STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345509	A. BUILDING _____ B. WING _____	C 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ABERDEEN	915 PEE DEE ROAD ABERDEEN, NC 28315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 8/5/24 through 8/8/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# D68Y11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/5/24 to 8/8/24. Event ID# D68Y11. The following intakes were investigated NC00216145, NC00219646 and NC00220231. 2 of the 4 complaint allegations resulted in a deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to place a resident's (Resident #83) call light within reach to allow for the resident to request staff assistance this was for 1 of 7 residents reviewed for accommodation of needs. The findings included: Resident #83 was admitted to the facility on 06/24/24 with diagnoses that included hemiplegia (paralysis of one side of the body) affecting left	F 558	Resident #83 continues to reside in the facility and remains in stable condition. Resident #83's call light was placed within reach immediately when identified. On 8/23/2024 the Administrator completed an audit of resident call lights to ensure they were within reach for each resident. There were no concerns identified during this audit. On 8/20/24 Director of Nursing and	8/28/24

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

Electronically Signed | 08/25/2024

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F 558	Continued From page 1 side, need for assistance with personal care, and type 2 diabetes mellitus. The admission Minimum Data Set (MDS) assessment dated 06/27/24 indicated Resident #83 was cognitively intact. He was dependent on staff for toileting hygiene, transfers, and dressing. He required maximum assistance with shower/baths, bed mobility, and dressing and moderate assistance with personal hygiene. He was always incontinent of bowel and bladder. He had functional limitation with range of motion of one side of his upper extremities. Resident #83 ' s care plan, last reviewed on 07/18/24, indicated he had an activities of daily living (ADL) self-care performance deficit related to hemiplegia and stroke. The interventions included for staff to encourage the resident to use bell to call for assistance. Another focus read Resident #83 had an actual fall and was at risk for further falls related to poor trunk control. The interventions included for staff to ensure resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needs a prompt response to all requests for assistance. A continuous observation was conducted on 08/05/24 from 12:11 PM through 12:32 PM of Resident #83. Resident #83 was lying in bed watching television. His lunch tray was brought in by Nursing Assistant (NA) #1. NA #1 raised the head of the bed up and assisted Resident #83 with setting his meal tray up and then exited the room. Resident 83 ' s call bell was on the floor out of his reach. An interview was conducted on 08/05/24 at 12:45	F 558	Administrator provided education with nursing staff with emphasis on ensuring residents' call lights are always within reach when resident is in bed. Education was completed on 8/22/2024. Nursing staff that did not receive the education by 8/22/2024 will be educated before starting their next scheduled shift. Any newly hired nursing staff hired will be educated during orientation by the Staff Development Coordinator or Director of Nursing. The Administrator and/or the Unit Manager(s) (UM) will conduct audits of 10 rooms a week for 4 weeks then 10 rooms a month for 2 months to ensure residents' call lights are within reach when resident is in bed. The Administrator will present the results of call light audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI Committee will review the call light audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 558	Continued From page 2 AM with Resident #83. He stated his call bell falls to the floor a lot and staff often forget to give it to him. He explained that he would wait for the nurse to bring in his medications or he would yell when he saw someone in the hall if he needed assistance. He also stated the call bell doesn ' t do any good if it was on the floor and it made him uneasy when he couldn ' t reach it. An observation and interview were conducted with Nursing Assistant (NA) #1 on 08/05/24 at 2:41 PM. He verified he was the direct care NA for Resident #83. He also verified the call bell in Resident #83 ' s room was on the floor beside the bed and out of his reach. He explained that he was in his room to give him his lunch try earlier but forgot to check call bell placement at that time. NA #1 then stated he did not realize Resident #83 ' s call bell was on the floor. He indicated he usually checks the call bell before leaving the rooms. NA #1 could not recall when Resident #83 last had his call bell. An interview was conducted on 08/07/24 at 12:43 PM with the Administrator and the Director of Nursing. They both stated the call bell should always be within the residents ' reach.	F 558		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		8/28/24

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F 584	Continued From page 3 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure resident rooms were in good repair. Rooms #304 and #308 had several patched areas of sheetrock putty exposed on walls and Room #306 had a missing plank panel	F 584	On 8/23/2024 Rooms #304 and #308 patches of drywall were fixed and painted and room #306 missing plank panel behind the headboard has been replaced.	

