STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HEALTH AND REHABILITATION	625 ASHLAND STREET ARCHDALE, NC 27263

(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 on 11/17/24 through 11/21/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# IHOY11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/17/24 through 11/21/24. Event ID# IHOY11. The following intakes were investigated NC00218969, NC00219662, NC00216867, NC00217670, NC00220795, NC00220282, NC00218168, NC00220810, NC00220548, NC00222794, NC00220671, NC00220365, and NC00212944. 16 of the 53 complaint allegations resulted in deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		12/18/24

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

Electronically Signed | 12/19/2024

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F 561	Continued From page 1 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to honor a resident's request for his hair to be trimmed to his preferred length by not coordinating a hair cut despite staff's knowledge of the resident's preference. This deficient practice affected 1 of 2 residents reviewed for choices (Resident #48). The findings included: Resident #48 was admitted to the facility on 08/05/24 with diagnoses which included muscle weakness. Review of Resident #48's admission Minimum Dat Set (MDS) dated 08/12/24 revealed the resident was cognitively intact. Review of Resident #48's care plan revealed the resident had an activity of daily living (ADL) self-care performance due to weakness and cognitive loss. The goal was for Resident #48 to improve the current level of function in (ADL) through the next 90 days. Interventions included Resident #48 would be able to provide personal	F 561	1. The Executive Director hired a beautician on 12/3/24 to provide choices to resident #48 to trim hair as resident #48□s preference. 2. All residents have the potential to be affected by the deficient practice. Any resident who has the desire to have a haircut to his/her preferred length, the facility will provide a beautician for resident preferred choices. A facility audited and completed by the Director of Nursing and Unit Managers to ensure any residents who has long hair and in need of a haircut get a haircut if he/she desires or the responsible party desires for the resident to get a haircut. An ADHOC Quality Assurance Performance Improvement Committee will be held on 12/11/2024 to formulate and approve a plan of correction for the deficient practice.	

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F 561	Continued From page 2 hygiene and oral care with supervision. An observation and interview conducted with Resident #48 on 11/17/24 at 12:10 PM revealed the resident's hair was long around his ears and down his neck. Resident #48 further revealed he was frustrated because he had not had his hair trimmed since admission and disliked his hair being long. Resident #48 indicated he had reported to multiple staff but could not recall their names that he needed a haircut but staff reported there was not a beautician at the facility. Interview conducted with Nurse #1 on 11/20/24 at 9:42 AM revealed there had not been a beautician to cut hair for several months. Nurse #1 further revealed nursing staff were unable to cut or trim hair due to not being trained or licensed. Nurse #1 stated she had heard several residents complain that they would like their hair to be cut or fixed. Nurse #1 indicated Resident #48 was a clean and well-kept resident and preferred his hair shorter. Interview conducted with Nurse Aide (NA) #1 on 11/20/24 at 9:58 PM revealed she consistently cared for and assisted Resident #48 with hygiene care. NA #1 further revealed she had never been educated to trim or cut hair. NA #1 stated she had heard other residents complain about there not being a facility beautician. NA #1 indicated she had not observed anyone working in the beauty shop in several months. Interview conducted with the Director of Nursing (DON) on 11/20/24 at 11:05 AM revealed she was aware residents had complained of not receiving haircuts. The DON further revealed facility staff were not allowed to cut hair, and it would have to	F 561	3. A beautician was hired on 12/3/24. An ongoing audit will be conducted by the nurse managers weekly for 12 weeks for 5 residents a week to ensure choices to receive a haircut is provided timely to any resident who desires a haircut of residents/responsible party choice for residents who are unable to make choices known. The Executive Director will review in QAPI monthly for 3 months. 4. An ongoing audit will be conducted by the nurse managers weekly for 12 weeks for 5 residents a week to ensure choices to receive a haircut is provided timely to any resident who desires a haircut. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director,	

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F 561	Continued From page 3 be done by a trained and licensed beautician. The DON indicated she was not aware Resident #48 preferred a haircut but expected residents to receive what they prefer. Interview conducted with the Administrator on 11/20/24 at 2:15 PM revealed he did not recall Resident #48 or other residents complain of not having their hair cut. It was further revealed he was aware the facility did not have anyone to cut hair for several months. The Administrator indicated he was working on getting someone hired, but expected for residents to get a hair cut if they would like.	F 561	Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. 5. 12/18/2024	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		12/18/24

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F 623	Continued From page 4	F 623		

made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 5 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to provide the resident and/or the Responsible Party with a written notification of the reason for a hospital transfer for 2 of 2 residents reviewed for hospitalization (Residents #37 &	F 623	1. Resident #37 and Resident #30 responsible party not notified of transfer/discharge. The Social Worker was educated by the Director of Nursing on the transfer/discharge process and	

