the presence of pain and/or muscle spasm." Clinical correlation was recommended.

On 3/14/24 Resident # 1 was transferred to the hospital ED (Emergency Department) for further evaluation. Review of 3/14/24 ED records revealed the following. Under the physician's assessment of the neck, the physician noted, "no cervical vertebral body tenderness. No step-off injury. No warmth erythema." A CT (computerized tomography) was completed. It revealed a Type II dens fracture without displacement, osteopenia, and degenerative changes of the spine." (The dens, which is also referred to as a the odontoid, refers to a bony element from the second cervical vertebrae). A discussion was held with the family, and they did not wish for the resident to have any type of surgery. After consulting with neurosurgery, the resident was placed in a cervical collar and transferred back to the facility's assisted living for care.

On 3/18/24 the NP noted the following in the resident's assisted living record. She had seen the resident who denied neck pain at the time.

Resident # 1's physician was interviewed on

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4/24/24 at 9:00 AM and reported the resident had not experienced any serious issues from the delay in the x-ray being performed.

The Director of Nursing (DON) was interviewed on 4/23/24 at 3:00 PM and reported the following. The facility had identified the x-ray had not been done as completed and investigated the cause. They found that the NP had entered the order into the computer on 3/11/24. Nurse # 2 had then gone into the computer and "confirmed" (acknowledged) the order. Nurse # 2 thought that the NP had called the mobile x-ray company and had not been aware it was his responsibility to do so when he confirmed the order. Then on 3/12/24 the resident was transferred to a different section of the facility, and the uncompleted order no longer appeared on the resident's new record.

On 4/23/24 the DON presented the facility had completed a corrective action plan.

The corrective action plan included the following:

Corrective action for resident involved
It was noted on 3/11/2024, Resident #1 experienced an unwitnessed fall. NP was notified and ordered a lumbar and spine x-ray. Nurse confirmed order in [electronic medical record], but did not contact x-ray vendor to come to facility to complete x-ray. On 3/12/2024, Resident # 1 transferred from skilled to ALF (assisted living facility). There was a delay in orders for obtaining an x-ray for Resident # 1. On 3/14/2024, it was noted by NP that initial x-ray had not been completed and 2nd x-ray was ordered and completed. Resident # 1 was sent to ER for further evaluation on 3/14/2024 following results of facility x-ray. X-ray results at the hospital

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indicated a cervical type ll dens fracture without displacement. Family decided against surgical intervention and resident returned to facility on 3/15/2024. Resident # 1 returned to facility with [cervical] collar for conservative treatment.

Corrective action for potentially impacted residents

On 3/ 15 /24 the Director of Nurses reviewed all x-ray orders received for the last 7 days to identify if x-ray orders had been obtained timely and the results reported to the physician/RP.
Results: No other residents affected

Systemic Changes

On 3/15/2024 the DON/ADON/SDC (Director of Nursing/ Assistant Director of Nursing/ Staff Development Coordinator) met and decided to make it a part of our quality assurance program and developed a plan of correction. On 3/15/2024 SDC began in-service of all licensed nursing staff (including agency) on the x-ray order process. This training included:
" The x-ray order process to include contacting the x-ray company and follow through to assure the ordered x-ray is completed.
" Post fall review and post fall care and documentation.
" Notification of Dr/RP if an ordered test is not completed.
The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 3/19/2024 will not be allowed to work until the training is completed.

Quality Assurance
The DON/ADON will monitor compliance with the

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F 776	Continued From page 6 x-ray or der process weekly for 2 weeks beginning 3/22/2024 and monthly for 3 months or until resolved for timely follow through in completing physician orders. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM (Health Information Manager), and the Dietary Manager. Completion date: 3/19/24 The following was done to validate the facility's corrective action plan. On 4/23/24 beginning at 9:20 AM a tour of the facility was completed. Residents were interviewed and there were no reports of any facility failure to obtain diagnostic studies. Additionally sampled residents, who had x-rays ordered, were reviewed. The x-rays had been completed as ordered for these additionally sampled residents. The facility presented documentation of inservices and audits completed per their corrective action plan. Nurses were interviewed during the survey and reported they had attended the inservice training. On 4/25/24 the facility's plan of correction date of 3/19/24 was validated.	F 776		

