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	345436	A. BUILDING _____ B. WING _____	C 03/29/2022

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WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDAL PLACE KNIGHTDALE, NC 27545

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E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		4/25/22

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

Electronically Signed | 04/16/2022

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to maintain and update the EP plan, update for current contacts, address EP collaboration, review and update the communication plan, update names and contact information, share information with residents or family members, complete a second tabletop or full-scale exercise, and put into place EP education. Findings included: A review completed of the facility's Emergency Preparedness plan material revealed: A. The EP plan had not been reviewed or updated annually. The current Administrator and the current Director of Nursing were not listed in the EP plan. There was no documented date of a last review. B. The EP plan was not updated for current contacts for Administrator or Director of Nursing. C. Policies and procedures regarding the EP plan policies and procedures, based on the emergency plan for risk assessment and the communication plan were not reviewed and updated annually. There was no documented date of last review.	E 001	The Executive Director reviewed and updated Facility Emergency Plan, to include current DON, contact information for Administrator or DON, including methods of sharing information from the Emergency Plan with residents and/or family members by 4/22/22. The Exec. Director and Life Safety Mgr. will, by 4/22/22, have scheduled a tabletop and/or full scale exercise. The Regional Director of Operations or designee will complete Quality Monitoring audit of the Emergency Plan to ensure it includes current DON, contact information for the current Administrator and DON, including methods of sharing information from the Emergency Plan with residents and/or family members; as well will ensure a tabletop and/or full scale exercise and emergency plan training. The Regional Director of Operations or designee will provide re-education to the Administrator regarding establishment of a facility Emergency Program. The Regional Director of Operations or designee will complete Quality Monitoring Audits monthly x 3, to ensure facility Emergency Plan is complete and	

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E 001	Continued From page 2 D. The EP plan for communication was not current, reviewed, nor updated. E. The EP plan did not establish methods in place for sharing information from the emergency plan with residents or family members. F. The facility failed to perform a tabletop or full-scale exercise. G. The facility failed to develop and put into place EP training plans. An interview was conducted with the Administrator and the Maintenance Director on 3/24/22 at 1:42 PM. The Administrator stated he had not been able to fully review the emergency preparedness plan of the facility as he recently accepted the position of Administrator. He stated it did not have the correct contact information for the Administrator or Director of Nursing and he was unaware if there had been any full scale or table-top exercise in the facility during the prior year. The Maintenance Director stated he had performed fire drills and tornado drills in the facility, but they had not participated in a full scale or tabletop exercise in the past year.	E 001	updated. The findings of the audits will be reported to the QAPI Committee monthly and updated as indicated. The Quality Monitoring Schedule will be modified based on findings.	
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 3/21/22 through 3/29/22. Event ID# Q3ZK11. Substandard Quality of Care was identified at: CFR 483.24 at tag F680 at a scope and severity (F)	F 000		

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F 000	Continued From page 3 An extended survey was also conducted. The following intakes were investigated NC00187348, NC00177206, NC00176959, NC00178286, NC00176341, and NC00187338. 6 of the 20 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. §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.	F 550		4/25/22

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F 550	Continued From page 4 §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, staff interviews, and record review the facility failed to promote dignity by standing over a resident while assisting the resident with a meal for 1 of 2 residents review for dignity (Resident #23). Findings included: Resident #23 was admitted to the facility on 8/25/21. Resident #23 ' s minimum data set assessment dated 1/18/22 revealed she was assessed as severely cognitively impaired and was independent with eating. Resident #23 ' s care plan dated 1/31/22 revealed the resident was care planned for activity of daily living self-care performance deficit related to impaired cognition. The interventions included to provide cueing to maximize independence with eating and encourage the resident to participate to the fullest extent possible with each interaction. On 3/22/22 at 9:11 AM Nurse Aide #1 was	F 550	Nurse Aide # 1 was immediately provided education regarding treating each resident with dignity and respect, to include sitting when assisting a resident with eating by the DON on 3/22/22. The DON or designee will complete Quality Monitoring Audits of current residents identified as requiring assistance with eating to ensure staff are maintaining dignity and respect, to include sitting when assisting residents with eating. The DON or designee will provide re-education to facility direct care staff (RN, LPN, CMA CNA, therapists) regarding treating each resident with dignity and respect; to include sitting when assisting a resident with eating. Direct care staff that has not completed education will complete the education prior to working the next scheduled shift. The DON or designee will contact Quality	

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F 550	Continued From page 5 observed standing over Resident #23 assisting the resident with her meal. The resident was sitting at the nurse's station and there were chairs avalible for the nurse aide. During an interview on 3/22/22 at 9:12 AM Nurse Aide #1 stated she preferred to stand because she felt lazy sitting next to resident. She stated she was trained to sit next to the resident to assist them with meals. She stated the reason she was trained to sit was to be able to help the resident more. She further stated when she had Resident #23 on her shift, she preferred to assist the resident with the meal because the resident would drop food on herself. During an interview on 3/22/22 at 12:48 PM the Director of Nursing stated staff were trained to sit with the resident and assist them. She further stated it was a dignity concern to not be sitting with the resident.	F 550	Monitoring Audits of 2 sampled resident requiring assistance with eating to ensure dignity is maintained weekly x 4 weeks, bi-monthly x 2. The findings of the audits will be reporting during the monthly QAPI committee meeting and updated as indicated. The QM schedule will be updated as indicated.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of active diagnoses (Resident #3 & #62), medications received (Resident #21), behaviors (Resident #61), falls (Resident #23) and use of restraints (Resident #43) for 6 of 20 MDS assessments reviewed.	F 641	RESIDENT # 3 ADMISSION MDS ASSESSMENT DATED 12/8/21 WAS REVIEWED AND MODIFICATION COMPLETED/SUBMITTED BY REGIONAL MDS TO INCLUDE DIAGNOSIS OF GERD AND ATRIAL FIBRILLATION. RESIDENT # 62 QUARTERLY MDS	4/25/22

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F 641	Continued From page 6 1. Resident #3 was admitted to the facility on 12/01/21 with diagnoses which included, hypertension, gastroesophageal reflux disease (GERD) and atrial fibrillation. Review of Resident #3's December 2022 Medication Administration Record (MAR) revealed he had received medications for hypertension, GERD, and atrial fibrillation. The admission Minimum Data Set (MDS) dated 12/08/21 for Resident #3 did not include diagnoses of hypertension, GERD or atrial fibrillation. An interview on 3/25/22 at 8:26 AM with MDS Nurse #1 revealed that Resident #3's MDS did not include the diagnoses for hypertension, GERD or atrial fibrillation and it should have. She stated it was because the diagnoses had just been missed. An interview on 3/25/22 at 9:53 AM with the Administrator revealed he expected the MDS to be completed accurately. 2. Resident #62 was admitted to the facility on 12/20/21 with diagnoses which included hip fracture, hypertension, and depression, obstructive uropathy. Review of Resident #62's February 2022 Medication Administration Record (MAR) revealed she had received medications for urinary tract infection (UTI), hypertension and depression. The quarterly Minimum Data Set (MDS) dated 2/28/22 for Resident #62 indicated she had an	F 641	ASSESSMENT DATED 2/28/22 WAS REVIEWED AND MODIFICATION COMPLETED/SUBMITTED BY REGIONAL MDS TO INCLUDE DIAGNOSIS OF HTN, DEPRESSION, OBSTRUCTIVE UROPATHY AND URINARY TRACT INFECTION. RESIDENT #21 QUARTERLY MDS ASSESSMENT DATED 1/14/22 WAS REVIEWED AND MODIFICATION COMPLETED/SUBMITTED BY REGIONAL MDS NURSE TO REFLECT ZERO INSULIN WAS ADMINISTERTED DURING ASSESSMENT LOOK BACDK PERIOD. RESIDENT # 61 ADMISSION ASSESSMENT MDS DATED 2/24/22 WAS REVIEWED AND MODIFICATION COMPLETED/SUBMITTED BY REGIONAL MDS TO REFLECT BEHAVIORS ADN REJECTION OF CARE DURING ASSESSMENT LOOK BACK PERIOD. RESIDENT #43 MDS ASSESSMENT DATED 1/25/22 WAS REVIEWED AND MODIFICATION COMPLETED/SUBMITTED BY MDS NURSE TO REMOVE CODIGN OF THE USE OF OTHER RESTRAINTS LESS THAN DAILY WHEN IN A CHAIR OR OUT OF BED. RESIDENT # 23 MDS ASSESSMENT DATED 1/18/22 WAS REDVIEWED AND MODIFICATION COMPLETED/SUBMITTED TO	

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F 641	Continued From page 7 indwelling urinary catheter. The MDS did not include diagnoses of hypertension, or depression, obstructive uropathy or UTI. An interview on 3/25/22 at 8:26 AM with MDS Nurse #1 revealed that Resident #62's MDS did not include the diagnoses for hypertension, depression, obstructive uropathy and UTI and it should have. She stated it was because the diagnoses had just been missed. An interview on 3/25/22 at 9:53 AM with the Administrator revealed he expected the MDS to be completed accurately. 3. Resident #21 was admitted to the facility on 10/21/21 with diagnoses which included Diabetes. The January 2022 Medication Administration Record revealed Resident #21 was administered no insulin. The quarterly Minimum Data Set Assessment dated 1/14/11 indicated Resident #21 received insulin on 1 of the 7 days during the assessment period. On 3/25/22 at 10:12 AM MDS nurse #1 stated she could not see where Resident #21 received insulin, so the MDS dated 1/14/21 which reported Resident #21 received insulin was an error. During an interview with the Administrator on 3/25/22 at 9:53 AM he stated he expected the MDS to be accurate. 4. Resident #61 was admitted to the facility on 2/17/22 with diagnoses which included dementia with behavioral disturbances. A note by Physician Assistant (PA) #1 dated	F 641	REFLECT FALLS DURING ASSESSMENT LOOK BACK PERIOD OF 10/18/21 THRU 1/18/22. REGIONAL MDS NURSE WILL COMPLETE QM AUDIT OF CURRENT RESIDENTS INDENTIFIED WITH COMPLETED MDS ASSESSMENTS IN LAST 90 DAYS TO ENSURE THAT THE MDS ASSESSMENT IS ACCURATELY CODED DURING THE ASSESSMENT LOOK BACK PERIOD. REGIONAL MDS NURSE WILL PROVIDE RE-EDUCATION TO MEMBERS OF THE IDT TEAM (MDS NURSE, DIETARY MGR, SW, ACT. DIR., DIRECTOR OF THERAPY) REGARDING ACCURATELY CODING THE MDS DURING ASSESSMENT LOOK BACK PERIOD TO INCLUDE CODING OF DIAGNOSIS, MEDICATIONS, BEHAVIORS, FALLS AND HTE USE OF RESTRAINTS. IDT TEAM MEMBERS MENTIONED ABOVE WHO DO NOT COMPLETE THE EDUCATION BY 4/25/22 WILL NOT BE ABLE TO WORK NEXT ASSIGNED SHIFT. REGIONAL MDS NURSE/DESIGNEE WILL CONDUCT QM AUDITS OF 2 SAMPLED RESIDENTS MDS WEEKLY X 4; BI-MONTHLY X 2 TO ENSURE THAT THE MDS ASSESSMENTS ARE ACCURATELY CODED. THE FINDINGS OF WILL BE REPORTED MONTHLY TO THE QAPI COMMITTE AND THE QM AUDIT SCHEDULES MODIFIED AS INDICATED.	

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2/18/22 documented Resident #61 was confused and combative at times.
PA #1 also documented a note on 2/23/22 which read "confused, pleasant today, combative at times."

The Admission Minimum Data Set (MDS) Assessment dated 2/24/22 revealed Resident #61 was severely cognitively impaired. He was coded as having no behaviors or rejection of care.

On 3/24/22 at 2:48 PM Nurse #3 stated Resident #61 had combative behaviors since he was admitted. She said it was difficult to provide incontinent care for him. She said it took one person to redirect him while the other person provided incontinent care.

