STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345116	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT HILLS CENTER FOR NURSING AND REHAB	109 S HOLDEN RD GREENSBORO, NC 27407

(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 12/2/24 through 12/5/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RCDT11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investation survey was conducted from 12/2/24 through 12/5/24. Event ID # RCDT11. The following intakes were investigated NC00212413, NC00212716, NC00213280, NC00214417, NC00214596, NC00214811, NC00215178, NC00215480, NC00215565, NC00217305, NC00217360, NC00217530, NC00217574, NC00219095, NC00219975, NC00220850, NC00222483, NC00222845, NC00222885, NC00223001, NC00223425, NC00223429, NC00223995, NC00224640. 13 of 90 complaint allegations resulted in a deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 553		12/30/24

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

Electronically Signed | 12/24/2024

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F 553	Continued From page 1 other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, and resident and staff interviews, the facility failed to offer a resident the opportunity to participate in his care plan meetings for 1 of 1 sampled resident reviewed for care planning (Resident #32). Findings included: Resident #32 was admitted to the facility on 3/10/22 with diagnoses which included: diabetes mellitus with diabetic peripheral angiopathy, vascular dementia, and major depressive disorder. The quarterly minimum data set (MDS) dated 9/12/24 indicated Resident #32 was cognitively	F 553	Resident #32 continues to reside in the facility and remains in stable condition. Care Plan meeting was held with resident and daughter on 12/11/2024. Social Work (SW) entered a note reflecting care plan meeting, items discussed, and resident/daughter response. On 12/20/2024 the Nursing Home Administrator (NHA) and SW completed an audit of upcoming care plan meetings to ensure residents due to have a care plan meeting has documentation of an invitation being sent with date and time of meeting and follow up documentation is in the resident medical record of having the care plan meeting. Any areas of concern	

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F 553	Continued From page 2 intact. During an interview on 12/02/24 at 10:34 a.m., when asked about his care plan meetings, Resident #32 stated he had resided at the facility for two years and no one had ever explained or discussed anything with him. There was no documentation in the medical record or provided by the social worker indicating Resident #32 attended or refused to attend his care plan meetings. An interview with the Director of Social Work (SW) on 12/04/24 at 1:39 p.m., revealed she began working at the facility in January 2024, and her responsibilities included scheduling the quarterly care plan meetings for all the facility's residents. She stated that in preparation for the quarterly meetings, she would send a generalized letter with her phone number to the residents' families informing them of the upcoming care plan meetings encouraging them to attend and to schedule a date and time. Two weeks after the letter, she would telephone the families/responsible parties of residents who were scheduled for a care plan meeting with the scheduled date and time of the resident's meeting. If the family/responsible party had a conflict scheduled date and time, then she would discuss a better date/time convenient for them. The SW stated she would also verbally notify the alert and oriented residents the day before or on the day of the meeting as well as the unit manager to ensure the resident was out of bed and dressed. The SW stated that Resident #32, his wife (via telephone) and/or his son (on-site) have attended the resident's care plan meeting in the designated room in the facility and sometimes	F 553	identified were corrected by the SW. On 12/23/2024 NHA educated SW regarding sending and documenting invitations sent to resident representatives and given to the resident noting date and time of resident's care plan meeting and to provide documentation in the medical record of care plan held, who was in attendance, and discussion held. The NHA or designee will audit care plan meetings to ensure invitations were given to resident and resident representatives with date and time of care plan meeting, that documentation of invitations be sent is in the medical record, and the medical record includes documentation of care plan meeting being held, who was in attendance, and discussion held. Audits will be conducted five (5) times a week for two (2) weeks then two (2) times a week for two (2) weeks then monthly for two (2) months. The NHA will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring.	

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F 553	Continued From page 3 in the resident's room. The SW was unable to recall the date of Resident #32's last care plan meeting. After further review of facility records, the SW revealed there was no documentation available indicating a care plan meeting for Resident #32 was held in October 2024 but acknowledged there should have been. She stated the most recent documented care plan meeting held for Resident #32 was on 3/23/23.	F 553		
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- §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;	F 584		12/30/24

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F 584	Continued From page 4 §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 record review, observations, and resident and staff interviews, the facility failed to maintain walls or baseboards in good condition for 6 of 13 rooms (Room #212, #213, #215, #217, #218 and #222). This occured for 1 of 2 halls (200 hall) reviewed for clean, comforatble, homelike environment. The findings included: 1. A continuous observation on 12/5/24 from 10:45 AM until 11:00 AM revealed the following: a. Resident room # 213 was observed to have baseboard that was not affixed to the wall. The baseboard could be observed leaning from the wall with dry wall exposed behind the baseboard. b. Resident room #212 to have baseboard missing from the wall under the TV under bed B. c. Resident room #215 revealed baseboard to missing beside the bathroom and baseboard was observed to be lyying on the floor by bed B.	F 584	The splatter marks on the walls and debris on room and bathroom doors for rooms 212, 213, 215, 217, 218, and 222 were cleaned on 12/4/2024. Maintenance initiated repairs of baseboards on 12/16/2024 with rooms 212 and 215 baseboards being reattached. On 12/16/2024 the holes in the wall in room 217 had sheetrock repaired. On 12/20/2024 the Nursing Home Administrator (NHA) and Maintenance Director completed a facility-wide audit of baseboards and walls. Areas of concern have been placed in TELS and will be addressed by the Maintenance Director and Maintenance Assistant. Planned repairs of remaining facility rooms will be ongoing. On 12/4/2024 the Nursing Home Administrator and Housekeeping Supervisor initiated a facility-wide audit of walls and doors. Areas of concern were corrected by the Housekeeping Supervisor.	

