STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345142	A. BUILDING ______ B. WING ______	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	**9200 GLENWATER DRIVE CHARLOTTE, NC 28262**

(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 02/26/24 through 02/29/24. An extended survey was conducted on 3/13/24. Therefore, the exit date was changed to 3/13/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 5DHV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/26/24 through 02/29/24. An extended survey was conducted on 3/13/24. Therefore, the exit date was changed to 3/13/24. Event ID# 5DHV11. The following intakes were investigated: NC00194259, NC00194299, NC00195171, NC00195816, NC00198744, NC00199456, NC00199915, NC00200033, NC00200171, NC00200564, NC00202360, NC00205487, NC00206564, NC00206648, NC00206793, NC00209280, NC00209603, NC00210218, NC00211199, NC00211430, NC00212318, NC00212339, and N00213384. 32 of the 65 complaint allegations resulted in deficiencies. Substandard Quality of Care was identified at: CFR483.24 at tag F679 at a scope and severity of H.	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)	F 561		4/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/29/2024

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

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F 561	Continued From page 1 (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 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 observations, record reviews, resident, and staff interviews, the facility failed to provide the resident's preference of showers for 1 of 10 residents reviewed for activities of daily living (ADL) (Resident #49). The findings included: Resident #49 was admitted to the facility on 04/22/21 and readmitted on 06/13/22 with diagnoses which included asthma, cerebral vascular accident or stroke, right side hemiplegia, aphasia, and diabetes mellitus type II.	F 561	F561 Self-Determination Resident #49 was provided a shower by a CNA on 3/01/2024. On 3/20/2024, the Social Worker (SW) conducted an interview with Resident #49 to ensure bathing preferences for resident. The Resident Care Guide will be updated to reflect the residents' bathing preference. On 3/04/2024 the SW initiated interviews of all residents with a BIMS of 13 or greater to ensure bathing preferences are being honored. The interviews will be completed by 3/22/2024. Residents with a	

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F 561	Continued From page 2 Review of Resident #49's annual Minimum Data Set (MDS) assessment dated 02/01/24 revealed she was cognitively intact and required total assistance with showering and bathing. The assessment also revealed Resident #49 had no rejection of care behaviors and according to the assessment, it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath. An observation and interview with Resident #49 on 02/27/24 at 9:25 AM revealed her up in her wheelchair and dressed for the day. The resident's skin that was visible was dry and flakey. The resident stated she was not getting her showers two times a week as scheduled and stated she preferred to take showers because the hot water felt good to her body. Resident #49 further stated she had not refused any of her showers but had not been offered showers two times per week as scheduled. On 02/28/23 at 2:00 PM a Resident Council meeting was held and Resident #49 was in attendance and again complained during the meeting that she was not getting her showers two times a week as scheduled. Review of the shower schedule for the hall on which the resident resided revealed Resident #49 was scheduled for showers on Tuesday and Friday on 2nd shift (3:00 PM to 11:00 PM). Review of the documentation of showers in the electronic medical record for Resident #49 revealed for the month of February she had only received two showers on 02/13/24 and 02/16/24. On the other days she was scheduled for showers the following was documented:	F 561	BIMS of 12 and below resident representative will be contacted for shower/bath preferences by 4/15/2024. On 3/19/24, the Unit Managers initiated an audit of all resident shower logs and electronic medical records for the previous week to ensure all showers/baths are being given as scheduled and per resident preference. By 3/29/2024, Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Unit Manager (UM) will update the care plan and care guide. The facility will review shower logs dating back to one week. The electronic health record will be reviewed to identify any missed showers/bed baths and to ensure resident preferences are upheld. Any missing showers will be reoffered promptly. On 3/15/2024, Staff Development Coordinator (SDC)/UM/ADON initiated an in-service with Nursing Staff, and Therapy Department on the activities of daily living (ADL) for showers, including offering all residents the opportunity of shower or bed bath. The nurse or CNA not attending the in-service by 3/29/2024 will receive the education before their next scheduled shift. Education will be provided to nurses and CNAs on the actions to be taken if a resident refuses a shower. On 3-21-24 in-service was initiated by SDC to include how the staff can find the bathing preference in the Resident Care Guide. The nurse or CNA not attending the in-service by 4/05/2024 will receive the education before their next scheduled shift. The training will be provided to all	

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F 561

Continued From page 3

Friday 02/02/24 partial bed bath
Tuesday 02/06/24 partial bed bath
Friday. 02/09/24 partial bed bath on 1st shift (7:00 AM to 3:00 PM)
Tuesday, 02/20/24 partial bed bath on 1st shift
Friday, 02/23/24 partial bed bath on 1st shift and on 2nd shift

An interview on 02/28/24 at 2:29 PM with Nurse Aide (NA) #4 who was assigned to care for Resident #49 on 02/02/24, 02/06/24, 02/20/24 and 02/23/24 revealed on the days she had not provided the resident with a shower she had given her a partial bath and documented a partial bath. She stated the resident got up early in the morning and sometimes wanted to go back to bed early afternoon before it was time for her shower so she just washed her up in bed. NA #4 further stated she had not asked if Resident #49's showers could be changed to 1st shift because she had been told all B bed residents had their showers on 2nd shift but said she would probably benefit from having her shower time changed from 2nd shift to 1st shift.

A telephone interview was attempted with NA #9 who was assigned to care for Resident #49 on 02/09/24 with voicemail message left for return call with no response from the NA.

An interview on 02/29/24 at 2:09 PM with Nurse #6 who was assigned to care for Resident #49 revealed she was not aware of the resident refusing showers and said the NAs had not reported to her that she had refused showers so she had not documented a progress note regarding the resident refusing showers.

F 561

new hires and agency nursing staff during orientation.
Beginning on 3/19/2024 the DON/ADON/UM will monitor the shower schedule 5 times weekly for 2 weeks in Interdisciplinary Team (IDT) to ensure showers are offered and/or given, bed baths are offered and/or given, preferences upheld, and nurse is notified if resident refused.
On 4/1/2024, using the Shower Audit tool, the DON/ADON/UM will audit 5 residents 2 x's weekly x 4 weeks then 1 time a month for 2 months. The audit will be done by interviewing the residents with a BIMS of 13 or higher and monitoring the shower log and electronic records for all other residents. Results of audit will be shared with the QAPI members monthly x 2 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance.

Date of Compliance 4/15/2024

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F 561	Continued From page 4 An interview on 02/29/24 at 3:10 PM with Unit Manager #1 revealed she was not aware Resident #49 was not receiving her showers as scheduled and said no one had reported it to her. She stated if the 2nd shift shower were not working for Resident #49, they could certainly switch her to 1st shift showers. Unit Manager #1 stated the normal process for showers was if the resident refused their shower the NA had to go back again a little later and ask the resident if she/he was ready to take their shower and if the answer was no again, the NA was to report that to the nurse. She stated then the nurse was to ask the resident and if the resident refused to the nurse, she was supposed to write a progress note indicating the resident had refused his/her shower despite being asked three times. Unit Manager #1 further stated the NA should have reported the timing of Resident #49's shower not working for her and it could have been changed to accommodate the resident. An interview on 02/29/24 at 4:53 PM with the Director of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said it was a process they were currently working on with the NAs. She stated she expected residents to have their showers as scheduled and said if they did not receive their showers, she expected them to receive a complete bed bath not a partial bed bath and for it to be documented. The DON further stated if the resident refused their shower, she expected the nurse to document the refusal in their progress notes.	F 561		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g)	F 641		4/15/24

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F 641	Continued From page 5 §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 code the Minimum Data Set (MDS) assessment for 3 of 6 residents (Resident #41, #102, #84) reviewed for Preadmission Screening and Resident Review (PASRR), and 1 of 3 residents (Resident #110) reviewed for restraints. Findings Include: 1. Resident #41 was admitted to the facility on 07/03/12 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, anxiety, and psychosis. Review of PASRR Level II determination letter from July 2021 revealed Resident #41 had met the requirements for a level II PASRR due to having mental illness diagnosis with specialized services required. The annual MDS assessment dated 01/13/24 indicated Resident #41 was cognitively intact and was not coded as having a level II PASRR. An interview with the MDS Coordinator on 02/29/24 at 3:28 PM revealed she had begun working at the facility in October 2023 and was not aware that Resident #41had a level II PASRR or that it had been coded on his MDS. She stated Resident #41's MDS did not reflect him having a level II PASRR assigned and that was an oversight based on human error and a correction would need to be made.	F 641	• The Minimum Data Set (MDS) Nurse modified the MDS assessments for residents #41, #102 and #84 related to Pre-Admission Screening and Annual Resident Review (PASARR) and resident #110 for limb restraint usage on 3/1/2024. • An initial audit of all MDS Assessments for PASARR, and restraint usage was performed by the MDS/SW beginning 3/12/2024 and completed by 3/22/2024. Any areas identified will be corrected by 4/14/2024 • Re-education of how to complete MDS assessments accurately provided to Administrator and MDS Coordinator by Regional MDS Consultant on 3/22/2024. Social Worker received Education of the PASARR process on 3/1/24 by the Administrator. New MDS nurses will receive orientation upon hire on accurate coding for PASARRs and restraints by the Regional MDS Consultant. • Director of Nursing, ADON or Administrator will complete audits of MDS assessments for PASARR, and all residents using restraints weekly for 4 weeks, and then monthly for 1 months. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 2 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the	

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F 641	Continued From page 6	F 641	Administrator for sustained compliance. • Date of Compliance: 4/15/24	

An interview with the Administrator on 02/29/24 at 4:08 PM revealed she had just begun at the facility on Monday 02/26/24 and was not aware of Resident #41 PASRR level not being reflected on his MDS. She stated their process would be for the MDS to reflect current PASRR level and to be accurate. She felt it was just an oversight based on human error on the part of the MDS Coordinator.

The Director of Nursing (DON) was interviewed on 02/29/24 at 4:45 PM revealed she was not aware of Resident #41 PASRR level was not reflected on his MDS and believed it was probably due to an oversight on the part of the MDS Coordinator. She stated MDS should reflect current PASRR level for all residents and a correction would need to be made.

2. Resident #102 was admitted to the facility on 11/07/20 with diagnoses that included dementia.

Review of PASRR level II determination letter from May 2021 revealed Resident #102 met the requirements for a level II PASRR due to diagnosis of dementia.

The annual MDS assessment dated 09/24/23 indicated Resident #102 was moderately cognitively impaired and was not coded as having a level II PASRR.

An interview with the MDS Coordinator on 02/29/24 at 3:28 PM revealed she had begun working at the facility in October 2023 and was not aware that Resident #102 had a level II PASRR or that it had not been coded on her

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F 641	Continued From page 7 MDS. She stated she believed Resident #102's MDS not reflecting her having a level II PASRR assigned was an oversight based on human error by the previous MDS Coordinator and a correction would need to be made. An interview with the Administrator on 02/29/24 at 4:08 PM revealed had just begun at the facility on Monday 02/26/24 and was not aware of Resident #102 PASRR level not being reflected on her MDS. She stated their process would be for the MDS to reflect current PASRR level and to be accurate and they felt it was just an oversight based on human error on the part of the MDS Coordinator. The Director of Nursing (DON) was interviewed on 02/29/24 at 4:45 PM revealed she was not aware of Resident #102 PASRR level was not reflected on her MDS and believed it was probably due to an oversight on the part of the MDS Coordinator. She stated MDS should reflect current PASRR level for all residents and a correction would need to be made. 3. Resident #84 was admitted to the facility on 2/8/19 with diagnoses of dementia, schizophrenia, and anxiety. The most recent annual Minimum Data Set assessment dated 10/31/23 indicated Resident #84 was not currently considered by the state level II PASRR process to have serious mental illness. Review of Resident #84's electronic medical record revealed a Halted level II PASRR identification number noted in the demographic information.	F 641		

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F 641		F 641		

Continued From page 8

During an interview on 2/29/24 at 3:34 PM MDS Coordinator #1 indicated it was the responsibility of the MDS coordinator to enter PASRR information onto the MDS assessment at admission and annually. She further indicated she initially understood Resident #84's PASRR to be halted and therefore Resident #84 was not considered to have a level II PASRR determination. However, she realized the PASRR section of the MDS should have been marked as having a level II PASRR, since the Resident was admitted with a PASRR number and mental health diagnoses.

The Director of Nursing (DON) was interviewed on 02/29/24 at 4:58 PM revealed she was not aware of Resident #84's PASRR level was not reflected on her MDS. She believed it was probably due to an oversight on the part of the MDS Coordinator staff changes. She stated her expectation was that MDS should reflect current PASRR levels for all residents.

An interview with the Administrator on 02/29/24 at 5:10 PM revealed had just begun at the facility on Monday 02/26/24 and she expected the MDS to be reviewed and coded correctly.

4. Resident #110 was admitted to the facility on 10/14/22.

The quarterly Minimum Data Sheet (MDS) assessment dated 12/1/23 indicated Resident #110 was coded for the use of a limb restraint less than daily. The previous annual MDS dated 9/11/23 indicated no use of restraints.

Review of Resident #110's current care plans

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F 641	Continued From page 9 dated 12/1/23 revealed Resident #110 had no restraint care plan. An interview was conducted with MDS Coordinator #1 and MDS Coordinator #2 on 2/29/24 at 3:56 PM. MDS Coordinator #1 explained Resident #110's MDS assessment dated 12/1/23 was completed by another MDS Coordinator who was no longer employed at the facility. The MDS Coordinator #2 confirmed Resident #110 did not use a limb restraint now and had not used one in the past. The MDS Coordinator #2 stated it was likely an entry issue and they would look into the entry. During an interview on 2/29/24 at 5:06 PM, the Administrator stated it was her expectation for MDS assessments to be completed accurately. The Administrator further stated that MDS entries should be checked before final submission.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and	F 644		4/15/24

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F 644 Continued From page 10

all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for resident with mental health diagnosis upon admission and residents with new mental health diagnoses for 3 of 6 residents (Resident# 141, #31, #49) reviewed for PASRR.

The findings include:

1. Review of Resident #141's medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on 08/31/23. The resident had been diagnosed with delusional disorder on 08/31/23 and dementia, severe, with psychotic disturbance as part of her admission. No PASRR level II had been completed per Resident #141 medical records.

During an interview on 02/29/24 at 4:05 PM with the Social Worker (SW) revealed she had been employed as the facility SW over the past year and since that time had been responsible for completing PASRR upon a resident admission, when a change in condition or behavior had occurred, or when there had been a new diagnosis. She revealed she would review a resident's diagnosis once they were admitted seeing if they would require a level II PASRR to be completed and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition. The SW

F 644

F644 Coordination of PASARR and Assessment

- Corrective action for residents #141, #31, and resident #49 was accomplished by submitting a PASARR level 2 by the Social Worker for identified residents on 3/25/2024. The Minimum Data Set (MDS) will be updated to reflect Level 2 once it is received by the MDS Director.
- Corrective action for all residents having the potential to be affected was an initial audit of all MDS Assessments for Pre-Admission Screening and Annual Resident Review (PASARR), performed by the MDS Director and Social Worker 3/12/2024 on and corrections were made as needed.
- Re-education of how and when to complete Level 2 PASARRs accurately provided to Social Workers and MDS Coordinators by Administrator on 3/01/2024. New MDS nurses and Social Workers will receive orientation upon hire on accurate coding for PASARR coding correctly by the Regional MDS Consultant. Social Services will attend interdisciplinary team meetings 5 times weekly with nursing where new diagnoses will be discussed.
- The Director of Nursing will complete audits of all new admission related to PASARR documentation weekly for 4 weeks, and then monthly for 1 month.