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F 842	Continued From page 7	F 842		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		5/10/24

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F 842	Continued From page 8 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews for two of ten sampled residents (Residents # 2 and # 6) the facility failed to ensure medical records were complete and accurate regarding medication administration (Resident # 2) and pressure sore assessment and care (Resident # 6). The findings included: 1. A review of Resident # 2's MARs (Medication	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	

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F 842	Continued From page 9 Administration Records) from February through April 2024 revealed the following information. The MAR included a chart code. A check mark meant a medication was administered. By each dose of Resident # 2's Carvedilol there was a space for the nurse to enter Resident # 2's pulse and BP. The directions to hold the medication for a systolic BP less than 100 and a pulse less than 60 appeared on the MARs. During an interview with the DON (Director of Nursing) on 4/24/24 at 3:00 PM the DON reported that each nurse, who administers medications is assigned electronic initials which are then entered on the electronic MAR when they administer medications. (The initials at times include numbers along with a nurse's initials). On 2/16/24 at 9:00 AM, Nurse # 3's assigned electronic initials appeared with a check mark. The resident's blood pressure was 110/66 and her pulse was 56. Nurse # 3 was interviewed on 4/24/24 at 1:45 PM and reported the following. She would not have administered the medication if the resident's pulse was in the 50's. At times the NAs (Nurse Aides) will tell them of a pulse, and she does not think the pulse is accurate. She will go back and check it. Therefore, she would have gone back to check the pulse on 2/16/24, found it to be above 60, administered the medication, but not noted what the repeat pulse was in the record. On 2/16/24 at 9 PM Nurse # 4's assigned electronic initials appeared with a check mark. The resident's BP was 131/65 and her pulse was 58.	F 842	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 The facility failed to ensure medical records were complete and accurate regarding medication administration (Resident # 2) and pressure sore assessment and care (Resident # 6). 1. Corrective action for resident(s) affected by the alleged deficient practice: On 04/ 24 /2024 the assigned nurse obtained ordered vital signs for the administration of Carvedilol for resident # 2 and administered the medication per ordered parameters. The medication was documented as administered following the ordered parameters for the medication. On 04/24 /2024 the wound nurse assessed resident # 6 for the presence of pressure ulcers with ordered treatments and documented assessment of any identified areas with no observed changes to areas of ordered treatment and provided and documented the treatment as ordered. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents are potentially at risk for the deficient practices. On 5/ 08 /2024 the Director of Nurses and Assistant Director of Nurses audited all medication orders with ordered parameters for the last 7 days for all current residents.	

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F 842	Continued From page 10 On 4/24/24 at 3:52 PM Nurse # 4 was interviewed and reported the following information. She would not have administered the Carvedilol if the resident's pulse had been 58. That was the whole reason she took vitals. She did not know why the check mark indicated the medication was administered. On 2/21/24 at 9:00 AM Nurse # 4's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 142/71 and her pulse was 57. Nurse # 4 was interviewed on 4/24/24 at 3:26 PM and reported she was familiar with Resident # 2 and routinely cared for the resident. She (Nurse # 4) was well aware of the parameters and had held the medication on other occasions. It did not make sense to her why the check mark appeared on 2/21/24 because she would not have given it. She felt there had been some error in the computer check but did not know why. On 2/29/24 at 9:00 PM Nurse # 6's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 148/59 and her pulse was 59. Nurse # 6 could not be reached for interview during the survey. On 3/1/24 at 9:00 PM Nurse # 7's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 148/58 and pulse 53. Nurse # 7 could not be reached during the survey. On 3/7/24 at 5 PM Nurse # 8's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 146/74 and her pulse was 58. Nurse # 8 was interviewed on	F 842	The audit consisted of a review of the electronic medication administration record for compliance with the administration of the medication following the ordered parameters. The results included __22___ of ___27_____ medication orders with parameters were administered following facility policy. As of 5/ 09 /24 all resident's medication orders with parameters were in compliance with facility policy for documentation of medications following ordered parameters. On 5/ 08 /2024 the Director of Nurses, Wound Nurse, Assistant Director of Nurses, initiated an audit of 100% of resident pressure ulcer treatments for the last 7 days for all current residents. The audit consisted of a review of the electronic treatment administration records for the presence of wound treatment orders that contained the site of treatment administration and that the order had been entered correctly. The results included that _19__ of __20__ ordered pressure ulcer treatments had site location included and were entered as ordered. On 5/ 08 /2024 the Director of Nurses/Assistant Director of Nurses and Wound Nurse audited all current residents with pressure ulcers for the presence of a wound assessment completed in the last 7 days. The results included: 17 of 20 residents with pressure ulcer orders has current wound assessments completed within the last 7 days. On 5/ 09 /2024 the Director of Nurses/Assistant Director of Nurses	