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F 584	Continued From page 5 d. Resident room #222 was observed was observed to have missing baseboard by bed A. Bed B had a section of baseboard lyying directly on floor. Review of the facility work orders from October 2024 through December 2024 revealed no work orders regarding baseboard repair. A continuous observation and interview was conducted with the Maintenance Assistant on 12/5/24 from 2:00 PM until 2:15 PM. He stated recently the facility began using an electronic system (TAILS) to document and track items that were in need of repair about a month ago. Prior to implementing the electronic tracking system staff would communicate concerns verbally. He revealed he was unaware of the missing baseboard in resident room #212. He stated if he was made aware he would have fixed the baseboard. He indicated he would only need glue to put the baseboard back in place. During observation of Resident room #213, the Maintenance Assistant stated he was not made aware and measured the missing baseboard in room #213 to be 6 feet. An observation in Resident room #222 with the Maintenance Assistant revealed about 4 feet of baseboard was missing and in need of repair to Resident room #222. Interview with the Administrator on 12/5/24 at 3:37 PM revealed it would be her expectation that staff report missing or loose baseboards to the Maintenance Director or Maintenance Assistant. The Administrator indicated the facility had been without a Maintenance Director for some time. During the time the facility was without a	F 584	On 12/23/2024 the Nursing Home Administrator completed education with the Director of Maintenance and Maintenance Assistant regarding the need to review TELS at least 5 days a week to identify any needed repairs and the prioritization of repairs throughout the facility with the use of a punch list. Facility staff were re-educated regarding the process of entering needed repairs into TELS system. Any newly hired Maintenance personnel and/or facility staff will be educated during orientation by the Nursing Home Administrator. On 12/20/2024 the Nursing Home Administrator completed education with the Housekeeping Supervisor and staff regarding the importance of maintaining a clean environment and completing rounds throughout the facility to identify and correct any areas of concern. Any newly hired Housekeeping personnel will be educated during orientation by the Nursing Home Administrator. The Nursing Home Administrator or designee will complete an audit of resident rooms to include baseboards, walls behind bed, and cleanliness of room to ensure baseboards are attached and/or not loose, there are no holes in the walls, and the room is clean. Nursing Home Administrator or designee will audit 10 rooms a week for four (4) weeks then 10 rooms a month for two (2) months. Any items identified will be placed in TELS and communicated to the Director of	

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F 584	Continued From page 6 Maintenance Director the facility was not using the electronic tracking system and were using word of mouth to communicate items in the facility that needed repair. 2. Room #218 was observed on 12/2/24 at 10:28am. The observation revealed red/orange splatter on the wall across from the bathroom, the door leading to the hall had black marks on the inside above the door handle, and there were black marks on her bathroom door also above the door handle. The Resident in room #218 was interviewed on 12/2/24 at 10:30am. The Resident stated housekeeping did not clean her room daily. On 12/4/24 at 10:52am a walk around occurred with the Housekeeping Manager and Administrator. Upon entering room #218, there was red/orange splatter on the wall across from the bathroom, the door leading to the hall had black marks on the inside above the door handle, and there were black marks on her bathroom door also above the door handle. The Housekeeping Manager was interviewed on 12/4/24 at 11:11am. The Housekeeping Manager explained that the assigned housekeeper would wipe down any touch areas, dust, clean the bathroom, and sweep/mop the floor daily. She also explained she performed walk around twice a week. The Housekeeping Manager stated if the housekeeper saw spillage or dirt on the walls/doors they were responsible for cleaning the area. During an interview with Housekeeper #1 on 12/4/24 at 11:22am, Housekeeper #1 discussed	F 584	Maintenance or conveyed to the housekeeping supervisor. The Nursing Home Administrator will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI)Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Completion date: 12/30/2024	

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F 584	Continued From page 7	F 584		

he was aware residents' walls were dirty and stated he had informed his supervisor. He explained due to the time constraint to get to each resident room, there was not enough time to clean all the areas and their walls.

The Administrator was interviewed on 12/5/24 at 1:50pm. The Administrator stated she was not made aware of the issues until the walk around.

3. An observation of room #217 occurred on 12/2/24 at 12:28pm. The observation revealed holes in the wall behind and below both resident's headboards. The resident by the window had 2 holes behind her bed right below the headboard and the resident by the door had 1 hole behind her headboard and 1 hole right below the headboard.

During an interview with both both residents in room #217 on 12/2/24 at 12:29pm, both residents stated the holes in their wall had been there at least 1 year.

A walk around occurred with the Maintenance Assistant and the Administrator on 12/4/24 at 10:52am. The Maintenance Assistant measured the holes for the resident by the window with the following results: 1. 3.5 by 8 inches and 2. 7.5 by 10 inches. Upon measuring the holes for the resident by the door the results were: 1. 7 by 7 inches and 2. 19 by 10 inches.

The Maintenance Assistant was interviewed on 12/4/24 at 11:08am. The Maintenance Assistant stated they do not complete walk around on a consistent basis. He explained they rely more on housekeeping and Nursing Assistants to complete work orders in their computerized

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F 584	Continued From page 8 system. The Maintenance Assistant stated he was unaware of the holes in the wall because no one had entered the issue into the computerized system. He explained that anyone can enter an issue into the computerized system which then sends an alert to his phone. The Maintenance Assistant stated once the issue has been fixed, he logs into the computerized system and marks the issue as completed. The Administrator was interviewed on 12/5/24 at 1:50pm. The Administrator stated she was not made aware of the issues until the walk around.	F 584		
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, observation, and resident and staff interviews, the facility failed to protect a resident's right to be free from neglect when Nursing Assistant (NA) #3 and the dietary staff did not ensure Resident #12 received lunch.	F 600	Resident #12 continues to reside in the facility and remains in stable condition. Resident was provided her requested sandwich.	12/30/24

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F 600	Continued From page 9 This occurred for 1 of 4 residents (Resident #12) reviewed for food preferences. The findings included: This tag is cross referenced to: F806 Based on observation, record review, and resident and staff interviews, the facility failed to provide a resident with an alternate preference during the lunch meal for 1 of 4 residents (Resident #12) reviewed for food preferences.	F 600	On 12/23/2024 the Nursing Home Administrator (NHA) and Social Worker (SW) completed an audit of alert and oriented residents regarding the request for alternative meals within the prior 7 days to ensure residents preference of meal alternatives were honored and received timely. Any areas of concern were addressed by the Assistant Dietary Manager. On 12/5/2024 the Regional Director of Dietary initiated education for dietary staff regarding the residents right to food choices and meal alternatives and prompt delivery of requested choice to ensure the residents nutritional needs are promptly met. Education was also provided regarding the process of alternatives and choices including once request is made, the Dietary Manager will deliver the alternative directly to the resident or Dietary Aides will deliver the alternative to the nurses station and provide the name of resident. Any newly hired dietary staff will be educated during orientation by the Dietary Manager. On 12/18/2024 the SDC completed education with staff regarding abuse/neglect to ensure staff are aware of varied degrees of neglect including, but not limited to, not providing meal alternatives when residents request. Education will be completed on 12/27/2024. Any newly hired staff will be educated during orientation by the SDC. The Nursing Home Administrator (NHA)	