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F 623	Continued From page 6 #30). The findings included: 1.Resident #37 was admitted to the facility on 9/1/23. The significant change Minimum Data Set (MDS) assessment dated 10/30/24 revealed Resident #37 was cognitively impaired. The discharge MDS assessment dated 11/11/24 revealed Resident #37 was discharged to the hospital on 11/11/24 and was readmitted on 11/18/24. Review of the nursing progress notes revealed there was no documentation that Resident #37 received written notice of discharge or transfer when she was sent to the hospital. An interview was conducted with the Social Worker on 11/19/24 at 11:48 am and she indicated that she did not send a transfer/discharge notice to the resident and/or the responsible party (RP) when Resident #37 was sent to the hospital on 11/11/24. She further revealed she was not sure what the process was for issuing the notices. An interview was conducted with the Unit Manager on 11/19/24 at 1:03pm and she indicated that she was the nurse assigned to Resident #37 at the time she was sent out to the hospital on 11/11/24. She further revealed she sent the discharge paperwork with Resident #37 to the hospital, but the paperwork did not include the notice of transfer/discharge to the hospital.	F 623	notification to responsible parties of the cognitive impaired residents and cognitive residents when discharging to the local hospital and updating recipients of the notice as soon as practicable once the updated information becomes available. 2. Any resident can be affected by the deficient practice. The Director of Nursing and Unit managers conducted an audit of all residents who have discharged to the local hospital in the last 30 days to ensure the transfer/discharge notice was completed, responsible party notified, and uploaded into resident chart. The Social Worker and nurses were educated on the process of completing a transfer/discharge notice when sending a resident to the local hospital on 12/16/24. An ADHOC Quality Assurance Performance Improvement Committee will be held on 12/11/2024 to formulate and approve a plan of correction for the deficient practice. 3. The nurses will complete and send notice transfer/discharge when sending any resident to the local hospital before a facility transfers or discharges a resident, the facility must- notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand and place the reasons for the transfer or discharge in the resident's medical record. The	

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F 623	Continued From page 7 Multiple attempts were made to interview Resident #37's Responsible Party (RP), but attempts were not successful. The Administrator was interviewed on 11/19/24 at 2:18 PM and stated he was aware of the requirements to send written notification to the resident and/or RP when a resident was transferred to the hospital. The Administrator indicated it was the Social Services Director responsibility to provide this information and was unaware this had not been completed. 2. Resident #30 was admitted to the facility on 3/29/24. A medical record review revealed Resident #30 was transferred to the hospital on 4/22/24 and readmitted to the facility on 5/1/24. She was transferred again to the hospital on 6/3/24 and readmitted to the facility on 6/8/24. The medical record review indicated there was no evidence the facility had notified the Responsible Party (RP) in writing for the reason for the transfer to the hospital. An interview occurred with the Social Services Director on 11/19/24 at 11:47 AM who stated she had not sent a written reason for the hospital transfer to the resident and/or RP. She indicated she was not aware of this requirement. Nurse #1 was interviewed on 11/19/24 and stated when a resident was transferred to the hospital a face sheet, Do Not Resuscitate information, the Medication Administration Record and any other information related to the hospital transfer were sent with the resident. She was unsure who sent the hospital transfer notice to the resident and/or	F 623	Director of Nursing and Unit Managers will conduct an audit 3 times a week x 12 weeks to ensure transfer/discharge notice is completed, responsible party is notified, and information is uploaded into the resident□s chart prior to sending residents out to the local hospital. The Executive Director will review in QAPI monthly for 3 months. 4. An ongoing audit will be conducted by the Director of Nursing and Unit Managers will conduct an audit 3 times a week x 12 weeks to ensure transfer/discharge notice is completed, responsible party is notified, and information is uploaded into the resident□s chart prior to sending residents out to the local emergency facility. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director,	

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F 623	Continued From page 8 RP. During an interview with the Director of Nursing (DON) on 11/19/24 at 1:57 PM, she indicated the Social Services Director was responsible for sending a written reason for the hospital transfer to the resident and/or RP. Multiple attempts were made to interview Resident #30's RP, which were unsuccessful. The Administrator was interviewed on 11/19/24 at 2:18 PM and stated he was aware of the requirements to send written notification to the resident and/or RP when a resident was transferred to the hospital. The Administrator indicated it was the Social Services Director responsibility to provide this information and was unaware this had not been completed.	F 623	Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. 5. 12/18/24.	
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		12/18/24

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F 625	Continued From page 9 paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide the resident and their Responsible Party (RP) a written notification of the bed hold policy upon a resident's transfer to the hospital for 2 of 2 residents (Resident #37 and & 30) reviewed for hospitalization. This practice had the potential to impact 54 of 54 residents at the facility. Findings included: 1.Resident #37 was admitted to the facility on 9/1/23. The significant change Minimum Data Set (MDS) dated 10/30/24 revealed Resident #37 was cognitively impaired. The discharge assessment dated 11/11/24 revealed Resident #37 was discharged to the hospital on 11/11/24 and was readmitted on 11/18/24. Review of the nursing progress notes revealed there was no documentation that Resident #37	F 625	1. Resident #37 and Resident #30 responsible party not notified of bed hold policy upon discharge to the local hospital. The Nurses were educated by the Director of Nursing on the bed hold policy process and notification to responsible parties of the cognitive impaired residents and cognitive residents when discharging to the local hospital. 2. Any resident can be affected by the deficient practice. The Director of Nursing and Unit managers conducted an audit of all residents who have discharged to the local hospital in the last 30 days to ensure the bed hold policy was completed. The Nurses were educated on the process of completing a bed hold policy when sending a resident to the local hospital on 12/16/24. An ADHOC Quality Assurance Performance Improvement Committee will be held on 12/11/2024 to formulate and approve a plan of correction for the	

