STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345202	A. BUILDING ______ B. WING ______	C 07/01/2021

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CAPITAL NURSING AND REHABILITATION CENTER	**3000 HOLSTON LANE RALEIGH, NC 27610**

(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 survey was conducted on 06/28/2021 through 07/01/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SJN811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/28/21 through 7/1/21. Event ID# SJN811. 2 of the 2 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		7/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 07/23/2021

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain the dignity of dependent residents as evidenced by a staff member's use of the term "feeder" to describe residents who needed assistance with eating (Resident #69) for 1 of 1 resident reviewed for dignity. Findings included: Resident #69 was admitted to the facility on 3/17/09 with diagnoses that included anemia, heart failure, and dementia. The most recent Minimum Data Set (MDS) assessment dated 03/29/21 revealed Resident #69 had severe cognitive impairment. Resident #69 was coded as total dependence with 1-person physical assistance with eating. Further review revealed the resident had a condition or	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: For the affected resident, Resident #67, the Certified Nursing Assistant was noted to use the term “feeder” when discussing the resident’s need to be assisted with feeding.	

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F 550 Continued From page 2

chronic disease that may result in a life expectancy of less than 6 months and was receiving hospice care.

An observation was conducted on 6/28/21 at 12:51 PM during lunch service. Nurse Aid (NA) #6 who had been delivering meal trays into resident rooms referred to Resident #69 as a "feeder" while in the doorway of Resident #69's room.

During an interview with NA #6 on 6/28/21 at 12:52PM, she stated she was not aware she had referred to Resident #69 as a feeder.

An interview with Nurse # 4 on 6/29/21 at 3:48 PM revealed she would address inappropriate language, to include referring to a resident as a feeder, with the NA # 6 and provide education.

Resident #69 was not able to be interviewed.

An interview was conducted with the Administrator on 7/1/21 at 12:17PM who revealed staff needed to respect the dignity of residents who require assistance with eating. She further revealed it was inappropriate to refer to any resident as a feeder.

F 550

1. Corrective action for residents with the potential to be affected by the alleged deficient practice.

The Certified Nursing Assistant was not aware that she had used the word “feeder” in reference to Resident #67, but was promptly educated by the resident’s assigned nurse on 6.30.2021, when the alleged deficient practice occurred, about the fact that this type of language is inappropriate.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

The DON, and designee audited meal times, on 7.2.2021, to ensure the use of “feeder” was not noted by any other employees. The audit found that the use of the word “feeder” did not occur during the audit.

3. Systemic Changes:

All nursing staff, including agency nurses and aides will be re-educated by the Director of Nurses/RN Supervisor on the use of the word “feeder” and ensuring language preserves the residents’ dignity by 7.23.2021.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

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F 550	Continued From page 3	F 550	The Director of Nursing or RN Supervisor will audit staff delivering meals to residents at two meals per audit for 2 weeks and then monthly for 3 months for compliance using words that ensure dignity for all residents. Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		7/23/21

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F 584	Continued From page 4 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to change a privacy curtain for 1 of 6 residents (Resident #64) reviewed for homelike environment. Findings included: Resident #64 was admitted to the facility in 11/7/20 with diagnoses that included chronic congestive heart failure and vascular dementia without disturbance. A review of the Comprehensive Minimum Data Set (MDS) dated 6/1/21 revealed Resident #64	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice:	

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F 584	Continued From page 5 had moderate cognitive impairment for daily decision making. Resident #64 required extensive assistance with one person for bed mobility, dressing, toileting, personal hygiene, and bathing. During an observation of Resident #64 on 6/28/21 at 12:45 PM the resident was sitting up in bed with eyes opened. The privacy curtain for Bed B had a medium sized dried brown substance midway the curtain on the left outer edge near the seam. An observation was conducted on 6/29/21 at 10:26 AM of Resident #64. Resident #64 was sitting up in the bed with his eyes opened and conversating. A medium sized dried brown substance was midway the privacy curtain on the left outer edge. An interview was conducted with Housekeeper #1 on 6/30/21 at 2:48 PM. The Housekeeper stated that housekeeping staff were to check the privacy curtains while cleaning resident's rooms. The Housekeeper stated privacy curtains were changed whenever they were soiled. She stated that anytime a privacy curtain was reported soiled it was removed and a clean curtain was hung. An interview was conducted with the housekeeping Supervisor on 6/30/21 at 3:00 PM. The supervisor stated privacy curtains were changed whenever they were soiled. There was no documentation of the last time privacy curtain was changed. An interview was conducted with the Administrator on 7/1/21 at 1:38 PM and she was informed of stained privacy curtain. The Administrator stated privacy curtains were to be	F 584	For the affected resident, Resident #64, the resident was noted to have a medium sized dried brown substance midway on the privacy curtain. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. The curtain, noted to have a dried brown substance on it, was promptly removed by the Housekeeping Supervisor, when it was brought to the facility's attention on 6.30.2021. The dirty curtain was promptly replaced with a clean curtain, and the soiled curtain was sent to laundry. No resident was noted to be affected by the soiled curtain. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: An audit was completed on 6.30.2021 of all privacy curtains in the facility by the housekeeping supervisor. No other curtains were noted to be soiled at the time of the audit. 3. Systemic Changes: All facility staff, including agency staff will be educated, by the DON or designee, on reporting soiled privacy curtains to the Housekeeping Supervisor, or the Floor Tech, this will be completed by 7/23/2021. Any soiled curtains found, will be promptly taken down to be laundered.	