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F 842	Continued From page 11 4/24/24 at 3:50 PM and reported the following. She would not have given the Carvedilol if the resident's pulse was 58. She was aware of the parameters and it would have been held. She did not know why the check mark was on the MAR. She was aware that at times the computer with the electronic MAR would glitch at times. At times it would also lock her out and she would have to call IT (information technology) to gain access back into the system. On 3/24/24 at 5 PM Nurse #9's assigned electronic initials appeared by a check mark by Carvedilol. The resident's BP was 126/70 and the pulse was 56. Nurse # 9 was interviewed on 4/24/24 at 3:45 PM and reported the following. She would not have given the medication with a pulse of 56. She did not know why the check mark was by the initials. The nurse further reported that at times the computer with the electronic MAR would at times glitch and freeze up. She would have to wait for about five minutes before it would allow her back in, and she speculated that might have contributed to the check mark being entered inaccurately. On 3/26/24 and 3/30/24 the evening doses were blank on the MAR. According to the MAR, nurses were to code if a resident had refused the mediation or was away from the facility. Neither of these were denoted. During an interview with the Director of Nursing (DON) on 4/25/24 at 11:22 AM, the DON reported nurses should be documenting at each administration according to the chart code/legend. There should not be blanks. On 4/3/24 at 5 PM the DON's assigned electronic initials appeared by a check mark by the	F 842	audited the last 7 days of pressure ulcer treatments to identify any treatments that were not documented as completed. The results included ___15__of __20____residents were in compliance with documentation of completed pressure ulcer treatments. On 5/ 09 /2024, the Director of Nurses notified the Medical Director and Responsible Parties of the treatments that were not documented as administered and the steps that will be taken to prevent future occurrences. As of 5/ 09 /2024 all residents with pressure ulcers had a completed wound assessment within the last 7 days, treatment orders were in compliance to include the site of administration of the treatment, that the treatment order had been entered correctly on the electronic treatment record and had been administered as ordered. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/06/2024 the Director of Nurses, Assistant Director of Nurses and Staff Development Coordinator began in-service education to all full time, part time, as needed licensed nurses and agency nurses on: • The importance of ensuring that treatments are administered as ordered by the physician and contain the site of administration for the ordered treatment. • That all pressure ulcers are assessed timely and that the assessment is	

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F 842	Continued From page 12	F 842		

Carvedilol. The resident's BP was 96/60 and her pulse was 57. During an interview with the DON on 4/24/24 at 3:00 PM, the DON stated she had not even realized she had even been assigned a set of electronic initials for the MAR until the surveyor requested that she try to identify which nurses' initials corresponded to which nurse. She had called the IT department and they told her that the assigned electronic initials on 4/3/24 were hers. She reported she had not been at the facility very long and had never administered medications since being employed at the facility. It did not make sense that her initials were on the MAR and it was an error of some sort in the electronic record, but she did not know how it had occurred.

On 4/14/24 at 9 AM Nurse # 3's assigned electronic initials appeared by a check mark by the Carvedilol. The resident's blood pressure was 134/69 and her pulse was 54.

Nurse # 3 was interviewed on 4/24/24 at 1:45 PM and reported she would not have administered the medication with a pulse of 54.

Nurses were observed as they administered medications on 4/25/24 beginning at 8:10 AM. The electronic MAR was not observed to glitch during the time of the medication pass.