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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 644	Continued From page 11 stated Resident #141 admission diagnosis and level of PASRR had simply been overlooked, however based on Resident #141 admission diagnosis of delusional disorder and dementia, severe, with psychotic disturbance and the preadmission PASRR level I, paperwork for a PASRR level II should have been completed. During an interview on 02/29/24 at 4:15 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #141 admission diagnosis of delusional disorder and dementia, severe, with psychotic disturbance a PASRR level II should have been completed. 2. Review of Resident #31's medical record revealed the resident had a PASRR level I completed prior to his admission and was admitted to the facility on 03/31/15. The resident was diagnosed with dementia with mood disturbance disorder on 05/05/23. No PASRR level II had been completed per Resident #31 medical records. During an interview on 02/29/24 at 4:05 PM with the Social Worker (SW) revealed she had been employed as the facility SW over the past year and since that time had been responsible for completing PASRR upon a resident admission, when a change in condition or behavior had occurred, or when there had been a new diagnosis. She revealed she would review a resident's diagnosis once they were admitted seeing if they would require a level II PASRR to be completed and should be notified by nursing if	F 644	Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) members for 2 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. • Date of Compliance: 4/15/24	

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F 644	Continued From page 12 a new diagnosis had been added for a resident or there had been a change in condition. The SW stated she had not been made aware of Resident #31's new mental health diagnosis of dementia with mood disturbance and felt it could have been an oversight, however based on his new diagnosis and the preadmission level I PASRR, paperwork for a PASRR level II should have been completed. During an interview on 02/29/24 at 4:15 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #31 newly added diagnosis of dementia with mood disturbance disorder a PASRR level II should have been completed. 3. Review of Resident #49's medical record revealed the resident had a PASRR level I completed prior to her admission and was admitted to the facility on 04/21/22. The resident was diagnosed with major depressive disorder on 11/28/22. No PASRR level II had been completed per Resident #49 medical records. During an interview on 02/29/24 at 4:05 PM with the Social Worker (SW) revealed she had been employed as the facility SW over the past year and since that time had been responsible for completing PASRR upon a resident admission, when a change in condition or behavior had occurred, or when there had been a new diagnosis. She revealed she would review a resident's diagnosis once they were admitted seeing if they would require a level II PASRR to	F 644		

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F 644	Continued From page 13 be completed and should be notified by nursing if a new diagnosis had been added for a resident or there had been a change in condition. The SW stated she was not aware of Resident #49 not having a level II PASRR, however based on her new diagnosis of major depressive disorder and the preadmission level I PASRR, paperwork for a PASRR level II should have been completed. During an interview on 02/29/24 at 4:15 PM with the Administrator revealed a PASRR level II should be completed in a timely manner upon admission for a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. She stated based on Resident #49 newly added diagnosis of major depressive disorder a PASRR level II should have been completed.	F 644		
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	F 657		4/15/24

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F 657	Continued From page 14 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, staff interviews, and observations the facility failed to revise a smoking care plan for Resident #75, resolve inactive care plans for Resident #51 and schedule quarterly care plan meetings (Resident #83) for 3 of 5 sampled residents. The findings included: 1. Resident #75 was admitted to the facility on 02/13/20 with hypertension. Review of Resident #75's quarterly Minimum Data Set (MDS) dated 12/14/23 revealed the resident was cognitively impaired and was independent for most activities of daily living (ADL). Review of Resident #75's quarterly smoking assessments dated 01/27/24 revealed the resident was an unsafe smoker and required to be supervised. Review of Resident #75's care plan revised on 03/29/23 revealed on the resident's care guide that resident smoking status was an independent	F 657	F657 Care Plan Timing and Revision " Resident #75 care plan was updated related to smoking on 3/20/2024. Resident #51 inactive care plan was resolved. Resident #83 had a care plan meeting on 3/26/2024. " On 3/22/2024, the Director of Nursing and Assistant Director of Nursing, Minimum Data Set (MDS) Coordinator initiated an audit of all resident care plans related to smoking and infections to ensure accuracy of the care plan. Social Services will audit resident Care Plan meeting schedules for the last 6 months to identify the residents who did not have a quarterly care plan meeting. Residents or Responsible parties who were not invited to participate in a care plan meeting over the last 6 months will be offered a care plan meeting by 4/15/2024 and the care plan meeting review documented on the sign in sheet. The audit will be completed by 3/31/2024. Quarterly care plan meetings will be scheduled for residents quarterly according to the MDS schedule and will	

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Continued From page 15

smoker and may smoke at time of own choice without supervision.

A joint interview with the MDS coordinator #1 and MDS coordinator #2 on 02/29/24 at 3:30 PM revealed Resident #75 was an unsafe smoker, and the resident's care plan should have reflected that.

An interview conducted with the Director of Nursing (DON) on 02/29/24 at 4:50 PM revealed Resident #75 was an unsafe smoker, and the resident's care guide should have reflected that. The DON further revealed staff review the resident's care guide for care areas.

An interview conducted with the Administrator on 02/29/24 at 5:15 PM revealed residents who are considered unsafe smokers should have been care planned as an unsafe smoker. It was further revealed Resident #75's care guide on the care plan should have not stated the resident was a safe smoker.

2. Resident # 51 was admitted to the facility on 2/2/21 with diagnoses including neurogenic bladder and a chronic autoimmune disorder that affects movement, sensation and bodily function.

Review of Resident #51's current care plans initiated 3/4/21 and revised on 4/2/23 revealed a focus area for the resident being at risk for actual infection related to COVID 19 Virus. Will be free of signs and symptoms of infection through next review. Interventions Medications as ordered, treatment as ordered, encourage resident compliance with infection, encourage resident to report signs and symptoms of infection to the nurse, and isolation precautions. A care plan

F 657

be invited to attend by social services.

" On 3/22/2024, the Staff Development Coordinator (SDC) initiated an in-service with all nurses regarding Care Plans emphasizing on accuracy of the care plan relating to resident smoking status and infections. The Administrator educated the social workers on care plan meetings including scheduling according to the MDS schedule quarterly and sending and documenting invitations to the resident and responsible party in the resident medical record. In-service will be completed by 4/15/2024. After 4/15/2024, any social worker who has not completed the in-service will be in-serviced prior to the next scheduled work shift. All newly hired social workers and nurses will be in-serviced during orientation regarding Care Plans by the SDC.

" The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and the MDS Nurses will review 15 resident care plans weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure resident care plan is accurate related to smoking, and infections. The audit will include the documentation of the care plan meeting review with resident and the resident's representative, and the audit will ensure the meeting was offered and documented. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.

" The DON will forward the results of Care Plan Audit Tool to the Quality Assurance Performance Improvement

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F 657	Continued From page 16 initiated on 3/28/22 and revised 4/2/23 stated at risk for actual infection r/t fungi candida, resident will receive appropriate treatment for infection with resolution through next review. Interventions medications as ordered by physician, and to educate care staff on performing personal hygiene. Resident #51 had a quarterly Minimum Data Set (MDS) assessment completed on 1/17/24. An interview with the MDS Coordinator #1 on 2/29/24 at 3:56 PM revealed that care plans should be reviewed and revised with each MDS assessment and be made inactive when a problem is resolved. MDS Coordinator #1 stated she was not aware that some of the care plans had not been revised in over a year. Stated that the last MDS Nurse left about two months ago had completed Resident #51 quarterly MDS on 1/17/24. MDS Nurse #1 indicated they were still trying to review and update everything. An interview with the Director of Nursing (DON) on 2/29/24 at 4:46 PM revealed that expectations were that care plans were initiated, revised, or completed as the resident condition changed. An interview with the Administrator on 2/26/24 at 5:06 PM revealed she expected all care plans to be updated and revised in a timely manner. Stated that the Corporate MDS Consultant was scheduled to be in the building the following week to help the new MDS staff with training and job duties since they are both relatively new to the position. 3. Resident #83 was admitted to the facility on 09/26/2022 with diagnoses that include dementia,	F 657	Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. " Date of Compliance 4/15/2024	

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F 657	Continued From page 17 and cerebral vascular accident (CVA). Review of the quarterly Minimum Data Set (MDS) assessment dated 12/01/2023 revealed Resident #83 had moderate cognitive impairment. Review of Resident 83's medical record revealed the last documented care plan meeting occurred on 11/08/2022. A phone interview was conducted with Resident #83's responsible party (RP) on 02/26/2024 at 1:13 PM. The RP revealed she had not attended a care plan meeting for Resident #83 in a very long time. She further stated that she believed there was no care plan meeting scheduled for Resident #83 for the entire 2023 calendar year. Social Worker (SW) #2 was interviewed 02/29/2024 at 8:37 AM. SW#2 confirmed Resident #83 had not had a care plan meeting since 11/08/2022. She stated she had only been in her position for 3 weeks and was currently working to get the care plan meetings caught up. She further stated that there were several residents who were long overdue for care plan meetings. She also revealed she expected care plan meetings to be scheduled quarterly. She also stated it would be the SW's responsibility to create and maintain the care plan meeting calendar, send out the care plan meeting invitations, and hold the care plan meeting. An interview was completed on 02/29/2024 at 9:06 AM with the Administrator. The Administrator stated that she realized the care plan meeting process was behind schedule and the facility was currently working to ensure care plan meetings were being held.	F 657		

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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 observations, record review, and staff interviews, the facility failed to follow physician orders for 1 of 4 wounds (non-pressure of left knee) on 1 of 3 residents (Resident #128) reviewed for wound care and failed to administer medications as ordered by the physician for 2 of 16 residents reviewed for medication errors (Residents #28 and #110). The findings included: Resident #128 was admitted to the facility on 11/24/22 and readmitted on 12/16/23 with diagnoses which included congestive heart failure, Alzheimer's disease, dementia, and osteoarthritis. Review of Resident #128's quarterly Minimum Data Set (MDS) assessment dated 02/06/24 revealed she was rarely/never understood and rarely/never understands and had no speech. The assessment also revealed she was severely impaired and was dependent on staff for assistance with all activities of daily living (ADL) and anticipation of her needs. The assessment additionally revealed she had two unhealed stage II pressure ulcers and had pressure reducing device for bed, nutrition, and hydration interventions to manage skin problems, pressure injury care, and application of medications and	F 658	• On 03/01/2024 a review of the last two months of the clinical record for Residents #28 and #110 was completed by the Facility Consultant, there were no change in condition noted and the residents' clinical status were stable. Nurse #8 was in serviced on the 6 rights of medication administration by the Director of Nursing (DON)/Staff Development Coordinator (SDC) on 3/20/2024. On 3/20/2024 the wound nurse who administered wound treatment to resident #128 on 2/28/24 during observation received an in-service regarding following physician orders for wound treatments. The wound nurse removed the incorrect dressings and placed the dressings as ordered on 2/28/24. On 3/17/2024 a skin assessment on resident #128 was done to identify any with new skin concerns or wounds to ensure all concerns have been assessed, treatment initiated as indicated, MD/Resident Representative (RR) notified. • On 3/20/2024, The Director of Nursing completed an audit of resident medical records from 12/10/2023 to 12/27/23 which did not indicate any additional medication errors. On	4/15/24

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F 658	Continued From page 19 dressings.	F 658		

F 658 — Summary Statement of Deficiencies:

Review of Resident #128's Treatment Administration Record (TAR) dated 02/01/24 through 02/29/24 revealed the following orders for wound care:

1. Cleanse the left knee with wound cleanser, apply dermasyn hydrogel AG (antimicrobial silver wound gel that facilitates moist wound healing), cover with gauze and dry dressing every day shift (7:00 AM to 7:00 PM) for wound healing.

2. Cleanse the right outer ankle with wound cleanser, apply xeroform (petroleum-based fine mesh gauze that has antimicrobial properties used for wound healing), and cover with dry dressing every day shift (7:00 AM to 7:00 PM) for wound healing.

An observation of wound care was made on Resident #128 on 02/28/24 at 9:13 AM with the Treatment Nurse. The Treatment Nurse gathered her supplies for the four wounds and began with the right outer ankle wound. She removed the old dressing, cleaned the wound with wound cleanser-soaked gauze and applied hydrogel AG-soaked gauze and covered it with a bordered gauze dressing. The Treatment Nurse then moved to the left knee, removed the old dressing, cleaned the wound with wound cleanser and applied xeroform gauze to the wound bed and covered it with a bordered gauze dressing. As she was completing the left knee dressing, the Treatment Nurse said, "I think I mixed up my dressings."

An interview on 02/29/24 at 9:59 PM with the Treatment Nurse revealed she realized while

F 658 — Provider's Plan of Correction:

3/15/2024, the facility Unit Managers initiated a 100% skin assessment on all residents. This audit is to identify any resident with new skin concerns or wounds to ensure all concerns have been properly assessed, treatment initiated as indicated, MD/RR notified. Audit will be completed by 4/5/2024.

- On 3/21/2024, the DON initiated an audit of all treatment administration records (TAR) for all residents from 3/19/24-3/20/24. This audit is to ensure treatments were completed per physician order with documentation on the TAR. The audit will be completed by 3/22/2024.
- The Staff Development Coordinator (SDC), or another licensed nurse will conduct observation of treatment administration for all nurses by 4/15/24. Any nurse not observed to do treatment administration will be observed on their next scheduled shift.
- All Nurses and Med-Aides including agency nurses and Med-Aides will be in-serviced regarding the 6 rights of medication administration which includes verifying the resident's identity prior to medication administration and administering medications as ordered and documenting medications by the SDC beginning 3/15/2024. All nurses and Med-Aides or agency nurses and Med-Aides not in-serviced by 4/05/24 will not work until the education is completed by the DON/SDC. After 4/5/24, all new nurses and Med-Aides and agency nurses and Med-Aides will be educated on the 6 rights of medication administration before working by the DON/SDC. The Unit

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F 658	Continued From page 20	F 658		

doing the left knee that she had mixed up the treatments on the right outer ankle and left knee and had applied the wrong treatments to the wounds. She stated she was nervous about being watched and had just mixed up the dressings for those two wounds even though she had labeled the treatments for each wound.

An interview on 02/29/24 at 11:51 AM with the Director of Nursing (DON) revealed she expected the wound treatments to be done as prescribed by the physician. She stated she thought the Treatment Nurse was nervous about being watched during wound care and just got the two wound treatments mixed up.

2. Resident #28 was admitted to the facility on 11/30/2022 with a diagnosis of anxiety and depression.

A quarterly Minimum Data Set (MDS) assessment dated 11/12/2023 revealed Resident #28 was cognitively intact. The MDS revealed Resident #28 received an antipsychotic medication during the assessment period.

The active physician's orders for December 2023 for Resident #28 included an order dated 11/09/23 for Seroquel 25 mg give 1 tablet by mouth two times a day for depression.

A Medication Administration Record (MAR) dated December 2023 revealed the Seroquel 25 mg scheduled for 8:00 PM was not documented as given on 12/10/2023.

3. Resident #110 was admitted to the facility on 10/14/2022.

Managers (UM), ADON/DON will complete an initial Med Pass return demonstration for all nurses and Med-Aides including agency by 4/5/24. After initial observation of all nurses, the DON/SDC/UM will observe 3 nurses and/or Med-Aides weekly for 4 weeks and then 3 per month for 2 months. The physician will be notified of any identified areas of concern. The Administrator or DON will review the audits weekly x 4 weeks then monthly x 2 month to ensure all areas of concern were addressed appropriately.

• On 3/19/24, the SDC initiated an in-service with all nurses regarding (1) Wound Process with emphasis on assessing, initiating treatment and notification of the MD/RR for all newly identified skin concerns or changes in wound status (2) Treatments/TAR documentation with emphasis on nurse responsibility to complete treatments in the absence of treatment nurse, signing TAR immediately after completing treatment and notification of the physician if treatment cannot be completed for further instructions. The in-service will be completed by 4/5/2024. After 4/5/2024, any nurse or agency nurse who has not worked or received the in-service will complete it before the next scheduled work shift. All newly hired nurses to include agency nurses will be in-serviced during orientation regarding Wound Process and TAR Documentation/Treatments

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A quarterly Minimum Data Set (MDS) assessment dated 12/01/2023 revealed Resident #110 was cognitively intact.