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F 584	Continued From page 4 on wall behind the headboard. This was for 3 of 8 rooms reviewed for comfortable, clean, and homelike environment. The findings included: a. During the initial tour on 08/05/24 at 10:50 AM, an observation of rooms 304 and 308 revealed the walls were patched in multiple areas with what appeared to be putty in preparation for painting. Observations were conducted during a round with the Maintenance Director on 08/07/24 at 11:37 AM. He verified rooms 304 and 308 had patched areas that needed to be painted. He stated the rooms were on his to do list but could not provide a date or timeframe he thought he would get to the projects. b. On 08/05/24 at 10:50 AM, an observation of room 306 revealed plank vinyl floor panels on the wall behind the headboard of the bed. One of the panels had fallen off exposing a dried clear substance that appeared to be glue. Observations were conducted during a round with the Maintenance Director on 08/07/24 at 11:37 AM. He verified room 306 had exposed glue from one of the vinyl panels falling off the wall. He stated the room was on his to do list but could not provide a date or timeframe he thought he would get to the projects. The Administrator was interviewed on 08/07/24 at 12:43 PM, and stated it was important for the environment to be well repaired and homelike. The Administrator indicated since she started working at the facility in April, they have been	F 584	On 8/23/2024 the administrator completed an audit of resident rooms to ensure rooms or other areas were in good repair. Items identified have been placed in TELS. Identified areas of concern during the audit will be addressed by the maintenance director/assistant and completed per schedule developed by Administrator and Regional of Plant Operations. On 8/22/2024 the Administrator educated the Maintenance director and Assistant Maintenance Director regarding Homelike Environment with emphasis on ensuring rooms remain in good repair and reviewing TELS at least 5 days per week to ensure maintenance items identified are addressed timely. On 8/20/2024 The Director of Nursing and Administrator initiated in-servicing of staff on placing work orders in TELS to ensure proper notification of maintenance regarding needed repairs. Education was completed on 8/22/2024. Staff members that have not received the education by 8/22/2024 will be educated prior to beginning their next scheduled shift. Newly hired employees will receive education during orientation from the Director of Nursing or Staff Development Coordinator. The Administrator and/or designee will audit 10 resident rooms weekly for 4 weeks then 10 rooms monthly for 2 months to ensure rooms are in good repair.	

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F 584	Continued From page 5 fixing many concerns that were present. She also stated the Maintenance Director was responsible for the concerns.	F 584	The Administrator will present the findings of a Home-Like Environment Audit to QAPI monthly for 3 months. QAPI committee will review Home-Like Environment Audit Tool to determine trends and or issues that may need further interventions and to determine the need for further monitoring.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to protect 1 of 4 residents (Resident #19), for his right to be free from physical abuse as evidence by another resident (Resident #9) slapping him with an open hand to the side of his head. The findings included:	F 600	Residents # 9 and #19 continue to reside in the facility in stable condition. They remain in separate rooms with no further occurrences. On 8/21/2024, the Administrator initiated an audit of facility initiated reportables for the past 30 days. This audit is to ensure required reportable events were reported	8/28/24

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F 600	Continued From page 6 Resident #9 was admitted to the facility on 10/31/14 with diagnoses that included schizophrenia and hemiplegia and hemiparesis of the left non-dominant side. Resident #9 ' s quarterly Minimum Data Set (MDS) assessment dated 7/12/24 indicated his cognition was intact. He exhibited no behavior during the look-back period. Resident #9 ' s care plan, last reviewed on 07/29/24 revealed a focus that read he was verbally aggressive related to poor impulse control. Resident was verbally aggressive and threatened bodily harm to staff and other residents. The interventions included when Resident #9 became agitated for staff to intervene before agitation escalated, guide him away from source of distress, and engage calmly in conversation. Resident #19 was admitted to the facility on 06/11/13 with diagnoses that included cerebral palsy, depression, and manic depression (bipolar disease). Resident #19's quarterly Minimum Data Set (MDS) assessment dated 04/19/24 indicated his cognition was intact. He exhibited no behavior during the look-back period. Resident #19 ' s care plan, last reviewed on 07/19/24 revealed a focus for him having a behavior problem. Resident #19 was easily agitated, episodes of refusing care, and hitting self when agitated. The interventions included he had episodes noted where he would yell out, "pow, pow, bang, bang" at inappropriate times and for staff to monitor behavior episodes and	F 600	in a timely manner and per HCPR guidelines. No areas of concern were identified. On 8/23/2024, the Administrator initiated an audit of progress notes for the past 7 days to identify any events that may be construed as abuse to ensure potential allegations of abuse were investigated and reported per HCPR guidelines when indicated. No areas of concern were identified. On 7/22/2024, the Regional Nurse Consultant conducted an in-service with the Administrator and Director of Nursing regarding facility policy on reportable events to include but not limited to abuse allegations that require reporting to DHHS within two hours. The education also included reporting allegations of abuse to APS and the local police department. The Administrator will review the investigative folder for facility-initiated reportable events, including allegations of abuse weekly for 3 months. This audit is to ensure the event is investigated and reported in a timely manner per HCPR guidelines. The Interdisciplinary Team will review progress notes and grievance logs 5 days weekly for 4 weeks, then 3 days weekly for 2 months to identify events that may be construed as abuse to ensure allegations of abuse are investigated and reported per facility protocol and HCPI guidelines when indicated.	