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F 584	Continued From page 6 changed when they were soiled.	F 584	4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Housekeeping Supervisor will monitor privacy curtains weekly for 2 weeks and then monthly for 3 months for compliance with monitoring for stains on privacy curtains. The Housekeeping Manager, or designee, will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in	F 623		7/2/21

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F 623	Continued From page 7	F 623		

accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which

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F 623	Continued From page 8 receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as	F 623		

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F 623	Continued From page 9 well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the long term care ombudsman of residents discharged to the hospital for 3 of 3 residents reviewed for hospitalization. (Resident #40, #32 and #9). The findings included: 1. Resident #40 was admitted to the facility on 2/4/21. Review of the medical record for Resident #40 revealed the resident was discharged to the hospital on 4/8/21 and re-admitted to the facility on 4/12/21. The resident was also discharged to the hospital on 4/15/21 and re-admitted to the facility on 4/19/21. ON 6/30/21 at 9:15 AM an interview was conducted with the Social Worker who stated she was not aware that the ombudsman was to be notified of residents that were discharged to the hospital. On 6/30/21 at 1:28 PM an interview was conducted with the Administrator who stated the ombudsman requested they send the discharge list once a month and the medical records staff was responsible for sending the list. The Administrator further stated a new medical records employee was hired about one and a half years ago and the medical records employee apparently was not trained to do this.	F 623	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: For the affected residents, Residents #40 and #32, the residents were noted to be discharged to the hospital, and their names were not sent to the Ombudsman upon discharge. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. For Resident #40, the resident was discharged to the hospital several months prior so it is not currently necessary to report to the Ombudsman, since the resident had readmitted prior to the survey. For Resident #32, the Ombudsman was sent notice of the transfer to the Emergency Department on 6.30.2021, as it should have been. The	

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F 623	Continued From page 10 An interview was conducted with the medical records employee and the administrator on 6/30/21 at 1:31 PM. The Medical Records Employee stated she had not been sending the monthly discharge list to the ombudsman because she did not know she was supposed to do this. On 7/1/21 at 12:39 PM an interview was conducted with the Director of Nursing and the facility ' s nurse consultant. The Nurse Consultant stated it was her expectation the list of discharges be sent to the ombudsman monthly. The Nurse Consultant further stated there was a change in the position and that information fell through the cracks. 2. A review of the medical record for Resident #9 revealed the resident was discharged to the hospital on 6/03/21 and re-admitted to the facility on 6/18/21. The resident was discharged to the hospital on 4/13/21 and readmitted to the facility on 4/15/21. During an interview with the Social Worker in 6/30/21 at 9:15AM, she stated she was not aware the Ombudsman was to be notified when residents were discharged to the hospital. An interview with the Administrator on 6/30/21 at 1:28PM revealed a list of residents discharged to the hospital was to be sent to the ombudsman each month. The Administrator stated the Medical Records employee was assigned the responsibility of providing a list to the Ombudsman. During an interview with the Medical Records employee on 6/30/21 at 1:31PM, she stated she had not been sending a list to the Ombudsman of residents discharged. She further stated she was	F 623	Ombudsman has asked that a list of discharged residents be sent monthly, and not one by one. Therefore, Resident #32 was sent on 6.30.2021 as it should have been. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: A list of all hospital discharges, for June 2021, was sent to the Ombudsman, Jennifer Link, on June 30, 2021. The list will be sent on the last day of each month, for the entire month, as requested by the Regional Ombudsman. 3. Systemic Changes: The Medical Records Director was educated on the need to send the list of hospital transfers each month on 6.30.2021 by the Administrator. 4.Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor monthly for 3 months for compliance sending the hospital transfer list to the Ombudsman. The Administrator, will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard.	

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F 623	Continued From page 11 not aware she was to send a list to the ombudsman monthly. An interview on 7/1/21 at 12:39PM with the facility's Nurse consultant revealed she expected a list of discharges to be sent to the Ombudsman monthly. She further revealed there was a change in the medical record staff and the information fell through the cracks. 3. Resident #32 was admitted to the facility on 12/14/20. A review of the Electronic Health Record (EHR) revealed Resident #32 was discharged to the hospital on 6/18/21. Resident #32 was re-admitted on 6/29/21 under hospice services. During an interview with the Social Worker in 6/30/21 at 9:15AM, she stated she was not aware the Ombudsman was to be notified when residents were discharged to the hospital. An interview with the Administrator on 6/30/21 at 1:28PM revealed a list of residents discharged to the hospital was to be sent to the ombudsman each month. The Administrator stated the Medical Records employee was assigned the responsibility of providing a list to the Ombudsman. During an interview with the Medical Records employee on 6/30/21 at 1:31PM, she stated she had not been sending a list to the Ombudsman of residents discharged. She further stated she was not aware she was to send a list to the ombudsman monthly. An interview on 7/1/21 at 12:39PM with the	F 623	The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	

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F 623	Continued From page 12 facility's Nurse consultant revealed she expected a list of discharges to be sent to the Ombudsman monthly. She further revealed there was a change in the medical record staff and the information fell through the cracks.	F 623		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.	F 645		7/22/21

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F 645	Continued From page 13 §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to screen new admission residents with diagnoses including mental illness for Level	F 645	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	

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II Preadmission Screening and Record Review (PASRR, a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines) for 2 of 3 residents reviewed for Preadmission Screening and Record Review (PASRR) (Resident #22 and Resident #14).

Findings included:

1. Resident #22 had been admitted on 3/24/2021. Her admitting diagnoses included Bipolar disorder.

Physician admission documentation dated 3/26/2021 noted Resident #22 had diagnoses including Bipolar 2 disorder. Noted her medications upon admission included Bupropion (antidepressant, used to treat depressive symptoms), Dextroamphetamine-amphetamine (stimulant, used to treat Bipolar symptoms), Divalproex Sodium (treats manic episodes associated with Bipolar disorder and seizures), and Quetiapine (antipsychotic, used to treat Bipolar depression). The assessment and plan noted "Bipolar 2: continue aggressive regimen with [Bupropion], [Dextroamphetamine-amphetamine], [Divalproex Sodium], and [Quetiapine]."