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F 625	Continued From page 10 received written notice of the bed hold policy when she was sent to the hospital. An interview was conducted with the social worker on 11/19/24 at 11:48 am and she indicated that she did not send the bed hold policy to the resident, resident representative when Resident #37 was sent to the hospital on 11/11/24. An interview was conducted with the unit manager on 11/19/24 at 1:03pm and she indicated that she was the nurse assigned to Resident #37 at the time she was sent out to the hospital on 11/11/24. She further revealed she sent the discharge paperwork with Resident #37 to the hospital, but the paperwork did not include the notice the bed hold policy information. Multiple attempts were made to interview the resident representative, but attempts were not successful. The Administrator was interviewed on 11/19/24 at 2:18 PM, and stated he was unaware the bed hold policy was not being sent to the resident and/or RP when a hospital transfer occurred. He explained that there was no process for advising a resident and/or their RP of the bed hold policy and one would be put in place. 2. Resident #30 was initially admitted to the facility on 3/29/24. A review of Resident #30's medical record indicated she was transferred to the hospital on 4/22/24 and readmitted to the facility on 5/1/24. Resident #30 was transferred again to the	F 625	deficient practice. 3. The nurses will complete a bed hold policy prior to sending any resident to the local hospital. Before a facility transfers or discharges a resident, the facility must-notify the resident and the resident's representative(s) of the bed hold policy the reasons for the move in writing and in a language and manner they understand and place the bed hold policy in the resident's medical record. The Director of Nursing and Unit Managers will conduct an audit 3 times a week x 12 weeks to ensure a bed hold policy is completed, responsible party is notified, and information is uploaded into the resident□s chart prior to sending residents out to the local hospital. The Executive Director will review in QAPI monthly for 3 months. 4. An ongoing audit will be conducted by the Director of Nursing and Unit Managers will conduct an audit 3 times a week x 12 weeks to ensure a bed hold policy is completed, responsible party is notified, and information is uploaded into the resident□s chart prior to sending residents out to the local hospital. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the	

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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 625	Continued From page 11 hospital on 6/3/24 and readmitted to the facility on 6/8/24. A quarterly Minimum Data Set (MDS) assessment dated 9/15/24 indicated Resident #30 was cognitively intact. An interview occurred with the Social Services Director on 11/19/24 at 11:47 AM, who stated she was unaware of a bed hold policy having to be sent to the resident and/or Responsible Party (RP) when a resident was hospitalized. On 11/19/24 at 12:00 PM, an interview was completed with Nurse #1. She stated she was unaware of a bed hold policy being sent when a resident was transferred to the hospital by the nursing department. The Administrator was interviewed on 11/19/24 at 2:18 PM, and stated he was unaware the bed hold policy was not being sent to the resident and/or RP when a hospital transfer occurred. He explained that there was no process for advising a resident and/or their RP of the bed hold policy and one would be put in place.	F 625	Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. 5. 12/18/2024	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and interviews with residents and staff, the facility failed to provide routine hair trimming as part of	F 677	1. Resident #16 and Resident #26 hair was cut by the beautician.	12/18/24

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	345450	A. BUILDING _____ B. WING _____	C 11/21/2024

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F 677	Continued From page 12 basic hygiene services for residents whose payor source was Medicaid. This was for 2 of 6 residents reviewed for Activities of Daily Living (ADL) (Residents #16 and #26). The findings included: 1. Resident #16 was admitted to the facility on 10/21/22. An annual Minimum Data Set (MDS) assessment dated 8/9/24 indicated Resident #16 was cognitively intact. During an interview and observation with Resident #16 on 11/17/24 at 11:45 AM, he expressed that he would like to have his hair cut as it was longer than he liked to wear it. He explained he had his hair cut about six to eight weeks ago by someone he paid to come cut his hair and that he had asked staff several times about getting his hair cut. Resident #16 was unable to recall the staff that he talked to about getting his hair cut. Resident #16's hair touched his collar in the back and was long around the ears. On 11/19/24 at 3:00 PM, the Social Services Director was interviewed and stated that she had begun employment at the facility towards the end of August 2024 and has not received any concerns about Resident #16 wanting his hair cut. She added she was unsure whose role it was to cut resident's hair. Nurse #1 was interviewed on 11/20/24 at 9:42 AM and stated that nursing staff did not trim resident's hair and didn't know how residents got their haircut.	F 677	2. The Director of Nursing completed a quality review on all residents on ADL care specific to hair trimming as part of basic hygiene for residents who are dependent and whose payer source is Medicaid on 12/11/24. Identified residents were provided with haircuts. On 12/11/24, the Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Clinical Services and or Nursing Supervisor. 3. The Director of Nursing, Nurse Managers re-educated nursing staff on all shifts by 12/16/24 on ADL care specific to residents who are dependent with care and need their hair trimmed, and as indicated for all dependent residents. Education will be completed by 12/16/24. 4. The Director of Nursing will conduct a random audit on 5 residents, weekly for 12 weeks, to ensure all residents who are dependent with care and who have Medicaid can be provided haircuts as indicated. The Director of Nursing will report the results of the quality monitoring audits to the QAPI committee ensure compliance is achieved and maintained, monthly for three months and then quarterly for 2 quarters Findings will be reviewed by QAPI committee monthly and Quality monitoring will be updated as	