2a. Resident # 6 was admitted to the facility on 3/26/24.

On the resident's admission date of 3/26/24, Nurse # 10 documented Resident # 6 had a pressure sore to her sacrum and the wound nurse was notified.

documented as completed following facility policy in the electronic heath record.
- Confirming that treatment orders are documented following completion of the ordered treatment.
- Notification of the MD/RP of any missed or refused treatments.
- Treatment error process and notification process.

On 5/6/2024 the Director of Nurses/Assistant Director of Nurses/Staff Development coordinator began in-service education to all full time, part time, as needed licensed nurses, agency nurses and medication aides on:
- Following physician orders to include parameters for administration such as vital signs and when to hold the ordered medication.
- Documentation of the administration or need to hold the ordered medication on the electronic medication administration record.
- Notification of the physician or responsible party of the need to hold the medication.
- Completion of a medication error report and notification process.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be

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F 842	Continued From page 13 Nure # 10 was interviewed on 4/25/24 at 11:09 AM revealing the notation that the resident had a pressure sore on 3/26/24 was not accurate. Nurse # 10 reported the following information. The hospital had reported the resident had a sacral pressure sore when they called report to the facility on 3/26/24. On 3/26/24 when she looked at the area, it was scar tissue and no longer open and in need of treatment. On the skin assessment sheet of 3/26/24, there were different areas to check if they were applicable to the resident. One of the areas was a pressure sore. She wanted to denote there had been a pressure sore at one point, and therefore she checked pressure sore. She (Nurse # 10) did not feel the other areas on the skin assessment would apply and there was no area to check scar tissue. 2b. On 4/1/24 Resident # 6 had a physician's order for wound care. There was no site specified in the order for which wound care was needed. The area was to be cleansed with wound cleanser and covered with a dry dressing every three days and PRN (as needed). On 4/10/24 this order was revised to denote the area in need of wound care was the resident's right heel. It was also revised on 4/10/24 to reflect the area should be cleaned with skin prep before the dressing was applied, and the frequency of the dressing change was to be every five days and PRN. This order stayed in effect until 4/24/24. A review of Resident # 6's April 2024 TAR (Treatment Administration Record) revealed the right heel dressing change was checked as completed on the following days: 4/2/24, 4/6/24, 4/15/24, 4/20/24. This reflected more days passed before the dressing was changed as ordered.	F 842	allowed to work until training has been completed by May 14, 2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses, or designee will monitor compliance utilizing the F 842 Treatment Process Audit Tool and the Medication with Parameters Order process tool weekly x 2 weeks then monthly x 3 months or until resolved. This will include review of 3 residents who meet the below areas of concern. The Nursing Leadership Team will monitor the medication administration/treatment administration documentation process as part of Daily Clinical, Monday through Friday. The audit will include review of the electronic medical record to identify any residents who have medication with parameter orders or pressure ulcer treatment orders that have not been documented as administered. In addition, pressure ulcer assessments will be monitored to assure they are completed timely and accurately and include treatment orders that reflect care of the identified site and that the treatment orders were entered correctly and initiated timely. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored	

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F 842	Continued From page 14 The facility Wound Nurse was interviewed on 4/25/24 at 10:30 AM and Resident # 6's record reviewed. The facility Wound Nurse reported the following information. The electronic medical record system was new to her. She came from a different clinical background which did not utilize the system. She was continuing to learn the system. There were standing orders that could be put in place for pressure sores. On 4/1/24 Resident # 6 was first identified to have a right heel pressure blister. Standing orders included to cleanse the area with skin prep and cover the area for protection. The first order had not been entered into the computer as a complete order to reflect that it was the right heel that needed treatment or the use of the skin prep. Also, when the order was placed in the computer, the days on which the dressing should have been changed should have had an open area on the TAR so that a treatment could be recorded. The system had "x"ed out days when the treatment was due. There was no place to chart the dressing changes on the TAR on some of the days it was due, but the dressings had been completed. The resident had another pressure sore that required more frequent checks, and every time she was in the room, she checked and applied skin prep to the heel on the correct schedule or as needed. The treatment nurse validated that the resident's record was incomplete in regards to dressing changes. The Director of Nursing was interviewed on 4/25/24 at 11:22 AM and reported that the electronic system should automatically populate the days on the TAR on which the dressings needed to be completed. She did not know why the system had not done so and reported there	F 842	and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager and the Dietary Manager. Date of Compliance: 05/15/2024	

