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	345284	A. BUILDING _____ B. WING _____	C 07/24/2024

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THE OAKS	901 BETHESDA ROAD WINSTON SALEM, NC 27103

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/21/24 through 7/24/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SUO611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/21/24 through 7/24/24. Event ID# SUO611. The following intakes were investigated: NC00210812, NC00213311, NC00214206, NC00214488, NC00215349, NC00216777, and NC00218314. 2 of the 15 complaint allegations resulted in a deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 553		8/6/24

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

Electronically Signed | 08/15/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 553	Continued From page 1 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to invite the resident to participate in the care planning process for 1 of 23 residents whose care plans were reviewed (Resident # 78). Findings Included: Resident #78 was originally admitted on 9/24/21. The most recent quarterly Minimum Data Set (MDS) assessment dated 6/28/24 revealed Resident #78 was cognitively intact. During an interview on 7/21/24 at 10:45 am, Resident #78 stated he had not been invited to attend a care plan meeting for a long time and that he wanted to be asked to attend his care plan meetings. An interview was conducted with the facility Social Worker on 7/23/24 at 12:22 pm. She indicated Resident #78 had not attended a care plan	F 553	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 compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1) Corrective action for resident(s) affected by the alleged deficient practice Resident #78 had a care plan scheduled, received an invitation and attended the care plan on July 24, 2024. 2) Corrective action for residents with the potential to be affected by the alleged deficient practice:	

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F 553	Continued From page 2 meeting since August 2022 and was not able to confirm if he had been invited to attend any of his care plan meetings after August 2022. She further revealed the Billing Office Manager was responsible for sending out care plan invitations. An interview was conducted on 7/23/24 at 2:16 pm with the Billing Office Manager. She revealed that she had not invited Resident #78 to his care plan meetings because Resident #78 always seemed to want to run things by his friend. She further revealed that she should have provided Resident #78 with an invitation to attend his care plan meetings and sent out an invitation to his friend as well. An interview was conducted on 7/24/24 at 12:12 pm with the facility Administrator. He indicated that residents should be invited to attend their care plan meetings.	F 553	On August 2, 2024, the Social Worker identified residents that were potentially impacted by this practice by completing an initial care plan audit on all current residents. This was completed on August 2, 2024. The results concluded that 46 of 111 residents did not have a care plan and were not invited. These residents received care plan invitations on August 13, 2024. 3) Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On August 5, 2024, the Administrator inserviced the care plan meeting team which consisted of the MDS Nurse, Dietary Manager, Business Office Manager, Activities Director and the Social Worker on the Care Plan Process policy. 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 Administrator or designee will monitor 5 resident care plans per week for 4 weeks and then monthly for 3 months using the Care Plan Monitoring Tool. 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	

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F 553	Continued From page 3	F 553	ongoing and will be reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have	F 565		8/6/24

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F 565	Continued From page 4 family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews the facility failed to provide resolution of Resident Council Meeting grievances for 3 of 3 monthly Resident Council Meetings. The Resident Council had repeated concerns regarding water cups were not filled timely and snacks were not available (2/19/24, 3/18/24, 4/15/24). Findings included: On 2/19/24 the Resident Council Meeting Minutes noted a nursing concern that residents water cups were not filled timely, and snacks were not available. The Resident Council Follow-Up form attached to the 2/29/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the resident council. On 3/18/24 the Resident Council Meeting Minutes noted a nursing concern that residents water cups were not filled timely, and snacks were not available. The Resident Council Follow-Up form attached to the 3/18/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the resident council. On 4/15/24 the Resident Council Meeting Minutes noted a nursing concern that residents water	F 565	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 compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1) Corrective action for resident(s) affected by the alleged deficient practice: A Resident Council Meeting was held on July 29, 2024 to go over Resident Council grievances. Grievances that were given to the resident council during the meeting regarding residents water cups not filled timely and snacks not available were put through the grievance process and resolved per the resident. 2) Corrective action for residents with the potential to be affected by the alleged deficient practice: The Administrator audited all grievances from July 1, 2024 to July 23, 2024 to ensure that there were no grievances that	