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F 677	Continued From page 13 An interview occurred with Nurse Aide #1 on 11/20/24 at 9:58 AM who was familiar with Resident #16. She stated Resident #16 had complained about needing his hair cut but she was unsure who to report it to. She added Nurse Aides did not cut residents hair. The Unit Manager was interviewed on 11/20/24 at 10:42 AM and stated she "had heard" Resident #16 was requesting a haircut, but there wasn't any staff in the building to cut his hair. She was unable to state how residents got their hair cut. The Director of Nursing was interviewed on 11/20/24 at 3:00 PM and stated that she had begun employment at the facility April 2024. She stated currently there was no staff in the facility able to cut hair, but residents could have a beautician/barber come in or their family to cut their hair. She was unaware that routine hair trimming was a covered service for residents whose payor source was Medicaid. An interview was completed with the Administrator on 11/21/24 at 8:15 AM and explained that he was unaware of Resident #16 requesting a haircut but expected residents to be able to get their hair cut as desired. He was unaware that routine hair trimming was a covered service for residents whose payor source was Medicaid. 2. Resident #26 was admitted to the facility on 6/6/23. A quarterly Minimum Data Set (MDS) assessment dated 10/21/24 indicated that Resident #26 was cognitively intact.	F 677	indicated. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse and at least one direct care staff. 5. 12/18/2024	

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F 677	Continued From page 14	F 677		

During an interview and observation with Resident #26 on 11/17/24 at 11:30 AM, he expressed that he would like to have his hair cut as it was longer than he liked to wear it and stated he couldn't recall the last time it was trimmed. He explained he had asked staff several times about getting his hair cut but was unable to recall which staff. Resident #26's hair touched his collar in the back and was long around the ears.

On 11/19/24 at 3:00 PM, the Social Services Director was interviewed and stated that she had begun employment at the facility towards the end of August 2024 and has not received any concerns about Resident #26 wanting his hair cut. She added she was unsure whose role it was to cut resident's hair.

Nurse #1 was interviewed on 11/20/24 at 9:42 AM and stated that nursing staff did not trim resident's hair and didn't know how residents got their haircut

An interview occurred with Nurse Aide #1 on 11/20/24 at 9:58 AM who was familiar with Resident #26. She stated Resident #26 has complained about needing his hair cut but was unsure who to report it to. She added Nurse Aides did not cut residents hair.

The Unit Manager was interviewed on 11/20/24 at 10:42 AM and stated she "had heard" Resident #16 was requesting a haircut, but there wasn't any staff in the building to cut his hair. She was unable to state how residents got their hair cut.

The Director of Nursing was interviewed on

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F 677	Continued From page 15 11/20/24 at 3:00 PM and stated that she had begun employment at the facility April 2024. She stated currently there was no staff in the facility able to cut hair but residents could have a beautician/barber come in or their family to cut their hair. . She was unaware that routine hair trimming was a covered service for residents whose payor source was Medicaid. An interview was completed with the Administrator on 11/21/24 at 8:15 AM and explained that he was unaware of Resident #26 requesting a haircut but expected residents to be able to get their hair cut as desired. He was unaware that routine hair trimming was a covered service for residents whose payor source was Medicaid.	F 677		
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. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews the facility failed to implement interventions to prevent further falls for Resident #6. This was for 1 of 3 residents reviewed for accidents (Resident #6). Findings included:	F 689	1. Resident #6 care plan audited to ensure appropriate interventions are in place for previous falls and appropriate for cognitive loss and unsteady gait. Director of Nursing provided shoes that fit resident #6. 2. The Director of Nursing and Nursing	12/18/24

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F 689	Continued From page 16 Resident #6 was admitted to the facility on 12/06/22 with diagnosis that included unsteadiness on feet, orthostatic hypotension, osteoporosis, and dementia. Resident #6's care plan, last revised 08/20/24, indicated she was risk for falls related to cognitive loss, history of falls, weakness, incontinence, and use of psychotropic medication. Resident #6 also had poor safety awareness and required frequent cueing of safety. She had an unsteady gait and continued to transfer/ambulate without assistance due to cognitive loss. The interventions included the following: · Undated intervention: Ensure that the Resident #6 was wearing appropriate footwear/non-skid socks when ambulating or mobilizing in wheel chair · Fall on 3/17/24: Assist resident with toileting if will allow. · Fall on 3/27/24: Re-orient resident to transfer status. · Fall on 5/29/24: Educate family on appropriate footwear. · Fall on 07/28/24: Encourage Resident #6 to call out for assistance with ambulation. Review of the quarterly Minimum Data Set (MDS) dated 08/12/2424 revealed Resident #6's cognition was severely impaired. She was independent with bed mobility and required supervision or touching assistance with toilet transfers, and chair to bed transfers. She was also coded as requiring moderate assistance with	F 689	Managers completed a quality review on all residents who has had falls in the last 30 days to ensure appropriate fall interventions are in place. On 12/11/24, the Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director, Director of Clinical Services and or Nursing Supervisor. 3. The Director of Nursing, Nurse Managers re-educated nursing staff on all shifts by 12/16/24 on ADL care specific to residents who are dependent with care and need their hair trimmed, and as indicated for all dependent residents. Education will be completed by 12/16/24. The Executive Director will review in QAPI monthly for 3 months. 4. The Director of Nursing will conduct an audit 3 times a week x12 weeks to ensure all residents who have a fall are care planned for appropriate fall interventions as indicated. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be	