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F 600	Continued From page 7 attempt to determine underlying cause. Another focus read that he had a communication problem related to him usually understanding verbal content, he usually understood others, and he had unclear speech. The interventions included to ensure/provide a safe environment and avoid isolation. The Facility Reported Incident (FRI) dated 07/22/24, revealed Resident #19 was witnessed striking his roommate, Resident #9. The report indicated the residents were immediately separated and an investigation began. The report also indicated there was no physical or mental injury or harm. Law enforcement was notified on 07/22/24 at 10:50 AM. A Behavior note dated 07/21/24 revealed Nursing Assistant (NA) #3 was walking past Resident #19 & #9 ' s room and witness Resident #19 slap Resident #9 in the face. Resident #19 stated he slapped Resident #9 because he wanted him to shut up. Resident #19 was educated to keep his hands to himself and stay on his side of the room. Attempts to interview NA #3 were unsuccessful. A statement written by Nursing Assistant #3 dated 07/22/24 revealed on 07/21/24 as she was walking down the hall, she could hear Resident #9 talking to himself as he did every night. She stopped at the room door and witnessed Resident #19 at Resident #9 ' s bed and he yelled, "shut the f**k up". She immediately went into the room to intervene but before she could get to the residents Resident #19 slapped Resident #9 with an open hand on his right hand/forearm. Resident #9 ' s right arm was up near his face and when his arm came down it hit his face. She yelled for	F 600	The Administrator will forward findings to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that may require further interventions put into place and to determine the need for further and/or frequency of monitoring.	

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F 600	Continued From page 8	F 600		

the nurse to assist.

A phone interview was conducted on 08/08/24 at 4:20 PM with Nurse #2. She verified she was the nurse for Resident #19 and #9 on 07/21/24. She stated the Nursing Assistant (NA) #3 informed her Resident #19 slapped Resident #9 and she immediately separated the two residents. Nurse #2 explained Resident #19 stated he slapped Resident #9 because he would not stop talking. She moved Resident #9 to a different room. She indicated prior to the incident Resident #9 was talking to himself while he was in bed. He was not yelling or cussing.

An interview with Resident #19 was conducted on 08/06/24 at 11:40 AM. He explained that Resident #9 was cussing him on 07/21/24 so he got up from his bed and slapped him across the head. He further explained Resident #9 just kept repeating the same words over and over and would not shut up, he was tired of hearing him. He stated he was not trying to hurt Resident #9 he just wanted him to be quiet.

An interview with Resident #9 was conducted on 08/06/24 at 11:55 AM. His speech was very hard to understand due to talking very low and he mumbled at times. He answered yes and no questions

appropriately. He stated Resident #19 slapped him with an open hand but did not explain why or any other details. He denied being in pain or being fearful when Resident #19 slapped him or afterwards.

Interview with the Administrator was conducted on 08/07/24 at 12:43 PM. She indicated the

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F 600	Continued From page 9 residents had been a good match for roommates up until that point and she never expected an altercation would occur. She stated Nurse #2 moved Resident #9 to a different room immediately and the nurse started the investigation, which was what she would expect the nurse to do. She further stated Resident #19 and Resident #9 have continued to reside at the facility on different halls. However, the nurse should have called her to notify her of the incident.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)	F 607		8/28/24