Nurse Aide #2 was interviewed on 3/24/22 at 2:51 PM. She stated Resident #61 did not like to be changed or bathed. She said he fought, and it was usually only when he is touched. She said he has had behaviors, since he arrived at the facility.

On 3/25/22 at 9:56 AM the MDS nurse #1 stated the nursing note on 3/8/22 was the first documented behaviors and that was not during the look back period, so the MDS was not coded to reflect Resident #61 ' s behaviors. She reported she did not interview staff members about Resident #61 ' s behaviors. She did not review the notes written by the PA dated 2/18/22 and 2/23/22.

During a telephone interview with the Regional MDS nurse on 3/25/22 at 9:56 AM she stated when coding behaviors on the MDs the staff should be interviewed in addition to a record

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review. She explained that if there was no documentation of Resident #61 ' s behaviors the MDS nurse could put in a note in the medical record to document the staff reported any behaviors.
5. Resident #23 was admitted to the facility on 8/25/21. Her active diagnoses included dementia with behavioral disturbances, history of falls, and anxiety.

A nursing note dated 10/26/21 revealed Resident #23 was found lying on the floor in the bathroom. She had no complaints of pain, or any injuries noted.

A nursing note dated 11/5/21 revealed on 10/28/21 Resident #23 had fall from her wheelchair in the dining room.

A nursing note dated 11/14/21 revealed Resident #23 fell from her chair while she was trying to reach the trash can.

A nursing note dated 12/17/21 revealed Resident #23 Resident slid off her chair at the nursing station shortly before dinner. There were no apparent injuries noted and her vital signs were stable.

Resident #23 ' s minimum data set assessment dated 1/18/22 revealed she was assessed as severely cognitively impaired and had sustained no falls since the prior assessment on 10/18/21.

During an interview on 3/22/22 at 2:29 PM the Regional Minimum Data Set Nurse stated the minimum data set assessment dated 1/18/22 was incorrect and Resident #23 had sustained multiple falls during the lookback period from

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10/18/21 through 1/18/22 and it should have been captured by the MDS. She concluded she completed the minimum data set assessment dated 1/18/22.

During an interview on 3/22/22 at 4:41 PM the Administrator stated falls should be accurately captures on minimum data set assessments.
6. Resident #43 was admitted to the facility on 10/19/2021 with diagnoses including cerebral infarction (a pathological process that results in an area of dead tissue in the brain) and diabetes mellitus type 2.

A review of the quarterly and modified quarterly Minimum Data Set (MDS) assessments for Resident #43 dated 01/25/2022 revealed he used other restraints less than daily when in a chair or out of bed.

A review of the medical record for Resident #43 revealed no indication restraints were used during the 7-day lookback period of his MDS assessments.

On 03/23/2022 at 8:14 AM an interview with MDS Nurse #1 indicated Resident #43 used no restraints. She stated Resident #43's quarterly MDS assessment dated 01/25/2022 was coded inaccurately in this area. She stated the Regional MDS Nurse had been showing her how to check the accuracy of MDS assessments in January 2022 and realized this error. MDS Nurse #1 went on to say as she was not able to submit modifications of MDS assessments, the Regional MDS Nurse was supposed to have corrected this on Resident #43's modified quarterly MDS assessment.

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F 641	Continued From page 11 On 03/23/2022 at 8:17 AM a telephone interview with the Regional MDS Nurse indicated she thought she had corrected the restraints area of Resident #43's quarterly MDS assessment with the modified quarterly MDS assessment. She stated she must not have corrected this area completely. She went on to say Resident #43 had not used restraints and the modified quarterly MDS assessment dated 01/25/2022 was still inaccurate. On 03/23/2022 at 11:07 AM an interview with the Director of Nursing indicated Resident #43's MDS assessments should accurately reflect the care he received.	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 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	F 644		4/25/22

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F 644	Continued From page 12 by: Based on record review and staff interviews the facility failed to refer a resident with a newly evident diagnosis of a serious mental illness for a Preadmission Screening and Resident Review (PASARR) evaluation for 1 of 2 residents reviewed for PASARR (Resident #22). Findings included: Resident #22 was admitted to the facility on 5/31/17. A review of Resident #22 ' s diagnoses revealed on 9/4/20 she was diagnosed with schizoaffective disorder, bipolar type and this was documented as her primary diagnosis. A review of Resident #22 ' s Minimum Data Set (MDS) assessment dated 1/17/22 revealed she was assessed as moderately cognitively impaired. She had no behaviors during the lookback period. Active diagnoses included schizophrenia. During an interview on 3/23/22 at 8:27 AM the Director of Nursing stated on 9/4/20 Resident #22 was given a diagnosis of schizoaffective disorder bipolar type. This was a new diagnosis during her stay. During an interview on 3/23/22 at 8:32 AM the Social Worker stated a new mental health diagnosis such as schizoaffective disorder would trigger a new PASARR screen. She stated she started working at the facility on 2/8/22 and was told by the administrator that there were some social work issues that were out of place and needed to be fixed. She stated she had not	F 644	SOCIAL SERVICE WILL REFER RESIDENT # 22 FOR PRE-ADMISSION SCREENING AND/OR RESIDENT REVIEW FOR LEVEL II EVALUATION DUE TO NEWLY DIAGNOSIS OF A SERIOUS MENTIAL ILLNESS. THE DON OR DESIGNEE WILL COMPLETE QUALITY MONITORING AUDIT OF CURRENT FACILITY RESIDENTS TO ENSURE RESIDENTS IDENTIFIED TO HAVE A SERIOUS MENTAL ILLNESS DIAGNOSIS WILL HAVE BEEN PRE-ADMISSION SCREENED/REVIEWED FOR LEVEL II PASSR THE ADMINISTRATOR OR DESIGNEE WILL PROVIDE RE-EDUCATION TO MEMBERS OF THE IDT TEAM (SW, LICENSES NURSES) THE REQUIRMENT FOR PASSR LEVEL II SCREENING. MEMBERS OF THE IDT TEAM THAT DO NOT COMPLETE THIS EDUCATION BY 4/25/22 WILL NOT BE ABLE TO WORK HIS/HER NEXT ASSIGNED SHFIT. THE ADMINISTRATOR OR DESIGNEE WILL CONDUCT QUALITY MONITORING AUDTIS OF NEW PHYSICIAN ORDERS AND/OR NEWLY ADMITTED RESIDENTS TO ENSURE RESIDENTS WITH NEW SERIOUS MENTAL ILLNESS DIAGNOSIS HAVE BEEN SCREENED FOR LEVEL II PASSR. THE FINDINGS WILL BE REPORTED MONTHLY TO THE QAPI	

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F 644	Continued From page 13 gotten to check all PASARR screens to see if they were up to date. The Social Worker indicated Resident #22 ' s last PASARR evaluation was completed prior to her admission in 2017 and was a Level I PASARR. She verified Resident #22 had not received a new PASARR screen with this new diagnosis and should have been rescreened. During an interview on 3/23/22 at 8:39 AM the Administrator stated the PASARR rescreen should have been completed for Resident #22.	F 644	COMMITTEE. THE QM SCHEDULED WILL BE UPDATED AS INDICATED BY FINDINGS.	
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	F 656		4/25/22

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F 656	Continued From page 14 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 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 observations, record review, and resident and staff interviews the facility failed to allow Resident #23 to participate to her fullest capacity when eating in accordance with her comprehensive care plan and failed to develop a comprehensive care plan for Resident #19, Resident #3, Resident #44, and Resident #12. This was for 5 of 16 Residents whose comprehensive care plans were reviewed. Findings included: 1. Resident #23 was admitted to the facility on 8/25/21. Her active diagnoses included dementia with behavioral disturbances, dysphagia, and anxiety. Resident #23 ' s minimum data set assessment dated 1/18/22 revealed she was assessed as severely cognitively impaired and was	F 656	THE MDS NURSE OR DESIGNEE WILL REVIEW AND UPDATE RESIDENT #23 TO INCLUDE INTERVENTIONS TO ENCOURAGE HER FULLEST CAPACITY WHEN EATING TO INCLUDE SIMPLE CUEING, PROVIDE QUIET ENVIRONMENT DURING MEALS AND PROVIDING FINGER FOODS AS APPROPRIATE. MDS NURSE/DESIGNEE WILL REVIEW AND UPDATE RESIDENT #19 CARE PLAN TO INCLUDE FOCUS AREAS OF DIABETES, DIALYSIS, ADL'S, FALLS, HYPERTENSION AND OTHER CARE AREAS PERSONALIZED TO THE RESIDENT. MDS NURSE/DESIGNEE WILL REVIEW AND UPDATE RESIDENT #3 CARE	

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F 656	Continued From page 15 independent with eating. Resident #23 ' s care plan dated 1/31/22 revealed the resident was care planned for activity of daily living self-care performance deficit related to impaired cognition. The interventions included to provide cueing to maximize independence with eating and encourage the resident to participate to the fullest extent possible with each interaction. On 3/22/22 at 9:11 AM Nurse Aide #1 was observed with Resident #23 assisting the resident with her meal. The nurse aide was using the utensils to offer the food to the resident. During an interview on 3/22/22 at 9:12 AM Nurse Aide #1 stated Resident #23 was able to feed herself with cueing but when she had Resident #23 on her shift, she preferred to assist the resident with the meal because Resident #23 would drop food on herself which caused double work for the nurse aide because she would then have to get the resident cleaned up after each meal. During an interview on 3/22/22 at 12:48 PM the Director of Nursing Resident #23 should be encouraged to participate in any activity of daily living to their fullest capability to ensure there is no decline to their activities of daily living ability. 2. Resident #19 was admitted to the facility on 1/06/22 with diagnoses which included hypertension, Diabetes Mellitus, and dependence on renal dialysis. The 5-day admission Minimum Data Set (MDS) dated 1/13/22 indicated that Resident #19 was cognitively intact and was limited assistance for most activities of daily living.	F 656	PLAN TO INCLUDE FOCUS AREAS OF DEMENTIA, DEPRESSION, ADLS AND OTHER CARE AREAS PERSONALIZED TO THE RESIDENT. MDS NURSE/DESIGNEE WILL REVIEW AND UPDATE RESIDENT #44 CARE PLAN TO INCLUDE FOCUS ARES OF CEREBRAL VASUCLAR ACCIDETN, PULMONARY EMBOLISM, OBSTRUCTIVE UROPATHY, SEIZURES, ADLS, INDWELLING CATHETER, ANTICOAGULANT AND ANTI-CONVULSANT MEDICATIONS, FALLS AND OTHER CARE AREAS PERSONALIZED TO THE RESIDENT. THE MDS NURSE/DESIGNEE WILL REVIEW AND UPDATE RESIDENT # 12 CARE PLAN TO INCLUDE FOCUS AREAS OF DIABETES MELLITUS, INDWELLING URINARY CATHETER, ADL'S, AND OTHER CARE AREAS PERSONALZIED TO THE RESIDENT. THE REGIONAL MDS NURSE/DESIGNEE WILL COMPLETE AUDIT OF NEWLY ADMITTED/RE-ADMITTED RESIDENTS FOR THE LAST 90 DAYS TO ENSURE THAT EACH RESIDENT HAS A COMPREHENSIVE CARE PLAN. THE REGIONAL MDS WILL PROVIDE EDUCATION TO THE IDT TEAM (MDS NURSE, ADMINISTRATOR, DON, ADON, ACT. DIR., DIETARY MANAGER AND DIRECTORY OF THERAPY) REGARDING	

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F 656	Continued From page 16 Review of Resident #19's care plan last reviewed on 1/14/22 revealed she only had 1 care plan focus for nutrition. Further review revealed no focus for Diabetes Mellitus, dialysis, activities of daily living, falling, hypertension or any other personalized care areas. An interview on 3/22/22 at 2:46 PM with MDS Nurse #1 revealed that Resident #19 did not have a comprehensive care plan and she should have. She stated it was because she had been helping with other duties and it just did not get completed. An interview on 3/25/22 at 9:53 AM with the Administrator revealed he had become aware during this recertification survey that Resident #19's comprehensive care plan had not been completed and thought it had just been missed. 3. Resident #3 was admitted to the facility on 12/01/21 with diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, and depression. The admission Minimum Data Set (MDS) dated 12/08/21 indicated that Resident #3 had severe cognitive impairment and was coded as total dependence for most activities of daily living. Review of Resident #3's care plan last reviewed on 3/04/22 revealed he only had 1 care plan focus for nutrition. Further review revealed no focus care areas for dementia, depression, activities of daily living, or any other personalized care areas. An interview on 3/22/22 at 2:46 PM with MDS Nurse #1 revealed that Resident #3 did not have	F 656	DEVELOPMENT/IMPLEMENATION OF RESIDENT COMPREHENSIVE CARE PLAN. IDT TEAM MEMBERS MUST COMPLETED THIS EDUCATION BY 4/25/22 TO BE ABLE TO WORK NEXT ASSIGNED SHIFT. THE ADMINISTRATOR/DESIGNEE WILL CONDUCT QM AUDITS OF 2 SAMPLED RESIDENTS' COMPREHENSIVE CARE PLANS WEEKLY X 4; BI-MONTHLY X 2 TO ENSURE THE RESIDENT CARE PLAN HAD FOCUS AREAS PERSONALIZED TO THE RESIDENT NEEDS. THE FINDING OF THE AUDITS WILL BE REPORTED MONTHLY TO THE QAPI COMMITTEE AND UPDATED AS INDICATED.	