The active physician's orders for December 2023 for Resident #110 included an order dated 12/04/23 for Amoxicillin 500 mg give 1 tablet by mouth two times a day for a bacterial infection for 10 days.

A Medication Administration Record (MAR) dated December 2023 revealed the Amoxicillin 500 mg scheduled for 8:00 PM was not documented as given on 12/10/2023.

A facility investigation summary dated 12/12/23 revealed the facility interdisciplinary team was reviewing the Medication Administration Audit report for the previous 48 hours and noted the medication errors and Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110 had not been administered their medication during the 7:00 PM to 11:00 PM shift. An investigation was then initiated, and the Medical Director was notified. The investigation was completed by the Regional Nurse Consultant who identified the cause of the incident was due to a nurse not reporting for the 7:00 PM to 11:00 PM shift.

An interview conducted on 02/28/24 at 4:30 PM with the Director of Nursing (DON) revealed on 12/10/23 around 6:30 PM she was told by Unit Manager #1 that Nurse #2 had called out for the 7:00 PM to 11:00 PM shift. She stated Unit Manager #1 told her that Nurse #3, Nurse #4 and Nurse #5 were instructed to split the medication cart and had taken report on the residents. She

F 658

- The UM/ADON/DON will complete 2 wound observations weekly x4 weeks, then monthly x1 month.

- The DON will present the findings of the Medication Administration observations and the treatment observations to the Quality Assurance Performance Improvement (QAPI) committee 1 time monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance.
- Date of Compliance 4/15/2024.

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F 658	Continued From page 22 stated she heard the next morning that some residents had not received their medication. The interview revealed residents including Resident #28 and Resident #110 did not receive any scheduled medication. She stated Nurse #5 told her she had completed her assigned half and thought someone else was going to administer the rest of the residents' medication. The DON stated it was a communication error between the nurses. She stated no adverse outcomes had occurred from the incident and no residents needed medical treatment due to not receiving their medication. On 02/29/24 at 11:20 AM an interview was conducted with the Medical Director. During the interview he stated he was notified by the facility that the residents had missed their medication on 12/10/23. The interview revealed he notified the Nurse Practitioner's that were in the facility of the incident and that nurses on the unit were monitoring the residents for any changes of condition. He stated no residents were having symptoms from not receiving their medication. The MD stated although medication such as anticoagulants, opioids, antipsychotics and insulin were significant, it would not be harmful to the residents to miss one dose. The interview revealed none of the residents identified to have missed their medication were sent to the hospital or experienced a change of condition.	F 658		
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;	F 677		4/15/24

F 677

Continued From page 23

This REQUIREMENT is not met as evidenced by:

Based on observations, record reviews, resident, and staff interviews, the facility failed to provide showers and hair washing to 1 of 10 residents (Resident #94) and failed to provide incontinence care as trained for 1 of 10 residents (Resident #51). These failures occurred for 2 of 10 residents reviewed for activities of daily living (ADL).

The findings included:

1. Resident #94 was admitted to the facility on 08/21/23 with diagnoses which included diabetes mellitus type II, vitamin deficiency, dementia, and anorexia.

Review of Resident #94's quarterly Minimum Data Set (MDS) assessment dated 02/21/24 revealed she was severely cognitively impaired and required total assistance with showering and bathing. The assessment also revealed Resident #94 had no rejection of care behaviors.

Review of Resident #94's care plan revealed a focus area for activities of daily living/personal care deficit related to dementia. The interventions included personal hygiene with substantial/maximal assistance and showering/bathing dependent on staff.

An observation and interview with Resident #94 on 02/26/24 at 11:42 AM revealed the resident sitting in her wheelchair in her room, dressed for the day. The resident's hair appeared greasy and disheveled and she stated she was not getting her showers as scheduled two times per week. Resident #94 further stated she preferred

F 677

F677 ADL Care Provided for Dependent Residents

- Resident #94 was provided a shower and hair wash on 3/1/24 CNA. Resident #51 was provided incontinent care on 2/28/24 by a different CNA. Showers/baths were offered to any resident who had not received a shower/bath per preference. On 3/19/24, the Unit Managers initiated an audit of all resident shower logs and electronic medical records for the previous week to ensure all showers/baths are being given as scheduled and per resident preference.
- CNA #1 provided one on one education by Director of Nursing on 2/28/24 on proper cleaning for a resident that has had a bowel movement. On 3/19/24, the Unit Managers initiated an audit of all resident shower logs and electronic medical records for the previous week to ensure all showers/baths are being given as scheduled and per resident preference. On 3/20/24, the social workers initiated Resident Preference Questionnaire with all residents with a BIMS of 13 or greater, regarding resident preferences to include but not limited to preferences for showers/baths and morning/evening. Residents with a BIMS of 12 and below resident representative will be contacted for shower/bath preferences by 4/15/2024. The Unit Managers/Assistant Director of Nursing (ADON) will update the care plan for all newly identified or changes in resident preferences.

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showers because she liked to get her hair washed when she was bathed.

Review of the shower schedule for the hall on which the resident resided revealed Resident #94 was scheduled for showers on Tuesday and Friday on 1st shift (7:00 AM to 3:00 PM).

Review of the documentation of showers in the electronic medical record for Resident #94 revealed for the month of February she had only received one shower on 02/27/24. On the other days she was scheduled for showers the following was documented:

Tuesday 02/06/24 no indication or documentation
Tuesday, 02/13/24 no indication or documentation
Tuesday, 02/20/24 no shower or bed bath given
Friday, 02/23/24 partial bed bath (not a complete bed bath)

A telephone interview on 02/29/24 at 10:46 AM with NA #8 who was assigned to care for Resident #94 on 02/06/24 and 02/13/24 stated if she were assigned to a resident and did not have time to give them a shower, she would wash them up in bed and document it as a partial bath but said it was not a complete bed bath. NA #8 stated she could not recall why she had not given Resident #94 a shower on 02/06/24 or 02/13/24 but said it was most likely due to staffing issues.

An interview on 02/28/24 at 10:34 AM with NA #12 who was assigned to care for Resident #94 on 02/09/24 revealed if she was assigned to the resident and had given her a complete bed bath instead of a shower it was due to not having time

F 677

Questionnaires will be completed by 4/5/24.

- On 3/20/24, Staff Development Coordinator (SDC) initiated a 100% education and return demonstration for all nurse aids that provide incontinence care to ensure proper technique. The SDC initiated 100% education of the shower schedules, and the expectation that 2 times weekly all residents are offered a shower per their preference. Any CNA not attending the in-service by 4/15/2024 will receive the education before their next scheduled shift. The training will be provided to all new hires and agency CNA staff during orientation.

- On 3/19/24, the Director of Nursing (DON) /Administrator will monitor the shower schedules 5 times weekly in IDT to ensure showers are given, bed baths offered, preferences upheld, and nurse notified if resident refused. Beginning On 3/25/24, Staff Development Coordinator will audit incontinence care of 3 residents on various shifts and residents weekly x 4 weeks then 1 time a month.

- On 3/25/24, using the Shower Audit tool, the Unit Managers/DON will audit 5 residents 2 x's weekly x 4 weeks then 1 time a month. The audit will be done by interviewing the residents with a BIMS of 13 or higher and monitoring the shower log and electronic records for residents with a BIMS of 12 or less. DON/ADON will review all audits for incontinence care, 2x's weekly x 4 weeks, then 1 time month. Results of the audits will be shared with

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to shower the resident. She stated they were short of help sometimes and it was less time-consuming to give residents a bed bath than shower.

An interview on 02/29/24 at 1:45 PM with NA #7 who was assigned to care for Resident #94 on 02/23/24 revealed she could not recall why she had not given the resident a shower as scheduled. She stated there were days they worked short of help and that could have been one of those days when she did not have time to give the resident a shower and just bathed her in bed and documented it as a partial bath. NA #7 further stated when she showered residents, she tried to cut their nails and shave them as needed but did not always have time to do so due to staffing issues.

An interview on 02/29/24 at 3:10 PM with Unit Manager #1 revealed she was not aware Resident #94 was not receiving her showers as scheduled and said no one had reported it to her. She stated the normal process for showers was if the resident refused their shower the NA had to go back again a little later and ask the resident if she/he was ready to take their shower and if the answer was no again, the NA was to report that to the nurse. Unit Manager #1 further stated that the nurse was to ask the resident and if the resident refused the nurse, she was supposed to write a progress note indicating the resident had refused her/his shower despite being asked three times. She indicated if the NAs were having difficulty completing their showers, they should have reported that to her so she could have provided them with additional staff to assist with showers.

An interview on 02/29/24 at 4:53 PM with the

F 677

the Quality Assurance Performance Improvement (QAPI) members monthly x 2 months or until a time determined by the QAPI members for sustained compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance.

- Date of compliance is 4/15/24

F 677 Continued From page 26 F 677

Director of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said it was a process they were currently working on with the NAs. She stated she expected residents to have their showers as scheduled and said if they did not receive their showers, she expected them to receive a complete bed bath not a partial bed bath and for it to be documented. The DON further stated if the resident refused their shower, she expected the nurse to document the refusal in their progress notes.

2. Resident # 51 was admitted to the facility on 2/2/21 with diagnoses including neurogenic bladder and a chronic autoimmune disorder that affects movement, sensation and bodily functions.

Resident #51's care plan initiated 1/17/24 revealed a focus area for the resident having an activities of daily living (ADL) self-care deficit due to [chronic autoimmune disorder that affects movement, sensation and bodily functions] and neurogenic bladder. The interventions included assisting with activities of daily living (ADL), dressing, grooming, toileting, promote independence and dignity, and provide positive reinforcement for all activities.

Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated 1/17/24 revealed total dependence for toilet and bathing. Impaired range of motion was noted to bilateral lower extremities. The resident was coded as always incontinent of bowel and for the presence of a supra pubic catheter.

An observation was conducted on 02/28/24 at

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F 677	Continued From page 27 1:40 PM of Resident #51 receiving incontinence care from NA #1. While providing incontinence care NA #1 was observed wiping the resident starting under the scrotum and wiping up towards his penis with wash cloth that had soap and water on it. NA#1 continued wiping several more times from under the scrotum up towards the resident's abdomen while using the same surface of the washcloth. When the resident turned on his side there was visible bowel movement on his left and right buttocks and anal area. NA #1 continued with the same washcloth and continued to wipe with downward motion and was observed wiping bowel movement from anal area towards the scrotum. The NA folded the washcloth to change surfaces when cleaning the resident. This process continued until all bowel movement was removed from the resident's skin. Interview on 02/28/24 at 1:50 PM with NA #1 revealed he believed he had done a good job providing incontinence care on Resident #51 and did not realize he had been wiping from lower perineal region to upper perineal area. Stated he was nervous and must not have been thinking. NA #1 stated that he should have started at the penis and wiped down toward the anal area, and from the anal area to the upper buttocks. NA #1 further stated he should have started on the upper perineal area and wiped down towards the scrotal area, and from the anal area to the upper buttocks. NA #1 stated he had been trained in how to provide incontinence care. Interview on 02/29/24 at 4:46 PM with the Director of Nursing (DON) revealed she would expect nursing staff to follow the care plans and facility policies. The DON stated that all employees have been trained in incontinence	F 677		

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F 677	Continued From page 28 care and the appropriate process was to always be followed.	F 677		
F 679 SS=H	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 4 of 5 residents reviewed for activities (Resident #17, 31, 35, and 110). The residents expressed not being able to leave the facility for over a year made them feel more dependent, less social, sad, and they missed getting out with the group to shop and socialize. The findings included: A review of the February 2024 activity calendar revealed activities for inside of the facility during the week and on the weekends. There were no activities scheduled for outside of the facility.	F 679	1. Transportation arrangements have been made and an outside activity has been scheduled by the Activities Director for a resident shopping trip and lunch trip on 3/21/24. Residents #17,31,35, and 110 were invited to this outing by the Activity Director and attended. On 3/19/2024, the facility van was taken to be repaired by the vendor by the Transportation Specialist. This repair with an anticipated date of completion for 3/26/24 2. On 3/14/2024 a resident council meeting was held by the operation's consultant specific to resident activities and the following requests were made, outside activities during good weather seasons, a basketball goal and new board games. On 3/14/2024 the Operations consultant ordered new board games and a basketball goal. The Activities Director	4/15/24

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F 679	Continued From page 29 Review of resident council minutes from February 2023 through February 2024 revealed grievances for scheduled group activities outside of facility were discussed each month during meetings and the response given from the previous Administrator was one of the facility vans was broken and unable to provide transportation for residents and the other facility van was only available for short distances to resident medical appointments. Observation on 02/26/24 at 9:30 AM revealed the facility was located within a business and residential complex that contained sidewalks, pedestrian crosswalks and was within walking distance to numerous local and commercial shops, grocery stores, local and commercial coffee shops, fast food, and sit-down restaurants. a. Resident #17 was admitted to the facility on 04/08/13. An Annual Minimum Data Set (MDS) dated 5/3/23 indicated Resident #17 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #17 was cognitively intact. An interview as conducted with Resident #17 on 2/28/24 at 2:00 PM during resident council meeting revealed there had not been a scheduled group activity outside of the facility in over a year and the resident council had requested one each month, made grievances, and met with the previous administrator about it and each time was told there was nothing they could do because the van was broken, and they had no other way to transport residents. She stated in her opinion	F 679	will schedule an outside activity monthly during mild weather months indicated on the activity calendar. 3. The Administrator in-serviced the Activities Director on developing calendars to meet the residents needs to include outside activities at least once monthly during good weather season on 3/13/2024. The Activities Director will review the monthly activity Calendar for the next month with resident council and incorporate any resident feedback into the activities and document that in the resident council meeting minutes monthly. All new Activities staff will receive the in-service during orientation. 4. The Activities Director will submit the monthly activity calendar prior to the beginning of the month, and resident council meeting minutes monthly to the Administrator to ensure all areas of concern are addressed. The Administrator will submit the findings of the resident council meeting to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to ensure compliance. The Administrator is responsible for the Plan of Correction and for sustained compliance. 5. Alleged Date of Compliance 4/15/24	

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group activities outside of the facility were important to the residents that were able to go and participate because it allowed them some lasting independence, socialization with the group and outside world, and helped with their mental and physical health, it made them feel normal and that they weren't just stuck in a facility. Resident #17 stated not being able to leave the facility in a year and participate in group activities outside the facility had sometimes made her feel as though she had lost some of her own independence and was having to rely on someone else to do her personal shopping instead of on her own. She revealed personally being able to do her own shopping and socializing with other people outside of the facility was very important to her. Resident #17 asked surveyor at the end of resident council meeting if she promised to share their concerns with administration about not being able to schedule activities outside of the facility over the past year and how important this matter was to all of them.

b. Resident #31 was admitted to the facility on 3/31/15.

An Admission Minimum Data Set (MDS) dated 10/28/23 indicated Resident #31 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #31 was cognitively intact.

An interview was conducted with Resident #31 on 2/28/24 at 2:00 PM during resident council meeting revealed he had been told for the past year that they were not allowed to schedule any group activities outside of the facility because they did not have resident transportation due to

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the van being broken. He stated he asked about alternate transportation that the residents could pay for if they wanted to and was also told no due to insurance reasons. He also stated that for the past year they have not been able to leave the facility for any outings other than to a doctor's appointment and after a while they get tired of looking at the inside of the facility. Resident #31 began shaking his head and looking down towards the floor and revealed that going out to eat at a restaurant and talking with the group or going into a store and being able to shop for your own personal belongings made you feel independent and normal, and he felt that not being able to do those things over the past year had made him less independent and more reliant on staff and not as social as he used to be and he would just like the opportunity to have those things again.

c. Resident #35 was admitted to the facility on 5/2/16.