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F 600	Continued From page 10	F 600	or designee will conduct an audit of five (5) alert and oriented residents weekly for 12 weeks to ensure residents who requested meal alternatives received their requested alternative in a timely manner. Any concerns will be addressed by the Dietary Manager. The NHA will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Completion date 12/30/2024	
F 638 SS=B	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 interview, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within the required time frame for 1 of 30 sampled residents (Resident #109) reviewed for submission of MDS assessments. The findings included: Resident #109 was admitted to the facility on	F 638	Resident #109 continues to reside in the facility and remains in stable condition. Resident's Minimum Data Set (MDS) self-care and mobility section with Assessment Reference Date (ARD) of 11/19/2024 was modified and transmitted on 12/19/2024. On 12/23/2024 the Regional Director of Clinical Services (RDCS) completed an	12/30/24

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F 638	Continued From page 11 8/12/24 with diagnoses which included orthopedic aftercare following surgical amputation and diabetes mellitus. The admission MDS dated 8/19/24 indicated Resident #109 was cognitively intact. Review of the medical record revealed the self-care and mobility section of Resident #109's quarterly MDS with the assessment reference date of 11/19/24 was not completed as of 12/4/24. During an interview on 12/05/24 at 9:58 a.m., the MDS Coordinator revealed she was on emergency leave from the facility on 11/25/24 to 12/2/24. She stated the self-care and mobility section of Resident #109's quarterly MDS should have been completed and submitted into the CMS system (Centers for Medicare and Medicaid Data Base System) by 12/3/24 by one of the facility's contracted remote MDS nurses.	F 638	audit of residents MDS for prior 30 days to ensure the residents' MDS have been completed at least quarterly and transmitted to Centers for Medicare and Medicaid Services (CMS) Data Base System. Any areas of concern identified will be modified by the MDS nurse and submitted to the CMS Data Base System. On 12/23/2024 the RDCS completed education with the MDS nurse, DON, and Assistant Director of Nursing (ADON) regarding completing and transmitting residents' MDS assessments at least quarterly according to ARD. Any newly hired MDS personnel will be educated during orientation by the Director of Nursing. The RDCS will conduct audits of residents' MDS Assessments to ensure MDS are completed at least quarterly and according to ARD. Audits will be conducted weekly for 12 weeks. Any areas of concern identified will be corrected by the MDS Coordinator. The NHA will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI)Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)	F 641		12/30/24

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F 641	Continued From page 12 §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 and staff interviews, the facility failed to accurately assesses residents in the area of accidents (Resident #76, Resident #42, Resident #58) and failed to complete the "functional abilities and goals" section (Resident #12) for 4 of 13 residents reviewed for Minimum Data Set (MDS) accuracy. The findings included: 1a. Resident #76 was admitted to the facility on 8/15/24. A Smoking assessment dated 8/15/24 indicated Resident #76 required supervision while smoking. The Admission Minimum Data Set (MDS) assessment dated 8/21/24 indicated Resident #76 was cognitively intact and was coded as not being a current tobacco user. An interview with the MDS Coordinator on 12/4/24 at 2:37 PM revealed Resident #76 was admitted to the facility as a smoker. Upon review of Resident #76's annual MDS assessment, the MDS Coordinator stated Resident #76 should have been coded as a current tobacco user. 1b. Resident #42 was admitted to the facility on 3/30/23 with diagnoses that included tobacco use. Review of a Smoking assessment dated 1/6/24 indicated Resident #42 was a tobacco user and was identified as safe to smoke unsupervised.	F 641	Residents #42, 58, and 76 continues to reside in the facility and remain in stable condition. Residents #42□s March 2024 Minimum Date Set (MDS), Resident 58□s January 2024 MDS, and Resident #76□s August 2024 MDS were modified and transmitted on 12/20/2024. Following review of Resident #12□s 1/18/2024 quarterly assessment, it was found the assessment was completed correctly. Therefore, modification is not required for this assessment. On 12/20/2024 the Regional Director of Clinical Services (RDCS) completed an audit of the past 90 days of MDS, specifically Section J1300 to ensure smoking is reflected accurately. Any areas of concern identified were corrected by the MDS Coordinator. On 12/23/2024 the RDCS completed education with the MDS Coordinator, Director of Nursing (DON), and Staff Development Coordinator (SDC) regarding accurately completing MDS including J1300. Any newly hired MDS staff will be educated during orientation by the Director of Nursing. The RDCS will conduct audits of Quarterly MDS J1300, Tobacco Use, and MDS transmissions 1 time a week for 12 weeks to ensure the MDS Section J1300 is	

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F 641	Continued From page 13 Review of Resident #42's annual MDS assessment dated 3/30/24 revealed he was coded as not being a current tobacco user. An interview with the MDS Coordinator on 12/5/24 at 2:31 PM revealed Resident #42 used tobacco/smoked. Upon reviewing Resident #42's MDS assessment, she stated it was not coded for current tobacco use and should have been. 1c. Resident #58 was admitted to the facility on 1/4/21 with diagnoses that included tobacco use. Review of Resident #58's annual MDS assessment dated 1/24/24 revealed he was coded as not being a current tobacco user. An interview with the MDS Coordinator on 12/5/24 at 2:31 PM revealed Resident #58 used tobacco/smoked. Upon reviewing Resident #58's MDS assessment, she stated it was not coded for current tobacco use and should have been. An interview conducted with the Administrator and Director of Nursing on 12/5/24 at 3:33 PM revealed they would expect the MDS to accurately identify a resident that currently used tobacco. Resident #76, Resident #42 and Resident #58 MDS assessments should have coded the residents as tobacco users. 2. Resident #12 was admitted to the facility on 9/22/22 with multiple diagnoses that included stage 4 kidney disease and diabetes. The quarterly Minimum Data Set (MDS) dated 1/18/24 revealed Resident #12 was cognitively intact. While reviewing the section of the MDS titled "functional abilities and goals", the section	F 641	completed accurately and transmitted timely. Any concerns identified will be corrected immediately by the MDS Coordinator. The NHA will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI)Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Completion date: 12/30/2024	

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F 641	Continued From page 14	F 641		

for self-care was observed not to be completed. Further reviews of subsequent quarterly MDS assessments were observed to have the self-care section filled out.

During an interview with MDS Nurse #1 on 12/3/24 at 2:48pm, the MDS Nurse explained she had been hired as the MDS Nurse in September 2024 and prior to that the facility relied on an outside contract company to complete the residents' MDS assessments. She explained the contract company continues to assist with completing MDS assessments. The MDS Nurse reviewed Resident #12's MDS assessment for 1/18/24 and confirmed the self-care section under "functional abilities and goals" was not completed. She also confirmed Resident #12 had not been hospitalized which she stated would have caused this section to be marked "not assessed" and/or not completed. MDS Nurse #1 stated she did not know why the section had not been filled out and explained it should have been.