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F 607	Continued From page 10 (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, Nurse #2 failed to implement the reporting portion of the abuse policy after Nurse Aide #3 (NA #3) told her Resident #19 slapped Resident #9 on the right hand/forearm. The facility also failed to notify Adult Protective Services (APS) regarding an allegation of abuse. This was for 1 of 4 Residents (Resident #9) reviewed for abuse. The findings included: a. A review of the facility's Abuse policy, last revised 2023, revealed new employees will be educated on the reporting process for abuse during the initial orientation. The policy read in part: The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes. A phone interview was conducted on 08/08/24 at 4:20 PM with Nurse #2. She verified she was the nurse for Resident #19 and #9 on the night of 07/21/24. She stated at approximately 2:45 AM NA #3 informed her Resident #19 slapped Resident #9, and she immediately separated the	F 607	Residents # 9 and #19 continue to reside in the facility in stable condition. They remain in separate rooms. The nurse was educated on 7/21/2024 by the Director of Nursing at the beginning of her shift and re-educated on 7/22/2024 regarding circumstances that constitute abuse and reporting abuse to the Administrator and Director of Nursing immediately upon identification of occurrence. On 7/22/2022, the Regional Nurse Consultant educated the Administrator regarding the notification of Adult Protective Services (APS) with reportable event that involves residents. On 7/22/2024, the Administrator initiated an in-service with staff regarding facility policy on reportable events to include but no limited to abuse that require immediate reporting to Administrator even if allegations are not substantiated during initial investigation. Education was completed on 7/24/24. Any staff member not educated will be educated before starting their next scheduled shift. Any newly hired staff member will be educated during orientation by the Staff Development Coordinator or Director of Nursing.	

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F 607	Continued From page 11	F 607		

two residents. She moved Resident #9 to a different room. She also stated Resident #9 stated Resident #19 hit him and denied pain after he was slapped. She indicated prior to the incident Resident #9 was talking to himself while he was in bed. He was not yelling or cussing. She further stated she did not call to report the incident to the Administrator because she was unaware of the facility policy. Her main concern was to keep Resident #9 safe.

Review of the orientation training, dated 07/19/24 through 07/22/24, which included the abuse policy, fire safety and emergency preparedness, was signed by Nurse #2 on 07/21/24 (after the incident).

An interview with the Director of Nursing was conducted on 08/06/24 at 1:15 PM. She stated Nurse #2, agency nurse, was the nurse on duty when Resident #19 slapped Resident #9. She explained Nurse #2 did not notify the administration after the incident because she did not feel it was abuse. The DON further explained that orientation training was given to Nurse #2 on 07/21/24 (after the incident).

An interview with the Administrator was conducted on 08/06/24 at 1:39 PM. She explained that Nurse #2, an agency nurse, was the nurse on duty when Resident #19 slapped Resident #9. She stated she had Nurse #2 come to the facility on 07/22/24 to write a statement related to the incident. When she questioned her on why she did not notify administration after Resident #19 slapped Resident #9 Nurse #2 told her because she did not feel it was abuse. Nurse #2 was reeducated on the abuse policy at that time. The Administrator then stated she expected

The Administrator will review the investigative folder for facility-initiated reportable events, including allegations of abuse weekly for 3 months. This audit is to ensure staff reported abuse immediately to the Administrator.

The Interdisciplinary Team will review progress notes and grievance logs 5 days weekly for 4 weeks, then 3 days weekly for 2 months to identify any event that may be construed as abuse to ensure allegations of abuse are reported per facility protocol and HCPR guidelines when indicated.

The Administrator will present findings to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues
that may require further interventions put into place and to determine the need for further and/or frequency of monitoring.

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F 607	Continued From page 12 nursing staff to report any type of abuse to the Administrator and/or the Director of Nursing immediately. b. An interview with the Administrator was conducted on 08/06/24 at 1:39 PM. She stated she submitted an initial report of abuse to the state regulatory agency on 07/22/24 regarding Resident #19 slapping Resident #9. She explained that she did not notify APS until 07/29/24 because she was unaware that she needed to report to APS. She indicated that she recently moved to North Carolina and her former state did not have to report to APS.	F 607		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636		8/28/24

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F 636	Continued From page 13 (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the	F 636	Resident #9's comprehensive	