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F 565	Continued From page 5 cups were not filled timely, and snacks were not available. The Resident Council Follow-Up form attached to the 2/29/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the resident council. a.Resident # 65 was admitted to the facility on 9/15/22. Resident #65's quarterly Minimum Data Set assessment dated 3/20/24 indicated she was cognitively intact and had no behaviors. On 7/22/24 at 2:00pm during the Resident council Meeting Resident #65 stated that snacks were not always available to residents and that water cups were not filled timely. She further revealed that these grievances had been an issue, and the facility has not addressed their concerns. b. Resident #15 was admitted to the facility on 10/19/22. Resident #15's quarterly Minimum Data Set assessment dated 4/30/24 indicated she was cognitively intact and had no behaviors. On 7/22/24 at 2:00pm during the Resident council Meeting Resident #15 stated that the residents in the meeting had made the facility aware that their water cups were not filled timely, and snacks were not always available to residents, and that the facility staff had not followed up with the committee on the status of their complaints. A review of the grievance logs for 2/1/24-4/30/24 revealed no group resident council grievances.	F 565	went unaddressed. The findings concluded that 14 of 14 grievances that were filed were addressed and followed up on. 3) Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On August 1, 2024, the Administrator inserviced the interdisciplinary team on the Grievance Policy and Procedure and to also include addressing grievances from the Resident Council Meeting. 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 Administrator or designee will monitor 5 grievances per week for 4 weeks and then monthly for 3 months using the Grievance Monitoring Tool. 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 and will be reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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F 565	Continued From page 6 An interview was conducted with the Activities Director on 7/23/24 at 10:58 am. She revealed that during the months of February, March, and April 2024 the process was for her to take minutes and note any grievances voiced during the meeting on the minutes and then to either report them to the facility social worker or the designated department head to address their departmental concerns. She further revealed that the follow-up was completed on the follow-up form by the department head and then she would review that information at the next meeting. An interview was conducted with the Director of Nursing on 7/24/24 at 11:56 am. She indicated that she should have addressed the concerns voiced during 2/16/24, 3/18/24, and 4/15/24 Resident Council Meetings and noted a synopsis of all efforts used to address their grievances. An interview was conducted with the Administrator on 7/23/24 at 2:06 pm and he indicated that grievances voiced during resident council meetings should be addressed and residents should have received follow up to their stated grievances.	F 565		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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F 689	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and Nurse Practitioner interview, the facility failed to provide incontinent care in a safe manner which caused a fall (Resident #29). This was for 1 of 3 residents reviewed for accidents. The findings included: Resident #29 was admitted to the facility on 9/20/2019 with diagnoses of Vascular Dementia and Hemiparesis (paralysis of one side of the body) affecting right side of body. Record review revealed Resident #29's care plan last reviewed 2/23/24, showed she required two person staff assistance to re-position and turn in bed. Review of the quarterly Minimum Data Set (MDS) dated 2/9/24 indicated Resident #29 was severely cognitively impaired. She had range of motion (ROM) limitations and impairment to the one side of her body-upper and lower extremity. She required substantial/maximum assistance personal hygiene and bed mobility. Review of incident report dated 2/28/24 revealed Resident #29 rolled off the bed to the floor during morning care while turned on her left side. The bed was in a high position at the time. The report stated the Nurse Practitioner (NP) and Nurse #8 were called to the room. Resident #29 was assessed and found to have a bump forming on her left forehead. Resident was lifted back to bed using mechanical lift. Orders given by NP to send resident out for evaluation and treatment.	F 689	Past noncompliance: no plan of correction required.	

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Emergency room notes dated 2/28/24 revealed Resident #29 had developed a hematoma (bruise) on the left side of her forehead described to be approximately an inch in diameter. A computerized tomography (CT) scan of the head and spine was negative for fracture or intracranial hemorrhage. She also received x-rays for her pelvis and upper/lower extremities which were also negative for fracture. No other treatments were provided, and Resident #29 returned to the facility the same day.