The Director of Nursing (DON) was interviewed on 12/4/24 at 9:42am. The DON explained the facility had been without an in-house MDS Nurse and had been utilizing a remote MDS company to help complete/review MDS assessments. She stated she had not known about Resident #12 not having the self-care portion of the section titled "functional abilities and goals" completed on her quarterly MDS assessment dated 1/18/24. The DON commented that the self-care section should have been completed for Resident #12.

An interview with the Administrator occurred on 12/5/24 at 1:30pm. The Administrator explained the facility always had an MDS Nurse but not always an MDS Nurse in-house. She stated in

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F 641	Continued From page 15 January 2024 there was a remote contracted MDS service completing the MDS assessments and explained she began working at the facility in January 2024 so she was not aware of who would have been reviewing the MDs assessments for accuracy. The Administrator stated she could not comment on why Resident #12 did not have her self-care assessment section completed on her quarterly MDS assessment dated 1/18/24. She did state the self-care section should have been completed.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		12/30/24

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F 656	Continued From page 16 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation record review and staff interview, the facility failed to develop a comprehensive care plan for the areas of smoking (Resident #76) and Activities of Daily Living (ADL) (Resident #5) for 2 of 18 residents whose care plans were reviewed. The findings included: 1. Resident #76 was admitted to the facility on 8/15/24. A facility smoking assessment dated 8/15/24 indicated Resident #76 required supervision while smoking. The Admission Minimum Data Set (MDS)	F 656	Residents #5 and 76 continue to reside in the facility and remain in stable condition. Resident #5s care plan was updated to reflect current Activities of Daily Living (ADL) status and Resident #76s care plan was updated to reflect smoking on 12/4/2024. On 12/23/2024 the Director of Nursing (DON) and Minimum Data Set (MDS) Coordinator reviewed care plans for residents to ensure each resident has an ADL care plan and resident who smoke have a smoking Care Plan. Any areas of concern were corrected by the MDS Coordinator.	

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F 656	Continued From page 17 assessment dated 8/21/24 indicated Resident #76 was cognitively intact and was coded as not being a current tobacco user. The smoking assessment dated 10/8/24 indicated Resident #76 did not require supervision while smoking and was considered an unsupervised smoker. Review of Resident #76's care plans were reviewed and did not include a care plan or interventions in the area of tobacco use/smoking. An interview with the MDS Coordinator/Nurse #1 on 12/4/24 at 2:37 PM revealed Resident #76 was a smoker when she was admitted to the facility. The MDS Coordinator stated Resident #67 did not have a care plan identifying smoking as an area of concern and one should have been developed. Resident #76 was interviewed on 12/4/24 at 3:34 PM. She stated she was a smoker and had smoked at the facility since admission. An interview with the Director of Nursing and the Administrator on 12/5/24 at 3:35 PM revealed Resident #76 was a tobacco user/smoker since her admission. They indicated Resident #76 should have had a care plan developed with interventions due to her tobacco use. 2. Resident #5 was admitted to the facility on 06/14/24 with diagnoses that included dementia and muscle weakness. The admission Minimum Data Set (MDS) dated 6/20/24 revealed Resident #5 had intact cognition	F 656	On 12/23/2024 the Director of Nursing completed education with the Minimum Data Set (MDS) nurse and Unit Managers (UMs) regarding review care plans to ensure residents who are smokers are care planned to reflect smoking and that each resident has an ADL care plan. Any newly hired MDS and/or UMs will be educated during orientation by the Director of Nursing. The DON or designee will complete an audit of resident care plans to ensure residents who smoke are care planned to reflect their smoking status and residents have an ADL care plan. Audit will be completed on 10 resident care plans three (3) times a week for two (2) weeks then weekly for two (2) weeks then monthly for two (2) months. Any areas of concern will be addressed by the MDS nurse. The DON will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI)Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Completion date: 12/30/2024	

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F 656	Continued From page 18	F 656		

and required substantial to maximum assistance with toileting hygiene, personal hygiene, shower/bathing, upper/lower body dressing, putting on/taking off footwear, bed mobility, and transfers.

Review of the Care Area Assessment dated 6/20/24 revealed Resident #5 triggered to have ADL function care planned.

Resident #5's comprehensive care plans, last revised on 09/29/24, did not include a plan that addressed her need for assistance with ADL care.

Multiple attempts were made to interview the previous MDS Nurse #2 but attempts were unsuccessful.

An interview was conducted with MDS Nurse #1 on 12/4/24 at 10:14 AM. She indicated that when a resident is coded to require assistance with ADL care and the CAA is triggered to proceed to the care plan then an ADL care plan should be developed and implemented at that time.

During an interview on 12/4/24 at 3:59 PM, the Director of Nursing reviewed Resident #5's care plan and confirmed the care plan did not include interventions relating to care needs, so that staff would know what level of care to provide. The DON stated it was an oversight, and Resident #5's ADL care plan should have reflected her care needs.

During an interview on 12/5/24 at 2:45 PM, the Administrator stated she would expect care plans to be developed to accurately reflect the resident's needs.

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F 657	Continued From page 19	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update a care plan for 1 of 3 residents (Resident #12) reviewed for care plans. The findings included: Resident #12 was admitted to the facility on	F 657	Resident #12 continues to reside in the facility and remains in stable condition. Resident #12□s care plan was updated, and review was completed on 12/202024. On 12/23/2024 the Director of Nursing (DON) and Minimum Date Set (MDS) nurse completed a review of resident care	12/30/24

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F 657	Continued From page 20 9/22/22. The quarterly Minimum Data Set (MDS) dated 9/20/24 revealed Resident #12 was cognitively intact. Upon reviewing Resident #12's care plan, it was observed that Resident #12's care plan had not been reviewed since 7/3/24. There was documentation under the care plan section of the electronic medical record for Resident #12 to have her care plan reviewed on 10/22/24. During an interview with MDS Nurse #1 on 12/3/24 at 2:48pm, the MDS Nurse explained she would have been responsible for ensuring Resident #12's care plan had been reviewed but stated she had not been placed in the MDS Nurse role until September 2024. The MDS Nurse stated she would not have reviewed the care plan in October 2024 as indicated in Resident #12's record unless there was a change in condition. She explained she only reviews care plans annually and/or if there is a change in condition. The Director of Nursing (DON) was interviewed on 12/4/24 at 9:42am. The DON discussed being the DON for only 3 months. She explained that she had been reviewing residents' care plans and had realized there were residents' who had not had a review of their care plans. She explained it was the responsibility of the MDS Nurse to track when care plan reviews were due. The DON stated residents should have their care plans reviewed every 3 months and/or if there was a change in the residents' condition. She stated she was unaware of Resident #12's care plan not being reviewed since July 2024.	F 657	plans to ensure care plans have been updated and a review completed at least quarterly and with any change of condition. On 12/23/2024 the DON completed education with the Minimum Data Set (MDS) nurse, Assistant Director of Nursing (ADON), and Unit Managers (UMs) regarding updating resident care plans and completing a care plan review at least quarterly and with any change of condition. Any newly hired MDS and/or UMs will be educated during orientation by the Director of Nursing. The DON or designee will complete an audit of resident care plans to ensure residents are updated and a review is completed at least quarterly and with change of condition. Audit will be completed on 5 days a week for 12 weeks during IDT meeting. Any areas of concern will be addressed by the MDS nurse. The DON will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI)Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Completion date: 12/30/2024	