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a comprehensive care plan and he should have. She stated it was because she had been helping with other duties and it just did not get completed.

An interview on 3/25/22 at 9:53 AM with the Administrator revealed he had become aware during this recertification survey that Resident #3's comprehensive care plan had not been completed and thought it had just been missed.
4. Resident #44 was admitted to the facility on 02/03/2022 with diagnoses including cerebral vascular accident (loss of blood flow to part of the brain which damages brain tissue), pulmonary embolism (a blood clot in the lungs), obstructive uropathy (blockage of urine flow), and seizures (convulsions).

A review of the admission Minimum Data Set (MDS) assessment for Resident #44 dated 02/10/2022 revealed he was cognitively intact. It further revealed Resident #44 required the extensive assistance of one person for toileting and the limited assistance of one person for personal hygiene. He had an indwelling bladder catheter. He received an anticoagulant (blood thinning) medication on 7 out of 7 look back period days of this assessment. The Care Area Assessment (CAA) summary revealed a triggered condition of indwelling catheter would be addressed in the care plan.

A review of Resident #44's medication administration and treatment record for March 2022 revealed he was receiving levetiracetam (an anti-convulsant medication) 1000 milligrams (mg) twice daily for convulsions. It further revealed he received catheter care three times daily and as needed.

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A review of Resident #44's medical record revealed no comprehensive care plan.

On 03/21/2022 at 3:44 PM in an interview Resident #44 stated he had a bladder catheter. He further indicated he had this in place since his admission to the facility. He stated he was not having any problems with this catheter and was receiving the care for it that he needed. He went on to say he had a history of seizures. He stated he received medication for this. He further indicated he had not had any seizures since his admission to the facility. Resident #44 stated he received a blood thinning medication and was not having any unusual bleeding or bruising. An observation of Resident #44 at the time of the interview indicated he had a bladder catheter connected to a urine collection bag which contained clear yellow urine.

In an interview on 03/23/2022 at 10:33 AM MDS Nurse #1 confirmed Resident #44 had no comprehensive care plan. She stated she would have been responsible for this. She went on to say she had fallen behind with comprehensive care plans and was trying to get caught up.

On 03/23/2022 at 11:18 AM an interview with the Director of Nursing (DON) indicated Resident #44 should have a comprehensive care plan which included the presence of his bladder catheter, his diagnosis of seizures, and his anti-coagulant medication.

5. Resident #12 was admitted to the facility on 12/22/2021 with diagnoses including diabetes mellitus (DM) type 2 and urinary retention.

A review of the admission MDS assessment for

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Resident #12 dated 12/29/2021 revealed she was cognitively intact. It further revealed she required the extensive assistance of one person for personal hygiene and toileting. She had an indwelling bladder catheter. Resident #12 received insulin injections on 7 out of 7 look back period days of this assessment.

A Resident #12's medication administration and treatment record for March 2022 revealed she was receiving Neutral Protamine Hagedorn (NPH) insulin 10 units (u) twice daily by subcutaneous (beneath the skin) injection for DM. It further revealed she received catheter care three times daily and as needed.

A review of Resident #12's medical record revealed no comprehensive care plan.

On 03/21/2022 at 2:24 PM an interview with Resident #12 indicated she was receiving insulin injections for her DM. She stated she had experienced no problems with her blood sugar being too high or too low. She went on to say she had a bladder catheter in place. She stated she was receiving the care for her bladder catheter that she needed and had no problems with her catheter. An observation of Resident #12 at the time of the interview indicated she had a bladder catheter connected to a urine collection bag which contained clear yellow urine.

In an interview on 03/24/2022 at 2:35 PM MDS Nurse #1 confirmed Resident #12 had no comprehensive care plan. She stated she would have been responsible for this. She stated she had gotten behind with comprehensive care plans. She went on to say the facility had an additional staff person coming in on the

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F 656	Continued From page 20 weekends to help her get caught up. On 03/24/2022 at 4:48 PM an interview the DON indicated Resident #12 should have a comprehensive care plan which included her bladder catheter and DM.	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 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:	F 657		4/25/22

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F 657	Continued From page 21 Based on record review and staff interviews, the facility failed to have care plan meetings for 4 of 9 residents reviewed for care plan meetings (Resident #3, 29, 43 & 44). 1. Resident #3 was admitted to the facility on 12/01/21 with diagnoses which included Alzheimer's disease and depression. The admission Minimum Data Set dated 12/08/21 indicated that Resident #3 had severe cognitive impairment and noted as total dependence on staff for most activities of daily living. An interview on 3/21/22 at 1:41 PM with Resident #3's Responsible Party (RP) revealed they had never been invited to a care plan meeting. An interview on 3/23/22 at 8:52 AM with the Social Worker revealed that Resident #3 had not had a care plan meeting since his admission on 12/01/21. She stated she was aware of this when she began working at the facility in February and had been trying to get the care plan meetings completed. An interview on 3/25/22 at 9:53 AM with the Administrator revealed he was aware that some residents had not had a care plan meeting and that the Social Worker was trying to get them completed. 2. Resident #29 was admitted to the facility on 9/26/17 with diagnoses which included congestive heart failure and chronic obstructive pulmonary disease. The quarterly Minimum Data Set dated 1/21/22 indicated Resident #29 was cognitively intact and	F 657	THE FACILITY SW WILL SCHEDULE AND INVITE RESIDENT #3, #29 AND #43 AND THEIR RESPONSIBLE PARTY TO A CARE PLAN MEETING TO REVIEW THE INDIVIDUAL RESIDENT CARE PLAN. THE ADMINISTRATOR OR DESIGNEE WILL COMPLETE QUALITY MONITORING AUDIT OF CURRENT FACILITY RESIDENTS TO ENSURE EACH RESIDENT AND/OR FAMILY MEMBER/RP HAS BEEN SCHEDULED AND INVITED TO A CARE PLAN MEETING THE LAST 90 DAYS. THE REGIONAL MDS NURSE WILL PROVIDE EDUCATION TO MDS NURSE, SW REGARDING TIMELY SCHEDULING AND PROCESS FOR INVITING RESIDENTS/RP'S TO CARE PLAN MEETINGS. THE ADMINISTRATOR OR DESIGNEE WILL CONDUCT QM AUDTITS OF 2 SAMPLED RESIDENT CARE PLANS WEEKLY X 4, BI-MONTHLY X 2 TO ENSURE THAT CARE PLAN MEETINGS WERE SCHEDULED AS REQUIRED. THE FINDINGS OF THE AUDITS WILL BE PROVIDED AT THE MONTHLY QAPI COMMITTEE MEETING AND QM AUDITS WILL BE ADJUSTED ACCORDING TO AUDIT OUTCOMES.	

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was noted as supervision or limited assistance for most activities of daily living.

An interview on 3/21/22 at 11:40 AM with Resident #29 revealed she did not remember attending a care plan meeting in a long time before the one she was invited to earlier this month.

An interview on 3/23/22 at 8:52 AM with the Social Worker revealed that Resident #29 had a care plan meeting on 9/01/21 and 3/02/22. She stated the resident should have had a care plan meeting between 9/01/21 and 3/02/22, but apparently, she had not.

An interview on 3/25/22 at 9:53 AM with the Administrator revealed he was aware that some residents had not had care plan meetings on time.

3.Resident #43 was admitted to the facility on 10/19/2021 with diagnoses including cerebral infarction (a pathological process that results in an area of dead tissue in the brain) and diabetes mellitus type 2.

A review of the modified quarterly Minimum Data Set (MDS) assessment for Resident #43 dated 01/25/2022 revealed he was moderately cognitively impaired. He required the extensive assistance of two people for bed mobility and transfers and the extensive assistance of one person for personal hygiene and toileting. He had no pain. He had no falls since his prior assessment.

A review of Resident #43's comprehensive care plan revealed a focus area initiated on 10/20/2021 of Resident #43's family wishes for

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him to remain at the facility for long term care. The goal was for Resident #43 and his family to communicate understanding of long term care. Interventions included encourage Resident #43 and his family to discuss fears and concerns.

A review of Resident #43's medical record revealed no evidence of a care plan meeting with Resident #43 or his family.

On 03/22/2022 at 8:57 AM a telephone interview with Resident #43's Representative (RP) indicated when Resident #43 was first admitted to the facility, she discussed his care and goals with facility staff and received a written summary of this. She went on to say she had not received any invitation or participated in any care plan meetings for Resident #43 since then. She further indicated she felt facility staff kept her updated on Resident #43's condition. She stated she would have participated in a care plan meeting if she had been invited.

In an interview on 03/23/2022 at 8:28 AM MDS Nurse #1 stated Resident #43 had not had a care plan meeting since his admission to the facility. She went on to say the facility had been without a Social Worker (SW) since October 2021. She further indicated she had been trying to keep up with discharges and MDS assessments and had gotten behind with care plan meetings. MDS Nurse #1 stated the facility now had a SW and she was getting additional help with MDS assessments. She went on to say she was working with the SW to get all residents care plan meetings scheduled and back on track.

In an interview on 03/23/2022 at 8:57 AM the SW confirmed Resident #43 had no documentation of

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a care plan meeting. She stated these usually went along with the MDS assessments so he should have had one around the time of his quarterly MDS assessment 01/25/2022. She went on to say when she started in her position in February 2022, she realized the facility was behind on care plan meetings. The SW stated she was working with MDS Nurse #1 to get these all scheduled and caught up.

On 03/23/2022 at 11:07 AM an interview with the Director of Nursing (DON) indicated Resident #43 should have had a care plan meeting at least every 3 months after his admission to the facility. She stated this was important so Resident #43 and his RP could be involved with his care planning, be kept updated on his progress, and participate in goal setting.

4. Resident #44 was admitted to the facility on 02/03/2022 with diagnoses including cerebral vascular accident (loss of blood flow to part of the brain which damages brain tissue), pulmonary embolism (a blood clot in the lungs), obstructive uropathy (blockage of urine flow), and seizures (convulsions).

A review of the admission Minimum Data Set (MDS) assessment for Resident #44 dated 02/10/2022 revealed he was cognitively intact. It further revealed Resident #44 required the extensive assistance of one person for toileting and the limited assistance of one person for personal hygiene. He had an indwelling bladder catheter. He received an anticoagulant (blood thinning) medication on 7 out of 7 look back period days of this assessment.