Resident #22's admission Minimum Data Set (MDS) assessment dated 3/31/2021 did not indicate she was currently considered by the state Level II PASRR process to have a serious mental illness, and serious mental illness was not checked as applicable. She was noted as having severe cognitive impairment. Her diagnoses included bipolar disease and depression. The MDS further indicated she had received

F 645

alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
Corrective action for resident(s) affected by the alleged deficient practice:

For the affected residents, Resident # 22 and Resident #14, the PASSAR number was not obtained timely.

1. Corrective action for residents with the potential to be affected by the alleged deficient practice.

A PASSAR number was requested for the Resident #22, just outside of her 30-day window (under the waiver). The resident had a valid PASSAR number at the time of the survey, however the Social Work Director requested an updated PASSAR number on 6.29.2021 due to resident's PASSAR expiring in August. Updated PASSAR was received on 7.2.2021. For Resident #14, a PASSAR was requested on 6.30.2021 due to resident having an Adult Care Home PASSAR number. The new PASSAR number was received on 7.7.2021.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

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NAME OF PROVIDER OR SUPPLIER: **CAPITAL NURSING AND REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE: **3000 HOLSTON LANE RALEIGH, NC 27610**	

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F 645	Continued From page 15 antipsychotic and antidepressant medication daily. Review of facility documentation revealed a Level II PASRR evaluation was requested on 5/13/2021. The Level II PASRR determination notification letter was dated 5/21/2021 and indicated placement for 90 days had been approved for Resident #22. On 6/29/21 at 2:09 PM an interview with the Social Worker (SW) was conducted. She stated for new residents, if they were here for short term or less than 30 days, a PASRR determination was not necessary. If the resident were staying long term a PASRR would be initiated if one had not been completed. The SW explained when Resident #22 had been admitted, the plan was for a short stay and then she would return to the community. She further explained Resident #22 had not been approved to return to her previous living situation and her Power of Attorney (POA) had been looking for another place for her to live. During a follow up interview with the SW on 7/01/2021 at 11:20 AM, she stated she thought she had 90 days to implement the PASRR because Resident #22 had planned on a short stay. She stated this had been an oversight and when she realized it should be 30 days, she requested the evaluation right away. An interview was conducted with the Administrator on 6/29/2021 at 4:59 PM. The Administrator stated the SW initiates and obtains the PASRR determination before day 30 of the resident stay. The Administrator explained she would expect the PASRR determination for Resident #22 to have been done within the 30-day timeframe.	F 645	An audit was completed on 7.1.2021 to ensure all residents, needing a PASARR number had one. The audit did find that one resident needed to have a PASSAR number, but she was still within the window of the 30-day period related to the PASSAR waiver. That number was obtained on 7.6.2021, well before day 30 of the 30-day waiver period. All other residents reviewed had a PASSAR number. 3. Systemic Changes: The SW Director was educated on 7.1.2021 on the need to obtain PASSAR numbers by the Administrator promptly after admission for all residents with Mental Health Diagnoses, and within 30 days for all residents without a Mental Health Diagnosis. The SW director was trained, additionally, by the MDS Consultant on 7.22.2021. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor PASSAR numbers weekly for 2 weeks and then monthly for 3 months for compliance with monitoring for compliance with obtaining PASSAR numbers as needed per the regulation. The Administrator or designee, will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns.	

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F 645	Continued From page 16 2. Resident #14 was admitted to the facility on 3/22/21, from an adult care home, with a diagnosis of bipolar disorder. A review of the admission Minimum Data Set (MDS) assessment dated 3/29/21 did not indicate Resident #14 was currently considered by the state Level II Pre-Admission Screening and Resident Review (PASRR) process to have a serious mental illness, and serious mental illness was not checked as applicable. Resident #14 was noted to have short-term and long-term memory deficits. Resident #14's diagnoses included depression and manic depression (bipolar disease). The MDS further indicated Resident #14 had received antipsychotic and antidepressant medication daily. A review of Resident #14's Electronic Health Record revealed a PASRR dated 10/3/17 with no expiration date for Adult Care Home level of care. Further review revealed Resident #14 was clinically noted to have the presence of a significant mental illness. During an interview with the Social Worker on 6/29/21 at 2:09PM she stated for new residents, if they were here for short term or less than 30 days, a PASRR determination was not necessary. If the resident were staying long term a PASRR would be initiated if one had not been completed. An interview was conducted with the Administrator on 6/30/2021 at 9:21AM. The Administrator stated the PASRR Level II Determination for Resident #14 was for Adult	F 645	Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	

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F 645	Continued From page 17 Care Home and that it was overlooked upon admission. She further stated the Social Worker would initiate a PASRR for this resident.	F 645		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		7/22/21

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Continued From page 18
whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and resident and staff interview the facility failed to develop an individualized care plan for 4 of 39 residents whose care plans were reviewed (Resident #19, #21, #40 and #43).

The findings included:

1. Resident #19 was admitted to the facility on 12/23/19 and had a diagnosis of chronic kidney disease stage 3 and congestive heart failure.

The resident's active care plan had an entry that was dated 12/31/19 and noted the resident was at risk for pressure ulcers. One of the interventions listed was to observe the resident's skin upon return from dialysis.

The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 3/24/21 revealed the resident was cognitively impaired. The MDS did not indicate the resident received dialysis.

On 6/30/21 at 12:06 PM the MDS Nurse stated in an interview that she used a system created care plan for resident care areas that had the intervention to observe the resident's skin upon return from dialysis and she did not change the interventions.

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The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
Corrective action for resident(s) affected by the alleged deficient practice:

For the affected residents, Resident #19, Resident #21, Resident #40, and Resident #43, the residents were noted to have information that did not apply to them on their Care Plan, under the interventions section.