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F 657	Continued From page 21 An interview with the Administrator occurred on 12/5/24 at 1:30pm. The Administrator discussed resident care plans should be reviewed when there is a change in condition and/or every 3 months. She explained the interdisciplinary team would review the care plan first and then the Social Worker would schedule the care plan meeting. The Administrator stated she did not know why Resident #12's care plan had not been reviewed since July 2024.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, and Physician interview, the facility staff failed to confirm residents had taken their medication and left the medication on their meal tray. The medication was found by dietary staff. This occurred for 2 of 2 residents (Resident #12 and Resident #58) reviewed for medication storage. The findings included: Resident #12 was admitted to the facility on 6/14/22 with multiple diagnoses that included diabetes and congestive heart failure. The quarterly Minimum Data Set (MDS) dated 7/30/24 revealed Resident #12 was cognitively intact.	F 658	Residents #12 and 58 continue to reside in the facility and remain in stable condition. On 8/16/2024 the former Dietary Manager did give Resident #58□s medications to the former Staff Development Coordinator (SDC) who informed Nursing Home Administrator (NHA) that she destroyed them. On 8/18/2024 the former Dietary Manager gave the medications for Resident #12 to Unit Manager (UM) #1 who then destroyed them. Neither resident can recall taking medications on 8/16/2024 or 8/18/2024 nor could they recall leaving medications on their meal trays On 12/2/2024 the UMs conducted	12/30/24

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F 658	Continued From page 22 Resident #58 was admitted to the facility on 1/4/21 with multiple diagnoses that included hemiplegia and hemiparesis. The quarterly Minimum Data Set (MDS) dated 7/25/24 revealed Resident #58 was cognitively intact. Review of the facility's timeline revealed on 8/16/24 the Administrator was sent pictures by the previous Dietary manager of medication that were left on Resident #58's meal tray. Again on 8/18/24 the Administrator received pictures from Medication Aide (MA) #4 of medication that was left on Resident #12's meal tray. The only other information present on the timeline was that education was provided to the two MAs (MA #4 and MA #3). Resident #12 was interviewed on 12/2/24 at 10:51am. Resident #12 stated she had not left any of her medication on her meal tray that she could remember. She explained the MAs would often leave her medication on her meal tray for her so she could take them during her meal but said she did not remember ever leaving her medication on her meal tray without taking them. Resident #58 was interviewed on 12/4/24 at 9:30pm. Resident #58 stated he could not remember if he had ever left medication on his meal tray. During an interview with Dietary Aide (DA) #3 on 12/2/24 at 2:25pm, DA #3 stated she recalled the medication being found on resident trays two times in August 2024. She stated she did not find the medication but saw DA #4 with them in her	F 658	room-to-room audits to ensure no medications were left at resident bedside. During lunch meal, the NHA and Director of Nursing (DON) conducted a room-to-room audit to ensure no medications were left at the residents bedside or on the meal tray. No areas of concern were identified. On 12/2/2024 the NHA and DON amended the current, ongoing Performance Improvement Plan (PIP) to increase the rooms audited during each audit performed and extended the length of time the audits will be conducted. On 12/5/2024 the Staff Development Coordinator (SDC) initiated education with licensed nurses and medication aides (CMA) regarding passing medication to include remaining with the resident until the medication is administered and taken and not leaving medications at the bedside or in undesignated areas. Education will be completed on 12/27/2024. Any newly hired licensed nurses or medication aides will be educated during orientation by the SDC. The DON, SDC, and/or UMs will conduct medication administration audits of 10 resident to ensure licensed nurses/CMAs are remaining with the resident until medication is taken, no medications are left at the bedside, and/or in undesignated areas. Audits will be conducted five (5) times a week for two (2) weeks then three (3) times a week for two (2) weeks, then weekly for two (2) months.	

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F 658	Continued From page 23 hand. DA #3 explained DA #4 gave the medication each time to the previous Dietary Manager. She stated she did not know what the previous Dietary Manager did with the medication. A telephone interview occurred with the previous Dietary Manager on 12/2/24 at 2:54pm. The Previous Dietary Manager recalled two times in August 2024 when meal trays were returned to the kitchen with medication on the trays. He stated he recalled one resident was Resident #12 and the other was Resident #58. The previous Dietary Manager explained he immediately called the Administrator both times who he said told him to give the medication to the Unit Manager each time. He stated he gave the medication to the previous Staff Development Coordinator (SDC), who he said was also acting as Unit Manager. During a telephone interview with the previous SDC on 12/2/24 at 3:48pm, the previous SDC stated she recalled one of the incidences when medication was found on a meal tray in August 2024. She explained she had received a call at home (could not remember from who) that there was medication found on a meal tray in the kitchen. The previous SDC stated she came back to the facility immediately and looked at the medication that was in the previous Dietary Managers possession to see if any of the medications were narcotics. She explained she did not remember who the medications belonged to, nor did she know what the previous Dietary Manager did with the medication. The previous SDC stated she never took the medication from the previous Dietary Manager. She explained the next thing she did was to check all the resident rooms to ensure no other medication was left in a	F 658	The DON will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI)Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Completion date: 12/30/2024	

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F 658	Continued From page 24	F 658		

resident room. The previous SDC stated that was all she could remember but said there should be an investigation file in the Administrator's office.

An interview occurred with the Regional Consultant, Regional Nurse Consultant and the Director of Nursing (DON) on 12/3/24 at 9:40am. The Regional Consultant explained the previous SDC had not completed an investigation. She stated the only thing completed was a disciplinary action form for MA #3. The Regional Consultant. Regional Nurse Consultant, and the DON all stated they did not know what happened to the medication that was found and that there was never an investigation completed as to what happened to the medication, audits, further education with staff, or follow up with the residents who did not receive their medication. The DON discussed a timeline that had been completed by the Administrator. The Regional Consultant explained in November 2024, the DON realized there had been a systemic problem with medications being left at the bedside and that the DON began a performance improvement plan.