A review of Resident #44's medical record

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F 657	Continued From page 25 revealed no comprehensive care plan. On 03/21/2022 at 3:44 PM an interview with Resident #44 revealed he did not recall receiving an invitation or participating in a care plan meeting since his admission to the facility. He stated he felt he had a good understanding of his care needs and medications. He went on to say he would have participated in a care plan meeting if he had been invited. On 03/23/2022 at 9:07 AM an interview with the SW indicated Resident #44 had not had a care plan meeting yet. She went on to say when she started in her position in February 2022, she realized the facility was behind on care plan meetings. The SW stated she was working with MDS Nurse #1 to get these all scheduled and caught up. On 03/23/2022 at 10:22 AM an interview with MDS Nurse #1 indicated Resident #44 had not had a care plan meeting since his admission to the facility. She went on to say the facility was behind on them. She stated she was working with the SW to get all residents care plan meetings scheduled and back on track. On 03/23/2022 at 11:18 AM an interview with the DON Resident #44 should have had a care plan meeting since his admission to the facility. She stated this was important so Resident #44 and his family could be involved with his care planning, be kept updated on his progress, and participate in goal setting.	F 657		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		4/25/22

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F 677	Continued From page 26 §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 trim dependent residents ' fingernails for 2 of 7 residents reviewed for activities of daily living care, and failed to wash a dependent resident ' s hair for 1 of 7 residents reviewed for activities of daily living care (Resident #16, Resident #117, and Resident #21). Findings included: 1. Resident #16 was admitted to the facility on 8/24/21. His active diagnoses included muscle weakness and dementia. Resident #16 ' s minimum data set assessment dated 1/11/22 revealed he was assessed as moderately cognitively impaired. He had no moods or behaviors. Resident #16 required extensive assistance with personal hygiene. Resident #16 ' s care plan dated 10/14/21 revealed the resident was care planned for activities of daily living self-care performance deficit. The interventions included to encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use call bell to call for assistance, and monitor, document, and report as needed any changes, any potential for improvement, reasons for self-care deficit, expected course, and declines in function.	F 677	RESIDENT #16 AND #117 FINGER NAILS WERE TRIMMED ON 3/33/33 BY CNA. RESIDENT #21 HAIR WAS WASHED ON 3/24/22 BY CNA THE DON OR DESIGNEE WILL COPMLETE QM AUDIT OF CURRENT RESIDENTS FINGERNAILS AND HAIR TO ENSURE CARE HAS BEEN PROVIDED AS NEEDED. THE DON OR DESIGNEE WILL PROVIDE RE-EDUCATION TO NURSING STAFF (RN, LPN, CMA CNA) PROVIDING ADL CARE TO RESIDENTS TO INCLUDE ASSISTING WITH CLEANING/TRIMMING NAILS AND HAIR CARE AS NEEDED. NURSING STAFF THAT DO NOT COMPLETE THIS EDUATION BY 4/25/22 WILL NOT BE ALLOWED TO WORK NEXT SCHEDULED SHIFT UNTIL COMPLETED. THE DON OR DESIGNEE WILL COMPLETE QM AUDITS OF TWO SAMPLED RESIDENTS WEEKLY X 4 AND THEN BI-MONTHLY X 2 --- AUDIT FINDINGS TO BE REPORTED MONTHLY TO THE QAPI COMMITTEE WITH QM AUDTS ADJUSTED AS INDICATED.	

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During observation on 3/21/22 at 1:43 PM Resident #16 was observed to have long, untrimmed nails. Resident #16 stated his fingernails were long and he would like them trimmed but no staff had offered, and he had not been able to request his nails be trimmed because staff were always in a hurry.

During observation on 3/22/22 at 8:43 AM Resident #16 was observed to have long, untrimmed nails.

During an interview on 3/22/22 at 11:15 AM Nurse Aide #1 stated she was familiar with Resident #16 and he did not refuse nail care. She stated the nurse aides should observe for nails being long during morning baths and trim nails for residents if the nails were long and the resident was not diabetic. She stated Resident #16 was not diabetic and the nurse aides would trim his nails. Upon observing the resident ' s nails, she concluded the nails were extremely long and should have been trimmed prior to now and she had not seen how long they were until now.

During an interview on 3/22/22 at 11:24 AM the Assistant Director of Nursing stated she was familiar with Resident #16. She further stated he had not refused nail care. She stated there was no schedule for nail care and it was up to the nurse aide to identify during morning care if a resident needed their nails trimmed. Upon observing Resident #16 ' s nails she concluded the resident ' s nails should have been trimmed prior to now.

During an interview on 3/22/22 at 11:27 AM the Director of Nursing stated there was no schedule for nail care and nurse aides were responsible for

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observing resident nails and trimming them as needed. Upon observing Resident #16 ' s nails she concluded his nails were very long and should have been trimmed prior to now.
2. Resident #117 was admitted to the facility on 3/8/22 with diagnoses which included dementia, aphasia, and high blood pressure.

A review of the admission Minimum Data Set revealed it was still in process.

A review of the interim care plan revealed Resident #117 had self-care deficits and required 1 person assistance for toileting, grooming and hygiene, and dressing.

On 3/22/22 at 8:22 AM Resident #117 was observed to have long fingernails on both hands. The fingernails on the left hand were also observed to be dirty.

On 3/22/22 at 11:23 AM Resident #117 stated he did not like to have his fingernails so long. He said he could not clip them because his clippers were at home and not here.

On 3/22/22 at 11:25 AM Nurse #3 stated nail care was completed with showers or baths or per resident request.

During an observation of Resident #117 on 3/22/22 at 11:27 AM with Nurse #3 she stated his fingernails were dirty and were too long. She noticed his right index and middle fingernails were also jagged. She said his fingernails needed to be cleaned and trimmed.

During an observation of Resident #117 on 3/22/22 at 11:34 the Director of Nursing (DON)

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stated his fingernails were long and dirty. She said there was no schedule for providing nail care and the nurse aides were responsible for observing residents ' nails and trimming them as needed.

On 3/22/22 at 1:05 PM NA #5 stated she gave Resident #117 a bath this morning but did not clean or clip his fingernails because she did not have time that morning. She said cleaning fingernails should be completed during the bath.

3. Resident #21 was admitted to the facility on 10/21/21 with diagnoses which included diabetes, atrial flutter, and pneumonia.

A review of the quarterly Minimum Data Set (MDS) dated 1/14/22 revealed Resident #21 was cognitively intact. She required extensive assistance with dressing and personal hygiene. She was totally dependent on staff for bathing.

On 3/22/22 at 8:57 AM Resident #21 ' s hair appeared dirty and greasy.

During the observation of Resident #21 on 3/22/22 at 8:57 AM she stated her hair had not been washed since she was admitted to the facility.

On 3/24/22 at 10:08 AM Resident #21 was observed up in a geriatric chair. She stated she received a bath his morning, but her hair was not washed.

On 3/24/22 at 2:37 PM Nurse Aide #5 stated she gave Resident #21 a complete bed bath this morning. She said a resident ' s hair was usually washed when they received a shower. She said

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F 677	Continued From page 30 she did not know if resident #21 would like to receive a shower. She stated she did not wash Resident #21 ' s hair during her bath today. On 3/24/22 at 2:38 PM Nurse Aide #5 observed Resident #21 ' s hair. Nurse Aide #5 stated the resident ' s hair looked greasy and dirty. During the observation Resident #21 stated she did get a bath this, but her hair was not washed. Resident #21 stated she wanted her hair washed today because it was dirty. On 3/24/22 at 3:56 PM the Director of Nursing (DON) stated she would expect a resident ' s hair to be washed as part of a full bed bath. She then confirmed Resident #21 had a full bed bath completed on 3/21/22, 3/22/22 and 3/23/22 based on the point of care documentation by the nurse aide. The DON said the resident ' s hair should have been washed if the hair looked dirty or greasy.	F 677		
F 679 SS=E	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 observations, record review, and staff	F 679	RESIDENT #56 AND #25 WILL BE	4/25/22

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F 679	Continued From page 31 and resident interviews the facility failed to provide an ongoing resident centered activities program based on identified resident individual interests for 2 of 2 residents reviewed for activities (Resident #56, Resident #25). Findings included: 1. Resident #56 was admitted to the facility on 7/4/17. Her active diagnoses included type 2 diabetes with other diabetic ophthalmic complications, coronary artery disease, and unspecified vision loss. Resident #56's most recent comprehensive minimum data set assessment dated 7/5/21 revealed she was assessed as cognitively intact. Her vision was severely impaired. Her preferences in activities were assessed as very important to have books, newspapers, and magazines to read, very important to have music she liked to listen to, somewhat important to be around animals such as pets, very important to keep up with the news, somewhat important to do things with groups of people, very important to do her favorite activities, very important to go outside and get fresh air when the weather was good, and very important to participate in religious services. Resident #56's care plan dated 10/28/21 revealed she was care planned for meeting emotional, intellectual, physical, and social needs. Resident #56 needed supervision and set up due to limited vision. The interventions included for all staff to converse with resident while providing care, invite the resident to scheduled activities, provide with activities calendar and notify resident of any changes to the calendar of activities, and provide	F 679	INTERVIEWED BY ACTIVITY DIRECTOR OR DESIGNEE TO IDENTIFY RESIDENT INDIVIDUAL INTEREST IN ACTIVITIES; EACH RESIDENT CARE CARE PLAN WILL BE REVIEWED AND UPDATED BASED ON THE RESIDENT'S INDIVIDUAL INTEREST IN ACTIVITIES BY 4/22/22. THE AD OR DESIGNEE WILL COMPLETE QM AUDITS OF CURRENT RESIDENTS TO IDENTIFY EACH RESIDENT'S INDIVIDUAL INTEREST IN ACTIVITIES. THE ADMINSTRATOR WILL PROVIDE EDUCATION TO ACTIVITY STAFF THAT THE FACILITY MUST PROVIDE, BASED ON THE COMPREHENSIVE ASSESSMENT AND CARE PLAN, AS WELL AS THE PREFERENCE OF THE INDIVIDUAL RESIDENT, AN ONGOING PROGRAM TO SUPPORT RESIDENTS IN THEIR CHOICE OF ACTIVITY, BOTH FACILITY SPONSORED GROUP AND INDIVIDUAL, AS WELL AS INDEPENDENT ACTIVITIES DESIGNED TO MEET THE INTEREST OF AND SUPPORT THE PHYSICAL, PSYCHO-SOCIAL WELL-BEING OF EACH RESIDENT, ENCOURAGING BOTH INDEPENDENCE AND INTERACTION IN THE COMMUNITY. THE AD OR DESIGNEE WILL SCHEDULE DAILY ACTIVITIES BASED ON THE CURRENT RESIDENTS INTERESTS. THE MONTHLY ACTIVITY CALENDAR WILL BE POSTED IN THE	

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F 679	Continued From page 32 assistance to activity functions. During an interview on 3/22/22 at 3:54 PM Resident #56 stated to her knowledge there was bingo available, and a person came and danced for the residents, but she did not play bingo because she could not see and did not like gambling. She stated she was able to find things to listen to on the TV and residents still came by and socialized with her, but she missed the old activities. She concluded she liked books on tape, coffee chat, and the times they would go shopping, but those actives were no longer being done and the activities provided which she enjoyed were very few and far between now since the Activities Director left. During an interview on 3/22/22 at 12:51 PM the Director of Nursing stated they did not have an activities director and she believed one was hired and would be starting at the end of the month. She could not remember when the prior activities director left. She further stated the staff still had bingo weekly and church on Sundays. There was also a dance instructor who came in periodically as well. During an interview on 3/22/22 at 1:51 PM the Administrator stated when hired on 12/1/21 there was no activities director, and he believed the previous activities director had left in the fall of 2021. He stated they hired an activities director who stayed briefly from 1/10/22 through 1/31/22. He stated they had not had a qualified activities director apply for the job after that point until a new activities director was hired whose start date was 3/29/22. Currently the activities provided by the facility were bingo every Tuesday and Thursday at 2:15 PM. Silver Sneakers dancing	F 679	FACILITY AND COPY GIVEN TO EACH RESIDENT. THE ADMINISTRATOR WILL COMPLETE QM AUDITS OF TWO CURRENT RESIDENTS WEEKLY X 4, BI-MONTHLY X 1 TO ENSURE THE FACILITY ACTIVITIES BEING OFFERED MEET THE RESIDENT'S INDIVIDUAL INTEREST. THE FINDINGS OF THE AUDITS WILL BE REPORTED TO THE MONTHLY QAPI COMMITTEE AND UPDATED AS INDICATED.	