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F 842	Continued From page 15 could be more training on the facility's electronic medical system. 2c. Review of Resident # 6's pressure sore assessments revealed the following information: 4/2/24-Sacral pressure sore 3.3 cm X 1.0 cm X 0.2 cm Stage II 4-9-24- Sacral pressure sore 2.1 cm X 1 cm X 0.1 cm Stage II 4/17/24-Sacral pressure sore 1 cm X 0.9 cm X 0.1 cm suspected deep tissue injury 4/23/24 Sacral pressure sore 1.4 cm X 1 cm X 0.1 cm Stage II pressure sore The facility wound nurse was interviewed on 4/25/24 at 10:30 AM and reported the following information. The pressure sore assessment of 4/17/24 was incorrect in the record, and the assessments were also incomplete in the electronic record. Resident # 6 had both a pressure sore to her sacral area and to her right heel. On 4/17/24 she had inadvertently entered the right heel pressure sore measurements as the sacral pressure sore measurements. She had also been measuring the right heel pressure sore every time she measured the sacrum, but she had not been entering all of the assessments in the resident's record. According to the Wound Care Nurse, the actual care of the wounds was her priority. She (the Wound Care Nurse) had the right heel measurements in her personal notes but had not yet had time to complete all the documentation in Resident # 6's record. Therefore, the record was not complete.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		5/10/24

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F 867	Continued From page 16 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.	F 867		

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F 867	Continued From page 17 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F 867		

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F 867	Continued From page 18 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facilities Quality Assurance/Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification survey of 2/25/22.	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal	

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F 867	Continued From page 19 This was for one repeat deficiency. The area of deficiency dealt with failure to maintain accurate and complete medical records. The continued failure of the facility during two federal surveys over the course of two years showed a pattern of the facility's inability to sustain an effective Quality Assurance/Performance Improvement program. The findings included: This citation is cross referred to: F 842 During the complaint investigation of 4/25/23, for two of ten sampled residents (Residents # 2 and # 6) the facility failed to ensure medical records were complete and accurate regarding medication administration (Resident # 2) and pressure sore assessment and care (Resident # 6). During the recertification survey of 2/25/22 the facility failed to maintain an accurate Medication Administration Record (MAR) for 1 of 5 residents reviewed for activities of daily living. On 4/25/24 at 11:10 AM the Administrator was interviewed revealing the following information. The Administrator was not employed at the facility when the facility was previously cited for medical records. Since her employment, they had a quality assurance program and met monthly to address identified issues and problems. The nursing staff had not brought up any issues with problems documenting accurately and completely in residents' electronic medical records so that any problems with medical records could be addressed within their quality assurance program.	F 867	and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: The facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification survey conducted on 2/25/22.The area of deficiency dealt was with failure to maintain accurate and complete medical records. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: • Corrective action has been taken for the identified concerns in the areas of: resident records -accurate and complete medical records (842) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 05/07/2024 to review the deficiencies from the April 23- April 25, 2024 Complaint Investigation survey, and reviewed the citations. On 05/07/2024, the Regional Clinical Consultant in-serviced the facility administrator and the Quality Assurance	

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F 867	Continued From page 20	F 867	Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 5/07/2024 the administrator completed in-servicing with the Quality Assurance Performance Improvement team members that includes the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager and the Medical Director on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who is a member of the committee which does not receive scheduled in-service training will not be allowed to work until training has been completed by 5/14/2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Regional Operations Director or designee will monitor compliance utilizing	

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F 867	Continued From page 21	F 867	the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the Quality Assurance Committee. Reports will be presented to the Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting until no longer deemed necessary for compliance with maintaining complete and accurate medical records. The Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager and Medical Director. Date of Compliance: 05/15/2024	