During an interview with Nurse Aide (NA) #5 on 7/22/24 at 11:38 am, she stated she was on the adjacent hall when she heard NA #4 call out for help. She stated she arrived at Resident #29's room and saw her on the floor. She stated NA #4 told her she was performing incontinent care and had rolled the resident onto her side. She stated she was trying to pull the under pad back toward the center of the bed when Resident #29 rolled off the other side. NA#5 stated the bed was in high position when she walked into the room. NA #5 stated the NP and Nurse #8 were down the hall when the incident occurred. She stated both came and assessed the resident. NA #5 stated she and NA #4 assisted Resident #29 back to bed using the mechanical lift. NA #5 also stated she had not worked with Resident #29 much but she did state she was available to assist NA #4 and did not know why she didn't ask for help.

NA#4 was not employed by the facility at the time of survey. Multiple attempts to reach her were unsuccessful.

Nurse #8 was not employed by the facility at the time of survey. Multiple attempts to reach her were unsuccessful.

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During an interview with the Nurse Practitioner (NP) on 7/24/24 at 11:00 am, she stated she was present in the facility when the resident fell. She stated she responded to the room along with Nurse #8 and assessed the resident from head to toe. The bed was in high position when she arrived to the room. She stated Resident #29 had a hematoma that was starting to form on her left forehead. The NP stated the resident's vitals were fine and she had no other complaints. She stated she decided to send her out for evaluation anyway because of the hematoma/head injury.

During an interview with the Nurse Consultant, the Administrator, and the Director of Nursing (DON) on 7/24/24 at 2:38 pm, the Administrator stated that he had been made aware of the incident as soon as it occurred and began a plan of correction on 2/29/24. The current DON was not employed at the facility during the incident, but she stated she did continue the monthly audits through May. The Nurse Consultant stated the individual care guide for each resident is available for all staff members for review and all staff members, including agency staff, are expected to follow the care guides when providing care to the residents for their safety. The administrator stated fall prevention is still a part of their monthly quality improvement meetings.

The facility provided the following Corrective Action Plan with a completion date of 3/7/24:

On 2/28/24, Resident #29 was receiving care by only one aide who attempted to turn Resident #29 in her bed by herself resulting in a fall. The bed was in a high position at the time. The report stated the Nurse Practitioner and Nurse #8 were

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called to the room. Resident #29 was assessed and found to have a bump forming on her left forehead. Resident was lifted back to bed using mechanical lift. The Nurse Practitioner gave orders to send resident out to the hospital for further evaluation.

On 2/29/24, the DON completed an audit of all current residents who required two staff members to assist with bed mobility.

On 2/29/24 the DON in-serviced all nursing staff, including agency, on the falls prevention policy and included using the care guides for bed mobility. The DON or designee will ensure that any staff who does not complete the in-service training by 3/4/24 will not be allowed to work.

The facility made the decision to discuss the deficiency, the plan of correction including monitoring, and when to begin discussing it in their weekly QA meetings on 3/7/24.

Beginning 3/8/24, the DON or designee will monitor staff weekly for 2 weeks, every other week x 2 months, and then monthly using the bed mobility monitoring tool to ensure staff members were following the care guides when providing incontinent care to residents and using two staff members for bed mobility as care planned. Reports will be presented to the weekly QA committee beginning 3/11/24 by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA meetings.

Allegation of Compliance Date: 3/7/24

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Interviews with nursing staff, including agency staff, revealed the facility had provided education and training on how to care for residents requiring two-person assistance for bed mobility and using the mechanical lift for transfers. The training also included where to locate information on residents who required two-person assistance for bed mobility and those who required the mechanical lift for transfers.
Staff rosters were provided by the facility and showed most of the training occurred on 2/29/24 with additional staff completing the training on 3/1/24. Any staff member who did not completed the training by 3/1/24 would not be allowed to work. All new agency staff and new hires completed the training during orientation.

The survey team did multiple observations during the week of residents who required two staff members for bed mobility. Staff members were observed providing incontinent care and bed baths using two staff members as needed based on the resident's care guide.