A telephone interview occurred on 12/4/24 at 12:31pm with MA #3. MA #3 remembered leaving medication on Resident #58's meal tray. She explained when she was passing the medication, Resident #58 requested his medication be left on his tray. MA #3 stated when she returned to his room, the meal and the medication were gone. She stated Nurse #7 came to her and explained the dietary department had told her there were medications left on Resident #58's meal tray. MA #3 discussed later that day in August 2024, Unit Manager (UM) #1 counseled her and supervised one medication pass. She explained she never

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saw the medication that was left on the meal tray and did not know what was done with the medication after it was found by the dietary department.

During a telephone interview with MA #4 on 12/5/24 at 2:25pm, MA #4 recalled the incident in August 2024 when there were medications left on a meal tray. She explained they belonged to Resident #12. MA #4 discussed never sending any photos to management regarding the medication. MA #4 explained she worked night shift (11:00pm to 7:00am) and never passed any medication but said management believed she had left them on Resident #12's meal tray. She stated management had given her a "talking to" about leaving medications on a meal tray.

During an interview with UM #1 on 12/4/24 at 1:00pm, UM #1 stated she did not recall anyone ever telling her that there had been medication left on a meal tray back in August 2024. She also stated she did not recall ever counseling MA #3.

DA #4 was interviewed on 12/4/24 at 1:23pm. DA #4 explained she remembered there had been two times in August where she found medications left on meal trays. She stated she could not remember the residents but stated she gave the cup of medications each time to the previous Dietary Manager. DA #4 discussed not knowing what the previous Dietary Manager did with the medications.

A telephone interview occurred with Nurse #7 on 12/5/24 at 9:18am. Nurse #7 stated she did not recall any incidences of medication being left on meal trays or receiving any medications from dietary.

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F 658	Continued From page 26 The Medical Director was interviewed on 12/5/24 at 2:37pm. The Medical Director explained he was never made aware of the incident where medications had been left on meal trays two times in August 2024. He stated staff should have identified what the medications were and notified himself or the Nurse Practitioner to see if there would have been any consequences to the resident not taking their medications. The Medical Director stated he should have been informed of the situation.	F 658		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide foot care and arrange podiatry services for 1 of 10 dependent residents reviewed for activities of daily living (ADL) care. Resident #5 was discovered to have long and jagged toenails on both feet that extended ¼ to ½ beyond the tip of her toes (Resident #5).	F 687	Resident #5 continues to reside in the facility and remains in stable condition. Social Work (SW) notified contracted services, 360 Care, who provides podiatry services. Resident #5 was seen by podiatrist 12/21/2024. Her toenails were trimmed and filed to Resident #5s satisfaction. No other foot concerns were identified by the podiatrist.	12/30/24

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F 687	Continued From page 27 The findings included: Resident #5 was admitted on 6/14/24 with the diagnoses included diabetes and dementia. The admission Minimum Data Set (MDS) dated 6/20/24 indicated Resident #5 was cognitively intact, and dependent (helper does all the effort) on staff for personal hygiene. Resident #5's comprehensive care plans, last revised on 09/29/24, did not include interventions that addressed her need for assistance with activities of daily living. Review of the podiatry schedules on 7/31/24, 9/5/24, and 11/5/24 revealed no consultation report or notation was made in Resident #5's chart that she had been seen by the podiatrist or had been scheduled to be seen. A review of Resident #5's electronic medical record from 6/14/24 through 12/5/24 revealed no documentation that indicated Resident #5 had received toenail trimming by staff or podiatry. Review of Resident #5's skin assessments done by nursing on the following dates 10/3/24, 10/26/24, 11/9/24, 11/16/24 revealed there was no information documented on the assessment about the condition of Resident #5's toenails. An observation and interview were conducted on 12/2/24 at 10:40 AM, Resident #5 was in her room lying in bed with her bare feet exposed. The toenails on both feet were jagged and had grown approximately ¼ to ½ inch beyond the tip of her toes. Resident #5 indicated that she would like to have her toenails cut but nobody had done it.	F 687	On 12/23/2024 Director of Nursing (DON), Unit Managers (UM), Wound Nurse, and Staff Development Coordinator (SDC) conducted a facility-wide audit of residents to ensure residents toenails are trimmed, filed, and clean. Any concern identified were addressed by nursing and/or resident was placed on podiatry list. On 12/13/2024 the SDC educated licensed nurses, certified medication assistants (CMA), and certified nursing aides (CNA) regarding evaluating residents feet during weekly skin assessments and care and/or showers to ensure residents toenails are trim, filed, and clean and if resident is diabetic a referral is to be sent to inform SW of residents need for foot care. Education will be completed by 12/27/2024. After 12/27/2024 any licensed nurses, CMAs, and/or CNAs who were not educated will be educated prior to beginning their next shift. Any newly hired licensed nurses, CMAs, and CNAs will be educated during orientation by the SDC. The DON, UMs, Wound Nurse, and/or SDC will audit 10 residents a week for four (4) weeks, then 10 residents a month for two (2) months to ensure residents toenails are trimmed, filed, and clean. Any areas of concern will be addressed by licensed nursing or CNAs. The DON will present the findings of the audit to the Quality Assurance	

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F 687	Continued From page 28 A follow-up observation was conducted on 12/4/24 at 9:02 AM. Resident #5 was lying in bed and there was no change of condition of Resident #5's toenails An interview was conducted on 12/4/24 at 9:52 AM, with NA #2. She stated she had worked with Resident #5 on a regular basis, and she recalled reporting to a nurse that Resident #5's toenails were long and needed to be seen by the podiatrist. NA #2 was not able to recall the name of the staff member she reported to or how long ago it was reported. An interview was conducted with Social Worker (SW) #1 on 12/4/24 at 10:06 AM and indicated she was responsible for coordinating the podiatry list and did not recall receiving a podiatry referral from nursing staff for Resident #5. She also indicated that podiatry referrals can be given to her verbally or in writing by the nursing staff. Once she receives the referral for podiatry she would contact the podiatry provider with the referral information. An interview was conducted on 12/5/24 at 9:17 AM, with Nurse #1 who stated she had completed the skin checks for Resident #5 on 11/2/24, 11/9/24, and 11/16/24 and did not notice if foot care was needed and must have been an oversight. She further revealed she thought Resident #5 had already been referred to podiatry as she was a diabetic and would have needed a podiatrist to provide the appropriate foot care. An interview was conducted on 12/4/24 at 3:59 PM, with the Director of Nursing (DON) who stated the podiatrist was scheduled every 3	F 687	Performance Improvement (QAPI)Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Completion date: 12/30/2024	