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F 689	Continued From page 17 dressing, personal hygiene, and shower transfers and required maximal assistance with toilet hygiene and shower/baths. She had no range of motion impairments. There was one fall coded during the look-back period. Review of the quarterly Minimum Data Set (MDS) dated 07/28/24 revealed Resident #6's cognition was severely impaired. She was independent with bed mobility and required supervision or touching assistance with toilet transfers, and chair to bed transfers. She was also coded as requiring moderate assistance with dressing, personal hygiene, and shower transfers and required maximal assistance with toilet hygiene and shower/baths. She had no range of motion impairments. There was one fall coded during the look-back period. Review of incident report dated 05/29/24 revealed Resident #6 was observed on the floor on her back with a laceration to the back of the head. Resident #6 stated she was looking out of the window, took a step back, and lost her balance. Predisposing situation factors included improper footwear and ambulating without assistance. Other information noted read that shoes were observed to be too big. Interdisciplinary team note read to educate family on appropriate footwear. Review of incident report dated 07/28/24 revealed Resident #6 was observed sitting on bathroom floor with a "goose egg" noted to the back of her head, pain to her knuckles. and a skin tear to her right forearm. Resident #6's shoes were noted to be too big. Resident #6 stated she slipped. Interdisciplinary team note read for Resident #6 encouraged to call out for assistance with ambulation.	F 689	modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. 5. 12/18/2024	

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F 689	Continued From page 18	F 689		

An observation and interview were conducted on 11/19/24 at 1:30 PM with Resident #6. She stated her shoes are about a half size too big. Resident was lying on her bed, fully dressed in slacks, a blouse, and tennis shoes. Her feet were crossed, and the back of her shoe/heel was visible revealing a gap approximately a inch between her heel and the inside of the heel of the shoe. She then stated her shoes do alter her balance at times resulting in her falling.

An interview was conducted on 11/19/24 at 1:50 PM with Nursing Assistant #4. She stated Resident #6's shoes are little big on her however she requested to wear them. She then stated that tennis shoes and a pair of house slippers was the only shoes Resident #6 had.

An interview was conducted on 11/19/24 at 1:50 PM with the Director of Nursing (DON). She stated she was aware Resident #6's shoes were too big after a fall on 05/29/24. An intervention was added to her focus for falls on 05/29/24 to educate family on appropriate footwear. She also stated she was under the impression the family had been notified to bring shoes that fit properly. She indicated she had not gone and looked at Resident #6's shoes. She explained that the intervention that was put in place after the 05/29/24 should have included preventions that the facility could do to prevent further falls due to her shoes being too big. She explained that she expected staff not to use the tennis shoes if they were too big and to use non-skid socks. The DON was aware Resident #6 had fallen again on 07/28/24 due to her shoes being too big and that she should not have fallen twice for the same reason. The DON further stated she was

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F 689	Continued From page 19 unaware she had not received shoes that fit better and had not followed up on the shoes. She then explained that falls were discussed every morning in the morning meeting and interventions are added to the care plans at that time. An interview was conducted on 11/21/24 at 9:36 AM with the Administrator. He stated he was not aware Resident #6's shoes were too big and possibly causing her falls. He also stated he expected the staff to make sure her shoes fit properly or to apply non-skid socks. He indicated the care plan interventions should reflect and coincide with the reason for the fall and that a root cause investigation should be completed post falls.	F 689		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, Nurse Practitioner, and staff interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 29 opportunities, resulting in a medication error rate of 6.9% for 2 of 3 residents (Resident #5 and Resident #16) during the medication administration observation. The findings included: a. Resident #16 was admitted to the facility on	F 759	1. The Director of Nursing completed medication administration competencies on nurses on the importance of administering all ordered mediations to all residents using the policy and procedures of medication administration. 2. Any resident has the potential to be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 12/11/2024 to formulate and approve a	12/18/24

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F 759	Continued From page 20 10/21/22 with a diagnosis of retention of urine. A review of Resident #16's active Physician's orders included a current order for Macrobid (antibiotic) capsules 100 milligrams initiated on 11/4/24, one capsule one time daily for long term urinary tract infection prophylaxis. On 11/19/24 at 8:25 AM, the Unit Manager, who was working as a floor nurse, was observed as she prepared 11 of 12 medications for Resident #16. It was noted the Unit Manager had pulled the card containing the ordered Macrobid out of the medication cart, but instead of dispensing the medication in the cup with the others, she laid the medication card down on top of the cart. The nurse then went into the resident's room to administer the other medication. She was asked to step out of the room to the medication cart and then asked to count the medications in the cup. She counted only 11 different medications. She was interviewed about the missing dose, and the Unit Manager stated she should have dispensed the antibiotic with the other medications being administered. She then proceeded to administer the antibiotic as well. b. Resident #5 was admitted to the facility on 10/16/13 with a diagnosis of dry eye. A review of Resident #5's active physician's orders included a current order for the month of November for Artificial Tears one drop in both eyes every morning and at bedtime for dry eye. On 11/19/24 at 9:08 AM, the Unit Manager was observed as she prepared 10 of the 11 medications ordered for Resident #5. It was noted that the Unit Manager took the Artificial Tears out of the medication cart and laid them on top of the cart. Once she had administered the oral	F 759	plan of correction for the deficient practice. 3. The Director of Nursing will contact the local Pharmacy to conduct medication administration audits with nurses to ensure medications are being provided per policy and procedures. The Director of Nursing and Unit Managers will conduct a random audit 3 times a week x 12 weeks to ensure all residents are being administered medications as ordered by the Physician. The Executive Director will review in QAPI monthly for 3 months. 4. An ongoing audit will be conducted by the Director of Nursing and Unit Managers will conduct a random audit 3 times a week x 12 weeks to ensure all residents are being administered medications as ordered by the Physician. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the	