An Annual Minimum Data Set (MDS) dated 6/11/23 indicated Resident #35 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #35 was cognitively intact.

An interview was conducted with Resident #35 on 2/28/24 at 2:00 PM during resident council meeting revealed she knew for a fact that resident council had made numerous grievances to the Administrator about not being able to schedule group activities outside of the facility and each time was told that was not possible because the van was broken, and they had no way to transport residents. She revealed they

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were also told they would have to continue with activities inside of the building or on the grounds of the facility and there was never any discussion of finding a different way to help with transportation. Resident #35 stated being able to go outside of the facility for group activities was important to her because she enjoyed interaction with her friends, and it helped with her mental health and allowed her some independence. She revealed not being able to have group activities outside of the facility had made her sad at times and miss what the world outside the facility was like.

d. Resident #110 was admitted to the facility on 10/14/22.

An Annual Minimum Data Set (MDS) dated 9/11/23 indicated Resident #110 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #110 was cognitively intact.

An interview was conducted with Resident #110 on 2/28/24 at 2:00 PM during resident council meeting revealed she along with the other residents in the meeting had been asking to schedule group activities outside of the facility for the past year at least and were always told by the previous Administrator the van was broken and they had no other way to transport residents. Resident #110 revealed being at the facility day in and day out sometimes made her feel sad and like she was always reliant on staff for her needs, but being able to get out of the facility and go out into the community for group activities allowed her to be more independent, socialize with her

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friends and the community in a different setting and gave her a break from being inside the building all the time and made her feel good.

An interview was conducted with the Activity Director (AD) on 02/28/24 at 2:30 PM revealed she had been working as the AD at the facility for the past 2 years and part of her responsibilities was scheduling and implementing resident activities inside and outside of the facility for each month. She stated prior to this past year, she would schedule monthly outings for the residents to attend outside of the facility such as going to eat at a restaurant, shopping, or the movies, but for the past year she had not been able to schedule any resident group activities outside of the facility due to transportation issues. She revealed one of the facility vans had been broken for over a year and she was told by the previous administrator the other facility van could only be used for medical appointments and residents would just have to participate in activities inside of the facility or on facility grounds. The AD stated she had brought the issue to Administration monthly of the residents requesting to schedule activities outside of the facility and each time was told no due to the transportation and alternate transportation for the residents was never discussed. She revealed she had been doing personal shopping for residents so they could continue to receive their preferences but understood that was not the same as the residents being able to leave the facility and shop for themselves or eat a meal together at a restaurant or watch a movie outside of the facility. She stated she felt like activities outside of the facility for those residents who could participate

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F 679	Continued From page 34 were important for their overall mental and physical well- being and allowed them some independence. During an interview conducted with the Administrator on 02/29/24 at 5:15 PM she revealed this was her first week of work at the facility and she was unaware of the facility vans needing repair and residents not having been to participate in activities outside of the facility over the past year. She stated she would investigate the issue and see what alternative transportation methods were available that could be used to assist with the residents being able to participate in activities outside of the facility until the situation with the vans could be resolved.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow physician orders for 1 of 4 wounds (pressure ulcer of right	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer	4/15/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	9200 GLENWATER DRIVE CHARLOTTE, NC 28262

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F 686

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outer ankle) on 1 of 3 residents (Resident #128) reviewed for wound care.

The findings included:

Resident #128 was admitted to the facility on 11/24/22 and readmitted on 12/16/23 with diagnoses which included congestive heart failure, Alzheimer's disease, dementia, and osteoarthritis.

Review of Resident #128's quarterly Minimum Data Set (MDS) assessment dated 02/06/24 revealed she was rarely/never understood and rarely/never understands and had no speech. The assessment also revealed she was severely impaired and was dependent on staff for assistance with all activities of daily living (ADL) and anticipation of her needs. The assessment additionally revealed she had two unhealed stage II pressure ulcers and had pressure reducing device for bed, nutrition, and hydration interventions to manage skin problems, pressure injury care, and application of medications and dressings.

Review of Resident #128's Treatment Administration Record (TAR) dated 02/01/24 through 02/29/24 revealed the following orders for wound care:

1. Cleanse the right outer ankle with wound cleanser, apply xeroform (petroleum-based fine mesh gauze that has antimicrobial properties used for wound healing), and cover with dry dressing every day shift (7:00 AM to 7:00 PM) for wound healing.

2. Cleanse the left knee with wound cleanser,

F 686

- 1.On 2/22/24, the facility physician ordered a wound treatment to "cleanse left knee with wound cleanser, apply Dermasyn hydrogel alignate (AG) to wound bed, cover with gauze, and dry dressing" for resident #128. On 2/23/24, the facility physician ordered a wound treatment to "Cleanse Right outer ankle with wound cleanser, apply xeroform, and cover with dry dressing" for resident #128.
- On 3/15/2024 The Unit Managers/Director of Nursing (DON)/Assistant Director of Nursing (ADON) initiated skin checks on all residents. This was done to identify any resident with new skin concerns or wounds. All concerns will be properly assessed, treatment initiated as indicated, Medical Director (MD)/Resident Representative (RR) were notified, documentation completed in the Wound Ulcer Flowsheet or Non-Ulcer Flowsheet, incident report completed for any newly identified wounds and care plan updated. All areas of concern will be immediately addressed by the DON to include assessment of resident, completion of incident report, notification of MD/RR, initiating treatment per MD orders, documentation in Wound Ulcer Flowsheet or Non-Ulcer Flowsheet and updating care plan.

- On 3/20/2024 the wound nurse who administered wound treatment to resident #128 on 2/28/24 during observation received an in-service regarding (1) Wound Process with emphasis on assessing, initiating treatment and

F 686

Continued From page 36

apply dermasyn hydrogel AG (antimicrobial silver wound gel that facilitates moist wound healing), cover with gauze and dry dressing every day shift (7:00 AM to 7:00 PM) for wound healing.

An observation of wound care was made on Resident #128 on 02/28/24 at 9:13 AM with the Treatment Nurse. The Treatment Nurse gathered her supplies for the four wounds and began with the right outer ankle wound. She removed the old dressing, cleaned the wound with wound cleanser-soaked gauze and applied hydrogel AG-soaked gauze and covered it with a bordered gauze dressing. The Treatment Nurse then moved to the left knee, removed the old dressing, cleaned the wound with wound cleanser and applied xeroform gauze to the wound bed and covered it with a bordered gauze dressing. As she was completing the left knee dressing, the Treatment Nurse said, "I think I mixed up my dressings."

An interview on 02/29/24 at 9:59 PM with the Treatment Nurse revealed she realized while doing the left knee that she had mixed up the treatments on the right outer ankle and left knee and had applied the wrong treatments to the wounds. She stated she was nervous about being watched and had just mixed up the dressings for those two wounds even though she had labeled the treatments for each wound.

An interview on 02/29/24 at 11:51 AM with the Director of Nursing (DON) revealed she expected the wound treatments to be done as prescribed by the physician. She stated she thought the Treatment Nurse was nervous about being watched during wound care and just got the two wound treatments mixed up.

F 686

notification of the physician/resident representative for all newly identified skin concerns or changes in wound status (2) Treatments/Treatment Administration Record (TAR) documentation with emphasis on nurse responsibility to complete treatments in the absence of treatment nurse, signing TAR immediately after completing treatment and notification of the physician if treatment cannot be completed for further instructions.

- On 3/15/2024, the facility Unit Managers initiated a 100% skin check on all residents. This audit is to identify any resident with new skin concerns or wounds. All concerns will be properly assessed, treatment initiated as indicated, MD/RR notified, documentation completed in the Wound Ulcer Flowsheet or Non-Ulcer Flowsheet, incident report completed for any newly identified wounds and care plan updated. All areas of concern will be immediately addressed by the DON to include assessment of resident, completion of incident report, notification of MD/RR, initiating treatment per MD orders, documentation in Wound Ulcer Flowsheet or Non-Ulcer Flowsheet and updating care plan. Audit will be completed by 4/5/2024

- On 3/21/2024, the DON initiated an audit of all treatment administration records (TAR) for all residents from 3/19/24-3/20/24. This audit is to ensure treatments were completed per physician order with documentation on the TAR. The DON will address all concerns identified during the audit to include

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UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	**9200 GLENWATER DRIVE CHARLOTTE, NC 28262**

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F 686	Continued From page 37	F 686	assessment of the resident, initiating treatment per physician order, notification of the physician of treatment omission/wound status for further recommendations and education of staff. The audit will be completed by 4/5/2024. • On 3/19/24, the SDC initiated an in-service with all nurses regarding (1) Wound Process with emphasis on assessing, initiating treatment and notification of the physician/resident representative for all newly identified skin concerns or changes in wound status (2) Treatments/TAR documentation with emphasis on nurse responsibility to complete treatments in the absence of treatment nurse, signing TAR immediately after completing treatment and notification of the physician if treatment cannot be completed for further instructions. The in-service will be completed by 4/5/2024. After 4/5/2024, any nurse including agency nurse who has not worked or received the in-service will complete in-service before next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Wound Process and TAR Documentation/Treatments • The IDT team to include Minimum Data Set Nurse, Nurse Supervisor, and Administrator will review Treatment Administration Report 5 times a week x 4 weeks then monthly x 1 month and 1 time weekly the SDC/DON will observe 2 resident treatments being performed; this audit will ensure the correct treatment per	

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F 686	Continued From page 38	F 686	Physician order is being done. This audit is to ensure treatments were completed per physician order and that the nurse documented on TAR following treatment. The DON will address all concerns identified during the audit to include completing treatment per physician order, assessment of the resident, notification of the physician for any missed treatments and re-training of staff. The DON will review the Treatment Administration Report 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns are addressed. • The DON will present the findings of the Treatment Administration Report to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Treatment Administration Report to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. • Date of Compliance 4/15/2024	
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	F 689		4/15/24

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UNIVERSITY PLACE NURSING AND REHABILITATION CENTER	**9200 GLENWATER DRIVE** **CHARLOTTE, NC 28262**

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F 689	Continued From page 39 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 and staff interviews the facility failed to complete a quarterly smoking assessment 1 of 3 residents reviewd for smoking (Resident #75). The findings included: Resident #75 was admitted to the facility on 02/13/20 with hypertension. Review of Resident #75s quarterly Minimum Dat set (MDS) dated 12/14/23 revealed the resident was cognitively impaired and was independent for most activities of daily living (ADL). Review of Resident #75's care plan revised on 03/29/24 revealed the resident had problematic manner in which the resident acts characterized by use of tobacco. The goal was for resident #75 to smoke safely in designated areas with supervision through the next review. Interventions included to evaluate residents ' ability to smoke safely on a consistent and regular basis. Review of Resident #75's quarterly smoking assessments revealed the resident did not receive a quarterly smoking assessment from 09/27/23 until 01/27/24. A joint interview was conducted with the MDS coordinator #1 and MDS coordinator #2 on 02/29/24 at 3:30 PM revealed Resident #75 was	F 689	F689 Free of Accidents, Hazards, Supervision, Devices and Devices • Resident #75 is no longer a smoker per resident choice and does not need a smoking assessment. Progress note completed with resident desire to no longer smoke; care plan updated to be a non-smoker. • On 3/25/24, the Regional Nurse Consultant audited all resident smokers for smoking assessments. All residents have current Smoking Assessments. • On 3/22/24, Staff Development Coordinator (SDC) initiated education for the nurses to include agency nurses on completing all assessments for Resident Smoking Assessment, supervised smoking residents' assessments are completed quarterly. The quarterly assessments are automatically generated by the Point Click Care (PCC) system quarterly, based on the admission Smoking assessment results. The nurses and agency nurses not attending the in-service on 3/22/24 will receive the training before their next scheduled shift, to be completed by 4/15/24. The training will be provided to all new nurse hires and agency nurses during orientation. • On 3/25/24, Minimum Data Set (MDS) /Director of Nursing (DON) /Assistant Director of Nursing (ADON) will audit 3	

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F 689	Continued From page 40 an unsafe smoker, and an assessment should have been completed quarterly. It was further revealed Resident #75 did not receive a quarterly smoking assessment from 09/27/23 until 01/27/24 and could not recall why it was not updated in the quarterly time frame. An interview conducted with the Director of Nursing (DON) on 02/29/24 at 4:50 PM revealed Resident #75 should have had a quarterly smoking assessment completed due to being an unsafe smoker. It was further revealed by the DON she was not aware Resident #75 had a late completed assessment and it should have been completed prior to 01/27/24. An interview conducted with the Administrator on 02/29/24 at 5:15 PM revealed residents who are considered unsafe smokers should have a smoking assessment completed quarterly. The Administrator stated she expected assessments to be completed in a timely manner.	F 689	resident smokers weekly to review prior week's documentation to ensure no change in condition that would warrant a new assessment or change in residents smoking preference. DON/ADON/UM will audit 3 resident smokers monthly x 2 months. The DON will submit the findings of the audit to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months to ensure compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. • Date of Compliance 4/15/24.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		4/15/24

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§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident and staff interviews, the facility failed to provide sufficient nursing staff to ensure resident were administered medications per the physician orders for 8 of 16 residents reviewed for significant medication errors (Residents #7, #28, #47, #51, #73, #79, #88, and #110) and provide assistance with showers and hair washing for 1 of 10 residents reviewed for assistance with activities of daily living (Resident #94).

The findings included:

1a. Resident #7 was admitted to the facility on 10/05/2020 with a diagnosis of diabetes mellitus.

A quarterly Minimum Data Set (MDS) assessment dated 11/20/23 revealed Resident #7 was severely cognitively impaired. Resident #7 was coded as received insulin 7 times during the assessment period.

The active physician's orders for December 2023

F 725

- Medication error reports were completed, and the Medical Director was notified for Resident #7, #28, #47. #51, #73, #79, #88 and #110 by the Registered Nurse (RN) on 12/10/2023. Vital signs were collected, and no adverse outcomes related to the medication errors were found on 12/15/2023 for the affected residents. Resident #94 received a shower on 2/27/24 and on 3/1/24 thereafter, as to follow the shower schedule of the resident. Skin assessments completed on resident #94 2/20/24, 3/5/24 and 3/19/24 revealed no new skin integrity issues.

- On 3/20/2024, The Director of Nursing (DON) completed an audit of resident medical records from 12/10/2023 and 12/27/2023 which did not indicate any additional medication errors. On 3/18/2024, a full facility audit of resident skin, using the skin assessment tool, was

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for Resident #7 included an order dated 08/07/23 for Insulin Detemir solution 100 units per milliliter (ml), inject 13 units at bedtime for diabetes and an order dated 11/06/2023 for Novolog flex pen solution pen- injector 100 units/ml sliding scale insulin four times a day for diabetes.

A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Detemir Solution 13 units, scheduled for 8:00 PM, was not documented as given on 12/10/2023 and the Novolog flex pen sliding scale insulin scheduled for 8:30 PM was not documented as given on 12/10/2023.

b. Resident #28 was admitted to the facility on 11/30/2022 with a diagnosis of hypertension, anxiety, diabetes mellitus and heart failure.

A quarterly Minimum Data Set (MDS) assessment dated 11/12/2023 revealed Resident #28 was cognitively intact. Resident #28 was noted to have received insulin 5 times during the assessment period. The MDS revealed Resident #28 received an antipsychotic medication during the assessment period.

The active physician's orders for December 2023 for Resident #28 included an order dated 11/10/23 for Lantus Solostar pen-injector 100 units/ml, inject 10 units at bedtime for diabetes, an order dated 11/09/2023 for Carvedilol oral tablet 6.25 mg 1 tablet by mouth two times a day for heart failure and an order dated 11/09/23 for Seroquel 25 mg give 1 tablet by mouth two times a day for depression.