1. Corrective action for residents with the potential to be affected by the alleged deficient practice.
All affected residents□ Care Plans were updated by the MDS Coordinator to include only information regarding their care, and all interventions are individuals

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On 7/1/21 at 12:29 an interview was conducted with the Director of Nursing (DON) and the nurse consultant. The DON stated it was her expectation for the care plans to be individualized for the resident and reflect their care needs.

2. Resident #21 was admitted to the facility on 9/14/19 and had a diagnosis of multiple sclerosis.

The resident's current care plan revealed an entry dated 9/16/19 that the resident was at risk for pressure ulcers. One of the interventions was to observe the resident's skin for redness and open areas upon return from dialysis.

The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 3/25/21 revealed the resident was cognitively intact and did not indicate the resident received dialysis.

During a resident interview on 6/29/21 at 10:30 AM the resident stated she was not on dialysis.

On 6/30/21 at 12:06 PM the MDS Nurse stated in an interview that she used a system created care plan that had the intervention to check the skin for redness and open areas upon return from dialysis and she did not change the interventions.

On 7/1/21 at 12:29 an interview was conducted with the Director of Nursing (DON) and the nurse consultant. The DON stated it was her expectation for the care plans to be individualized for the resident and reflect their care needs.

3. Resident #40 was admitted to the facility on

F 656

for their needs on 7.2.2021.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

An audit was completed on 7.15.2021 of all Care Plans for current residents in the facility by the MDS Coordinator, and the MDS Assistant. Any areas for improvement to ensure all interventions were up to day and applicable, were made at the time of the audit.

3. Systemic Changes:

The Regional MDS Consultant provided education to the MDS Coordinator, MDS Assistant, Dietary Manager, Social Services Director and Activities Director on 7/22/21. This education focused on what areas should be addressed on the care plan for each resident. It included what to care plan and how to add items to the care plan. This included the importance of ensuring that any items that are used from the care plan library are individualized for that specific resident. The education also emphasized the importance of ensuring that care plans are tailored to each resident based on their specific needs. The importance of reviewing and revising care plans at least quarterly and as needed as the resident's condition changes was also reviewed during this educational session.

IDT care planning team will meet weekly (at a minimum of every 7 days) to review

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2/4/21 cerebrovascular accident (stroke) and dementia.

The resident's current care plan noted an entry dated 2/5/21 that the resident was at risk for pressure ulcers. One of the interventions was to observe the resident's skin for redness and open areas upon return from dialysis.

The most recent Minimum Data Set (MDS) Assessment dated 3/24/21 revealed the resident had severe cognitive impairment. The MDS did not indicate the resident received dialysis.

On 6/30/21 at 12:06 PM the MDS Nurse stated in an interview that she used a system created care plan that had the intervention to check the skin for redness and open areas upon return from dialysis and she did not change the interventions.

On 7/1/21 at 12:29 an interview was conducted with the Director of Nursing (DON) and the nurse consultant. The DON stated it was her expectation for the care plans to be individualized for the resident and reflect their care needs.

4. Resident #43 was admitted to the facility on 2/2/21 and had a diagnosis of Alzheimer's Dementia.

The Quarterly Minimum Data Set (MDS) Assessment dated 6/30/21 revealed the resident had severe cognitive impairment. The MDS did not indicate the resident received dialysis.

The resident's current care plan revealed an entry dated 2/4/21 that noted the resident was at risk for pressure ulcers and to observe the skin for

F 656

22 Medical records to ensure the care plan is inclusive and does not include information that does not pertain to the resident. 100% of active resident records will be reviewed by the IDT care plan team at a minimum of every 4 weeks.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Regional MDS Consultant will perform care plan audits for 10 residents to ensure that care plans are individualized. This QA audit will be completed weekly x 1 month and then monthly x 2 or until substantial compliance is achieved. The Administrator or DON will report the findings to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director

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F 656	Continued From page 21 redness and open areas upon return from dialysis. On 6/30/21 at 12:06 PM the MDS Nurse stated in an interview that she used a system created care plan that had the intervention to check the skin for redness and open areas upon return from dialysis and she did not change the interventions. On 7/1/21 at 12:29 PM an interview was conducted with the Director of Nursing (DON) and the nurse consultant. The DON stated it was her expectation for the care plans to be individualized for the resident and the care plan to reflect the resident's needs. .	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		7/22/21

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and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to update residents' care plans to reflect the care required for 2 of 39 residents whose care plans were reviewed (Resident #19 and #21).

The findings included:

Resident #19 was admitted to the facility on 12/23/19 and had a diagnosis of osteoarthritis, rheumatoid arthritis and dementia.
1a. The resident's current care plan revealed an entry dated 12/31/19 that noted the resident was to be transferred with "minimal assist with pull to stand at parallel bar."

The most recent Minimum Data Set (MDS) assessment dated 6/22/21 noted the resident had severe cognitive impairment and required total assistance of 2 persons for transfers.

On 6/30/21 at 2:59 PM the MDS Nurse stated in an interview that she received a sheet from rehab as to how the resident was to be transferred for the entry dated 12/31/19. The Nurse further stated once she put an intervention in the care plan she did not go in and take it out even though

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The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
Corrective action for resident(s) affected by the alleged deficient practice:

For the affected residents, Resident #19 and Resident #21, Care Plans were not updated timely. Resident #19 had a change in transfer status, and the Care Plan was not updated to reflect the change. Additionally, the Care Plan referenced TED hose, that were no longer ordered for the resident. Resident #21 was noted to not have a transfer status listed on the CP.

1. Corrective action for residents with the

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the intervention no longer applied to the resident. The MDS Nurse continued and stated she did not know she had to be that specific in the care plan.