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who brought in music and performed for the residents every Wednesday at 2:00 PM. Church every Sunday at 10:00 AM. These activities were paged overhead, and nurse aides communicated and assisted residents to the dining room for the events.

2. Resident #25 was admitted to the facility on 1/21/21. Her active diagnoses included anemia, heart failure, diabetes mellitus, and muscle weakness.

Resident #25's most recent comprehensive minimum data set assessment dated 12/6/21 revealed she was assessed as moderately cognitively impaired. Her preferences in activities were assessed as very important to have books, newspapers, and magazines to read, very important to listen to music she liked, very important to keep up with the news, very important to do things with groups, very important to participate in her favorite activities, very important to go outside to get fresh air when the weather was good, and very important to participate in religious services or practices.

Resident #25's care plan dated 8/3/21 revealed she was care planned for activities. The interventions included to encourage ongoing family involvement, introduce the resident to residents with similar background, interests and encourage/facilitate interaction, invite the resident to scheduled activities, provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility, provide with a Community Life calendar and notify resident of any changes to the calendar of activities, respect resident rights to not attend out of room group

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activities, provide the resident with independent activities to use in room, and assist the resident to and from activities.

During observation on 3/21/22 at 11:05 AM Resident #25 was observed coloring a coloring book in her room.

During an interview on 3/21/22 at 11:08 AM Resident #25 stated no activities were provided besides bingo and some dancer that came one in a while and performed to her knowledge. She further stated bingo was okay, but she would like more variety and maybe crafts to do. Arts and crafts were not provided to her by the facility but used to be. She further stated she had to have family and friends bring her coloring books and word search puzzles to have anything to do in her room and the coloring book she was working on right now was provided by family. She concluded she did not get any schedule for activities and whished the facility still had activities as they had back when there was an activities director in the facility.

During an interview on 3/22/22 at 12:51 PM the Director of Nursing stated they did not have an activities director and she believed one was hired and would be starting at the end of the month. She could not remember when the prior activities director left. She further stated the staff still had bingo weekly and church on Sundays. There was also a dance instructor who came in periodically as well.

During an interview on 3/22/22 at 1:51 PM the Administrator stated when hired on 12/1/21 there was no activities director, and he believed the previous activities director had left in the fall of

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F 679	Continued From page 35 2021. He stated they hired an activities director who stayed briefly from 1/10/22 through 1/31/22. He stated they had not had a qualified activities director apply for the job after that point until a new activities director was hired whose start date was 3/29/22. Currently the activities provided by the facility were bingo every Tuesday and Thursday at 2:15 PM. Silver Sneakers dancing who brought in music and performed for the residents every Wednesday at 2:00 PM. Church every Sunday at 10:00 AM. These activities were paged overhead, and nurse aides communicated and assisted residents to the dining room for the events.	F 679		
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by:	F 680		4/25/22

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F 680	Continued From page 36 Based on record reviews, observation, resident interview, and staff interviews, the facility failed to ensure the activities program was directed by a qualified professional. This resulted in the facility's failure to develop, implement, supervise, and provide ongoing evaluation of the activities program. This deficient practice had the potential to affect all 67 residents in the facility. Findings included: During observation on 3/21/22 at 12:02 PM there was no activities calendar observed posted in the facility. Review of the undated Manager of Resident Activities Job Description revealed the duties of the Activities Director included to assist with planning, organizing, implementing, and evaluating the activity programs of the facility. During an interview on 3/22/22 at 3:54 PM Resident #56 (Resident #56's most recent Minimum Data Set assessment dated 3/2/22 revealed she was assessed as cognitively intact) stated to her knowledge there was bingo available, and a person who came and danced for the residents, but she did not play bingo because she could not see and did not like gambling. She concluded she liked books on tape, coffee chat, and the times they would go shopping, but those activities were no longer being done and the activities provided which she enjoyed were very few and far between now since the activities director left. During an interview on 3/22/22 at 12:51 PM the Director of Nursing stated they did not have an activities director and she believed one was hired	F 680	THE FACILITY ACTIVITY DIRECTOR HAS BEEN HIRED AND STARTED 3/29/22. THE NEWLY HIRED ACTIVITY DIRECTOR WILL BE ASSIGNED TO A QUALIFIED ACTIVITY DIRECTOR AT A SISTER FACILITY TO PROVIDE ORIENATION, BE AVAILABLE FOR QUESTIONS AND ANSWER/VALIDATE SCHEDULED ACTIVITY PROGRAMS IN THE FACILITY. THE FACILITY AD HAS BEEN SCHEDULED FOR THE STATE APPROVED AD TRAINING PROGRAM ON 5/9/22. THE SISTER FACILITY'S QUALIFIED AD WILL PROVIDE WEEKLY CALL TIME FOR THE NEXT 8 WEEKS WITH THE FACILITY'S AD TO REVIEW UPCOMING SCHEDULED ACTIVITIES TO ENSURE THAT ACTIVITIES BEING PROVIDED MEET THE INDIVIDUAL NEEDS OF THE CURRENT RESIDENTS AND THAT DOCUMENTATION IS ON THE QM TOOL ---- THE FINDINGS OF QM AUDITS WILL BE REPORTED TO THE QAPI COMMITTEE MONTHLY AND UPDATED AS INDICATED.	

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F 680	Continued From page 37	F 680		

and would be starting at the end of the month. She could not remember when the prior activities director left. She further stated the staff still had bingo weekly and church on Sundays. There was also a dance instructor who came in periodically as well. She concluded the Administrator was more involved with the activities.

During an interview on 3/22/22 at 1:51 PM the Administrator stated when hired on 12/1/21 there was no Activities Director, and he believed the previous activities director had left in the fall of 2021. He stated they hired an Activities Director who stayed briefly from 1/10/22 through 1/31/22. They had not had a qualified activities director apply for the job after that point until the new Activities Director was hired who was going to be onboarded and her start date was 3/29/22. Currently the activities provided by the facility were bingo every Tuesday and Thursday at 2:15 PM. Silver Sneakers dancing who brought in music and performed for the residents every Wednesday at 2:00 PM. Church every Sunday at 10:00 AM. These activities were paged overhead, and nurse aides communicated and assisted residents to the dining room for the events. The new Activities Director would be on-boarded next week and would have calendars placed in common areas as well as in each resident room. He stated currently the residents did not have activities calendars put in place in their rooms or a calendar in the common area. There had been a calendar with the limited activities posted in the common area up through February 2022, but the company changed the vendor for their calendars, and they did not get one for this month but would have one for next month with the new Activities Director. He stated the Minimum Data Set (MDS) nurses were completing the activities

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F 680	Continued From page 38 assessments and updating the care plans, but due to not having an activities coordinator, they did not have documented monitoring of activities or have one on one activities being provided.	F 680		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff and physician interviews the facility failed to complete a non-pressure dressing change as ordered by the physician for 1 of 2 residents (Resident #9) reviewed for wound care. Findings included: Resident #9 was admitted to the facility on 08/17/2021 with diagnoses including type 2 diabetes mellitus (DM), lymphedema (swelling in an arm or leg caused by a lymphatic system blockage), cellulitis (a bacterial skin infection) of right and left leg and difficulty walking. A review of the quarterly Minimum Data Set (MDS) assessment for Resident #9 dated 11/24/2021 revealed he was severely cognitively impaired. It further revealed he had no behaviors or rejection of care. He had 2 venous or arterial	F 684	RESIDENT #9 RIGHT AND LEFT LEG NON-PRESSURES WERE ASSESSED BY ATTENDING PHYSICIAN ON 4/7/22; NO NEW ORDERS GIVEN. THE DON OR DESIGNEE WILL COMPLETE QM AUDITS OF CURRENT RESIDENTS IDENTIFIED WITH PRESSURE AND NON-PRESSUE WOUNDS TO ENSURE PHYSICIAN ORDERS ARE BEING FOLLOWED IN REGARD TO WOUND CARE AND DOCUMENTATION ON TREATMENT RECORD. THE DON OR DESIGNEE WILL PROVIDE RE-EDUCATION TO LICENSED NURSES IN REGARD TO FOLLOWING PHYSICIAN ORDERS RELATED TO WOUND CARE AND	4/25/22

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F 684	Continued From page 39 ulcers present. He received the application of nonsurgical dressings with the application of ointments/medications other than to feet. A review of the comprehensive care plan for Resident #9 revealed a focus area initiated 08/18/2021 of impaired skin integrity to bilateral lower extremities. The goal last revised on 02/12/2022 was for Resident #9 to have minimal complications through the next review. Interventions included treatments as ordered and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate, and any other notable changes or observations. a. A physician's order for Resident #9 initiated on 11/11/2021 revealed right and left leg cleanse with wound cleanser, apply zinc oxide (a topical medication) to entire leg then apply calcium alginate (a type of dressing) to wound bed, wrap with rolled gauze starting at mid foot to below knee followed by Coban (a type of elastic wrap) every Monday and Thursday evening shift (3PM-11PM) and as needed for soiling. The discontinue date for this order was 03/04/2022. A review of the February 2022 Treatment Administration Record (TAR) for Resident #9 revealed no documentation on 02/28/2022 this treatment was completed. Multiple attempts at telephone interview with Nurse #3 assigned to Resident #9 on 02/28/2022 from 3PM-11PM were unsuccessful. b. A physician's order for Resident #9 initiated on 03/07/2022 revealed right and left leg cleanse with wound cleanser, apply oil emulsion dressing	F 684	DOCUMENTING ON TREATMENT RECORD. LICENSED NURSING STAFF MUST COMPLETE THIS EDUCATION BY 4/25/22 OR THEY CANNOT WORK HIS/HER NEXT SHIFT UNTIL COMPLETED. THE DON OR DESIGNEE WILL COMPLETE QM AUDTS OF 2 SAMPLED RESIDENTS WEEKLY X 4, BI-MONTHLY X 1 TO ENSURE RESIDENTS ARE RECEIVING WOUND CARE AND HAVE ASSOCIATED DOCUMENTATION IS IN PLACE AS DIRECTED BY THE ORDER AND CARE PLAN. THE FINDINGS OF THE AUDITS WILL BE REPORTED TO THE QAPI COMMITTEE MONTHLY AND THE AUDITS WILL BE UPDATED AS/IF INDICATED.	

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F 684	Continued From page 40	F 684		

to wound bed followed by Unna Boot (a compressive dressing used in the treatment of venous stasis ulcers), wrap with rolled gauze starting at mid foot to below knee followed by Coban every Monday and Thursday evening shift and as needed for soiling. There was no discontinue date for this order.

A review of the March 2022 TAR for Resident #9 revealed no documentation on 03/21/2022 this treatment was completed.

On 03/22/2022 at 11:43 AM an observation of Resident #9 revealed he had dressings intact to his lower extremities. They did not appear to be soiled. In an interview at that time, Resident #9 stated his lower extremity treatments were not completed yesterday like they were supposed to be. He further indicated they were done today instead. He went on to say he did not know why his treatments were not done yesterday. He stated he could not recall if this had happened before.

On 03/22/2022 at 3:54 PM an interview with Nurse #4 indicated she was assigned to Resident #9 on 03/21/2022 from 3PM-11PM. She stated she did not complete his lower extremity wound treatments because the treatment nurse was supposed to do them. Nurse #4 went on to say the treatment nurse contacted her by telephone on 03/21/2022 and told her she would be in to do Resident #9's lower extremity treatments on 03/22/2022 so she had not done them.

On 03/22/2022 at 4:02 PM an interview with the Assistant Director of Nursing (ADON) indicated the facility had a treatment nurse who came to the facility on Monday and Thursday to do

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Resident #9's wound treatments. She stated the treatment nurse had not come to the facility on 03/21/2022. The ADON further indicated if the treatment nurse was not available to do the wound treatments, the nurse assigned to Resident #9 should be completing them as ordered.