A Medication Administration Record (MAR) dated December 2023 revealed the Lantus Solostar

F 725

initiated to identify other residents who could be impacted by inconsistency in completing showers. This audit will be completed by 4/5/24.

• On 3/20/2024 Director of Nursing (DON) and Staff Development Coordinator (SDC) initiated an in-service to all nurses and medication aide regarding proper notification to Director of Nursing in any case of an absence or tardy that will cause the medication cart not to be attended, so a nurse or medication aide can be scheduled to cover the absence or tardiness. On 3/20/2024 DON and SDC initiated an in-service to all Nurses, medication aides including agency nurses and medication aides regarding the 6 rights of medication administration which includes verifying the resident's identity prior to medication administration and administering medications as ordered and documenting medications by the nurse. Nurses, medication aides, agency nurses and medication aides not in-serviced by 4/14/24 will not be allowed to work until the education is completed by the DON/SDC. After 4/14/24, all new nurses, medication aides and agency nurses and medication aides will be educated on the 6 rights of medication administration before working by the DON/SDC. On 3/19/2024 Administrator met with staffing scheduler to begin implementation of a shower team each day Monday-Saturday to ensure resident showers are given per schedule and preference. On 3/20/2024 DON and SDC initiated an in-service to all

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pen-injector 100 units/ml 10 units, Carvedilol oral tablet 6.25 mg and Seroquel 25 mg scheduled for 8:00 PM, were not documented as given on 12/10/2023.

c. Resident #47 was admitted to the facility on 10/13/2019 with a diagnosis of depression and schizophrenia and anxiety.

A quarterly Minimum Data Set (MDS) assessment dated 10/01/2023 revealed Resident #47 was severely cognitively impaired. Resident #47 was coded as receiving antipsychotic medication, antianxiety medication, antidepressant medication and opioids.

The active physician's orders for December 2023 for Resident #47 included an order dated 02/19/22 for Seroquel 200 mg give 1 tablet by mouth at bedtime for mood, an order dated 03/10/22 for Lorazepam 1 mg by mouth two times a day for agitation, an order dated 08/25/22 for Trazodone 125 mg by mouth at bedtime for insomnia and an order dated 04/07/23 for Percocet oral tablet 10-325mg give 1 tablet by mouth three times a day for severe pain.

A Medication Administration Record (MAR) dated December 2023 revealed the Seroquel 200 mg, Trazodone 125 mg, Lorazepam 1 mg and Percocet oral tablet 10-325mg scheduled for 8:00 PM were not documented as given on 12/10/2023.

d. Resident #51 was admitted to the facility on 11/14/2022 with a diagnosis of diabetes mellitus and atrial fibrillation.

A quarterly Minimum Data Set (MDS)

F 725

Certified Nursing Assistant (C.N. A) regarding protocol for giving showers and communication with their Nurse, Unit Manager (UM) or DON/ADON when showers cannot be given. Any Certified Nursing Assistant (C.N.A.) not in-serviced by 4/14/24 will not be allowed to work until the training is completed by an SDC/DON. All new and agency C.N.A. will receive the same training upon hire.

- The Administrator will meet with the staffing scheduler daily to review staffing x5 days per week and ongoing to ensure a shower team is in place, and all nursing carts are covered. Shower sheets (as a secondary piece of documentation to point of care will be brought to The Interdisciplinary Team (IDT) by Unit Manager (UM) for review and confirmed against shower schedule daily 5 days per week x4 weeks and then weekly x2 months. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance.
- Date of compliance 4/15/24

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assessment dated 09/30/2023 revealed Resident #51 was moderately cognitively impaired. Resident #51 was coded as receiving insulin on 7 days during the assessment period. The MDS revealed Resident #51 had received an anticoagulant during the assessment period.

The active physician's orders for December 2023 for Resident #51 included an order dated 11/15/22 Insulin Glargine solution 100 units/ml inject 12 units at bedtime for diabetes, an order dated 11/15/22 for Eliquis tablet 5 mg by mouth two times a day for anticoagulant therapy and an order dated 7/16/23 for Metformin 500 mg 1 tablet by mouth two times a day for diabetes.

A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Glargine solution 100 units/ml 12 units, Eliquis tablet 5 mg and Metformin 500 mg scheduled for 9:00 PM were not documented as given on 12/10/2023.

e. Resident #73 was admitted to the facility on 06/19/2023 with a diagnosis of depression.

An annual Minimum Data Set (MDS) assessment dated 10/30/2023 revealed Resident #73 was cognitively intact. Resident #73 was coded as received an antidepressant during the assessment period.

The active physician's orders for December 2023 for Resident #73 included an order dated 06/20/23 for Trazodone 50 mg 1 tablet by mouth at bedtime for insomnia.

A Medication Administration Record (MAR) dated December 2023 revealed the Trazodone 50 mg scheduled for 8:00 PM was not documented as

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F 725	Continued From page 45 given on 12/10/2023. f. Resident #79 was admitted to the facility on 11/10/2023 with a diagnosis of diabetes mellitus. An admission Minimum Data Set (MDS) assessment dated 11/16/2023 revealed Resident #79 was moderately cognitively impaired. Resident #79 was coded as received insulin on 7 days during the assessment period. The active physician's orders for December 2023 for Resident #79 included an order dated 11/14/23 for Insulin Glargine solution 100 units/ml inject 2 units at bedtime for diabetes. A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Glargine solution 100 unit/ml 2 units scheduled for 9:00 PM was not documented as given on 12/10/2023. g. Resident #88 was admitted to the facility on 10/02/2020 with a diagnosis of hypertension, heart failure and coronary artery disease (CAD). A quarterly Minimum Data Set (MDS) assessment dated 10/15/2023 revealed Resident #88 was severely cognitively impaired. The active physician's orders for December 2023 for Resident #88 included an order dated 03/31/22 for Metoprolol Tartrate 25 mg give 0.5 tablet by mouth two times a day for heart failure. A Medication Administration Record (MAR) dated December 2023 revealed the Metoprolol Tartrate 12.5 mg scheduled for 9:00 PM was not documented as given on 12/10/2023.	F 725		

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h. Resident #110 was admitted to the facility on 10/14/2022 with a diagnosis of hypertension and atrial fibrillation.

A quarterly Minimum Data Set (MDS) assessment dated 12/01/2023 revealed Resident #110 was cognitively intact.

The active physician's orders for December 2023 for Resident #110 included an order dated 1/10/23 for Carvedilol 3.125mg 1 tablet by mouth two times a day for hypertension and an order dated 12/04/23 for Amoxicillin 500 mg give 1 tablet by mouth two times a day for a bacterial infection for 10 days.

A Medication Administration Record (MAR) dated December 2023 revealed the Amoxicillin 500 mg and Carvedilol 3.125 mg scheduled for 8:00 PM were not documented as given on 12/10/2023.

An interview was conducted on 02/28/24 at 4:00 PM with Nurse #1. She stated on 12/10/23 she was working the 7:00 AM to 7:00 PM shift assigned to Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88, and Resident #110. The interview revealed Nurse #2 had contacted her after 12:00 PM stating she would not be coming into work for the 7:00 PM to 11:00 PM shift to take over the resident assignment. She stated she told Nurse #2 she would need to contact management and let them know. The interview revealed she then told Unit Manager #1 that she did not think Nurse #2 would be coming into the facility for her assigned shift. She stated report on the residents was given to Nurse #3, Nurse #4 and Nurse #5 who were told by the Unit Manager #1 to split the

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F 725	Continued From page 47 medication cart. The interview revealed she had offered to stay over to cover the shift from 7:00 PM to 11:00 PM but was told it was necessary by the scheduler. She stated she left the facility at 7:00 PM. An interview conducted on 02/28/24 at 3:36 PM with Unit Manager #1 revealed on 12/10/23 she was notified later in the day by Nurse #1 that Nurse #2 was not going to come in for the scheduled 7:00 PM to 11:00 PM shift. She stated she called the scheduler who no longer works in the facility and Director of Nursing (DON) to let them know they were going to be a nurse short. The interview revealed the scheduler could not get in touch with Nurse #2 so Unit Manger #1 then notified Nurse #3, Nurse #4 and Nurse #5 they would need to split the medication cart for the 7:00 PM to 11:00 PM shift. She stated Nurse #4 told her she needed to get some food and would look at the medication cart when she returned, and Nurse #5 stated the medication cart had too many residents to split. She stated she then left the facility at 7:00 PM and did not know until 12/12/23 that the residents had never received their scheduled medication on the evening of 12/10/23. An interview was attempted with Nurse #2 on 02/28/24 and on 02/29/24 with no return phone call received. An interview was attempted with Nurse #3, Nurse #4 and Nurse #5 on 02/29/24 with no return phone call received. An interview conducted on 02/28/24 at 4:30 PM with the Director of Nursing (DON) revealed on 12/10/23 around 6:30 PM she was told by Unit	F 725		

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Manager #1 that Nurse #2 had called out for the 7:00 PM to 11:00 PM shift. She stated Unit Manager #1 told her that Nurse #3, Nurse #4 and Nurse #5 were instructed to split the medication cart and had taken report on the residents. She stated she heard the next morning that some residents had not received their medication. The interview revealed that Nurse #5 had given half of the assigned residents their medication, but the other 8 residents Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110 did not receive any scheduled medication. She stated Nurse #5 told her she had completed her assigned half and thought someone else was going to administer the rest of the residents' medication. The DON stated it was a communication error between the nurses. The interview revealed the residents' vital signs were obtained on 12/11/23 along with blood glucose levels for the diabetic residents. She stated no adverse outcomes had occurred from the incident and no residents needed medical treatment due to not receiving their medication.

2. Resident #94 was admitted to the facility on 08/21/23 with diagnoses which included diabetes mellitus type II, vitamin deficiency, dementia, and anorexia.

Review of Resident #94's quarterly Minimum Data Set (MDS) assessment dated 02/21/24 revealed she was severely cognitively impaired and required total assistance with showering and bathing. The assessment also revealed Resident #94 had no rejection of care behaviors.

Review of Resident #94's care plan revealed a focus area for activities of daily living/personal

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care deficit related to dementia. The interventions included personal hygiene with substantial/maximal assistance and showering/bathing dependent on staff.

An observation and interview with Resident #94 on 02/26/24 at 11:42 AM revealed the resident sitting in her wheelchair in her room, dressed for the day. The resident's hair appeared greasy and disheveled, and she stated she was not getting her showers as scheduled two times per week. Resident #94 further stated she preferred showers because she liked to get her hair washed when she was bathed.

Review of the shower schedule for the hall on which the resident resided revealed Resident #94 was scheduled for showers on Tuesday and Friday on 1st shift (7:00 AM to 3:00 PM).

Review of the documentation of showers in the electronic medical record for Resident #94 revealed for the month of February she had only received one shower on 02/27/24. On the other days she was scheduled for showers the following was documented:

Date	Documentation
Tuesday 02/06/24	no indication or documentation
Tuesday, 02/13/24	no indication or documentation
Tuesday, 02/20/24	no shower or bed bath given
Friday, 02/23/24	partial bed bath (not a complete bed bath)

A telephone interview on 02/29/24 at 10:46 AM with Nurse Aide (NA) #8 who was assigned to care for Resident #94 on 02/06/24 and 02/13/24 stated if she were assigned to a resident and did

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not have time to give them a shower, she would wash them up in bed and document it as a partial bath but said it was not a complete bed bath. NA #8 stated she could not recall why she had not given Resident #94 a shower on 02/06/24 or 02/13/24 but said it was most likely due to staffing issues.

An interview on 02/28/24 at 10:34 AM with NA #12 who was assigned to care for Resident #94 on 02/09/24 revealed if she was assigned to the resident and had given her a complete bed bath instead of a shower it was due to not having time to shower the resident. She stated they were short of help sometimes and it was less time-consuming to give residents a bed bath than shower.

An interview on 02/29/24 at 1:45 PM with NA #7 who was assigned to care for Resident #94 on 02/23/24 revealed she could not recall why she had not given the resident a shower as scheduled. She stated there were days they worked short of help and that could have been one of those days when she did not have time to give the resident a shower and just bathed her in bed and documented it as a partial bath. NA #7 further stated when she showered residents, she tried to cut their nails and shave them as needed but did not always have time to do so due to staffing issues.

An interview on 02/29/24 at 3:10 PM with Unit Manager #1 revealed she was not aware Resident #94 was not receiving her showers as scheduled and said no one had reported it to her. She indicated if the NAs were having difficulty completing their showers, they should have reported that to her so she could have provided

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them with additional staff to assist with showers.

An interview on 2/29/23 at 12:30 PM with the Nursing Scheduler who has been in her position for the last two months. The Scheduler revealed that all call ins by nursing staff go to the Director of Nursing (DON) who then tells her what needs to be filled. The Nursing Scheduler stated she filled out the schedules in advance, so staff can pick up extra hours and staff were good about picking open shifts. She explained the problem was the call ins and trying to find someone to fill the opening. The scheduler further stated she was not on call and worked Monday through Friday 8:00 AM to 5:00 PM so after hours and on the weekends, it falls on nurse management to fill open positions. The scheduler stated she was not aware of a situation where there was not a nurse for a cart when other nurses did not step up and take care of the cart. The Nursing Scheduler indicated the following were the staffing levels she was expected to maintain. The Scheduler went on to say that it was hard to keep those levels of staffing in the building, but she tried hard to get positions filled so staff were not short, but that it happens at times and there is nothing that can be done about it.

1. 7:00 AM-3:00 PM shift 10-12 Nurse Aides (NAs) and 3 NAs on memory care.
2. 7:00 AM-3:00 PM shift 6 Nurses and 2 nurses on memory care.
3. 3:00 PM-11:00 PM shift 10-12 NAs and 2-3 NAs on memory care
4. 3:00 PM-11:00 PM shift 5 Nurses and 2 nurses on memory care
5. Memory care works 7:00 AM - 7:00 PM so this covers the third shift.
6. 11:00 PM -7:00 AM shift 9-10 NAs and 2-3 on

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F 725	Continued From page 52 memory care Interview on 02/29/24 at 4:46 PM with the Director of Nursing (DON) revealed she would expect nursing staff to communicate in a timely manner when they are not going to report to work so that the facility has time to try and fill the open position. They have been posting open positions on their website and have recently started using a staffing agency to assist with staffing levels. An interview on 02/29/24 at 4:53 PM with the Director of Nursing (DON) revealed they had struggled with getting the NAs to give and document showers and said it was a process they were currently working on with the NAs. She stated she expected residents to have their showers as scheduled and said if they did not receive their showers, she expected them to receive a complete bed bath not a partial bed bath and for it to be documented. The DON further stated if the resident refused their shower, she expected the nurse to document the refusal in their progress notes.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726		4/15/24

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F 726	Continued From page 53 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, family member and staff interviews, the facility failed to provide effective orientation to a new nurse when Nurse #8 failed to supervise Nurse #9 during medication administration resulting in a resident receiving the wrong medications. This deficient practice affected 1 of 1 resident reviewed for medication administration. (Resident #83). The findings included: Resident #83 was admitted to the facility on 09/26/2022 with diagnoses including cerebral vascular accident (CVA), high blood pressure, dementia, and diabetes mellitus (DM). Review of the December 2023 physician orders for Resident #83 revealed the following medications:	F 726	1. On 12/27/2023 Resident #83 was assessed by the nurse and had stable vital signs and no health-related concerns were noted related to the medication error. The physician and responsible party were notified by the nurse of the medication error. The Nurse Practitioner visited Resident #83 on 12/27/2023 and found the resident to be in no distress. Nurse #8 was in serviced on the 6 rights of medication administration by the Director of Nursing (DON) and Staff Development Coordinator (SDC) 4/5/2024. Nurse #9 is no longer employed. 2. The Director of Nursing completed an audit of resident medical records from 12/10/23 to 12/27/2023 which did not indicate any additional medication errors.	