On 7/1/21 at 9:00 AM Nurse #1 stated in an interview that Resident #19 was total assist with transfers and was transferred with a mechanical lift.

On 7/1/21 at 9:28 AM an interview was conducted with the Rehab Director who stated when the resident was admitted in 2019 she had contractures of both knees and she had severe dementia. The Rehab Director further stated that after therapy the resident was evaluated on 3/10/20 to be transferred with a mechanical lift since the resident was unable to fully extend her legs.

1b. Review of the resident's current care plan revealed an entry dated 1/17/20 that the resident was to have TED (Thrombo-Embolus Deterrent) stockings and to apply in the morning and remove at bedtime. Review of the physician's orders revealed no order for TED hose.

On 6/30/21 at 2:44 PM, Resident #19 was observed to receive incontinence care and did not have TED hose on her feet and legs. During the care, Nursing Assistant (NA) #1 stated she had never known the resident to wear TED hose.

On 6/30/21 at 2:59 PM an interview was conducted with the MDS Nurse who stated the resident's TED stockings were discontinued on 3/9/20. The MDS Nurse stated when reviewing a resident's care plan she looked to make sure the category or focus area was there but did not look at the interventions and once she added an

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potential to be affected by the alleged deficient practice.
All affected residents Care Plans were updated by the MDS Coordinator to include only pertinent transfer status, and other order information on 7.2.2021. Non-applicable information was removed from the interventions.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

An audit was completed on 7.15.2021 of all Care Plans for current residents in the facility by the MDS Coordinator, and the MDS Assistant. Any areas for improvement to ensure all interventions were up to day and applicable, were made at the time of the audit.

3. Systemic Changes:

The Regional MDS Consultant provided education to the MDS Coordinator, MDS Assistant, Dietary Manager, Social Services Director and Activities Director on 7/22/21. This education focused on what areas should be addressed on the care plan for each resident. It included what to care plan and how to add items to the care plan. This included the importance of ensuring that any items that are used from the care plan library are individualized for that specific resident. The education also emphasized the importance of ensuring that care plans are tailored to each resident based on their specific needs. The importance of

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intervention she did not remove it even if the intervention no longer applied to the resident. The MDS Nurse stated she did not know she had to be that specific.

2. Resident #21 was admitted to the facility on 9/14/19 and had a diagnosis of multiple sclerosis.

The resident's current care plan last reviewed on 6/23/21 did not specify how the resident was to be transferred.
A Minimum Data Set (MDS) Assessment dated 6/24/21 noted the resident was cognitively intact and required extensive assistance of one person for transfers.

On 6/30/21 at 2:59 PM an interview was conducted with the MDS Nurse who stated she used a system created care plan for the resident care areas and did not update or change them. The MDS Nurse further stated when she looked at the care plan she made sure the category or focus area was there but did not look at the interventions and did not know she had to be that specific.

On 7/1/21 at 10:40 AM, Resident #21 was observed to be transferred from the bed to a wheelchair with the use of a total mechanical lift.

On 7/1/21 at 11:38 AM the Rehab Director stated in an interview that Resident #21 was re-evaluated after a hospitalization on 7/6/20, was dependent on staff for transfers and was to be transferred with a total mechanical lift.

On 7/1/21 at 12:29 PM an interview was conducted with the Director of Nursing (DON) and

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reviewing and revising care plans at least quarterly and as needed as the resident’s condition changes was also reviewed during this educational session.

IDT care planning team will meet weekly (at a minimum of every 7 days) to review 22 Medical records to ensure the care plan is inclusive and does not include information that does not pertain to the resident. 100% of active resident records will be reviewed by the IDT care plan team at a minimum of every 4 weeks.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Regional MDS Consultant will perform care plan audits for 10 residents to ensure that care plans are individualized. This QA audit will be completed weekly x 1 month and then monthly x 2 or until substantial compliance is achieved. The Administrator or DON will report the findings to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse,

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F 657	Continued From page 25 the nurse consultant. The DON stated it was her expectation for the care plans to be individualized for the resident and reflect the resident's needs.	F 657	and Rehab Director.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide nail care for 5 of 6 dependent residents reviewed for Activities of Daily Living (ADL) (Residents #67, #13, #53, #28 and #36). Findings included: 1. Resident #67 had been admitted on 3/31/2017. Her diagnoses included dementia and anxiety. Resident #67's most recent quarterly Minimum Data Set (MDS) assessment dated 6/03/2021 indicated she had severe cognitive impairment, was able to feed herself with supervision and required extensive to total care for all other ADLs. Resident #67's ADL Care Plan initiated on 4/10/2017 indicated she had an ADL self-care performance deficit related to dementia. The care plan goal was to improve [her] current level of function. Interventions included anticipate [her] needs and to check nail length and trim and clean as necessary. Report any changes to the nurse. Another care plan most recently updated on 5/03/2021 indicated [Resident #67] is resistive to care related to anxiety and occasionally verbally abusive. He care plan goal was for the resident to	F 677	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: For the affected residents, Residents #67, #13, #53, #28, and #36, were noted to have a brown matter under their fingernails. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. All affected residents' nails were cleaned on 6.30.2021 by the Certified Nursing	7/23/21

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cooperate with care for 90 days. Interventions included if [Resident #67] resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again.

An observation on 6/28/2021 at 11:52 AM Resident #67 in bed, appeared clean, without odors, nails long with brown matter under the nails.
An observation on 6/28/2021 at 3:33 PM Resident #67 wanting to get out of bed, appeared clean, without odors, nails long with brown matter under the nails.
An observation on 6/29/2021 at 8:17 AM Resident #67 in bed, appeared clean, without odors, nails long with brown matter under the nails.

An interview with Nurse Aide (NA) #2 was conducted on 6/30/21 at 1:19 PM. NA #2 stated Resident #67 required extensive to total care with ADLs. She explained NA #5 completed nail care for the residents once weekly.