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F 636	Continued From page 14 facility failed to complete an annual Minimum Data Set (MDS) assessment within the required time frame for 1 of 19 residents reviewed for MDS assessments (Residents #9). The findings included: Resident #9 was admitted to the facility on 10/31/14. A review of Resident #9's most recent MDS assessment was dated 7/12/24 and was coded as a annual assessment. The electronic medical record indicated the assessment was "export ready" and had not been transmitted. An interview was conducted on 08/07/24 at 11:48 AM with the MDS nurse. She stated the annual MDS assessments for Residents #9 had not been transmitted as required. She explained that there had been a lot of admissions and discharges, and she had gotten behind. The MDS nurse stated she was in the process of getting the assessments completed and transmitted. An interview was conducted on 08/07/24 at 11:52 AM with the Administrator and Director of Nursing. They stated the MDS assessments should be transmitted within the required time frame.	F 636	assessment dated 7/12/2024 was reviewed by the Director of Nursing and transmitted on 8/9/2024. On 8/23/2024 the Director of Nursing and Minimum Data Set nurse completed an audit of active residents who have incomplete comprehensive assessments that flagged as late. On 8/23/2024, the Director of Nursing re-educated the Minimum Data Set nurse regarding timely completion and transmission of comprehensive assessments and reviewed the MDS portal to determine when comprehensive assessments are due for completion and transmission. The Director of Nursing will conduct weekly audits on 5 residents for 4 weeks then 10 residents monthly for 2 months to ensure timely completion of all comprehensive assessments. Director of Nursing will present audits to Quality Assurance Performance Improvement (QAPI) committee for review for 3 months. QAPI committee will determine trends and/or issues that may warrant further monitoring.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 637		8/28/24

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F 637	Continued From page 15 purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff, Medical Director (MD) interviews and record review, the facility failed to complete a significant change Minimum Data Set (MDS) after 2 areas of significant decline. This was for 1 of 19 residents reviewed for MDS accuracy (Resident #24). The findings included: Resident #24 was admitted on 2/22/22 with cumulative diagnoses congestive heart failure, chronic obstructive pulmonary disease, and dementia. Review of his quarterly MDS dated 5/22/24 indicated Resident #24 had severe cognitive impairment and required substantial staff assistance with Activities of Daily Living (ADLs). He was coded as frequently incontinent of bladder and always incontinent of bowel, weight of 111 pounds with no known weight loss, and no pressure ulcers. A review of Resident #24's medical record revealed he developed a stage 3 ulcer described as pressure to his sacrum on 6/7/24. A review of Resident #24's weights for the last 3 months from 5/2/24 (113.2 pounds) to 7/25/24	F 637	Resident #24 continues to reside in the facility and remains in stable condition on comfort care. A Significant Change MDS was completed for weight loss and pressure injury on 8/7/2024 and transmitted on 08/09/2024. On 8/23/2024, the Director of Nursing audited residents who had a significant change in condition within the past 30 days to ensure a significant change MDS is completed indicating the resident's change of condition. On 8/23/2024 the Director of Nursing educated the MDS nurse regarding capturing a resident's significant change and the inclusion of the change of condition in the significant change MDS. The Director of Nursing will audit significant changes identified during morning clinical meeting to ensure the MDS nurse captures the resident's significant change on the MDS. Audit will be completed 5 times a week for 4 weeks then monthly for 2 months.	

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F 637	Continued From page 16 (102.6 pounds) was a loss of 10.6 pounds or 9.36% weight loss in 3 months. Review of Resident #24's comprehensive care plan revealed a care area revised on 6/10/24 regarding a pressure ulcer to his sacrum related to incontinence, cognitive decline. New interventions included to assess, record and monitor wound healing and report improvements or declines to the MD, and to educate family and caregivers on importance of positioning/repositioning, mobility, nutrition and incontinence care. Another care area which had been revised on 6/14/24 regarding his potential for nutritional problems related to his mechanically altered and therapeutic diet and include significant weight changes. There were new interventions in place including a protein supplement and zinc added to aid in his wound healing. An interview was completed on 8/6/24 at 12:20 PM with the MD. He stated Resident #24 has had an overall physical decline in the last 3 months or so and his family had decided to go with comfort care rather than hospice. He stated as his condition progressed, the facility would continue to treat his pressure ulcer and his weight loss, but his family stated they did not want Resident #24 sent out to the hospital. The MD stated his pressure ulcer and weight loss were unavoidable. An interview was completed on 8/7/24 at 11:45 AM with the MDS Nurse. She stated she revised Resident #24's care plan for his newly developed pressure ulcer and weight loss in June and then opened a quarterly MDS on 7/23/24 and should have realized that a significant change MDS was needed instead of the quarterly. She stated it was	F 637	The Director of Nursing will present the findings of the audits to the Quality Assurance Performance Improvement (QAPI) committee for review for 3 months. QAPI committee will determine trends and/or issues that may warrant further monitoring.	