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F 726	Continued From page 54 -Sertraline (antidepressant) 150 milligrams (mg) 1 tablet by mouth one time a day for depression. -Vimpat Oral Solution (anti-seizure) 250mg by mouth two times a day for seizures. -Divalproex Sodium (anti-seizure) delayed release 250 mg 3 tablets by mouth twice a day for neurological disorder. -Xarelto (anticoagulant) 20 mg 1 tablet by mouth one time a day for deep vein thrombosis prevention. -Amlodipine Besylate 10 mg 1 tablet by mouth daily for high blood pressure. Resident #30 was admitted to the facility on 11/03/2022. A review of the physician orders dated December 2023 revealed Resident #30 had orders for: -Diltiazem (cardiac medication) 120mg extended release 1 capsule by mouth one time a day for atrial fibrillation. -Citalopram Hydrobromide 10 mg one tablet by mouth daily for depression. -Lasix (diuretic/fluid pill) 20 mg by mouth one time day for fluid. -Seroquel (antipsychotic) 25 mg by mouth three times a day for schizoaffective disorder -Ativan (anti-anxiety) 0.5 mg by mouth twice a day for anxiety. Review of an incident report dated 12/27/2023 at 1:30 PM written by Nurse #8 revealed Resident #83 had received Resident #30's medications which included: Lasix 20 mg, Ativan 0.5 mg, Seroquel 25 mg, Celexa 10 mg, and Diltiazem 120 mg. An interview was conducted on 02/26/2024 at 13:20 PM with Resident #83's RP. The RP stated	F 726	3. All Facility Nurses and med-aides including agency nurses and med-aides will be in-serviced regarding the 6 rights of medication administration which includes verifying the resident's identity prior to medication administration by the Staff Development Coordinator (SDC) beginning 3/15/2024. Facility nurses, med-aides or agency nurses, med-aides not in-service by 4/5/2024 will not be allowed to work until the education is completed by the SDC/DON. After 4/5/2024, all new nurses, med- aides and agency nurses will be educated on the five rights of medication administration before working by the SDC/DON. The Unit Managers, Assistant Director of Nursing (ADON) or DON will complete a Med Pass Check Off tool for all nurses and med-aides including agency nurses and med-aides by 4/5/2024 and on 3 nurses, med-aides per week on varying shifts and days of the week using the Med Pass Check Off tool to validate nurse skills for 4 weeks and then 3 per month for 3 months. 4. The DON will review the Med Pass Check Off tools weekly for 4 weeks and submit them to the Administrator for compliance. The Administrator will submit the findings of the Med Pass Check Off audits with Quality Assurance Performance Improvement (QAPI) monthly for 3 months to ensure compliance. 5. Date of Compliance 4/15/24	

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the facility reported to her that a medication error had occurred. She further stated that a new nurse who was still being oriented gave Resident #83's the wrong medications. She also stated that the nurse in training should not have been allowed to administer medications without another staff member being present.

Multiple unsuccessful attempts were made to contact Nurse #8, and Nurse #9 (nurse in training) for interview.

An interview was conducted on 02/28/2024 at 11:40 AM with the Director of Nursing (DON). The DON revealed that during a medication pass, Resident #83 was given the incorrect medications. Nurse #9 was being oriented by Nurse #8. Nurse #8 was standing at the medication cart and Nurse #9 went into the room to administer the medications. Nurse #9 got confused about the room numbers and got bed A and bed B mixed up. Nurse #8 went into the room when she saw Nurse #9 at Resident #83's bedside. Nurse #9 had already given Resident #30's medications to Resident #83. The DON also stated Nurse #8 and Nurse #9 were no longer employed by the facility. She further stated Nurse #8 should have stayed with Nurse #9 throughout the entire medication pass especially when actually administering the medications at the bedside. She stated nursing staff should have provided the correct medication to the correct resident. The DON also revealed Nurse #8 and Nurse #9 completed the facility nursing orientation which included a review of the "Six Rights of Medication Administration" (a method used during medication administration to safeguard residents before giving the medications).

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F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews, and family member, staff, and Medical Director interviews, the facility failed to prevent significant medication errors when Nurse #9 administered medications to Resident #83 prescribed for Resident #30 which included Lasix (fluid pill), Ativan (a medication used to treat anxiety, Seroquel (an antipsychotic), Celexa (an antidepressant), and Diltiazem (used to treat cardiac disorders). The facility also failed to prevent significant medication errors when medications were not administered as ordered by the physician. This deficient practice affected 9 of 16 residents reviewed for significant medication errors (Resident # 83, #7, #28, #47, #51, #73, #79, #88, and #110.) . The findings: 1. Resident #83 was admitted to the facility on 09/26/2022 with diagnoses including cerebral vascular accident (CVA), high blood pressure, dementia, and diabetes mellitus (DM). Review of the quarterly Minimum Data Set (MDS) assessment dated 12/01/2023 revealed Resident #83 had moderate cognitive impairment. The MDS revealed Resident #83 was not receiving diuretics, anti-anxiety, or anti-psychotics. Review of the December 2023 physician orders for Resident #83 revealed the following medications:	F 760	1. On 12/27/2023 Resident #83 was assessed by the nurse and had stable vital signs and no health-related concerns were noted related to the medication error. The physician and responsible party were notified by the nurse of the medication error. The Nurse Practitioner visited Resident #83 on 12/27/2023 and found the resident to be in no distress. Nurse #8 was in serviced on the 6 rights of medication administration by the Staff Development Coordinator (SDC)/Director of Nursing (DON) on 3/20/2024. Nurse #9 is no longer employed. Medication error reports were completed, and the Medical Director was notified for Resident #83, #7, #28, #47. #51, #73, #79, #88 and #110 by the RN on 12/10/2023. Vital signs were collected, and no adverse outcomes related to the medication errors were found by 12/15/2023 for the affected residents. 2. On 3/20/2024, The Director of Nursing completed an audit of resident medical records from 12/10/2023 and 12/27/2023 which did not indicate any additional medication errors. 3. All nurses and med-aides including agency nurses and med-aides will be in serviced regarding the 6 rights of medication administration which includes verifying the resident's identity prior to	4/15/24

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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

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-Sertraline (antidepressant) 150 milligrams (mg) 1 tablet by mouth one time a day for depression.
-Vimpat Oral Solution (anti-seizure) 250 mg by mouth two times a day for seizures.
-Divalproex Sodium (anti-seizure) delayed release 250 mg 3 tablets by mouth twice a day for neurological disorder.
-Xarelto (anticoagulant) 20 mg 1 tablet by mouth one time a day for deep vein thrombosis prevention.
-Amlodipine Besylate 10 mg 1 tablet by mouth daily for high blood pressure.

Resident #30 was admitted to the facility on 11/03/2022.

A review of the physician orders dated December 2023 revealed Resident #30 had orders for:
-Diltiazem (cardiac medication) 120 mg extended release 1 capsule by mouth one time a day for atrial fibrillation.
-Citalopram Hydrobromide 10 mg one tablet by mouth daily for depression.
-Lasix (diuretic/fluid pill) 20 mg by mouth one time day for fluid.
-Seroquel (antipsychotic) 25 mg by mouth three times a day for schizoaffective disorder
-Ativan (anti-anxiety) 0.5 mg by mouth twice a day for anxiety.

An incident report dated 12/27/2023 written by Nurse #8 revealed Resident #83 had received Resident #30's medication which included: Lasix 20 mg, Ativan 0.5 mg, Seroquel 25 mg, Celexa 10 mg, and Diltiazem 120 mg at 10:00 AM in addition to her own morning medications. The incident was reported to the on-call provider at 1:20 PM after Nurse #8 realized Resident #83 had been given Resident #30's medications.

F 760

medication administration and administering medications as ordered and documenting medications by the RN beginning 3/15/2024. Any Licensed, registered nurses or agency nurses not in serviced by 4/5/24 will not be allowed to work until the education is completed by the RN. After 4/5/24, all new and agency nurses will be educated on the six rights of medication administration before working by the RN. The RN and LPN Unit Managers, ADON or DON will complete a med pass check off for all nurses including agency by 4/5/24 and on 3 nurses per week on varying shifts and days of the week using the Med Pass Check Off tool to validate nurse skills for 4 weeks and then 3 per month for 3 months. The Director of Nursing or Assistant Director of Nursing will audit 10% of all Medication Administration records weekly x 4 weeks then monthly x 1 month to ensure medications are being administered per physician order utilizing a Medication Administration record (MAR) audit tool. The physician will be notified of any identified areas of concern. The Administrator or DON will review and initial the audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed appropriately.

4. The DON will review the med pass check off tools and medication administration Audit tool weekly for 4 weeks and submit to the NHA for compliance. The NHA will submit the findings of the med pass check off audits with QAPI monthly for 3 months to ensure

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F 760	Continued From page 58 Resident #83 was noted to be in no acute distress and at her baseline. Resident #83's responsible party (RP) was notified of the medication errors on 12/27/2023 at 1:35 PM. Resident #83's documented vital signs dated 12/27/2023 at 1:35 PM revealed the following: blood pressure123/74 (normal range systolic (top number) less than 120 and diastolic (bottom number) less than 80), temperature 97.2 (normal range 97 to 99), pulse 55 beats per minute (normal range 60-100), respirations 14 breaths per minute (normal range 12-20), oxygen saturation 94% (normal range 92% or greater) on room air. Review of the Nurse Practitioner (NP) acute visit note dated 12/27/2023 revealed Resident #83 was being seen due to a medication error. Resident #83 received Lasix, Ativan, Seroquel, Celexa, and Diltiazem in error. The NP visit note further revealed Resident #83 appeared at her baseline with stable vital signs and was awake and alert and offered no complaints. The NP's note also indicated Resident #83 was in no acute distress and no adverse reactions were noted. The provider ordered vital signs to be checked every shift for 24 hours and to closely monitor Resident #83 for low blood pressure and sedation. An interview was conducted on 02/26/2024 at 13:20 PM with Resident #83's RP. The RP stated the facility reported to her that a medication error had occurred. She further stated that a new nurse who was still being oriented gave Resident #83's the wrong medications. She also stated that the nurse in training should not have been allowed to administer medications without	F 760	compliance. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. 5. Date of compliance 4/15/2024	

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another staff member being present. She also indicated the facility contacted the pharmacy and Resident #83's doctor.

Multiple unsuccessful attempts were made to contact Nurse #8 and Nurse #9 (the nurse in training).

An interview was conducted on 03/05/2024 at 9:03 AM. The pharmacist stated there was no medication error report on file for Resident #83 for 12/27/2023. She further stated the concern with the Amlodipine and the Diltiazem would be for hypotension. She also stated hypotension would develop on the day of administration due to the short half-life of the drugs.

An interview was conducted on 03/05/2024 at 09:36 with the Nurse Practitioner (NP) who evaluated Resident #83. The NP stated she was notified of the medication errors the morning of 12/27/2023 and she does not remember exactly what time she evaluated Resident #83, but she stated it was before 12:00 PM. She also indicated she was most concerned with the cardiac medications: Amlodipine and the Diltiazem and the potential for hypotension. She further added Resident #83 was stable during her evaluation and that she asked the nursing staff to monitor Resident #83 and notify her if the resident became hypotensive or had any other clinical concerns.

An interview was conducted on 02/28/2024 at 11:40 AM with the Director of Nursing (DON). The DON revealed that during a medication pass, Resident #83 was given the incorrect medications. Nurse #9 (nurse in training) was being oriented by Nurse #8. Nurse #8 was

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F 760	Continued From page 60 standing at the medication cart and Nurse #9 went into the room to administer the medications. Nurse #9 got confused about the room numbers and got bed A and bed B mixed up. Nurse #8 went into the room when she saw Nurse #9 at Resident #83's bedside. Nurse #9 had already given Resident #30's medications to Resident #83. The DON also stated Nurse #8 and Nurse #9 were no longer employed by the facility. The DON further revealed Nurse #8 had immediately notified the physician, assessed the resident, and notified the RP following the incident. The DON stated the staff did everything they should have after the incident occurred. She further stated Nurse #8 should have stayed with the nurse in training throughout the entire medication pass especially when actually administering the medications at the bedside. She stated nursing staff should have provided the correct medication to the correct resident. 2a. Resident #7 was admitted to the facility on 10/05/2020 with a diagnosis of diabetes mellitus. A quarterly Minimum Data Set (MDS) assessment dated 11/20/23 revealed Resident #7 was severely cognitively impaired. Resident #7 was coded as received insulin 7 times during the assessment period. The active physician's orders for December 2023 for Resident #7 included an order dated 08/07/23 for Insulin Detemir solution 100 units per milliliter (ml), inject 13 units at bedtime for diabetes and an order dated 11/06/2023 for Novolog flex pen solution pen- injector 100 units/ml sliding scale insulin four times a day for diabetes. A Medication Administration Record (MAR) dated	F 760		

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December 2023 revealed the Insulin Detemir Solution 13 units, scheduled for 8:00 PM, was not documented as given on 12/10/2023 and the Novolog flex pen sliding scale insulin scheduled for 8:30 PM was not documented as given on 12/10/2023.

b. Resident #28 was admitted to the facility on 11/30/2022 with a diagnosis of hypertension, anxiety, diabetes mellitus and heart failure.

A quarterly Minimum Data Set (MDS) assessment dated 11/12/2023 revealed Resident #28 was cognitively intact. Resident #28 was noted to have received insulin 5 times during the assessment period.

The active physician's orders for December 2023 for Resident #28 included an order dated 11/10/23 for Lantus Solostar pen-injector 100 units/ml, inject 10 units at bedtime for diabetes, an order dated 11/09/2023 for Carvedilol oral tablet 6.25 mg 1 tablet by mouth two times a day for heart failure.

A Medication Administration Record (MAR) dated December 2023 revealed the Lantus Solostar pen-injector 100 units/ml 10 units, Carvedilol oral tablet 6.25 mg and Seroquel 25 mg scheduled for 8:00 PM, were not documented as given on 12/10/2023.

c. Resident #47 was admitted to the facility on 10/13/2019 with a diagnosis of depression, schizophrenia, anxiety and bilateral chronic lymphedema with lower extremity pain.

A quarterly Minimum Data Set (MDS) assessment dated 10/01/2023 revealed Resident

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#47 was severely cognitively impaired. Resident #47 was coded as receiving antipsychotic medication, antianxiety medication, antidepressant medication and opioids.

The active physician's orders for December 2023 for Resident #47 included an order dated 02/19/22 for Seroquel 200 mg give 1 tablet by mouth at bedtime for mood, an order dated 03/10/22 for Lorazepam 1 mg by mouth two times a day for agitation, an order dated 08/25/22 for Trazodone 125 mg by mouth at bedtime for insomnia and an order dated 04/07/23 for Percocet oral tablet 10-325mg give 1 tablet by mouth three times a day for severe pain.

A Medication Administration Record (MAR) dated December 2023 revealed the Seroquel 200 mg, Trazodone 125 mg, Lorazepam 1 mg and Percocet oral tablet 10-325mg scheduled for 8:00 PM were not documented as given on 12/10/2023.

d. Resident #51 was admitted to the facility on 11/14/2022 with a diagnosis of diabetes mellitus and atrial fibrillation.

A quarterly Minimum Data Set (MDS) assessment dated 09/30/2023 revealed Resident #51 was moderately cognitively impaired. Resident #51 was coded as receiving insulin on 7 days during the assessment period. The MDS revealed Resident #51 had received an anticoagulant during the assessment period.