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F 759	Continued From page 21 medication the Unit Manager then stated she was going to wheel Resident #5 down to the cafeteria as that was the resident's preferred location to visit with others during the day. She left the area without dispensing the eye drops. On 11/19/24 at 9:22 AM the Unit Manager was interviewed and stated she should have given the eye drops but that she forgot she had not given them. On 11/19/24 at 12:10 PM the Nurse Practitioner was interviewed regarding the missed medications. She stated it was her expectation that the nurses follow her orders and give the medications as she had written. The Director of Nursing was interviewed on 11/19/24 at 3:12 PM. She stated it was her expectation that the nurses give all medications as they are ordered. The Administrator was interviewed on 11/19/24 at 3:20 PM. He stated he expected the nurses to follow the medication administration policy and administer medications from one hour before the ordered time to one hour after the ordered time.	F 759	Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. 5. 12/18/2024	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		12/18/24

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F 761	Continued From page 22 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to date opened vials of insulin and insulin pens stored 2 of 2 medication carts (B and C hall cart, and D and E hall cart) the facility failed to keep a medication refrigerated per manufacturer guidelines in 1 of 2 medication carts (B and C hall cart), and also failed to discard expired medications in 1 of 1 medication storage room. The findings included: a. An observation was conducted on 11/19/24 at 11:19 AM of the D and E hall cart with Nurse #1. The observation revealed 5 Lispro insulin pens were opened and undated, 2 of the 5 Lispro insulin pens were not labeled with resident names, 1 Lantus insulin pen was opened and undated, 1 Basaglar insulin pen was opened and undated. Nurse #1 verbalized that all opened	F 761	1. The Director of Nursing observed all medication carts to ensure all insulins were labeled, medications not out of date, TB solution is dated and stored in the refrigerator. The Director of Nursing educated nurses per policy and procedures on labeling and storage of medications. 2. All residents have the potential to be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 12/11/2024 to formulate and approve a plan of correction for the deficient practice.	

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F 761	Continued From page 23 medications should have been dated with the date they were opened. The medications were given to Nurse #3 to be discarded. Per the manufacturer's instructions, insulin should be discarded after 28 days of opening, b. An observation was conducted on 11/19/24 at 2:14 PM of the B and C hall cart with the Unit Manager. The observation revelaed 1 vial of Lantus insulin was opened and undated, 1 Lantus insulin pen was opened and undated, 1 Insulin Aspart pen was opened and undated, 1 Basaglar pen was opened and undated, 1 Ozempic pen was opened and undated. Per the manufacturer's instructions, insulin should be discarded after 28 days of opening, The observation also revealed 2 vials of tuberculin purified protein derivative (PPD) testing solution opened and undated, and they were stored in the same box. The vials were not refrigerated per the manufacturer's instructions that stated PPD vials should always be kept refrigerated and protected from light when not in immediate use. The Unit Manager stated all medications should have been dated when they are opened and that refrigerated medications should have been stored in the refrigerator. The medications were given to the Unit Manager to be discarded. c. An observation of the medication storage room was conducted on 11/19/24 at 3:00 PM with Nurse #1. 1 bottle of stock medication Allergy Relief tabs was unopened, and the manufacturer's stamped expiration date was 9/24. Nurse #1 stated that expired medications should be discarded. The medications were given to Nurse #1 to discard. Pharmacist #1 was interviewed on 11/19/24 at	F 761	3. The Director of Nursing will educate nurse on the policy and procedures of medication labeling and storage. The Director of Nursing and Unit Managers will conduct audits weekly for 12 weeks to ensure medications are labeled and stored per policy and procedures. The Director of Nursing will report the results of the quality monitoring audits to the QAPI committee ensure compliance is achieved and maintained, monthly for three months and then quarterly for 2 quarters Findings will be reviewed by QAPI committee monthly and Quality monitoring will be updated as indicated. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse and at least one direct care staff. 4. The Director of Nursing and Unit Managers will audit weekly for 12 weeks to ensure medications are labeled and stored per policy and procedures. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee	

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F 761	Continued From page 24 4:25 PM. He stated he visits the facility once each month. His last visit was on November 12th. He verbalized he sample audited 10% of the carts during his visit. He stated he gave the few expired or undated medications to be disposed of by the nurse. On 11/19/24 at 3:12 PM the Director of Nursing (DON) was interviewed. She stated she expected the nurses to date all medications when they are opened and store them correctly. She stated that insulin was supposed to be discarded 28 days after opening. She revealed that the unit managers were responsible for auditing the medications carts for expired medications. The Administrator was interviewed on 11/19/24 at 3:20 PM. He stated he expected the nurses to date all medications when they were opened. He stated he expected insulin to be discarded 28 days after being opened.	F 761	and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. 5. 12/18/2024	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		12/18/24

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F 842	Continued From page 25	F 842		

that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(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, 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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(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(h)(5) The medical record must contain-