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F 637	Continued From page 17 her oversight. An interview was completed on 8/7/24 at 12:24 PM with the Administrator and the Director of Nursing (DON). The DON stated Resident #24 has had a continuous decline in recent months and a significant change MDS would have been expected before now. The Administrator stated she expected the MDS Nurse to have caught the 2 area of decline since those areas had already been captured in his care plan in June.	F 637		
F 638 SS=C	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within the required time frame for 5 of 19 resident MDS assessments reviewed (Residents #17, #81, #24, #42 and #19). The findings included: a. Resident #17 was admitted to the facility on 4/11/24. A review of Resident #17's most recent MDS assessment was dated 7/19/24 and was coded as a quarterly assessment. The electronic medical record indicated the assessment was "in progress" and had not been completed.	F 638	Residents #17, #81, #24, #42, and #19 continue to reside in the facility and remain in stable condition. A quarterly assessment was completed for each resident between the dates of 8/7/2024 through 8/9/2024 and transmitted on 08/09/2024. On 8/23/2024, the Director of Nursing completed an audit of residents due for a quarterly assessment within the past 30 days to ensure quarterly assessments were completed timely. Areas of concern were addressed. On 8/23/2024 the Director of Nursing educated the MDS nurse regarding timely	8/28/24

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F 638	Continued From page 18 b. Resident #81 was admitted to the facility on 2/27/24. A review of Resident #81's most recent MDS assessment was dated 7/16/24 and was coded as a quarterly assessment. The electronic medical record indicated the assessment was "in progress" and had not been completed. c. Resident #42 was admitted to the facility on 7/1/20. A review of Resident #42's most recent MDS assessment was dated 7/20/24 and was coded as a quarterly assessment. The electronic medical record indicated the assessment was "in progress" and had not been completed. d. Resident #24 was admitted to the facility on 2/22/22. A review of Resident #24's most recent MDS assessment was dated 7/23/24 and was coded as a quarterly assessment. The electronic medical record indicated the assessment was "in progress" and had not been completed. e. Resident #19 was admitted to the facility on 06/11/13. A review of the medical record revealed a quarterly MDS assessment was completed on 4/23/24. A review of Resident #19's most recent MDS assessment was dated 7/20/24 and was coded as a quarterly assessment. The electronic medical record indicated the assessment was "in progress" and had not been completed.	F 638	completion of quarterly MDS assessments. Director of Nursing will review the timely completion of quarterly assessments to ensure the MDS nurse completes and transmits quarterly assessments timely. Audit will be completed 5 times a week for 4 weeks then monthly for 2 months. Director of Nursing will present audits to Quality Assurance Performance Improvement (QAPI) committee for review for 3 months. QAPI committee will determine trends and/or issues that may warrant further monitoring.	

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F 638	Continued From page 19 An interview occurred with the MDS nurse on 8/7/24 at 11:46 AM, who stated the quarterly MDS assessments for Residents #17, #81, #42, #24 and #19 had not been completed as required. She explained that there had been a lot of admissions and discharges, and she had gotten behind. The MDS nurse stated she was in the process of getting the assessments completed and transmitted. On 8/7/24 at 12:24 PM, the Administrator and Director of Nursing were interviewed and stated they expected the MDS assessments to be completed within the required time frame.	F 638		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to	F 640		8/28/24

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F 640	Continued From page 20 standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment within the required time frame for 1 of 4 residents reviewed for MDS assessments (Residents #61). The findings included: Resident #61 was admitted to the facility on 05/23/24.	F 640	Resident #61 no longer resides in the facility. Resident #61's discharge MDS was completed and transmitted on 08/09/2024. On 8/23/2024, the Director of Nursing audited residents discharged within the past 30 days to ensure a discharge MDS assessment was completed timely. Areas of concern identified during audit were	