An interview with NA #5 was conducted on 6/30/2021 at 1:57 PM. She stated she sometimes had a specific assignment to assist with ADL and nail care. She explained "it had been awhile" since she had this assignment.

An interview with Nurse #3 who regularly cared for Resident #67 was conducted on 6/30/2021 at 2:14 PM. The nurse stated Resident #67 required extensive to total care for her ADLs and nails should be cleaned and checked daily or at minimum on shower days.

An interview was conducted with the Director of Nursing (DON) on 6/29/21 at 4:46 PM. The DON stated unless the resident was diabetic or on

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Assistant assigned to them.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

An audit was completed on 6.30.2021, by the Director of Nursing, of all residents' nails in the facility. Any nails needing cleaning, or trimming were completed at that time.

3. Systemic Changes:

All nursing staff, including agency staff, will be educated on nail care by 7.23.2021 by the Director of Nursing or designee. The education provided was in regards to the facility's nail care policy.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The DON, or designee will monitor residents' nails weekly for 2 weeks and then monthly for 3 months for compliance with nail care. The Administrator or DON will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary

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F 677	Continued From page 27 coumadin or the family preferred the resident to go out of the facility for nail care, the NAs should be providing nail care daily and as needed. The DON explained the NAs should clean and check nails when showering or bathing the residents. 2. Resident #13 had been admitted on 7/21/2017. Her diagnoses included chronic obstructive pulmonary disease, diabetes, and dementia. Resident #13's most recent comprehensive Minimum Data Set (MDS) dated 6/11/2021 indicated she had memory problems and required extensive to total care with ADLs. Resident #13's ADL Care Plan initiated on 7/31/2017 indicated she had an ADL self-care deficit related to activity intolerance and shortness of breath. The care plan goal was to improve [her] current level of function. Interventions included to anticipate [her] needs, and [she] requires staff assistance with grooming and personal hygiene. An observation on 6/28/2021 at 3:43 PM Resident #13 in bed, appeared clean, without odors, nails long with brown matter under the nails. An observation on 6/29/2021 at 8:16 AM Resident #13 in bed, appeared clean, without odors, nails long with brown matter under the nails. An observation on 6/29/2021 at 3:39 PM Resident #13 in bed, appeared clean, without odors, nails long with brown matter under the nails. An interview with Nurse Aide (NA) #3 was conducted on 6/29/2021 at 3:39 PM. NA #3 stated Resident #13 required extensive to total care and was able to feed herself after set-up and encouragement. She explained NA #5 goes around and cuts the residents nails. An interview with NA #5 was conducted on	F 677	Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	

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6/30/2021 at 1:57 PM. She stated she sometimes had a specific assignment to assist with ADL and nail care. She explained "it had been awhile" since she had this assignment.

An interview with Nurse #3 who regularly cared for Resident #13 was conducted on 6/30/2021 at 2:14 PM. The nurse stated Resident #13 required extensive to total care for her ADLs and nails should be cleaned and checked daily or at minimum on shower days.

An interview was conducted with the Director of Nursing (DON) on 6/29/21 at 4:46 PM. The DON stated unless the resident was diabetic or on coumadin or the family preferred the resident to go out of the facility for nail care, the NAs should be providing nail care daily and as needed. The DON explained the NAs should clean and check nails when showering or bathing the residents.

3. Resident #53 had been admitted on 5/19/2020. His diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting dominant right side and aphasia
Resident #53's most recent comprehensive Minimum Data Set (MDS) assessment dated 5/25/2021 indicated he had a memory problem and required extensive to total assistance with ADLs.
Resident #53's ADL Care Plan initiated on 5/21/2020 indicated he had an ADL self-care deficit related to cerebral vascular accident and hemiplegia. The care plan goal was to receive staff assistance with all aspects of daily care to ensure all [his] needs are met. Interventions included to anticipate [his] needs.

An observation on 6/28/2021 at 12:18 PM

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Resident #53 in bed, appeared clean and without odors, fingernails long.
An observation on 6/28/2021 at 3:41 PM Resident #53 in bed, appeared clean and without odors, fingernails long.
An observation on 6/29/2021 at 8:21 AM Resident #53 in bed, appeared clean and without odors, fingernails long.

An interview with Nurse #2 was conducted on 6/29/2021 at 4:01 PM. Nurse #2 stated she checked on her residents for any possible needs when first arriving for her shift and each time she's in any resident room. She stated she had worked at this facility about one month and was not sure of the process for fingernails.

On 6/29/2021 at 4:21 PM Resident #53 was observed with Nurse #2. Nurse #2 indicated Resident #53's nails were long and should be trimmed.

An interview was conducted with the Director of Nursing (DON) on 6/29/21 at 4:46 PM. The DON stated unless the resident was diabetic or on coumadin or the family preferred the resident to go out of the facility for nail care, the NAs should be providing nail care daily and as needed. The DON explained the NAs should clean and check nails when showering or bathing the residents.

3. Resident #28 was admitted to the facility 12/17/20. His diagnoses included cerebrovascular accident and seizure disorder.

Resident #28 's most recent Comprehensive

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MDS dated 3/12/21 indicated he was cognately intact, was able to feed himself with supervision and required extensive assistance for all other ADLS.

Resident #28's ADL Care Plan dated 1/28/21 revealed he had an ADL Self- Care Performance Deficit related to right foot amputation. The care plan goal was to receive staff assistance with all aspects of his daily care to ensure his daily needs were met. Interventions included anticipate his needs.

An observation of Resident #28 was conducted on 6/28/21 at 2:53 PM. Resident # 28 was in bed, appeared clean, had no odors and fingernails had brown matter under the nails.