On 03/23/2022 at 11:45 AM a telephone interview with Nurse #5 indicated she was the facility's treatment nurse. She stated she called the facility on 03/21/2022 and let the nurse know she would not be in to do Resident #9's lower extremity wound treatments that day. She stated she came in on 03/22/2022 and completed them instead. She went on to say there was no reason the facility nurse assigned to Resident #9 could not have done his treatment on 03/21/2022, she just preferred to do it herself. An attempt was made during this interview to ask Nurse #5 about Resident #9's lower extremity wound treatment on 02/28/2022, however, Nurse #5 abruptly ended the conversation indicating she would continue the interview at another time. Multiple follow up calls to Nurse #5 were unsuccessful.

A review of the hours worked for Nurse #5 provided by the facility revealed Nurse #5 was assigned time off on 02/28/2022 and 03/21/2022 and did not work in the facility on those days.
On 03/23/2022 at 12:00 PM an interview with the Director of Nursing (DON) indicated Resident #9 had a physician's order for his lower extremity wound treatments to be done on Monday and Thursday. She stated if Nurse #5 was not available to complete these treatments as ordered, the facility nurse assigned to Resident #9 that day should have completed it.

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F 684	Continued From page 42 On 03/24/2022 at 9:41 AM an interview with Physician #1 indicated he was the facility wound doctor. He stated he had been following Resident #9's lower extremity wounds for several months and came to the facility every Thursday to complete Resident #9's lower extremity wound treatments himself and to monitor and document the wound status. He stated Resident #9's lower extremity wounds were improving. He stated Resident #9's lower extremity wound treatments were ordered to be completed on Monday and Thursday and he would expect them to be done as ordered. He stated Nurse #5 usually completed these, but if Nurse #5 was not available to complete the treatments as scheduled, the nurse assigned to Resident #9 should be completing them.	F 684		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff and family interviews the facility failed to provide nail care or arrange podiatry services for 1 of 1 resident (Resident #9)	F 687	RESIDENT #9 WAS SEEN BY PODIATRY ON 3/28/22 THE DON OR DESGINEE WILL	4/25/22

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F 687	Continued From page 43 reviewed for foot care. Findings included: Resident #9 was admitted to the facility on 08/17/2021 with diagnoses including type 2 diabetes mellitus (DM) and difficulty walking. A review of the quarterly Minimum Data Set (MDS) assessment for Resident #9 dated 11/24/2021 revealed he was severely cognitively impaired. It further revealed he had no behaviors or rejection of care. He required the extensive assistance of one person for bed mobility, transfers, personal hygiene, and toileting. Resident #9 required the total assistance of one person for bathing. He used a wheelchair for mobility. A review of the comprehensive care plan for Resident #9 revealed a focus area initiated on 02/12/2022 of DM. The goal was for Resident #9 to have no complications from DM through the next review. An intervention was to refer Resident #9 to a podiatrist to monitor and document foot care needs and to cut long nails. On 03/21/2022 at 11:11 AM an interview with Resident #9 indicated he had not had his toenails trimmed or been seen by a podiatrist (foot doctor) since his admission to the facility. He stated about two weeks ago someone came and asked him if he wanted to be seen by a podiatrist to have his toenails trimmed and he said he did. He went on to say today he was told, although the podiatrist was in the facility, he could not be seen because he was not on the list. Resident #9 stated he could not see his toenails to know if they were long but his family had mentioned to	F 687	COMPLETE QM MONITORING AUDITS OF CURRENT RESIDENTS NAILS TO ENSURE THEY ARE CLEANED AND TRIMMED; THE AUDIT WILL REVIEWING OF CURRENT RESIDENTS NEED FOR PODIATRY CONSULTS AND/OR SCHEDULED CONSULTS. THE DON OR DESIGNEE WILL PROVIDE RE-EDUCATION TO NURSING STAFF (LICENSED NURSES AND ASSISTANTS) AND SW REGARDING PROCESS FOR COMMUNICATING AND SCHEDULING OF RESIDENTS IDENTIFIED NEEDING/REQUESTING PODIATRY. STAFF MUST COMPLETE EDUCATION BY 4/25/22 OR THEY CANNOT WORK NEXT SCHEDULED SHIFT. THE DON OR DESIGNEE WILL COMPLETE QM AUDITS OF 2 SAMPLED RESIDENTS WEEKLY X 4; BI-MONTHY X 1 TO ENSURE RESIDENTS RECEIVE TIMELYI CARE AND/OR PODIATRY CONSULT IF/AS NEEDED. THE FINDINGS OF THESE AUDTS WILL BE COMMUNICATED AND REVIEWED MONTHLY AT QAPI WITH AUDITS BEINGA ADJUSTED AS INDICATED.	

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him that they were and needed trimming. He further indicated he did not walk and did not wear shoes. He stated when he got up into his wheelchair, he wore socks. He went on to say he had no pain in his feet. An observation of Resident #9's feet at the time of the interview revealed the toenails of both feet were thickened and discolored. The nails of the 2nd and 3rd toes on his left foot and the 3rd toe on his right foot were observed to be ¼ to ½ inch long and curved downward.

On 03/22/2022 at 12:13 PM an interview with the Social Worker (SW) indicated she received a list from the podiatry clinic on 02/24/2022 of residents to be seen at the next facility visit on 03/21/2022. She stated she gave this list to the nurses on duty that day and instructed them to add any residents who were not on the list and needed to be seen. The SW went on to say Resident #9 had not been on the initial list to be seen by the podiatrist on 03/21/2022 and had not been added by nursing. She stated there was no reason Resident #9 could not have been seen by the podiatrist at the facility. She further indicated the next scheduled podiatry visit to the facility would be in 3 months.

A review of Resident #9's medical record revealed no evidence he was not seen by a podiatrist since his admission to the facility.

A review of the podiatry visit lists provided by the facility for 09/28/2021, 12/15/2021 and 03/21/2022 revealed Resident #9 was not present on the list of residents to be seen on those dates.

On 03/22/2022 at 12:34 PM an interview with Nurse Aide (NA) #2 indicated she was familiar

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with Resident #9. She stated she provided him his bed bath that morning which included washing his feet. She stated she had not noticed his toenails were long and had not reported anything about them to his nurse that day.

On 03/22/2022 at 4:25 PM an observation of Resident #9's feet and toenails was conducted with the Assistant Director of Nursing (ADON). She stated the toenails of both feet were thickened and discolored. She confirmed the nails of the 2nd and 3rd toes on his left foot and the 3rd toe on his right foot were ¼ to ½ inch long and curved downward. She stated this was not something nursing staff could have managed. She went on to say Resident #9 would need to be seen by a podiatrist. The ADON further indicated she could not say how long his toenails had been this way, but she would have expected nursing staff to have noticed this and followed up with getting Resident #9 on the list to be seen by podiatry.

On 03/22/2022 at 3:23 PM a telephone interview with Nurse #2 indicated she was the nurse on duty assigned to Resident #9 on 02/24/2022 on the 7AM-3PM shift. She stated she did not recall ever seeing a podiatry list but because Resident #9 was a diabetic, he would need to be seen by a podiatrist for toenail trimming. She stated nurses could let the ADON or SW know if a resident needed to be added to the podiatry list. Nurse #2 went on to say she did not recall observing Resident #9's toenails being long or needing trimming. She further indicated she did not recall NAs ever notifying her of this.

On 03/22/2022 at 7:21 PM a telephone interview with NA #3 revealed she had been the Medication

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F 687	Continued From page 46	F 687		

Aide for Resident #9 on 03/05/2022 and 03/12/2022 on the 3PM-11PM shift. She stated she performed Resident #9's weekly skin assessments on those days. She further indicated this included looking at his feet. She went on to say she did not recall there being any issues with Resident #9's toenails being long or needing to be trimmed.

On 03/23/2022 at 1:01 PM an interview with the Director of Nursing (DON) indicated she observed Resident #9's toenails with the ADON last evening. She stated Resident #9's toenails were thick, discolored, long and curved downward. She further indicated this was not something facility staff could manage and Resident #9 would need to be seen by a podiatrist. She went on to say she could find no documentation in Resident #9's medical record he had been seen by a podiatrist since his admission to the facility. The DON stated the condition of Resident #9's toenails should have been noticed by NA staff when they provided his bath and reported to nursing or noticed by nursing staff when they completed his weekly skin assessments. She stated nursing staff should have referral made for Resident #9 to be seen by a podiatrist before now. The DON went on to say nursing referral and resident request was what got a resident on the list to be seen by the podiatrist.

On 03/23/2022 at 1:18 PM a telephone interview with Resident #9's Representative (RP) indicated she visited Resident #9 in the facility last week, observed his toenails and felt he needed to be seen by a podiatrist as the toenails were thick, long, curved and needed attention. She went on to say Resident #9 expressed to her at that visit

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F 687	Continued From page 47 he was excited because he thought the podiatrist was coming to trim them this week. Resident #9's RP stated she was notified by the facility on 03/22/2022 that Resident #9 had not been seen by the podiatrist on 03/21/2022 and now would need to go outside the facility to be seen.	F 687		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review the facility failed to provide services consistent with the resident ' s needs when a substantial snack was not provided on dialysis days when 1 (Resident #19) of 1 resident reviewed for dialysis missed a meal on scheduled dialysis days. The findings included: Resident #19 was admitted to the facility on 1/6/22. The admission Minimum Data Set Assessment dated 1/13/22 indicated Resident #19 was cognitively intact. She was independent with eating and received dialysis. Her diagnoses included end stage renal disease, dependence on dialysis diabetes, and high blood pressure. The care plan dated 1/14/22 included Resident	F 698	RESIDENT #19 WILL BE PROVIDED SUBSTANTIAL SNACK TO TAKE WITH EHR TO EACH DIALYSIS APPOINTMENT BY CHARGE NURESE. DIETARY MANAGER AND DON/DESIGNEE WILL COMPLETE QM OF CURRENT RESIDENTS RECEIVING DIALYSIS TO ENSURE THAT A SUBSTANTIAL SNACK IS PROVIDED PRIOR TO EACH DIALYSIS APPOINTMENT. ADMINSTRATOR OR DESIGNEE WILL PROVIDE EDUCATION TO DIRECT CARE STAFF AND DIETARY STAFF WITH REGARD TO FACILITY PROCESS TO OBTAIN BAGGED SUBSTANTIAL SNACK PRIOR TO LEAVING THE FACILITY FOR DIALYSIS. STAFF WHO DO NOT COMPLETE THIS EDUCATION	4/25/22

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F 698	Continued From page 48 #19 was a nutritional risk related to a therapeutic diet, diuretic therapy, and dialysis attendance. The interventions included provide and serve diet as ordered and to monitor intake and record every meal. On 3/22/22 at 8:43 AM Resident #19 stated she doesn ' t receive lunch before she goes to dialysis. She stated she was hungry when she returned from dialysis and had to wait until dinner was served to get food. She stated she wanted a snack so she would not be so hungry. On 3/23/22 at 8:26 AM Resident #19 stated she had not received a snack on her dialysis days for the last 2 months. She reported she leaves for dialysis around 10:00 AM and returns to the facility around 4:00 PM. She reported she did not know why she was no longer receiving a snack. She said she was always hungry before she returned from dialysis and felt bad before the dinner trays arrived. Resident #19 stated she had previously asked for a snack but had not received one, so she stopped asking. On 3/23/22 at 9:16 AM Dietary Aide #1 stated the kitchen no longer made snack bags for residents. She stated Resident #19 previously received a sandwich and chips as a snack on her dialysis days. Dietary Aide #1 stated they have not sent snack bags in "a long time." She did not know why they no longer made snack bags for residents going to dialysis. On 3/23/22 at 9:19 AM Nurse #4 reported the kitchen was supposed to provide Resident #19 with a snack meal, but they had not been providing it. She stated she had never observed Resident #19 receive a snack meal. She said she	F 698	BY 4/25/22 WILL NOT BE ALLOWED TO WORK THEIR NEXT SHIFT. THE ADMINISTRATOR/DESIGNEE WILL CONDUCT QM AUDITS OF 1 SAMPLED RESIDENT REQUIRING DIALYSIS WEEKLY X 4; BI-MONTHLY X 1 AND REPORT AUDIT FINDINGS TO QAPI COMMITTE MONTHLY; AUDITS WILL BE UDPATED AS INDICATED.	