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F 842	Continued From page 26 (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 reviews, and staff interviews, the facility failed to have complete and accurate documentation for wound care (Residents #30, #55 and #56). This was for 3 of 35 resident records reviewed. The findings included: 1. Resident #30 was originally admitted to the facility on 3/29/24 with diagnoses of surgical aftercare for right below the knee amputation, and diabetes type 2. Resident #30 was seen in the hospital 4/22/24 to 5/1/24 for wound healing complication to the right below the knee amputation site. She underwent a revision to an above the knee amputation and returned to the facility for surgical wound care. Resident #30 required another hospitalization from 6/3/24 to 6/8/24 for altered mental status. Resident #30's physician orders revealed the following: - An order dated 6/10/24 to clean the wound to the left forearm with wound cleanser, apply Xeroform gauze (a sterile, medicated,	F 842	1. The Director of Nursing and Unit Managers conducted an audit for the past 30 days to ensure wound care treatments are documented as provided without any omissions. Residents #30, #55, and #56 treatment records were audited for the past 30 days to ensure there was no omissions. 2. All residents have the potential to be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 12/11/2024 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing will educate nurse on the policy and procedures of documentation of treatments per policy and procedures. The Director of Nursing and Unit Managers will audit daily in clinical for 12 weeks to ensure treatments are provided and documented per policy	

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F 842	Continued From page 27 non-adhering protective dressing) and a dry dressing daily. - An order dated 6/10/24 to cleanse the surgical incision to the right leg with normal saline. Apply Xeroform gauze and dry dressing daily. The June 2024 Treatment Administration Record (TAR) was reviewed and revealed the left forearm and right leg wound care had not been documented as completed or refused by Resident #30 for the day shift on 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/15/24, 6/16/24, 6/24/24, and 6/27/24. On 11/20/24 at 1:20 PM, an interview occurred with the Unit Manager. She explained she had been the facility wound care nurse from March 2024 until November 2024. She explained that she was pulled to the floor a lot during the month of June 2024 but always made sure the wound care had been completed. She was scheduled for the 7:00 AM to 7:00 PM shift on 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/24/24 and 6/27/24 and could not recall Resident #30 refusing wound care to her left forearm or right leg. She verified the dates in question and stated she completed the wound care as ordered but had forgotten to sign them as completed. The DON was interviewed on 11/20/24 at 3:00 PM. She was scheduled on the 7:00 AM to 7:00 PM shift to care for Resident #30 on 6/15/24 and 6/16/24. After reviewing the TAR she stated she could not recall Resident #30 refusing wound care and that she completed it as ordered but must have forgotten to sign it off as completed. The DON added she would expect documentation to be complete and accurate.	F 842	and procedures. The Director of Nursing will report the results of the quality monitoring audits to the QAPI committee ensure compliance is achieved and maintained, monthly for three months and then quarterly for 2 quarters Findings will be reviewed by QAPI committee monthly and Quality monitoring will be updated as indicated. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director, and Minimum Data Assessment Nurse and at least one direct care staff. 4. The Director of Nursing and Unit Managers will audit daily in clinical for 12 weeks to ensure treatments are provided and documented per policy and procedures. The results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee	

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F 842	Continued From page 28 An interview was completed with the Administrator on 11/21/24 at 8:15 AM, who stated he expected wound care documentation to be complete and accurate. 2. Resident #55 was admitted to the facility on 4/18/24 with diagnoses that included a right femur fracture, end stage renal disease and congestive heart failure. Resident #55's physician orders included the following: " An order dated 5/3/24 to cleanse the open area to the coccyx with wound cleanser, apply calcium alginate (a highly absorbent dressing) and cover with bordered gauze every night shift. This order was changed on 5/8/24 to be completed during the day shift. On 5/15/24 this order was changed to cleanse the pressure wound to the coccyx with wound cleanser, apply calcium alginate with silver and a super absorbent dressing every day. " An order dated 5/8/24 to cleanse the pressure wound to the left hip with wound cleanser, apply calcium alginate and cover with bordered gauze every day shift. The May 2024 TAR was reviewed and revealed the left hip and coccyx wound care had not been documented as completed or refused by Resident #55 on 5/3/24, 5/4/24, 5/5/24, 5/10/24, 5/11/24, 5/13/24, 5/14/24, 5/16/24 and 5/19/24. On 11/19/24 at 2:00 PM, a phone interview occurred with Nurse #2 who was scheduled to care for Resident #55 on 5/14/24 and 5/19/24. She stated she made sure wound care was completed but may have forgotten to document it	F 842	members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. 5. 12/18/2024	

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F 842	Continued From page 29	F 842		

as complete.

A phone interview was completed with Nurse #3 on 11/20/24 at 2:04 PM. She was scheduled to care for Resident #55 on the night shift on 5/3/24, 5/4/24, 5/5/24 and 5/13/24. She could not recall Resident #55 refusing wound care and stated she always ensured it was completed but may have forgotten to document that it was completed.

A phone interview was completed with Nurse #4 on 11/20/24 at 2:10 PM, who was scheduled to care for Resident #55 on the night shift on 5/11/24. He could not recall Resident #55 refusing wound care but may have gotten busy and forgot to document the wound care as completed.

On 11/20/24 at 2:23 PM, a phone interview occurred with Nurse #5 who was scheduled to care for Resident #55 on 5/16/24. She recalled Resident #55 and could not recall her refusing wound care. She stated she forgot to sign the TAR that the wound care had been completed.

The DON was interviewed on 11/20/24 at 3:00 PM. She reviewed the May 2024 TAR for Resident #55 and stated she would expect the documentation to be complete and accurate.

An interview was completed with the Administrator on 11/21/24 at 8:15 AM, who stated he expected wound care documentation to be complete and accurate.

3. Resident #56 was admitted to the facility on 3/26/24 with diagnoses that included diabetes

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type 2 and a stage 3 pressure ulcer to the sacral region.