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F 640	Continued From page 21 A review of Resident #61's most recent MDS assessment was dated 7/20/24 and was coded as a discharge assessment. The electronic medical record indicated the assessment was "in progress" and had not been transmitted. An interview was conducted on 08/07/24 at 11:48 AM with the MDS nurse. She stated the discharge MDS assessment for Resident #61 had not been completed as required. She explained that there had been a lot of admissions and discharges, and she had gotten behind. The MDS nurse stated she was in the process of getting the assessment completed and transmitted. An interview was conducted on 08/07/24 at 11:52 AM with the Administrator and Director of Nursing. They stated the MDS assessment should be completed within the required time frame.	F 640	corrected immediately by the MDS nurse. On 8/23/2024 the Director of Nursing educated the MDS nurse regarding timely completion of discharge MDS assessments. Director of Nursing will review the timely completion of discharge assessments to ensure the MDS nurse completes and transmits discharge assessments timely. Audit will be completed 5 times a week for 4 weeks then monthly for 2 months. Director of Nursing will present audits to Quality Assurance Performance Improvement (QAPI) committee for review for 3 months. QAPI committee will determine trends and/or issues that may warrant further monitoring.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, physician and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of urinary status, and upper extremity range of motion. This was for 2 of 19 MDS assessments reviewed (Resident #37 and Resident #49). The findings included:	F 641	Residents # 37 and #49 continue to reside in the facility and remain in stable condition. Resident #37's 7/7/2024 MDS Section H Bladder and Bowel was revised to indicate Subsection H0300 Urinary Continence as "note rated" on 8/9/2024 and transmitted on 8/9/2024. Resident #49's 6/8/2024 MDS Section GG Activities of Daily Living was revised to indicate	8/28/24

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F 641	Continued From page 22 1. Resident #37 was admitted to the facility on 7/1/24. Her diagnoses included neuromuscular dysfunction of the bladder. The Admission Minimum Data Set (MDS) assessment dated 7/7/24 indicated Resident #37 was cognitively intact. She was coded with an indwelling catheter and always incontinent of bladder. A review of the July 2024 physician orders included indwelling urinary catheter to straight drainage related to urinary retention. On 8/7/24 at 11:46 AM, an interview occurred with the MDS Nurse who reviewed the 7/7/24 admission MDS assessment and indicated Resident #37 should have been marked as not rated for urinary continence since she had a urinary catheter during the MDS 7-day look back period. She felt the error was an oversight. The Administrator and Director of Nursing were interviewed on 8/7/24 at 12:24 PM and stated they would expect the MDS to be coded accurately. 2. Resident #49 was admitted on 9/1/23 with a diagnosis of dementia with severe behavioral disturbance. An observation was completed on 8/5/24 at 11:48 AM. Resident #49 was sitting at a table in the common area waiting for his lunch tray. There was no evidence of any problems with his range of motion to either of his hands. A review of his quarterly Minimum Data Set	F 641	limited range of motion in Subsection 0115 on 8/23/2024 and transmitted on 08/23/2024. On 8/23/2024 the Director of Nursing completed an audit of residents' MDS Sections G and H to ensure information coded accurately reflects resident's condition. Areas of concern identified during audit were corrected immediately by the MDS nurse. On 8/23/2024 the Director of Nursing educated the MDS nurse regarding accurately coding the residents' MDS to ensure information provided accurately reflects resident's condition. The Director of Nursing will review Sections G and H to ensure the MDS Assessment accurately reflects the resident's current condition. Audit will be completed 5 times a week for 4 weeks then monthly for 2 months. The Director of Nursing will present the findings of audits to Quality Assurance Performance Improvement (QAPI) committee for review for 3 months. QAPI committee will determine trends and/or issues that may warrant further monitoring.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 23	F 641		

(MDS) dated 6/8/24 was coded for limited range of motion on one side of his upper extremities. A review of his previous quarterly MDS dated 3/8/24 indicated he was not coded for impairment to either of his upper extremities.

A review of Resident #49's comprehensive care last revised on 8/4/24 did not include information or interventions to include a right upper extremity range of motion impairment.

A review of a Medical Director (MD) progress note dated 5/31/24 read Resident #49 was being seen via video link. The note did not include a diagnosis of right sided hemiparesis but did note under the neurological section there was right hemiparesis with a right hand contracture on visual assessment.

An interview and observation of Resident #49 was completed on 8/5/24 at 2:40 PM with Nursing Assistant (NA) #2. While observing Resident #49, NA #2 stated the resident did not have a hand contracture or any decrease in range of motion in any of his extremities.

An interview and observation of Resident #49 was completed with the MD on 8/6/24 at 12:00 PM. Upon observation, the MD stated during the video visit on 5/31/24, it must have been the way Resident #49 was holding his right hand that lead him the believe he had a right hand contracture but on assessment today (8/6/24), he had been mistaken and Resident #49 did not have right sided hemiparesis or a right hand contracture and was sorry if he caused any confusion.