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F 687	Continued From page 29 months and it was expected that any residents who needed podiatry service be added to the schedule. She said the nurse aides were responsible for reporting to nursing when resident's toenails were extremely long or sharp, and/or needed podiatry to trim/cut the nails. The DON further stated the nurses were responsible for completing the weekly full body assessments which would include the condition of resident's toenails. The interview further revealed the nurses were responsible for notifying the SW verbally or in writing when a resident required podiatry services. The DON further revealed that Resident #5 was a diabetic and therefore should have been referred to the podiatrist for services and felt it was an oversight by the nursing staff.	F 687		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview and physician interviews, the facility failed to follow physician orders for oxygen administration for 2 of 4 sampled residents reviewed for respiratory care (Resident #40 and Resident #14). The findings included:	F 695	Residents #40 and #14 continue to reside in the facility and remain in stable condition. The Unit Manager evaluated the respiratory status of both residents. Residents #40 and #14 SaO2 98% and SaO2 97% respectively, lungs clear, no dyspnea or shortness of breath noted, and oxygen maintained at 2L per	12/30/24

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F 695	Continued From page 30 1. Resident #40 was admitted to the facility on 2/26/21 with a diagnosis that included Chronic Obstructive Pulmonary Disease (COPD), respiratory failure and vascular dementia. Physician order dated 5/16/24 stated continuous oxygen at 2 liters via nasal cannula (NC) and as needed (PRN) to maintain {oxygen} saturation (SATS) greater than 90%. Care plan last revised 6/15/24 stated Resident #40 had oxygen therapy. The goal stated Resident #40 would have no signs or symptoms of poor oxygen absorption. The interventions included provide oxygen per physician order. Review of quarterly Minimum Data Set (MDS) assessment dated 10/21/24 indicated Resident #40 had moderate cognitive impairment and received oxygen. She required extensive assistance with bed mobility and had no rejection of care coded during the look back period. Review of Resident #40's vital signs for 12/2/24, 12/3/24 and 12/4/24 revealed her oxygen SATS to be greater 90%. Resident #40 was observed on 12/2/24 at 10:27 AM. She was observed to be laying in bed and receiving oxygen via NC. The oxygen concentrator was observed to be set at .5 liters. Resident #40 had no signs or symptoms of respiratory distress. Resident #40 was observed on 12/3/24 at 3:44 PM revealed Resident #40 to have oxygen via NC. The oxygen concentrator was observed to be set at .5 liters. During the observation,	F 695	physician order. On 12/23/2024 the Director of Nursing (DON) and Staff Development Coordinator (SDC) completed an audit of residents who receive continuous oxygen to ensure liter flow is set at proper setting per physician order. Any areas of concern were corrected by the Unit Managers (UM). On 12/5/2024 the SDC educated licensed nurses regarding ensuring oxygen concentrator liter flow for residents with continuous oxygen is set per physician order. Education will be completed on 12/27/2024. After 12/27/2024 any licensed nurses who have not been educated will be educated prior to beginning their next scheduled shift. Any newly hired licensed nurses will be educated during orientation by the SDC. The UMs or designee will conduct audits once a day for four (4) weeks then monthly for two (2) months to ensure residents with continuous oxygen have the concentrator liter flow set per physician order. Any areas of concern will be addressed by the UMs immediately. The NHA will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI)Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring.	

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Resident #40 showed no signs or symptoms of respiratory distress.

Resident #40 was observed on 12/4/24 at 8:54 AM. She was observed to laying in bed and receiving oxygen via NC. The oxygen concentrator was observed to be set at .5 liters. Resident #40 had no signs or symptoms of respiratory distress.

Interview with Nurse #2 on 12/4/24 at 11:00 AM indicated she had entered Resident #40's room in the morning of 12/4/24. She stated she observed Resident #40's oxygen to be set at .5 liters. She stated when she observed the oxygen was not set according to the physician order, she adjusted Resident #40's oxygen concentrator to 2 liters. Nurse #2 further stated Resident #40 would not be able to adjust her oxygen setting independently.

Interview with the Director of Nursing (DON) on 12/4/4 at 11:00 AM revealed nurses should check supplemental oxygen settings daily.

In a follow up interview with DON on 12/5/24 at 3:28 PM revealed nursing staff should ensure residents oxygen orders were followed as written by the physician.

Interview with the Physician on 12/5/24 at 2:59 PM stated it was his expectation that staff follow physician orders as written until they were modified or discontinued. He stated Resident #40 had no STATS lower than 90% due to receiving .5 liters of oxygen.

2. Resident #14 admitted to the facility on 9/17/2021. Resident #14's diagnoses included

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chronic obstructive pulmonary disease (COPD), congestive heart failure, and anxiety disorder.

Resident #14 had a physician order in place dated 11/27/2023 which read in part: continuous oxygen at 2 liters.

Resident #14 had a care plan in place revised on 4/24/2024 related to oxygen therapy for COPD. Interventions included oxygen settings via nasal cannula at 2 liters per minute continuously.

Resident #14's annual Minimum Data Set (MDS) assessment dated 9/17/2024 revealed she was cognitively intact, no mood or behaviors indicated and received oxygen therapy.

An observation on 12/02/2024 at 10:26 AM revealed Resident #14 sitting edge of bed. Resident #14 had her nasal cannula (NC) in her nares. An observation completed of the in-room oxygen concentrator revealed the oxygen setting at 3.5 liters (L). No signs or symptoms of distress observed.

A follow up observation of Resident #14 was completed on 12/02/2024 at 12:36 PM which revealed Resident #14's in-room oxygen concentrator setting remained at 3.5L. Resident #14 was eating lunch at this time. No signs or symptoms of distress noted.

Resident #14 was observed at breakfast on 12/03/2024 09:38 AM which revealed her in-room oxygen concentrator remained at 3.5L. No signs or symptoms of distress noted.

An interview with Medication Aide (MA) #5 was completed on 12/04/2024 at 10:08 AM. MA #5

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F 695	Continued From page 33	F 695		

stated Resident #14 received supplemental oxygen and was compliant with her supplemental oxygen. MA #5 further stated Resident #14 did not adjust her in-room oxygen concentrator settings at will. MA #5 verbalized Resident #14 should be on 2 or 3 liters of supplemental oxygen. MA #5 verified the physician order in the electronic medication administration record (eMAR) which revealed Resident #14 was ordered continuous oxygen at 2L via nasal cannula.