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F 698	Continued From page 49 had not previously worked with Resident #19 but if the resident did not have a snack and wanted one, she would give the resident a package of nabs. Nurse #4 was not aware Resident #19 reported she was hungry upon returning from dialysis. On 3/23/22 at 10:40 AM the Dietary Manager stated they send an early breakfast to residents who go to dialysis, and she thought those residents also received a snack bag which was delivered to the nursing unit. She stated she was only employed at the facility for the last 3 weeks and did not know the snack bags were not being made or sent to Resident #19. A telephone interview with the Registered Dietitian on 3/25/22 at 10:40 AM she stated dialysis residents should receive a snack meal to replace the missed meal and an early meal tray prior to leaving or upon returning to the facility. On 3/25/22 AT 10:45 AM the Assistant Director of Nursing stated if a resident missed a meal while at dialysis it was not adequate nutrition for the dialysis resident.	F 698		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff and record review the facility failed to ensure a resident diagnosed with dementia who exhibited	F 744	RESIDENT # 61 CARE PLANS WILL BE REVIEWED AND UPDATED TO INCLUDE INTERVENTIONS ON HOW	4/25/22

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F 744	Continued From page 50 combative behaviors during care had a person centered and individualized care plan with interventions that directed staff on how to provide care and treatment for 1 (Resident #61) of 2 residents reviewed for dementia care. The findings included: Resident #61 was admitted to the facility on 2/17/22 with diagnoses which included dementia with behavioral disturbances. The Admission Minimum Data Set (MDS) Assessment dated 2/24/22 revealed Resident #61 was severely cognitively impaired. He was usually understood and able to understand. He was noted to have inattention and disorganized thinking which fluctuated. He was coded as having no behaviors or rejection of care. Resident #61 required extensive to total assistance with activities of daily living. He received antipsychotic medications all 7 days of the review period. His active diagnoses included dementia. The Care Area Assessment indicated delirium and cognitive loss/dementia were triggered to be included in the care plan. A medical record review revealed a note dated 2/28/22 by Nurse #4 documented, "becomes combative with incontinent care, grabbing onto staff, bedding and squeezing staff hands and arm." On 3/1/22 a note by Nurse #6 read: "resident during ADL (activities of daily living) car hitting and kicking and grabbing staff hands holding tight you have to struggle with care." A physician note dated 3/2/22 read in part follow	F 744	TO PROVIDE CARE AND TREATMENT TO A RESIDENT WITH DEMENTIA WHO IS EXHIBITING COMBATIVE BEHAVIOR DURING CARE BY MDS. THE REGIONAL MDS NURSE/DESIGNEE WILL COMPLETE QM AUDITS OF RESIDENTS IDENTIFIED WITH DEMENTIA EXHIBITING BEHAVIORS TO ENSURE THAT INTERVENTIONS ADDRESS HOW TO PROVIDE CARE. THE REGIONAL MDS NURSE/DESIGNEE WILL PROVIDE RE-EDUCATION TO THE IDT TEAM (DON, ADON, SW, ACT. DIR, SW, ADMINISTRATROR) IN REGARD TO CARE PLANNING OF RESIDENTS WITH DEMENTIA EXHIBITING BEHAVIORS; ANY MEMBER OF THE IDT TEAM WHO HAS NOT COMPLETED THIS TRAINING BY 4/25/22 WILL NOT BE ALLOWED TO WORK HIS/HER NEXT SHIFT. THE REGIONAL MDS NURSE/DESIGNEE WILL CONDUCT QM AUDITS OF 2 SAMPLED RESIDENTS TO ENSURE INVERVENTION ARE REFLECTED ON THE CARE PLAN ON HOW TO CARE FOR RESIDENTS WITH DEMENTIA WHO ARE EXHIBITING BEHAVIORS --- WEEKY X 4; BI-MONTHLY X 1 --- REPORTED TO THE QAPI COMMITTE MONTHLY WITH AUDITS BEING UPDATED AS INDICATED.	

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F 744	Continued From page 51	F 744		

up dementia. The plan for dementia read intermittent behavioral disturbances, continue Seroquel (antipsychotic medication), Aricept, Namenda. (Aricept and Namenda are cognition enhancing medications commonly used to treat dementia). Monitor for needs.

A review of the current care plan dated 3/17/22 did not include any information related to resident #61 ' s diagnosis of dementia and included no person-centered interventions/approaches for staff on how to provide care and treatment for the resident.

On 3/24/22 at 2:48 PM Nurse #3 stated Resident #61 was combative. She said it was difficult to provide incontinent care for him. She said it took one person to redirect him while the other person provided incontinent care.

Nurse Aide #2 was interviewed on 3/24/22 at 2:51 PM. She stated Resident #1 did not like to be changed or bathed. She said he fights, and it was usually only when he was touched. She said he did not have behaviors every day, but he did have behaviors most days. She added she talked to Resident #61 about his family members, so she did that to help distract him.

During an interview with the Social Worker (SW) on 3/25/22 at 9:24 AM she stated Resident #61 was seen by psychiatric doctor. A psychiatrist note that indicated Resident #61 was seen for dementia, psychosis, and combativeness during care was reviewed with the SW. The SW acknowledged she was aware Resident #61 had a diagnosis of dementia with behavioral disturbance and he displayed the associated behavioral symptoms of combativeness.

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F 744	Continued From page 52 During a telephone interview with the Regional MDS nurse on 3/25/22 at 9:56 AM she stated there was not a completed care plan for Resident #16. She added the care plan should have been completed by 3/2/22 but it was not. The care plan development was the responsibility of the MDS nurse.	F 744		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on interviews with residents, interviews with facility staff and the consulting Dietician and test tray results the facility failed to provide food that was served at an appetizing temperature for 4 of 4 residents (Resident #62, #59, #58, & #19), reviewed for food palatability. This had the potential to affect all the residents who received food from the dietary department. The findings included: a. Resident #62 was admitted to the facility on 12/20/21. The quarterly Minimum Data Set Assessment dated 2/28/22 indicated Resident #62 was cognitively intact.	F 804	ADMINISTRATOR WILL ORDER A NEW PELLET WARMER FOR KITCHEN BY 4/25/22. THE DIETARY MANAGER WILL PROVIDE TEST TRAYS ON EACH UNIT TO ENSURE THE MEALS ARE SERVED AT AN APPETIZING TEMPERATURE -- These test trays will be checked my the DON or designee. THE DIETARY MGR. WILL PROVIDE EDUCATION TO THE DIETARY STAFF IN REGARD TO PALABILITY AND PROPER FOOD TEMPERATURES; STAFF THAT HAVE NOT COMPLETED	4/25/22

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F 804	Continued From page 53 On 3/21/22 at 11:18 AM Resident #62 reported the food she was served was frequently cold. b. Resident #59 was admitted to the facility on 2/28/22. The admission Minimum Data Set Assessment dated 3/4/22 indicated Resident #59 was cognitively intact. On 3/21/22 at 12:34 PM Resident #59 reported the food was frequently too cold. c. Resident #58 was admitted to the facility on 2/23/22. His admission Minimum Data Set Assessment dated 2/3/22 revealed he was cognitively intact. On 3/21/22 at 1:12 PM Resident #58 stated he did not eat again today because his food was always cold. d. Resident #19 was admitted to the facility on 1/06/22. The admission Minimum Data Set Assessment dated 1/13/22 indicated Resident #19 was cognitively intact. On 3/22/22 at 8:43 AM Resident #19 stated the food was always cold. On 3/23/22 at 11:39 AM the food temperature on the tray serving line were obtained prior to beginning the tray line. The food temperatures were within the requirements for food holding. As the tray line plating process began Cook #1 was observed to remove the plates from the plate warmer located on the Cook's left hand side. The plate warmer was observed to be plugged in and the plates were warm. Cook #1 was able to hold the plates without using a heat resistant glove. Cook #1 did not use the plate pellets (These are	F 804	THIS EDUCATION BY 4/25/22 WILL NOT BE ALLOWED TO WORK THEIR NEXT SHIFT. THE DIETARY MANAGER/DESIGNEE WILL CONDUCT QM AUDITS ON 2 SAMPLED RESIDENTS WEEKLY X 4; BI-MONTHLY X 2 TO ENSURE MEALS ARE SERVED AT AN ACCEPTABLE TEMPERATURE. THE AUDIT FINDINGS WILL BE REPORTED TO THE QAPI COMMITTEE MONTHLY AND AUDIT REFREQUENCY CHANGED IF/AS INDICATED.	

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F 804	Continued From page 54	F 804		

metal pellets shaped like the plate which are heated and placed under the plate to keep the plate hot.) which were observed on the right hand side of the tray line.

On 3/23/22 at 12:25 PM Cook #1 stated she did not use the pellets because the plates were warm.

On 3/23/22 at 12:30 PM Dietary Aide #1 stated the heated pellets had not been used in the last 2 years. She said there was an electrical malfunction, so they stopped using the pellets.

On 3/23/22 at 12:58 PM the cart of trays for Nursing Station 3 left the kitchen.

On 3/23/22 at 1:17 PM the trays from the cart for Nursing Station 2 were all passed to the residents. At that time the test tray evaluation was conducted with the Dietary Manager. The Dietary Manager sampled the food items and reported the ham, roasted pork, yams, and baked apples were not hot enough. She said the collards were warmer than the other foods but not hot.

On 3/24/22 at 2:06 PM during an interview with the Food Service District Manager she stated the food should be hot. She was not aware the kitchen staff were not using the pellets to help maintain the temperature of the foods.

On 3/25/22 at 10:28 AM a telephone interview was conducted with the Registered Dietitian. The Registered Dietitian stated she it at the facility for 1 day every 2 weeks. She said cold food for residents was a concern that needed to be corrected.

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F 809	Continued From page 55	F 809		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff and the consulting Registered Dietitian and record review the facility failed to regularly provide a nourishing snack at bedtime when the time between the evening meal and the following day ' s breakfast meal exceeded 14 hours. This had the potential to affect all the residents who were able to eat food. The findings included: A review of the Meal Delivery Times indicated the Dinner meal was provided to Station 1 at 5:00 PM, to Rehab hall at 5:25 PM and to Station 2 at	F 809	FACILITY MEAL TIMES WERE ADJUSTED TO NOT EXCEED THE 14 HOUR WINDOW FROM EVENING MEAL TO BREAKFAST ON 3/29/22. THE NEW MEAL SCHEDULE WAS ADOPTED AFTER REVIEW AND ACCEPTANCE OF THE RESIDENT COUNCIL. THE COUNCIL ALSO REQUESTED SNACKS BE PROVIDED 3X DAILY --- THIS PROCESS WILL BE IMPLEMENTED. THE DIETARY MANAGER/DESIGNEE WILL PROVIDE EDUCATION TO FACILTY STAFF REGARDING NEW	4/25/22

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F 809	Continued From page 56 5:45 PM. The Breakfast meal was listed as Station 1 at 8:00 AM, Rehab Hall at 8:15 AM and Station 2 at 8:30 PM. The time between dinner and breakfast meal delivery for Station 1 was 15 hours, for Rehab hall was 14 hours and 50 minutes, and the time for Station 2 was 14 hours and 45 minutes. During an interview with the Dietary Manager on 3/25/22 at 8:36 AM she stated the kitchen provided peanut butter crackers (commercially prepared) and animal cracker which are placed on a tray in the dining room for the nursing staff to come and get for the residents. She stated she had been employed as the dietary manager for 3 weeks and was not aware the evening meal and the breakfast meal were more than 14 hours apart. On 3/25/22 at 3:05 PM Nursing Aide #4 stated she would get a snack if a resident requested one, but bedtime snacks were not offered to the residents every day. On 3/25/22 at 10:50 AM the consulting Registered Dietitian stated she would expect for residents to be offered a nourishing bedtime snack when the time between dinner and breakfast was greater than 14 hours.	F 809	MEALTIMES, CART DELIVERY LOG, SNACK DELIVERY LOG ADN THE PROCEDURE FOR BEDTIME SNACKS TO BE OFFERED TO EACH RESIDENT. STAFF WHO HAVE NOT COMPLETED THIS EDUCATION WILL NOT BE ALLOWED TO WORK THEIR NEXT SHIFT AFTER 4/25/22. THE DIETARY MGR/DESIGNEE WILL CONDUCT QM AUDITS: TWO SAMPLED RESIDENTS: WEEKLKY X 4; BI-MONTHLY X 2 TO ENSRUE BEDTIME SNACKS ARE AVAILABLE AND OFFERED --- FINDINGS WILL BE REPORTED MONTHLY TO THE QAPI COMMITTEE WITH QM AUDIT SCHEDULED UPDATED AS ADVISED.	
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		4/25/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON REHABILITATION AND HEALTHCARE	1000 TANDAL PLACE KNIGHTDALE, NC 27545