The active physician's orders for December 2023 for Resident #51 included an order dated 11/15/22 Insulin Glargine solution 100 units/ml inject 12 units at bedtime for diabetes, an order

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dated 11/15/22 for Eliquis tablet 5 mg by mouth two times a day for anticoagulant therapy and an order dated 7/16/23 for Metformin 500 mg 1 tablet by mouth two times a day for diabetes.

A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Glargine solution 100 units/ml 12 units, Eliquis tablet 5 mg and Metformin 500 mg scheduled for 9:00 PM were not documented as given on 12/10/2023.

e. Resident #73 was admitted to the facility on 06/19/2023 with a diagnosis of depression.

An annual Minimum Data Set (MDS) assessment dated 10/30/2023 revealed Resident #73 was cognitively intact. Resident #73 was coded as received an antidepressant during the assessment period.

The active physician's orders for December 2023 for Resident #73 included an order dated 06/20/23 for Trazodone 50 mg 1 tablet by mouth at bedtime for insomnia.

A Medication Administration Record (MAR) dated December 2023 revealed the Trazodone 50 mg scheduled for 8:00 PM was not documented as given on 12/10/2023.

f. Resident #79 was admitted to the facility on 11/10/2023 with a diagnosis of diabetes mellitus.

An admission Minimum Data Set (MDS) assessment dated 11/16/2023 revealed Resident #79 was moderately cognitively impaired. Resident #79 was coded as received insulin on 7 days during the assessment period.

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The active physician's orders for December 2023 for Resident #79 included an order dated 11/14/23 for Insulin Glargine solution 100 units/ml inject 2 units at bedtime for diabetes.

A Medication Administration Record (MAR) dated December 2023 revealed the Insulin Glargine solution 100 unit/ml 2 units scheduled for 9:00 PM was not documented as given on 12/10/2023.

g. Resident #88 was admitted to the facility on 10/02/2020 with a diagnosis of hypertension, heart failure and coronary artery disease (CAD).

A quarterly Minimum Data Set (MDS) assessment dated 10/15/2023 revealed Resident #88 was severely cognitively impaired.

The active physician's orders for December 2023 for Resident #88 included an order dated 03/31/22 for Metoprolol Tartrate 25 mg give 0.5 tablet by mouth two times a day for heart failure.

A Medication Administration Record (MAR) dated December 2023 revealed the Metoprolol Tartrate 12.5 mg scheduled for 9:00 PM was not documented as given on 12/10/2023.

h. Resident #110 was admitted to the facility on 10/14/2022 with a diagnosis of hypertension and atrial fibrillation.

A quarterly Minimum Data Set (MDS) assessment dated 12/01/2023 revealed Resident #110 was cognitively intact.

The active physician's orders for December 2023 for Resident #110 included an order dated 1/10/23 for Carvedilol 3.125mg 1 tablet by mouth

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two times a day for hypertension and an order dated 12/04/23.

A Medication Administration Record (MAR) dated December 2023 revealed the Amoxicillin 500 mg and Carvedilol 3.125 mg scheduled for 8:00 PM were not documented as given on 12/10/2023.

A facility investigation summary dated 12/12/23 revealed the facility interdisciplinary team was reviewing the Medication Administration Audit report for the previous 48 hours and noted the medication errors and Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110 had not been administered their medication during the 7:00 PM to 11:00 PM shift. An investigation was then initiated, and the Medical Director was notified. The investigation was completed by the Regional Nurse Consultant who identified the cause of the incident was due to a nurse not reporting for the 7:00 PM to 11:00 PM shift.

An interview was conducted on 02/28/24 at 4:00 PM with Nurse #1. She stated on 12/10/23 she was working the 7:00 AM to 7:00 PM shift assigned to Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110. The interview revealed Nurse #2 had contacted her after 12:00 PM stating she would not be coming into work for the 7:00 PM to 11:00 PM shift to take over the resident assignment. She stated she told Nurse #2 she would need to contact management and let them know. The interview revealed she then told Unit Manager #1 that she did not think Nurse #2 would be coming into the facility for her assigned shift. She stated report on the residents

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was given to Nurse #3, Nurse #4 and Nurse #5 who were told by the Unit Manager #1 to split the medication cart. The interview revealed she had offered to stay over to cover the shift from 7:00 PM to 11:00 PM but was told it was necessary by the scheduler. She stated she left the facility at 7:00 PM.

An interview conducted on 02/28/24 at 3:36 PM with Unit Manager #1 revealed on 12/10/23 she was notified later in the day by Nurse #1 that Nurse #2 was not going to come in for the scheduled 7:00 PM to 11:00 PM shift. She stated she called the scheduler who no longer works in the facility and Director of Nursing (DON) to let them know they were going to be a nurse short. The interview revealed the scheduler could not get in touch with Nurse #2 so Unit Manger #1 then notified Nurse #3, Nurse #4 and Nurse #5 they would need to split the medication cart for the 7:00 PM to 11:00 PM shift. She stated Nurse #4 told her she needed to get some food and would look at the medication cart when she returned, and Nurse #5 stated the medication cart had too many residents to split. She stated she then left the facility at 7:00 PM and did not know until 12/12/23 that the residents had never received their scheduled medication on the evening of 12/10/23.

An interview was attempted with Nurse #2 on 02/28/24 and on 02/29/24 with no return phone call received.

An interview was attempted with Nurse #3, Nurse #4 and Nurse #5 on 02/29/24 with no return phone call received.

An interview conducted on 02/28/24 at 4:30 PM

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F 760	Continued From page 67 with the Director of Nursing (DON) revealed on 12/10/23 around 6:30 PM she was told by Unit Manager #1 that Nurse #2 had called out for the 7:00 PM to 11:00 PM shift. She stated Unit Manager #1 told her that Nurse #3, Nurse #4 and Nurse #5 were instructed to split the medication cart and had taken report on the residents. She stated she heard the next morning that some residents had not received their medication. The interview revealed that Nurse #5 had given half of the assigned residents their medication, but the other 8 residents Resident #7, Resident #28, Resident #47, Resident #51, Resident #73, Resident #79, Resident #88 and Resident #110 did not receive any scheduled medication. She stated Nurse #5 told her she had completed her assigned half and thought someone else was going to administer the rest of the residents' medication. The DON stated it was a communication error between the nurses. The interview revealed the residents' vital signs were obtained on 12/11/23 along with blood glucose levels for the diabetic residents. She stated no adverse outcomes had occurred from the incident and no residents needed medical treatment due to not receiving their medication. On 02/29/24 at 11:20 AM an interview was conducted with the Medical Director. During the interview he stated he was notified by the facility that the residents had missed their medication on 12/10/23. The interview revealed he notified the Nurse Practitioner's that were in the facility of the incident and that nurses on the unit were monitoring the residents for any changes of condition. He stated no residents were having symptoms from not receiving their medication. The MD stated although medication such as anticoagulants, opioids, antipsychotics and insulin	F 760		

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F 760	Continued From page 68 were significant, it would not be harmful to the residents to miss one dose. The interview revealed none of the residents identified to have missed their medication were sent to the hospital or experienced a change of condition.	F 760		
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. §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, staff interviews, and record review the facility failed to record an open date on multi-dose insulin pens, failed to discard	F 761	• On 2/28/24, Director of Nursing (DON) removed and discarded the Glargine insulin pen and Novolin insulin	4/15/24

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an expired insulin pen and failed to store unopened insulin pens in the refrigerator for 2 of 4 medication carts (Garden City Cart #1 and Arboretum Cart #2) which were reviewed for medication storage.

The findings:

Review of the manufacturer's package insert for Glargine stated to store unopened Glargine insulin pens in a refrigerator and in-use (opened) insulin pens at room temperature for 28 days.

1a. An observation of the Garden City medication cart #1 was conducted on 02/28/2024 at 11:11 AM with Nurse #6 and the Director of Nursing. The observation revealed an opened Glargine insulin pen and an opened Novolin insulin pen that were not dated. The medication cart observation also revealed an opened insulin pen with an open date of 12/08/2023 which had passed the 28-day expiration date of 01/05/2024.

An interview was conducted with Nurse #6 on 02/28/2024 at 11:26 AM who stated she thought 3rd shift (11:0 PM to 7:00 AM) nursing staff were responsible for checking the medications carts for expired medications and she did not realize the insulin pens were not dated and that one was expired.

1b. An observation of the Arboretum Cart #2 was conducted on 02/28/2024 at 12:03 PM with Nurse #7 and the Director of Nursing. The observation revealed 2 unopened insulin pens were stored in the medication cart and were labeled as "refrigerate until opened" and one Glargine insulin pen with an open date that was illegible. The ink had smeared, and the opening date was

F 761 (Plan of Correction)

pen that were not labeled with an open/expired date from the medication cart #1 on Garden City. On 2/28/24, the DON removed and discarded the 2 unopened insulin pens and Glargine insulin pen on Arboretum medication cart #2.

- On 2/29/24 the Unit Managers (UM)/DON/Assistant Director of Nursing (ADON) initiated an audit of all medication carts and medication storage rooms. The audit is to ensure medication is labeled with an “open” date or “use by” date when opened if indicated and if medications require refrigeration.
- On 2/28/24, the Staff Development Coordinator (SDC) initiated an in-service with all nurses and medication aides to agency include nurses and medication aides regarding the Medication Storage with emphasis on (1) checking medications before administration for expired dates (2) appropriately discarding expired medications per pharmacy policy, (3) labeling medications with an “open” date or “use” by date when indicated, and (4) if medications require refrigeration, they are in the refrigerator. In-service will be completed by 4/5/24. After 4/5/24 Any nurse or medication aide who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses and medication aides to include agency nurses and medication aides, will be educated in medication storage and labeling during orientation.
- The unit managers will audit all

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F 761	Continued From page 70 unidentifiable. An interview was conducted with Nurse #7 on 02/28/2024 at 12:24 PM who stated she did not realize there was no open date on the insulin pens, and she thought the pharmacy placed the open date on the insulin pens. She also stated she did not know the unopen insulin pens required refrigeration and she did know how long the insulin pens had been in the medication cart. She also added she did not realize the insulin pen open date was not legible. She further stated she did not know who was responsible for checking the medication carts. An interview was conducted with the Director of Nursing (DON) on 02/28/2024 at 1:12 PM. The DON revealed all insulin pens should have been labeled when opened for use with a 28-day expiration date sticker. She also indicated that all nurses were responsible for putting the date of opening on the insulin pens and checking all medications in the medication carts. She further stated that she expected all insulin pens to be labeled when opened and discarded 28 days after opening. She also stated that all unopened insulin pens should be stored in the refrigerator until ready for use and that no expired medications should be available for use in the medication carts.	F 761	medication carts and medication storage rooms weekly x 4 weeks then monthly x 2 months utilizing the Storage of Drugs and Biological Audit. The audit is to ensure medications are labeled with an “open” date or “use by” date when opened if indicated and all medications that require refrigeration are in the refrigerator. The Director of Nursing (DON) will review the Storage of Drugs and Biological Audit tool weekly x 4 weeks, then monthly x 2 months. • The Director of Nursing will forward the results of the Storage of Drugs and Biological Audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Storage of Drugs and Biological Audit to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. • Date of compliance 4/15/24	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		4/15/24

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F 812	Continued From page 71 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to remove expired food items and unlabeled items which belonged to staff for 1 of 3 resident's nourishment rooms. These practices had the potential to affect food served to residents. Findings included: An observation and interview was conducted with Nurse Aide (NA) #5 on 02/26/24 at 10:15 AM revealed an 8 oz. fat free milk with the best by date of 02/24/24 and three separate lunch bags not labeled in the memory care unit nourishment room. NA #5 indicated nursing staff on the memory care unit had stored their personal items in the nourishment room because the nursing staff break room was on the other side of the facility. NA #5 stated nursing staff had been educated to not store personal items in the nourishment room and to discard any expired items.	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary • On 2/26/24, the 8-ounce fat free milk was discarded by the Dietary Manager, and all employee lunch bags were relocated to the appropriate break area. The refrigerator for all units (SPARC, Arboretum, and Garden City) nourishment rooms were inspected to ensure no other milks were outdated, and no employee lunch bags were being stored. • A 100% audit of all nourishment rooms in the facility was conducted by the Dietary Manager/Supervisor on 3/20/24 to ensure all milk that was undated or expired, and all employee lunch bags were removed immediately. • Education was conducted by the Dietary Manager/Supervisor and the Staff Development Coordinator for 100% of all dietary staff on the guidelines for checking and clearing all outdated milk and following the manufacturers guidelines on	

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F 812	Continued From page 72 An interview conducted with the Dietary Manager (DM) on 02/06/24 at 10:30 AM revealed dietary aides check nourishment rooms daily but could not recall if any staff had checked them over the weekend. It was further revealed nursing staff had been educated not to store personal items in the nourishment rooms refrigerators and to also throw away any expired items that were found. An interview conducted with the Director of Nursing (DON) on 02/29/24 at 4:55 PM revealed nursing staff were educated not to store personal belongings in the nourishment rooms because there was a staff break room available with a refrigerator. The DON further stated she was unaware staff had stored items in the memory care nourishment room refrigerator. The DON indicated dietary aides were responsible for checking nourishment rooms, but nursing staff was also responsible for throwing out items if found that needed to be discarded. An interview conducted with the Administrator on 02/29/24 at 5:10 PM revealed she expected staff to check nourishment rooms daily and to discard any expired or unlabeled items. The Administrator further revealed it was not appropriate for nursing staff to store personal items in the nourishment room refrigerator.	F 812	the product for a date to discard as well as nursing staff on personal items being stored in the resident's nourishment room refrigerators. The staff were instructed to put all personal items including food items in the staff breakroom and not the nourishment rooms. The education began on 3/15/24 and will be completed on 4/15/2024. Any dietary personnel or nursing personnel who have not worked or received the in-service will complete in-service prior to their next scheduled work shift. Any newly hired staff will be educated by the Staff Development Coordinator or Dietary Manager/Supervisor during orientation and before their first shift starts. • The Dietary Manager/Aide/Administrator implemented an audit tool on 3/20/24 that will be used daily x4 weeks and then monthly x2 months to monitor the nourishment rooms to include checking that outdated products and staff items are not being stored. All audits will be taken to Quality Assurance Improvement (QAPI) team. The audit will be reviewed monthly x2 months and discussed with the Interdisciplinary team (IDT) members. IDT team will determine at that time the need for continued monitoring. The Dietary Manager is responsible for the Plan of Correction and the Administrator for sustained compliance. • Date of Compliance: 4/15/2024	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		4/15/24

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F 867	Continued From page 73	F 867		

§483.75(c) Program feedback, data systems and monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

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F 867	Continued From page 74 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F 867		

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F 867	Continued From page 75 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the focused infection control survey that	F 867	• On 3/28/2024, The Facility Nurse Consultant initiated an audit of previous citations and action plans within the past year to include accuracy of assessments, food procurement, store/prepare/serve food under sanitary conditions, and	

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occurred on 02/13/21, the recertification and complaint investigation surveys that occurred on 06/24/21 and 08/25/22. This failure was for three deficiencies that were originally cited in the areas of Accuracy of Assessments (F641), Food Procurement, Store/Prepare/Serve Food Under Sanitary Conditions (F812) and Infection Prevention and Control (F880) and were subsequently recited on the current recertification and complaint investigation survey of 02/29/24. The repeat deficiencies during multiple surveys of record show a pattern of the facility's inability to sustain an effective QA program.

The findings included:

This tag is cross referred to:

F641: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 6 residents (Resident #41, #102, #84) reviewed for Preadmission Screening and Resident Review (PASRR), and 1 of 3 residents (Resident #110) reviewed for restraints.

During the recertification and complaint investigation survey conducted 08/25/22 the facility failed to accurately code the Minimum Data Set (MDS) assessment related to tobacco use for residents reviewed for smoking.