An observation of Resident #28 was conducted on 6/29/21 at 10:26 AM. Resident #28 was in bed, appeared clean, had no odors, and fingernails had brown matter under the nails.

An interview was conducted with NA #6 on 6/30/21 at 2:00 PM. She stated Resident #28 required extensive assistance with ADLS. Nurse #6 stated nail care was provided on a weekly basis and as needed. NA#6 stated she looked at resident nails when she assisted with ADL care.

An interview was conducted with the Administrator on 7/1/21 at 1:38 PM and she was informed that residents had brown matter under fingernails. The Administrator stated she expected that staff provided nail care daily for residents.

4. Resident #36 was admitted to the facility on 4/28/21 with diagnoses that included diabetes

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F 677	Continued From page 31 and hypertension. Resident #36's Admission MDS Assessment dated 5/5/21 indicated she was cognitively intact, required set up help only with eating and extensive assistance with all other ADLS. Resident # 36's ADL Care Plan date 4/29/21 revealed she had an ADL Self Care Performance Deficit related to impaired balance, limited mobility and limited range of motion. Interventions included to anticipate her needs and she required staff assistance with grooming and personal hygiene. An observation of Resident #36 was conducted on 6/28/21 at 3:18 PM. Resident #36 was sitting up in the wheelchair at the bedside, appeared clean, had no odors and a brown colored substance beneath her fingernails. An observation of Resident #36 was conducted on 6/29/21 at 8:41 AM. Resident #36 was in bed, appeared clean, had no odors, and a brown colored substance under her fingernails. An interview was conducted with NA#7 on 6/29/21 at 4:34 PM. She stated that nail care was performed during Resident #36's AM care. NA #7 stated she assisted with nail care when it was assigned. An interview was conducted with the Administrator on 7/1/21 at 1:38 PM and she was informed that residents had brown matter under fingernails. The Administrator stated she expected that staff provided nail care daily for residents.	F 677		

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		7/23/21

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Based on observations, record review, resident and staff interview the facility failed to keep an indwelling urinary catheter bag and tubing off the floor for 1 of 1 resident (Resident #28) reviewed for catheter care.

The findings included:

Resident #28 was readmitted to the facility on 12/17/20 with diagnoses that included cerebrovascular accident, bladder outlet obstruction, and seizure disorder.

Review of the physician orders dated 12/17/20 revealed an order for indwelling catheter: size 16 Fr (French) Balloon 5ml (milliliter), Catheter care every shift, Ensure leg band in place.

A review of the most recent Comprehensive Minimum Data Set (MDS) Assessment dated 3/12/21 indicated he was cognitively intact. Resident #28 required extensive assistance with activities of daily living (ADLs, was able to feed himself with supervision and had an indwelling catheter.

Review of the care plan dated 10/2/20 revealed a care plan for indwelling catheter related to bladder outlet obstruction with chronic urinary retention. The goal was to show no signs and symptoms of urinary infection through review date of 6/30/2021. The interventions included: position catheter bag and tubing below the level of the bladder and away from entrance room door.

An observation of Resident #28 was conducted on 6/28/2021 at 12:30 PM. Resident #28 was laying in the bed. The catheter tubing was kinked, and catheter bag was laying on the floor.

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Corrective action for resident(s) affected by the alleged deficient practice:

For the affected resident, Resident #28, the resident was noted to have indwelling catheter bag on the floor, beside the bed on two occasions.

1. Corrective action for residents with the potential to be affected by the alleged deficient practice.
The affected resident refuses to wear a leg bag, and Statlock catheter securement device is ordered. Supervising RN ensured catheter was in place on 7.1.2021 when facility was notified of concern by survey team.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

An audit was completed on 7.1.2021, by the Director of Nursing, of all residents with catheters to ensure catheter bags were away from the floor and devices were in place to ensure they stay in place.

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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 690	Continued From page 34 An observation of Resident #28 was conducted on 6/29/21 at 10:26 AM. Resident #28 was laying in the bed and the catheter bag was laying on the floor. An interview was conducted with NA #6 on 6/30/21 at 2:33PM. She stated Resident #28 had an indwelling catheter. NA #6 stated the catheter tubing was supposed to be up off the floor. The NA further stated Resident #28 moved the bed up and down with the bed control and the catheter bag does lay on the floor when the bed is in the lowest position. During an interview with Nurse #3 on 6/29/21 at 4:00 PM she stated that Resident #28 required staff assistance for care. Nurse #3 stated Resident #28 had an indwelling catheter due to urinary retention. The nurse stated that catheter tubing was to be kept below the bladder and off the floor. An interview was conducted with the Administrator on 7/1/21 at 1:38 PM and she was informed of resident's catheter tubing being on the floor. The Administrator stated staff were expected to keep the catheter bag off the floor.	F 690	3. Systemic Changes: All nursing staff, including agency staff, will be educated on catheter care by 7.23.2021, by the Director of Nursing, or designee. The education provided was in regards to the facility's catheter care policy. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing, or designee will monitor residents' catheters weekly for 2 weeks and then monthly for 3 months for compliance with catheter policy. The Administrator or Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	
F 761 SS=D	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	F 761		7/23/21

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	345202	A. BUILDING ______ B. WING ______	C 07/01/2021

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F 761	Continued From page 35 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 and staff interview the facility failed to discard an expired medication and failed to date an opened medication for 1 of 1 medication storage rooms reviewed for medication storage. The findings included: During an observation of the medication storage room on 6/30/21 at 3:00 PM, 2 multidose vials of opened and accessed Tuberculin Purified Protein were in the medication refrigerator. One vial had a handwritten sticker that had an	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice:	

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F 761

Continued From page 36

opened date of May, but the actual date was not legible. The second vial was opened and there was no opened date.

A review of the manufacturer's instruction label on the box indicated the medication should be discarded 30 days from the time date medication was opened.