Staff interviewed all verbalized they had been observed performing incontinent care and bed baths by the DON or designee and were able to verbalize where to locate the care guide for each individual resident.
Review of the monitoring tool showed audits were performed weekly x 2 weeks, every other week x 1 month and then monthly for an additional 2 months. No further falls related to care have occurred.

The Corrective Action plan was validated on 7/24/24 and concluded the facility had implemented an acceptable corrective action plan on 3/7/24.

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 690	The statements made on this plan of	8/6/24

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	345284	A. BUILDING _____ B. WING _____	C 07/24/2024

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F 690	Continued From page 13 interviews, the facility failed to secure the urostomy (an opening in the urinary system) tubing per the physician order on 1 of 4 residents observed for urinary catheters (Resident #48). Findings included: Resident #48 was admitted to the facility on 6/5/24. Resident 48's diagnoses included urinary bladder cancer with urine retention. His admission Minimum Data Set (MDS) assessment, dated 6/12/24, revealed the resident was moderately cognitively impaired. He required extensive assistance with activities of daily living, including incontinent care, had a urostomy and was always incontinent of bowel. Review of Resident 48's plan of care, dated 7/22/24, revealed a urostomy, related to urinary bladder cancer, with interventions including anchoring (through use of the leg band) the catheter (tubing) to prevent excess tension. Review of the physician's s order for Resident #48, dated 6/6/24, revealed an order for urostomy catheter care every shift and as needed. Ensure the leg band is in place. On 7/23/24 at 8:05 AM, during the observation of incontinent care for Resident #48, provided by Nurse Aide #3, the urostomy tubing was observed to be unsecured to the resident's leg. There was no anchoring device present on the resident's legs. On 7/23/24 at 8:20 AM, during an interview, Resident #48 indicated he was not sure about securing the urostomy catheter tubing and could not recall the anchoring device on his legs.	F 690	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 facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1) Corrective action for resident(s) affected by the alleged deficient practice: Resident #48 had a leg band placed on 7/23/24 by the nurse. 2) Corrective action for residents with the potential to be affected by the alleged deficient practice: On 8/2/24 the DON performed an audit of all residents with foley catheter or urostomy. This included observations of residents to ensure orders were accurate and in place as written. The audit revealed 4 of 107 residents contained foley catheters had leg bands acquired appropriately. The audit also revealed that 1 of 107 residents contained urostomy and had leg band acquired appropriately. 3) Measures/Systemic changes to prevent reoccurrence of alleged deficient practice. On August 1, 2024 all nursing staff was educated on Foley Catheters, Urostomy	

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F 690	Continued From page 14 On 7/23/24 at 8:55 AM, during an interview, Nurse Aide #3 indicated that she did not know that Resident #48 had his urostomy catheter tubing unsecured at the beginning of her shift. She continued it was the responsibility of the nurses to apply the anchors to secure the urinary catheter tubing to the resident's leg. She did not observe the anchoring device on resident's legs. On 7/23/24 at 10:05 AM, during an interview, Nurse #8 indicated she was not aware Resident #48 did not have his urostomy tubing secured to the leg, nor did he have the stabilization device (leg band) on his leg. Nurse #8 confirmed that it was the nurses' responsibility to secure the urinary catheter tubing to the resident's leg. Nurse #8 did not check the urinary catheter tubing status at the beginning of her shift today. The nurse aides did not report absences of tubing anchor for Resident #48. On 7/23/24 at 1:15 PM, during an interview, the Director of Nursing (DON) expected the nursing staff to have secured the urinary catheters tubing to prevent injury to the resident and to maintain the urine flow.	F 690	and the care needed for same. This included properly securing the device to prevent injury/trauma. This education will be on-going. 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 DON or designee will monitor weekly x 4 weeks, then monthly x3 months, no less than 2 residents, to include any new admits in the previous week using the Catheter Audit Tool. Results will be presented to the weekly QA committee by the DON or Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing and will be reviewed at the weekly QA meeting. The weekly QA meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM and the Dietary Manager.	
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an	F 791		8/6/24