F812: Based on observation and staff interviews, the facility failed to remove expired food items and unlabeled items which belonged to staff for 1 of 3 resident's nourishment rooms. These practices had the potential to affect food served to residents.

F 867

infection control and prevention to ensure the Quality Assurance Performance Improvement (QAPI) committee has maintained and monitored interventions that were put into place. Action plans were revised, updated and presented to the QAPI Committee by the Quality Assurance (QA) Nurse for any concerns identified. The Facility Nurse Consultant will address all concerns identified during the audit, including staff training. Audit will be completed by 4/5/24.

• On 3/21/2024, the Facility Nurse Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Quality Assurance (QA) Nurse regarding the Quality Assurance Performance Improvement (QAPI) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 3/21/2024. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QAPI Process.

• All data collected for identified areas of concerns to include accuracy of assessments, food procurement,

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During the recertification and complaint investigation survey conducted 06/24/21, the facility failed to remove expired food items in the refrigerator in 1 of 4 nourishments rooms and failed to label and date opened food items stored for use in 3 of 4 nourishment rooms.

During the recertification and complaint investigation survey conducted 08/25/22, the facility failed to discard produce with signs of spoilage, remove expired food items and date leftover food stored ready for use in the walk-in cooler.

F880: Based on observations, record reviews, and staff interviews, the facility failed to ensure staff implemented their handwashing/hygiene policy as part of their infection control policy when the Treatment Nurse did not perform hand hygiene and don clean gloves after cleaning two wounds with wound cleanser and one wound with normal saline and before applying treatment to the wounds for two residents (Resident #128 and Resident #43) and did not doff gloves, sanitize hands and don clean gloves after wound care and prior to touching the resident's (Resident #128) pillows and bedding. The Treatment Nurse was also observed during wound care on another resident (Resident #126) with Methicillin-Resistant Staphylococcus Aureus (MRSA) and Carbapenem-Resistant Enterobacterales (CRE) in the wound and she did not doff gloves, sanitize hands and don clean gloves after cleaning the wound which had brown colored drainage and before applying the treatment to the wound and with the same gloves on the Treatment Nurse used to clean the drainage from the wound was observed touching the bed controls to lower the resident's bed and

F 867

store/prepare/serve food under sanitary conditions, and infection prevention and control will be taken to the QAPI committee for review monthly x 3 months by the Director of Nursing. The QAPI committee will review the data and determine if a plan of corrections is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse.

- The Facility Nurse Consultant will ensure the facility is maintaining an effective QAPI program by reviewing and initialing the Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include accuracy of assessments, food procurement, infection control and all current citations and QA plans are followed and maintained monthly x2. The Facility Nurse Consultant will immediately retrain the Administrator and DON for any identified areas of concern. The Administrator is responsible for the Plan of Correction and for sustained compliance.
- Date of compliance 4/15/2024.

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F 867	Continued From page 78 touching the trash bag on the resident's bed. In addition, another staff member (Nurse Aide (NA) #1) was observed providing incontinence care of bowel movement to a resident (Resident #51), and with the same gloves on that he had cleaned the resident with touching the resident's closet door, bedside drawer and over bed table. These failures occurred for 3 of 3 residents reviewed for wound care and 1 of 3 residents reviewed for incontinence care. During the focused infection control survey conducted 02/13/21 the facility failed to ensure dietary staff implemented the facility's infection control measures when 2 staff members failed to wear a facemask covering their mouth and nose while working in the kitchen. During an interview on 02/29/24 at 5:19 PM with the Administrator she revealed the QAPI committee meets monthly with department heads, administrative staff, the Medical Director, and at least quarterly the Pharmacist and Registered Dietician attend and monthly attend by phone. She reported they currently had Process Improvement Plans (PIPs) addressing some of the issues she and the corporate advisors had identified at the facility. Some of the PIPs currently being addressed included grievances, care plan meetings, resident weights, and physician visits. She also reported they would be putting PIPs into place to address the current concerns addressed during the current recertification and complaint survey. The Administrator stated the PIPs would be ongoing and monitored to ensure ongoing and future compliance.	F 867		
F 880 SS=E	Infection Prevention & Control	F 880		4/15/24

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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 §483.70(e) 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;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a

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F 880	Continued From page 80 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 observations, record reviews, and staff interviews, the facility failed to ensure staff implemented their handwashing/hygiene policy as part of their infection control policy when the Treatment Nurse did not perform hand hygiene and don clean gloves after cleaning two wounds with wound cleanser and one wound with normal saline and before applying treatment to the wounds for two residents (Resident #128 and Resident #43) and did not doff gloves, sanitize	F 880	F 880 Infection Control • On 2/28/2024 the nurse responsible for treatments for resident #128 was in serviced by the Director of Nursing (DON)/Staff Development Coordinator (SDC) on Infection Control for Wound Care including proper handwashing. The Certified Nursing Assistant (CNA) #1	

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hands and don clean gloves after wound care and prior to touching the resident's (Resident #128) pillows and bedding. The Treatment Nurse was also observed during wound care on another resident (Resident #126) with Methicillin-Resistant Staphylococcus Aureus (MRSA) and Carbapenem-Resistant Enterobacterales (CRE) in the wound and she did not doff gloves, sanitize hands and don clean gloves after cleaning the wound which had brown colored drainage and before applying the treatment to the wound and with the same gloves on the Treatment Nurse used to clean the drainage from the wound was observed touching the bed controls to lower the resident's bed and touching the trash bag on the resident's bed. In addition, another staff member (Nurse Aide (NA) #1 was observed providing incontinence care of bowel movement to a resident (Resident #51), and did not remove his gloves and perform hand hygiene before touching the resident's closet door, bedside table drawer and other surfaces. These failures occurred for 3 of 3 residents reviewed for wound care (Resident #128, #43, and #126) and 1 of 3 residents reviewed for incontinence care (Resident #51).

The findings included:

The facility's policy entitled "Handwashing Policy" which is part of the Infection Control Policies and Procedures last revised on 04/2023 read in part: Personnel are required to wash their hands after each direct or indirect resident contact for which handwashing is indicated by acceptable standards of practice. An alcohol-based hand sanitizer may be used for handwashing unless the hands are visibly soiled. The hands should be free of dirt and organic material when using an

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responsible for catheter care for Resident #51 was educated on proper handwashing technique and Infection control related to catheter care by the Director of Nursing DON/Staff Development Coordinator (SDC) on 2/28/24.

- A complete return demonstration observation audit will be performed for all nursing staff on hand washing, catheter care and wound care beginning on 3/19/24 to be completed by 4/15/24.
- On 3/15/2024 the Staff Development Coordinator (SDC) initiated an in-service regarding handwashing with all staff including the agency staff. Any staff member not in serviced by 4/15/2024 will not be allowed to work until they are in-service for handwashing by the SDC. Newly hired staff and nursing agency staff will be in-service on handwashing by the SDC in orientation before beginning work.
- On 3/20/2024 the Staff Development Nurse initiated an in-service including the wound care (nurses) and catheter care skills check off with all nursing staff including agency by 4/5/2024, after which staff or agency will not be allowed to work until they are in serviced for handwashing by the SDC. Newly hired staff and the agency staff will be in service on handwashing, catheter and wound care by the SDC in orientation before beginning work.
- Beginning 4/5/2024, the RN supervisors will observe 3 staff, to include C.N.A. #1 providing direct resident wound and catheter care using the Wound Care and Catheter Care Audit Tool weekly on

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F 880	Continued From page 82 alcohol hand sanitizer. The hands should be washed with soap and water after exposure to blood or body fluids. Personnel should wash their hands: " After contact with blood, body fluids, secretions, excretions and equipment or articles contaminated by them. " After removing gloves and before performing procedures in which a normally sterile part of the body is entered. " Before and after touching wounds. " After situations during which microbial contamination of hands is likely to occur. " After touching inanimate sources that are likely to be contaminated with virulent or epidemiologically significant microorganisms. " Between resident contacts. " When otherwise indicated to avoid transfer of microorganisms to other residents and environments. " When indicated between tasks and procedures to prevent cross contamination of different body sites. " When hands are visibly and obviously soiled." 1. a. A wound observation was made on 02/28/24 at 9:13AM on Resident #128 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. The Treatment Nurse washed her hands with soap and water and donned clean gloves to remove the resident's dressing from her right ankle which had a small amount of drainage on the old dressing. She doffed her gloves after removing the dressing, sanitized her hands, donned clean gloves, and cleansed the wound with wound cleanser-soaked gauze. The Treatment Nurse then proceeded without doffing her gloves, sanitizing her hands, and donning	F 880	varying shifts for 2 months. All findings will be presented by the Administrator or Director of Nursing to the Quality Assurance and Performance Improvement team (QAPI), for review and recommendations for 2 months and as needed. The Director of Nursing is responsible for the Plan of Correction and the Administrator for sustained compliance. • Date of Compliance 4/15/24	

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clean gloves, and applied the hydrogel gauze and ankle dressing and reapplied her boot. The Treatment Nurse then moved to the wound on the left knee and doffed her gloves, sanitized her hands, donned new gloves, and proceeded to clean the left knee with wound cleanser-soaked gauze and without doffing her gloves, sanitizing her hands and donning clean gloves applied xeroform gauze to the knee and covered with a border gauze dressing. The Treatment Nurse then moved to the wound (a skin tear) on the left arm and removed the dressing and cleansed the wound with normal saline and without doffing her gloves, sanitizing her hands, and donning new gloves applied xeroform gauze to the wound and covered with a border gauze dressing. With the same gloves on the Treatment Nurse adjusted the resident's bed with the controls, positioned her in bed with pillow between her legs, gathered her trash, doffed her gloves, left the room, and sanitized her hands in the hallway after discarding the trash.

b. A wound observation was made on 02/29/24 at 9:30 AM on Resident #43 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. The Treatment Nurse cleaned the wound with anasept (antimicrobial skin and wound cleaner)-soaked gauze and without doffing her gloves, sanitizing her hands, and donning new gloves she applied the treatment of hydrocolloid dressing to the wound. With the same gloves on, she re-attached the resident's brief and adjusted the resident's bed with the controls, repositioned the pillow under her head. The Treatment Nurse then threw away her trash, washed her hands with soap and water, brought out the trash bag, discarded it and sanitized her

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hands.
An interview on 02/29/24 at 9:59 AM with the Treatment Nurse revealed she did not realize she had not doffed her gloves after cleaning the wounds, sanitized her hands and donned clean gloves before applying treatment and dressings to the wounds. She stated she was just nervous about someone watching her and forgot to do the correct procedure.

An interview on 02/29/24 at 11:51 AM with the Infection Preventionist (IP) revealed they had done several in-services on handwashing, donning, and doffing personal protective equipment (PPE) but said she would do one-on-one education with the Treatment Nurse. The IP stated any time nurses went from a dirty procedure (cleaning a wound bed) to a clean procedure (applying treatment to wounds) they should doff their gloves, sanitize their hands, and don clean gloves and especially if they are touching objects in the resident's room that the resident may later touch.

An interview with the Director of Nursing (DON) on 02/29/24 at 12:00 PM revealed the Treatment Nurse had shared with them her errors during treatments for Resident's #128 and #43. The DON stated she thought the Treatment Nurse was nervous having someone watching her and she and the IP would re-educate her on proper hand hygiene procedures and would be monitoring her during some of her treatments.

2. A wound observation was made on 02/28/24 at 10:34 AM on Resident #126 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. She stated Resident #126 was

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F 880	Continued From page 85 on enhanced barrier precautions due to Methicillin-Resistant Staphylococcus Aureus (MRSA) and Carbapenem-Resistant Enterobacterales (CRE) in the wound. The Treatment Nurse washed her hands with soap and water and donned clean gloves to remove the resident's dressing from her right ankle which had a small amount of drainage on the old dressing. She doffed her gloves after removing the dressing, sanitized her hands, donned clean gloves, and cleansed the wound with wound cleanser-soaked gauze. The Treatment Nurse then doffed her gloves, sanitized her hands and donned clean gloves. She then lifted Resident #126's left foot and began cleaning the wound again with brown colored drainage observed on the gauze. The Treatment Nurse then proceeded without doffing her gloves, sanitizing her hands, and donning clean gloves, and applied the dermacol collagen and calcium alginate with silver and covered the wound with kerlix. With the same gloves on the Treatment Nurse adjusted the resident's bed with the controls, positioned her in bed with pillow between her legs, gathered her trash, doffed her gloves, left the room, and sanitized her hands in the hallway after discarding the trash. An interview on 02/29/24 at 11:51 AM with the Infection Preventionist (IP) revealed they had done several in-services on handwashing, donning, and doffing personal protective equipment (PPE) but said she would do one-on-one education with the Treatment Nurse. The IP stated any time nurses went from a dirty procedure (cleaning a wound bed) to a clean procedure (applying treatment to wounds) they should doff their gloves, sanitize their hands, and don clean gloves and especially if they are	F 880		

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touching objects in the resident's room that the resident may later touch.

An interview with the Director of Nursing (DON) on 02/29/24 at 12:00 PM revealed the Treatment Nurse had shared with them her errors during treatments for Resident #126. The DON stated she thought the Treatment Nurse was nervous having someone watching her and she and the IP would re-educate her on proper hand hygiene procedures and would be monitoring her during some of her treatments.

3. Resident # 51 was admitted to the facility on 2/2/21 with diagnoses including neurogenic bladder and a chronic autoimmune disorder that affects movement, sensation and bodily functions.

Resident #51's care plan initiated 1/17/24 revealed a focus area for the resident having an activities of daily living (ADL) self-care deficit due to [chronic autoimmune disorder that effects movement, sensation, and bodily functions] and neurogenic bladder. The interventions included assisting with activities of daily living (ADL), dressing, grooming, toileting, promote independence and dignity, and provide positive reinforcement for all activities.

Review of Resident #51's quarterly Minimum Data Set (MDS) assessment dated 1/17/24 revealed total dependence for toilet and bathing. Impaired range of motion was noted to bilateral lower extremities. The resident was coded as always incontinent of bowel and for the presence of a suprapubic catheter.

An observation was conducted on 02/28/24 at

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1:40 PM of Resident #51 receiving incontinence care. NA #1 was observed washing his hands and applied gloves. NA #1 was observed cleaning bowel movement from Resident #51's right and left buttocks using a wet washcloth and soap. After the bowel movement was cleaned up the NA went to the closet to get a clean adult brief without removing his dirty gloves. He returned to bedside and opened the drawer of the bedside table to retrieve the barrier cream, opened it, and applied the cream to the resident's buttocks. NA#1 proceeded to apply the adult brief and change bed linens and was still wearing dirty gloves. NA #1 was also observed touching his uniform. After NA #1 had completed the incontinence care and changed the bed linens, he removed his gloves and washed his hands. After washing his hands NA #1 was observed picking up the barrier cream, placing the cap back on the tube and putting the barrier cream back into the beside table. Then NA #1 picked up the trash and dirty linen bags, opened the resident door and continued down the hallway and placed the trash and soiled linens into barrels. NA#1 then sanitized his hands using hand sanitizer.

Interview on 02/28/24 at 1:50 PM with NA #1 revealed he believed he had done a good job providing incontinence care on Resident #51 and did not realize he had to remove dirty gloves and perform hand hygiene immediately after care was completed and before touching surfaces in the room. NA #1 stated he thought since his gloves were not visibly dirty that he was okay to continue care but stated he had washed his hands before and after care.

Interview on 02/29/24 at 4:46 PM with the Director of Nursing (DON) revealed she would

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F 880	Continued From page 88 expect nursing staff to follow the policy for hand hygiene and glove policy and procedures. The DON stated that all employees had been trained in hand hygiene and glove policy and procedures and the appropriate process was to always be followed.	F 880		