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F 812	Continued From page 57 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 observations and interviews with facility staff the facility failed to maintain the sanitizer in the dish machine at the proper concentration. This action had the potential to affect food served to residents in the facility. The findings included: During an observation of the facility low temperature dish washing machine on 3/23/22 at 10:01 AM Dietary Aide #2 stated she did not know how to test the dish machine to be sure it was sanitizing the dishes. She stated Dietary Aide #1 was responsible for checking the dish machine calibrations. Dietary Aide #1 could not locate the test strips needed to check the sanitizer for the dish machine. Dietary Aide #1 asked the Dietary Manager for test strips. The Dietary Manager located the test strips and checked the chlorine concentration for the dish machine. The strip registered 10 parts per million (ppm). The Dietary Manager stated the concentration needed to be at least 50 ppm. The Dietary Manager obtained	F 812	DIETARY MANAGER (DM)/DESIGNEE PROVIDED DIETARY AIDE #1 AND #2 EDUCATION IN REGARD TO ACCEPTABLE TEMPERATURE RANGES FOR THE WASH AND RINSE OF THE DISH MACHINE, POLICY AND PROCEDURE FOR CHECKING THE CHLORINE SANITIZER AND TESTING 3/23/22. DM WILL COMPLETE EDUCATION OF TEMPERATURE OF THE WASH AND RINSE OF THE DISH MACHINE AND VALIDATION OF ACCEPTABLE RANGE OF CHLORINE SANITIZER. STAFF MUST COMPLETE BY 4/25/22 TO BE ABLE TO WORK THEIR NEXT SCHEDULED SHIFT. THE DM WILL CONDUCT QM AUDITS OF THE DISH MACHINE TO ENSURE TEMPERATURES ARE IN ACCEPTABLE RANGE/LOGGED AND THE CHLORINE	

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F 812	Continued From page 58 another test strip and rechecked the concentration. The results were again 10 ppm. The Dietary Manager stated she would need to contact the company who performs maintenance for the machine to determine why the chlorine concentration was not adequate. On 3/23/22 at 10:30 AM Dietary Aide #1 stated she did not test the machine on 3/23/22 prior to washing the breakfast trays. On 3/23/22 at 4:26 PM the Dietary manager stated the dish machine repair company service technician had not arrived and she would need to contact him again. The telephone call revealed the repair company would not arrive until the following day. The repair company then provided the dietary manager guidance to refill, prime the sanitizing solution, and recheck the machine. On 3/24/22 at 9:30 AM the dish machine repair person stated he had inspected and adjusted the dish machine 3 weeks ago. He had replaced all the tubing lines including the one for the sanitizer. He stated if the tubing was not correctly placed into the bucket of sanitizer it would not flow into the machine correctly. He added his inspection revealed the machine was working properly at that time. The Corporate District Dietary Manager was interviewed on 3/24/22 at 2:06 PM. She stated she had been informed the dish machine was not meeting the requirement for sanitization. She stated it was important for the dish machine to properly sanitize the dishes to prevent possible illness.	F 812	SANITIZER IS TESTED: 3 X WEEKLY X 4; BI-MONTHLY X 3 --- FINDINGS OF THE AUDITS WILL BE REPORTED MONTHLY TO THE QAPI COMMITTEE WITH THE AUDIT SCHEDULES BEING MODIFIED AS INDICATED.	
F 814 SS=E	Dispose Garbage and Refuse Properly	F 814		4/25/22

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F 814	Continued From page 59 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 observations and interviews with facility staff the facility failed to keep the dumpster area free of debris for 2 of 2 dumpsters observed. The findings included: On 3/23/22 at 10:40 AM an observation of the dumpster area with the Dietary Manager revealed a broken cart with 3 black shelfs and silver rails was behind dumpster #1 (left side dumpster). The top black shelf was broken away from the rest of the cart. There were old, dried leaves on and under the cart. Also, beside and under part of the broken cart was a 4 inch wide by 4 foot long piece of wood. This piece of wood had a large torn piece of plastic wrapped partially around one part of it. The piece of plastic was shredded in places and had various colors of brown, green, and yellow substances throughout. The entire area behind dumpster 1 was covered in 3 - 6 inches of dried leaves. The area behind Dumpster #2 (the right side dumpster) also had 3 - 6 inches of dried leaves, a piece of a foam hinge plate with black dirt markings on the inside, a one quart size empty container of liquid eggs, numerous plastic lids for cups and various other debris. Some of the items were mixed into or under the leaves. The fence behind the 2 dumpsters had fallen down and the wheel of the black cart was observed through a hole in the fallen wooden fence panel. Various pieces of plastic and trash was observed on the far side of the fallen fence panel.	F 814	THE DIETARY MANAGER AND MAINTENANCE DIRECTOR REMOVED ALL DEBRIS AROUND THE SURROUNDING AREA OF THE DUMPSTERS ON 3/24/22. THE ADMINISTRATOR/DESIGNEE WILL PROVIDE EDUCATION TO ALL STAFF IN REGARD TO THE FACILITY DUMPSTER MUST BE FREE OF DEBRIS ON THE SURROUNDING GROUND AT ALL TIMES. STAFF WHO HAVE NOT COMPLETED THIS EDUCATION BY 4/25/22 WILL NOT BE ABLE TO WORK UNTIL EDUCATION IS COMPLETED. TEH DIETARY MANAGER WILL COMPLETE QM AUDITS TO ENSURE THAT ALL AREA SURROUNDING THE DUMPSTER IS FREE OF DEBRIX 3 X PER WEEK FOR 12 WEEKS; THE FINDINGS OF THE AUDITS WILL BE REPORTED TO THE QAPI COMMITTE MONTHLY WITH THE QM AUDIT FREQUENCY MODIFIED AS INDICATED.	

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F 814	Continued From page 60 On 3/23/22 at 10:43 AM the Dietary Manager stated she had requested to have lighting placed in the dumpster area because the dietary staff who worked at night were frightened to have to place trash into the dumpsters in the dark. She stated the area could attract pest since there was so much debris in the area. On 3/23/22 at 10:47 AM the Administrator observed the dumpster area. He reported the area was littered with debris and the some of the debris appeared to be old. He added he had observed the dumpster area previously but had not looked behind the dumpsters.	F 814		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		4/25/22

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F 842	Continued From page 61	F 842		

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and

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F 842	Continued From page 62 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate documentation of the wound treatments for 1 of 4 Resident's medical records reviewed. (Resident #9). Findings included: Resident #9 was admitted to the facility on 08/17/2021 with diagnoses including type 2 diabetes mellitus (DM), lymphedema (swelling in an arm or leg caused by a lymphatic system blockage), cellulitis (a bacterial skin infection) of right and left leg and difficulty walking. A review of the quarterly Minimum Data Set (MDS) assessment for Resident #9 dated 11/24/2021 revealed he was severely cognitively impaired. A physician's order for Resident #9 initiated on 11/11/2021 revealed right and left leg cleanse with wound cleanser, apply zinc oxide (a topical medication) to entire leg then apply calcium alginate (a type of dressing) to wound bed, wrap with rolled gauze starting at mid foot to below knee followed by Coban (a type of elastic wrap) every Monday and Thursday evening shift (3PM-11PM) and as needed for soiling. The discontinue date for this order was 03/04/2022. A review of the February 2022 Treatment Administration Record (TAR) for Resident #9	F 842	RESIDENT # 9: RIGHT AND LEFT LEG NON-PRESSURE WOUNDS WERE ASSESSED BY ATTENDING PHYSICAIN ON 4/7/22: NO NEW ORDERS OBTAINED. THE DON/DESIGNEE WILL COMPLETE QM AUDITS OF CURRENT RESIDENTS IDENTIFIED WITH PRESSURE AND NON-PRESSURE AREAS TO ENSURE PHYSICIAN ORDERS ARE BEING FOLLOWED WITH REGARD TO WOUND CARE AND SUCH IS DOCUMENTED ON THE TREATENT RECORD. THE DON/DESIGNEE WILL PROVIDE RE-EDUCATION TO LICENSED NURSES IN REGARD TO FOLLOWING PHYSICIAN ORDERS RELATED TO WOUND ARE AND DOCUMENTING ON THE TREATMENT RECORDS --- STAFF WHO DO NOT COMPLETE THIS EDUCATION BY 4/25/22 WILL NOT BE ALLOWED TO WORK UNTIL COMPLETED. DON/DESIGNEE WILL COMPLETE QM AUDITS OF 2 SAMPLED RESIDENTS WEEKLY X 4; BI-MONTHLY X 1 TO ENSURE RESIDENTS ARE RECEIVING WOUND CARE AS ORDERED AND	

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F 842	Continued From page 63 revealed no documentation on 02/07/2022 his lower extremity wound treatments were completed. A physician's order for Resident #9 initiated on 03/07/2022 revealed right and left leg cleanse with wound cleanser, apply oil emulsion dressing to wound bed followed by Unna Boot (a compressive dressing used in the treatment of venous stasis ulcers), wrap with rolled gauze starting at mid foot to below knee followed by Coban every Monday and Thursday evening shift and as needed for soiling. There was no discontinue date for this order. A review of the March 2022 TAR for Resident #9 revealed documentation his lower extremity wound treatments were completed by Nurse Aide (NA) #3 on 03/07/2022. On 03/22/2022 at 7:21 PM a telephone interview with NA #3 indicated she had not completed Resident #9's lower extremity wound treatments on 03/07/2022. She stated she was a medication aide and was not allowed to complete dressing changes or wound treatments. She stated she must have documented the completion of this treatment in error. On 03/23/2022 at 11:45 AM a telephone interview with Nurse #5 indicated she was the facility's treatment nurse. She stated she came to the facility on Mondays and Thursdays to complete Resident #9's lower extremity wound treatments. She went on to say if she was present in the facility then she did the treatment. An attempt was made during this interview to ask Nurse #5 specifically about the completion of Resident #9's lower extremity wound treatment on 02/07/2022	F 842	THAT CARE IS DOCUMUENTED ON TREATMENT RECORD. QM AUDIT FINDINGS WILL BE REPORTED MONTHLY TO THE QAPI COMMITTEE WITH THE QM AUDIT FREQUENCY WILL BE UPDATED AS INDICATED.	

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F 842	Continued From page 64	F 842		

and 03/07/2022 and any documentation of the completion, however, Nurse #5 abruptly ended the conversation indicating she would continue the interview at another time. Multiple follow up calls to Nurse #5 were unsuccessful.

A review of the Resident #9's medical record revealed no documentation by Nurse #5 regarding the completion of his lower extremity wound treatments on 02/07/2022 or 03/07/2022.

A review of the hours worked for Nurse #5 provided by the facility revealed Nurse #5 was present in the facility on 02/07/2022 from 6:30 PM to 7:25 PM and on 03/07/2022 from 5:46 PM to 6:46 PM.

On 03/23/2022 at 12:00 PM an interview with the Director of Nursing (DON) indicated Nurse #5 had access to the TAR for Resident #6. She stated if Nurse #5 completed Resident #9's lower extremity wound treatments on 02/07/2022 and 03/07/2022 Nurse #5 should have documented the completion on the TAR or in the nursing progress notes. The DON went on to say there was no other place Nurse #5 would have documented the completion of these treatments. She further indicated nursing staff should not be documenting the completion of Resident #9's lower extremity wounds if they had not done them.