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F 791	Continued From page 15 outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to assist a resident in obtaining dentures. This occurred for 1 of 3 residents reviewed for dental services.	F 791	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	

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F 791	Continued From page 16 The findings included: Resident # 2 was admitted 9/20/19 with diagnosis that included hemiplegia. A review of the annual comprehensive Minimum Data Set (MDS) dated 7/7/24 revealed Resident #2 was cognitively impaired and had no rejection of care. The MDS indicated Resident #2 had obvious or likely cavity or broken natural teeth, no difficulty swallowing or chewing and had weight loss. A review of the care plan revised 1/10/24 included a focused area that was initiated 5/19/22, that read, Resident #2 is at risk for weight fluctuations secondary to hemodialysis. A review of Resident #2's orders revealed a mechanically altered diet. A review of the dental provider #1's documentation for Resident #2 revealed: 1) 4/3/23 Patient had dentures would like new dentures. 2) 10/23/23 Patient requests upper denture. Waiting for approval for lower partial. An interview was conducted with Resident #2 on 7/21/24 at 10:53 am. Resident #2 revealed he had dentures at one time due to missing teeth but could not recall when the last time he had dentures. Resident #2 indicated he had requested new dentures from the facility dentist but had not received any dentures to date. Resident #2 indicated he was able to eat with current diet but when he had dentures, he was able to eat a regular consistency diet and enjoyed	F 791	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 compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. 1) Corrective action for resident(s) affected by the alleged deficient practice: Resident #2 attended a dental appointment on August 13, 2024 and the denture process was initiated. 2) Corrective action for residents with the potential to be affected by the alleged deficient practice: On August 12, 2024 the Administrator interviewed all alert and oriented residents to see if they are having mouth pain or needed dental services and assessed all non-alert and oriented residents to see if they are having mouth pain or needed dental services. The audit revealed 0 of 111 residents were in need of dentures. 3) Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On August 5, 2024, the Administrator inserviced the Social Worker on the Dental Services Policy to include accessing dental care with-in 72 hours of notification.	

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F 791	Continued From page 17 eating his food more. A telephone interview was conducted with the dental provider #1 on 7/23/24 at 11:48 am. She revealed Resident #2 was treated last at the facility on 10/23/23 and upper dentures had been approved by Medicaid and the provider was waiting on Medicaid approval for the lower partial. She further revealed the facility terminated their contract before the new dentures could be made. A telephone interview was conducted with dental provider #2 on 7/23/24 at 5:10 pm and she indicated that she worked with the facility to assist in the transition process. She further revealed the dental provider had met with the social worker on 1/30/24 as part of the transition process. The dental provider counseled the social worker on the process of transitioning over residents to their services and provided the new consent forms so the social worker could contact residents or resident representatives to offer services and have consents signed for those who were interested. Dental provider #2 indicated the facility did not provide any referral information to the provider for Resident #2 and was not a current patient of record. An observation was conducted of Resident #2 on 7/23/24 at 3:00 pm eating a chicken snack provided by his responsible party. Resident #2 was able to eat the chicken without difficulty. An interview was conducted with the responsible party on 7/23/24 at 3:04 pm. She indicated that she was not sure why Resident #2 had not received dentures yet and should have had them by now. She further revealed that she had not been contacted by the facility or any dental	F 791	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 Administrator or designee will monitor 5 residents dental needs per week for 4 weeks and then monthly for 3 months using the Dental Monitoring Tool. 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 and will be reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.	

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F 791	Continued From page 18 providers regarding the status of the requested dentures. An interview was conducted with the social worker on 7/24/24 at 8:58 am. She confirmed that she received the new consent forms from dental provider #2 in January of 2024 but did not reach out to Resident #2 or his responsible party to offer dental services because she got busy. An interview was conducted with the Administrator on 7/24/24 at 12:06 pm. He indicated dental services should be provided to residents in a timely manner and the facility social worker should have offered Resident #2's responsible party the opportunity to transition Resident #2 to the new dental provider for services.	F 791		