An interview was completed on 8/6/24 at 3:25 PM with Nurse #1. She stated she always worked this

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	345509	A. BUILDING _____ B. WING _____	C 08/08/2024

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F 641	Continued From page 24 unit and was familiar with all of the residents. She confirmed Resident #49 had never hand a right hand contracture. An interview was completed on 8/7/24 at 11:45 AM with the MDS Nurse. When asked about the quarterly MDS dated 6/8/24 compared to the previous quarterly dated 3/8/24 in the area of upper extremity range of motion, she explained she read the MD progress note dated 5/31/24 and coded the assessment based on that note. When asked if she observed Resident #49's right hand, she stated she had but did not think she should question the MD. An interview was completed on 8/7/24 at 12:24 PM with the Administrator and the Director of Nursing (DON). The DON stated she expected the MDS to question the MD if she knew his documentation was inaccurate or if she was not comfortable in doing so, she should have come to her and she would have done it. The Administrator stated she expected Resident #49's quarterly MDS dated 6/8/24 to be coded accurately in the area of range of motion.	F 641		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 943		8/28/24

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F 943	Continued From page 25 §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide abuse training to Nurse #2 prior to her working at the facility. This was for 1 of 5 employees reviewed for abuse training. The findings included: An interview with the Director of Nursing (DON) was conducted on 08/06/24 at 1:15 PM. She stated there was an incident of resident to resident abuse on 07/21/24 at 2:45 AM. Nurse #2, agency nurse, was the nurse on duty when Resident #19 slapped Resident #9. The DON explained Nurse #2 did not notify the administration after the incident because she did not feel it was abuse. The DON further explained that orientation training, which included the abuse policy, was given to Nurse #2 on 07/21/24. Review of orientation training, dated 07/19/24 through 07/22/24, which included the abuse policy, was signed by Nurse #2 on 07/21/24 at 7:00 PM. A phone interview was conducted on 08/08/24 at 4:20 PM with Nurse #2. She verified 07/20/24 was the first time she worked at the facility and then returned on 07/21/24 from 7:00 PM until 7:00 AM. She also verified she was the nurse for Resident #19 and #9 on the night of 07/21/24. She stated at approximately 2:45 AM on 07/21/24	F 943	Residents # 9 and #19 continue to reside in the facility in stable condition. They remain in separate rooms. The nurse was educated on 7/21/2024 by the Director of Nursing at the beginning of her shift and re-educated on 7/22/2024 by the Administrator regarding circumstances that constitutes abuse and reporting abuse to the Administrator immediately upon identification of occurrence. On 7/22/2024, the Regional Nurse Consultant educated Administrator regarding the notification of Adult Protective Services (APS) with abuse allegations that involves residents. On 8/20/2024, the Administrator initiated an in-service with staff regarding facility policy on reportable events to include but not limited to abuse that require immediate reporting to the Administrator even if allegations are not substantiated during initial investigation. Any staff who did not receive the education will be educated prior to beginning their next scheduled shift. Any newly hired staff member will be educated in orientation by the Director of Nursing or Staff Development Coordinator.	

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F 943	Continued From page 26 Nursing Assistant (NA) #3 informed her Resident #19 slapped Resident #9 and she immediately separated the two residents. She moved Resident #9 to a different room. Nurse #2 further stated she did not call to report the incident to the Administrator because she was unaware of the facility policy regarding abuse. Nurse #2 then stated she received orientation education from the Director of Nursing which included the abuse policy on 07/21/24 at 7:00 PM. An interview with the Administrator was conducted on 08/06/24 at 1:39 PM. She explained that Nurse #2, an agency nurse, was the nurse on duty when Resident #19 slapped Resident #9. She stated she had Nurse #2 come to the facility on 07/22/24 to write a statement related to the incident. When the Administrator questioned her on why she did not notify administration after Resident #19 slapped Resident #9, Nurse #2 told her because she did not feel it was abuse. Nurse #2 was reeducated on the abuse policy on 07/22/24 by Administrator. The Administrator indicated the goal was for agency staff to be provided orientation prior to working their first shift by the DON.	F 943	The Administrator will review the investigative folder for facility-initiated reportable events, including allegations of abuse weekly for 4 weeks. This audit is to ensure staff reported abuse immediately to the Administrator and/or the Director of Nursing. The Interdisciplinary Team will review progress notes and grievance logs 5 days weekly for 4 weeks, then 3 days weekly for 2 months to identify any event that may be construed as abuse to ensure allegations of abuse are reported per facility protocol and HCPR guidelines when indicated. The Administrator will forward findings to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to determine trends and/or issues that may require further interventions put into place and to determine the need for further and/or frequency of monitoring.	