A review of the Resident #56's physician orders included an order dated 5/23/24 to cleanse the pressure ulcer to the sacrum with normal saline. Apply calcium alginate with silver and collagen powder to the wound bed and cover with a bordered gauze every day shift.

The June 2024 TAR was reviewed and revealed the sacral wound care had not been documented as completed or refused by Resident #56 on 6/3/24, 6/4/24, 6/6/24, 6/7/24, 6/8/24, 6/9/24, 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/15/24, 6/16/24, 6/24/24 and 6/25/24.

On 11/20/24 at 1:20 PM, an interview occurred with the Unit Manager. She explained she had been the facility wound care nurse from March 2024 until November 2024. She explained that she was pulled to the floor a lot during the month of June 2024 but always made sure the wound care had been completed. She was scheduled for the 7:00 AM to 7:00 PM shift on 6/4/24, 6/6/24, 6/7/24, 6/8/24, 6/9/24, 6/10/24, 6/11/24, 6/12/24, 6/13/24, 6/24/24 and 6/25/24 and could not recall Resident #56 refusing wound care to her sacrum. She verified the dates in question and stated she completed the wound care as ordered but had forgotten to sign them as completed.

The DON was interviewed on 11/20/24 at 3:00 PM. She reviewed the May 2024 TAR for Resident #56 and stated she would expect the documentation to be complete and accurate.

An interview was completed with the Administrator on 11/21/24 at 8:15 AM, who stated

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F 842	Continued From page 31 he expected wound care documentation to be complete and accurate.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		12/18/24

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F 880	Continued From page 32 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to disinfect a glucometer (used to check a resident's blood glucose level) after using per manufacturer's guidelines for 1 of 1 resident (Resident #29). The glucometer was individually assigned to Resident #29 and stored in the medication cart.	F 880	1. The facility has established an infection prevention program that includes preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, and visitors according to the national standards on	

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F 880	Continued From page 33 The findings included: Review of facility policy titled "Blood Glucose Monitoring and Disinfecting" revised date 4/20/22 read in part; clean and disinfect the meter with disinfecting wipes (per manufacture guidelines), place meter in resident specific bag for storage. Review of the glucometer manufacturer's guidelines stated to disinfect, the meter's surface should be thoroughly wet with a Sani cloth wipe and allowed to remain wet for a full 2 minutes. Let air dry. A continuous observation was made on 11/19/24 from 1:04 PM to 1:10 PM. Nurse #1 opened the medication cart and removed the glucometer labeled for Resident #29. She then entered Resident #29's room prepared to check her blood glucose level. She cleaned Resident #29's finger on her left hand with an alcohol swab and then pricked the finger with a lancet device to obtain a blood sample. Nurse #1 then placed a drop of blood onto the testing strip that had been inserted into the glucometer. Nurse #1 then disposed of the trash. She removed her gloves and exited the room. She proceeded back to the medication cart where she performed hand hygiene. She then opened the bottom drawer of the cart, retrieved the pouch labeled with Resident #29's name and placed the used meter into the pouch and put it back into the medication cart without cleaning it and closed the drawer. Nurse #1 was immediately interviewed regarding the facility's policy for cleaning glucometers after use. She stated that it was the policy to clean the meters both before and after use. Nurse #1 then	F 880	12/11/24. The Director of Nursing conducted surveillance to ensure nurses are properly disinfecting glucometers after use per manufacturer□s guidelines for resident #29. 2. Any resident who requires glucose monitoring can be affected by the deficient practice. An ADHOC Quality Assurance Performance Improvement Committee will be held on 12/11/2024 to formulate and approve a plan of correction for the deficient practice. 3. The Director of Nursing educated nurses on disinfecting glucometers after each use per manufacturer guidelines. Nurses will be educated on the disinfecting glucometers per manufacturer guidelines on hire. The Director of Nursing and Unit Managers will conduct a random audit on 5 residents 3 times a week x 12 weeks to ensure nurse are disinfecting glucometers per manufacturer guidelines after each resident use. The Executive Director will review in QAPI monthly for 3 months. 4. An ongoing audit will be conducted randomly by the Director of Nursing and Unit Managers on 5 residents 3 times a week x 12 weeks to ensure nurse are disinfecting glucometers per manufacturer guidelines after each resident use. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345450	A. BUILDING _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 34 retrieved the soiled meter out of the cart and wiped it down with an alcohol pad and placed it in a plastic cup to dry. She was questioned about what product was supposed to be used to clean the meters. Nurse #1 stated that she used alcohol swabs to clean the meters, but there was "something specific that was supposed to be used", but she didn't know the name of it. There were no disinfecting wipes on the cart. An interview was conducted with the Director of Nursing on 11/19/24 at 3:12 PM. She stated that nurses were supposed to clean/disinfect the glucometers after testing blood sugars of all residents using Sani wipes and that it is unacceptable to use alcohol swabs. The Administrator was interviewed on 11/19/24 at 3:20 PM. He stated that he expected the facility policy to be followed for cleaning/disinfecting glucose testing meters.	F 880	results of the Quality Improvement Monitoring will be reported to the Quality Assurance Performance Improvement Committee by the Executive Director and or Director of Clinical Services to ensure compliance is achieved and maintained. The Executive Director will present the Plan of Correction to Quality Assurance Performance Improvement Committee and oversee the Quality Improvement Monitoring as observed by the Executive Director. Quality Monitoring scheduled may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff. 5. 12/18/2024	