An observation with Medication Aide (MA) #5 was completed on 12/04/2024 at 10:11 AM. MA #5 observed the in-room oxygen concentrator setting at 3.5L. MA #5 was observed to adjust the in-room oxygen concentrator setting to 2L per the physician order. MA #5 explained nurse aides (NA) do not adjust oxygen settings. Nurses or the assigned MA were responsible for checking and ensuring the residents were on the correct ordered liter. MA #5 stated her process was to check the settings when delivering medications and if the resident verbalized they were not feeling any air flowing. MA #5 did not recall when she last checked Resident #14's in-room oxygen concentrator settings.

An interview was completed with Resident #14 on 12/04/2024 at 10:15 AM. Resident #14 verbalized she had received supplemental oxygen for a long time since being at the facility. She stated the oxygen setting should have been at 2L and was not certain when the setting changed. Resident #14 verbalized that she did not manipulate her in-room oxygen concentrator settings.

An interview with Unit Manager #1 on 12/04/2024

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	345116	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT HILLS CENTER FOR NURSING AND REHAB	109 S HOLDEN RD GREENSBORO, NC 27407

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F 695	Continued From page 34 10:30 AM revealed nurses should be monitoring their residents on supplemental oxygen and ensuring the in-room oxygen concentrators were on the correct ordered liter. NAs were not responsible for manipulating oxygen settings or monitoring. Nurses should be checking the in-room oxygen concentrators every shift to make sure the correct ordered liter was still in place for their residents on supplemental oxygen. Unit Manager #1 verbalized she had not seen Resident #14 manipulate her oxygen settings on her in-room oxygen concentrator. An interview with the Director of Nursing (DON) on 12/04/2024 at 11:00 AM stated nurses should be checking supplemental oxygen settings daily to ensure residents were on the correct ordered liter. An interview with the Physician was completed on 12/05/2024 at 3:17 PM. The Physician explained Resident #14's in-room oxygen concentrator should have been set at the correct ordered liter. The Physician continued to state if Resident #14 required an increase, then he could have assessed her.	F 695		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a	F 806		12/30/24

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F 806	Continued From page 35 different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide a resident with an alternate preference during the lunch meal for 1 of 4 residents (Resident #12) reviewed for food preferences. The findings included: Resident #12 was admitted to the facility on 9/22/22 with multiple diagnoses that included stage 3 pressure ulcer and diabetes. The quarterly Minimum Data Set (MDS) dated 9/20/24 revealed Resident #12 was cognitively intact and was independent with eating. Resident #12 was documented as being on a therapeutic diet. Resident #12 was interviewed on 12/2/24 at 10:32am. The resident discussed not liking the food at the facility. She explained she would often ask for an alternate meal or a sandwich and would not receive any alternate or sandwich. Resident #12 stated "that is why I keep food in my room" and pointed to a shelf that had canned food. The lunch meal was observed with Resident #12 on 12/2/24 at 12:15pm. Nursing Assistant (NA) #3 was observed to provide Resident #12 with her lunch tray. Resident #12 requested a ham and cheese sandwich because she did not like her meal. NA #3 was observed telling Resident #12 she would go to the kitchen and get her sandwich.	F 806	Resident #12 continues to reside in the facility and remains in stable condition. Resident was provided her requested sandwich. On 12/23/2024 the Nursing Home Administrator (NHA) and Social Worker (SW) completed an audit of alert and oriented residents regarding the request for alternative meals within the prior 7 days to ensure residents preference of meal alternatives were honored and received timely. Any areas of concern were addressed by the Assistant Dietary Manager. On 12/5/2024 the Regional Director of Dietary initiated education for dietary staff regarding the residents right to food choices and meal alternatives and prompt delivery of requested choice to ensure the residents nutritional needs are promptly met. Education was also provided regarding the process of alternatives and choices including once request is made, the Dietary Manager will deliver the alternative directly to the resident or Dietary Aides will deliver the alternative to the nurses station and provide the name of resident. Any newly hired dietary staff will be educated during orientation by the Dietary Manager. The Nursing Home Administrator (NHA) or designee will conduct an audit of five (5) alert and oriented residents weekly for	

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F 806	Continued From page 36 At 2:55pm on 12/2/24 Resident #12 was observed in the hallway in her wheelchair. Resident #12 stated she never received any lunch today and was hungry. The resident explained the sandwich she had asked for was never brought to her, so she had nothing to eat for lunch. During an interview with NA #3 on 12/2/24 at 3:00pm, the NA confirmed she had been the NA who had requested the sandwich from the kitchen for Resident #12. She explained she went to the kitchen right after Resident #12 told her that she wanted a ham and cheese sandwich and informed one of the dietary aides. She stated she could not remember who the dietary aide was. NA #3 stated she was unaware Resident #12 never received her lunch and thought the kitchen staff would have brought the resident her sandwich. An interview with Dietary Aide #1 occurred on 12/2/24 at 3:15pm. Dietary Aide stated he was the one who was told Resident #12 wanted a ham and cheese sandwich for lunch. Dietary Aide #1 produced the wrapped ham and cheese sandwich that he stated he made for Resident #12. He explained he thought NA #3 would come back and deliver the sandwich to Resident #12 and was unaware this did not happen until now. Dietary Aide #1 stated he was also unaware Resident #12 did not receive anything for lunch and questioned the surveyor if he should offer Resident #12 something to eat now. The surveyor informed Dietary Aide #1 Resident #12 was hungry, so Dietary Aide #1 was observed to approach Resident #12 and asked the resident if she wanted her sandwich. Resident #12 was heard telling Dietary Aide #1 she would like her sandwich because she was hungry.	F 806	12 weeks to ensure residents who requested meal alternatives received their requested alternative in a timely manner. Any concerns will be addressed by the Dietary Manager. The NHA will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review audits to determine trends and/or issues that may need further interventions and/or the need for additional monitoring. Completion date: 12/30/2024	

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F 806	Continued From page 37	F 806		

Observation of Resident #12 occurred on 12/2/24 at 3:30pm. Resident #12 was observed eating her sandwich she had requested.

The Administrator was interviewed on 12/2/24 at 3:18pm. The Administrator discussed the floor staff and dietary staff working together to ensure that residents received requested food items. She stated she would have expected the floor staff to ensure the residents receive a lunch meal.

During an interview with the Assistant Dietary Manager on 12/5/24 at 10:18am, the Assistant Dietary Manager explained if a resident wanted an alternate meal, then the NA or a dietary staff would ask the resident what they wanted and if the kitchen had the food available, they would fix the resident what they requested. She further explained, once the food was prepared the Dietary Aide or the Assistant Dietary Manager would deliver the requested food items to the resident. The Assistant Dietary Manager stated when NA #3 requested the ham and cheese sandwich for Resident #12, the NA did not provide the Dietary Aide with the information of who the sandwich was for, so they were unable to provide the meal to Resident #12.