An interview was conducted with the Director of Nursing on 6/30/21 at 1:30 PM. She stated that multiuse vials were to be dated when opened.

F 761

No residents were affected by the alleged deficient practice.

1. Corrective action for residents with the potential to be affected by the alleged deficient practice.

The 2 undated bottles of Tubersol were removed, by the Director of Nursing from the medication refrigerator immediately on 6/30/2021. No resident was identified to be affected.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

Audits of all medication carts and the medication storage room was completed on 6/30/2021 by the Director of Nurses & RN Supervisor. No other undated medications were found.

3. Systemic Changes:

All nurses including agency nurses will be re-educated by the Director of Nurses/Rn Supervisor on the facility Medication Storage and dating policy, this will be completed by 7/23/2021. The pharmacist consultant was notified of the survey findings on 7/1/2021 and will perform monthly audits of the medication carts and medication room to assist the facility in discarding and monitoring dating of medications that are opened.

4. Monitoring Procedure to ensure that the

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F 761	Continued From page 37	F 761	plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or RN Supervisor will audit medication refrigerators and medication carts weekly for 2 weeks and then monthly for 3 months for compliance with monitoring of dating of applicable medications after medications are opened. The Pharmacist Consultant will submit a monthly report to the Director of Nursing. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	
F 812 SS=D	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, 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	F 812		7/23/21

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F 812	Continued From page 38 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 observations and staff interviews the facility failed to provide a barrier between ready to eat foods or silverware and the server's bare hands for 1 of 2 staff members (Nurse Aide #6) during 1 of 5 dining observations. (Resident #64) The findings included: A continuous observation of the 400 Hall dining was conducted on 6/28/21 from 12:30 PM to 12:55 PM. NA#6 was observed assisting Resident #64. Resident #64's lunch plate contained 2 pieces of a hamburger bun and the bottom half had chopped meat placed on it. The top bun was sitting beside the bottom on the plate. NA#2 moved the top bun over to place on top of the bottom bread and meat with her bare hands. An interview was conducted with NA#6 on 6/28/21 at 12:45 PM. NA#6 stated she felt that since she had performed hand hygiene, it was alright to touch the bread with her hand. An interview was conducted with the Administrator on 7/1/21 at 1:38 PM and she was informed that staff touched a resident's food with bare hands. The Administrator stated staff should	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: For the affected resident, Resident #64, the Certified Nursing Assistant was noted to move top of hamburger bug to meat and lower half of bun with her bare hand. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. The Certified Nursing Assistant was not notified of the alleged deficient practice, by the surveyor, until the task was complete. Therefore, the alleged deficient	

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F 812	Continued From page 39 not have touched the resident's food with bare hands.	F 812	practice for Resident #64 could not be corrected. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The DON, and designee audited meal times, 7.2.2021, to ensure the policy is being followed regarding food safety and handling of finger foods. No deficient practices were noted during audit of meal times. 3. Systemic Changes: All nursing staff, including agency nurses and aides will be re-educated by the Director of Nurses/RN Supervisor on the proper feeding policies for food safety by 7.23.2021. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or RN Supervisor will audit staff feeding residents at two meals per audit for 2 weeks and then monthly for 3 months for compliance with food safety policies. Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement	

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F 812	Continued From page 40	F 812	Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain one of one dumpster in good condition that contained waste and was free of leaks. The findings included: During the initial tour on 6/28/21 at 10:15 AM the dumpster was observed with the dietary manager. The dumpster had a rusty hole on the right long side of the dumpster that dripped. A pool of sludge approximately 20 inches long and 2-4 inches wide with wet sludge. Four flies were observed hovering over the wet sludge. The front of the dumpster was observed with four feet of grease located between the front wheels. On 6/30/21 at 8:09 AM and on 7/1/21 at 8:34 AM the dumpster was observed to be in the same condition. During an observation with the dietary manager on 7/01/21 at 9:46 AM the dumpster was observed to have a pool of sludge approximately 20 inches long and 2-4 inches wide with wet sludge. Five flies were observed hovering over the wet sludge. The front of the dumpster was	F 814	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: No residents were affected by the alleged deficient practice. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. Waste Management was called by the maintenance director on 7.1.2021 regarding the alleged deficient practice.	7/14/21

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F 814	Continued From page 41 observed with four feet of grease between the front wheels and two flies were observed hovering. On 7/1/21 at 9:49 AM the dietary manager stated she did not realize the dumpster was leaking, she thought it looked like grease from the wheels. She indicated she would call the waste company and have the dumpster replaced right away. In an interview on 7/01/21 at 10:10 AM the Administrator agreed the dumpster should not leak and indicated staff had called for the dumpster to be replaced. On 7/01/21 at 10:13 AM the maintenance man stated once before he had called the dumpster company to report a leak, which was fixed. He indicated he had called the company and they would replace the dumpster.	F 814	They came for the service call on 7.14.2021. Waste Management picked the dumpster up off of the ground for inspection, and to take it to be dumped. Upon inspection there were no holes in the dumpster. The Waste Management employee stated the dumpster was in perfect repair and that you would always have flies outside of a dumpster, during the summer months. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Since the dumpster was in good repair, when Waste Management lifted it, there were no changes needed to prevent reoccurrence. 3. Systemic Changes: The dietary manager, and maintenance director were educated, but the Administrator, 7.1.2021 to monitor the dumpster for any leakage, and promptly notify Waste Management and the Administrator of any leakage. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will audit the appearance of leakage and the absence of “sludge” for 2 weeks and then monthly for 3 months for compliance of no leakage	

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F 814	Continued From page 42	F 814	and the absence of sludge. Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Dietary Manager, Maintenance Director, Social Work Director, Infection Control Nurse, and Rehab Director.	