STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification and Complaint Investigation Survey was conducted on 6/27/22 through 7/1/22. The survey team returned to the facility 07/07/22 to obtain additional information. Therefore, the exit date was changed to 07/07/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# WSKS11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/27/22 through 07/01/22. The survey team returned to the facility 07/07/22 to obtain additional information. Therefore, the exit date was changed to 07/07/22. There were fifty (50) complaint allegations investigated and twenty-eight (28) were substantiated. Event ID# NC00178916, NC00183206, NC00187436, NC00187761, NC00188252, NC00188258, NC00188349, NC188455, NC00188873, NC00189719. Immediate Jeopardy was identified at: CFR 483.10 at tag F 580 at a scope and severity of (K). CFR 483.25 at tag F 686 at a scope and severity of (K). CFR 483.70 at tag F 835 at a scope and severity of (K). F 686 constituted Substandard Quality of Care. Immediate Jeopardy began on 03/03/22 and was removed on 07/03/22. An extended survey was conducted.	F 000		
F 550	Resident Rights/Exercise of Rights	F 550		8/4/22

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

Electronically Signed | 08/01/2022

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

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F 550 SS=D	Continued From page 1 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. §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	F 550		

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F 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to treat residents in a dignified manner when 1 of 4 residents (Resident #39) was not provided toileting before wetting herself, her clothing and the floor, and failed to provide incontinence care to 1 of 4 residents prior to the resident (Resident #10) wetting through her brief and through her clothing onto her bed pad. The findings included: 1. Resident #39 was admitted to the facility on 04/28/21 and readmitted on 12/11/21 with diagnoses which included atherosclerotic heart disease, atrial fibrillation, coronary artery disease, chronic obstructive pulmonary disease, and muscle weakness. Review of Resident #39's annual Minimum Data Set (MDS) assessment dated 05/05/22 revealed the resident had adequate vision, was cognitively intact and required extensive assistance of 2 staff members with transfers and toileting. The MDS also revealed Resident #39 was occasionally incontinent of bowel and bladder. Review of Resident #39's physician orders for June 2022 revealed the following order: Furosemide 20 milligrams (mg) by mouth every morning. Review of Resident #39's care plan dated 06/09/22 revealed a focus area for resident	F 550	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding On 07/01/22 DON immediately interviewed both resident's to see that their needs were being met and identified no concerns at this time. Beginning on 07/01/2022 the DON/designee, completed an audit (skin checks) on all resident's to identify any incontinent concerns (interviewable and non-interviewable). No other concerns were identified. On 07/11/22 DON/designee interviewed incontinent residents that are able to be interviewed and found no other concerns, those that were not interviewable, a visual check of incontinent needs were completed and no other residents were affected. Licensed nurses and nursing assistants will be educated by the DON or designee by 08/04/2022 on resident's requiring assist with toileting. Any licensed staff that cannot be reached with the initial education time frame will not receive an	

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F 550	Continued From page 3 having a self-care deficit and requiring up to extensive assistance with activities of daily living related to generalized, chronic weakness, debility secondary to multiple diagnoses and neuropathy. The interventions included assistance of 2 staff with toileting, promote independence and provide positive reinforcement for all activities attempted, refer to therapy (physical therapy (PT), occupational therapy (OT), and speech therapy(ST)), and transfers with sit to stand lift. An observation and interview on 06/27/22 at 12:16 PM revealed Resident #39 in her wheelchair in her room. The resident stated about a week ago she had put on her call light for assistance to the bathroom (could not remember the time or day) and stated it was 45 minutes before anyone came to answer the light. She stated she had timed the response by the clock on the wall in her room. The resident further stated when the Nurse Aide (NA) (could not remember her name) responded and assisted her up on her feet she wet herself and her clothing and the floor where she was standing. She stated it made her "feel like crap." Resident #39 indicated she knew when she had to go to the bathroom and did not want to lose her continence because she had to wait for assistance to the bathroom. A phone interview was attempted on 06/29/22 at 9:20 AM, 06/29/22 at 5:00 PM and 06/30/22 at 12:00 PM with NA #15 who had taken care of Resident #39 with no return call. An interview on 07/01/22 at 11:18 AM with the Administrator and Regional Director of Clinical Services revealed they expected all residents to be treated with respect and dignity. The	F 550	assignment until educated. Agency licensed nurses and newly hired licensed nurses and nursing assistants will have this education during orientation. All staff in-service will be conducted regarding call lights and resident's rights. During routine rounds the leadership staff will monitor for compliance. All resident's and RP's received a copy of resident's rights. To maintain ongoing compliance an audit will be conducted by the DON/designee with 5 random interviewable resident's, and 5 skin checks on non-interviewable resident's 5x week for 2 weeks and then 2x weekly for 2 weeks and once a week for eight weeks. Administrator will report the results of the audits to the QAPI committee for review and recommendations for 3 months thereafter. Completion date 08/04/2022.	

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F 550	Continued From page 4	F 550		

Administrator stated it was her expectation that residents be toileted in a timely manner and said no one should have to wait 45 minutes for assistance with toileting.

2. Resident #10 was admitted to the facility on 03/22/21 and readmitted on 11/02/21 with diagnoses which included type II diabetes, hypertension, cardiac arrhythmia, generalized weakness and debility.

Review of Resident #10's quarterly MDS assessment dated 03/24/22 revealed the resident was cognitively intact and required total assistance of 2 staff with transfers, and extensive assistance of 2 staff with toileting. The MDS also revealed she was always incontinent of bowel and bladder.

Review of Resident #10's care plan dated 06/22/22 revealed a focus area for resident having a self-care deficit requiring assistance with activities of daily living related to generalized weakness and debility. The interventions included assistance of 2 staff with toileting, promote independence, provide positive reinforcement for all activities attempted, refer to therapy PT, OT and ST and transfer with total lift.

An interview on 06/27/22 at 12:22 PM with Resident #10 revealed Nurse Aides (NAs) would come into her room when she rang her call light to have her brief changed and turn the light off without providing incontinence care. She stated there had been days she had gone all day without being changed and had wet through her pants and said this had happened several times last week. She stated it last happened on Saturday during the day shift and the NAs had to change

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F 550	Continued From page 5 her pants because she had wet through them. She stated it made her feel like "they had forgotten about me and my needs." A phone interview was attempted on 06/29/22 at 9:20 AM, 06/29/22 at 5:00 PM and 06/30/22 at 12:00 PM with NA #15 who had taken care of Resident #10 with no return call. An interview on 07/01/22 at 11:18 AM with the Administrator and Regional Director of Clinical Services revealed they expected all residents to be treated with respect and dignity. The Administrator stated it was her expectation that residents be provided incontinence care every 2 hours and as needed and said no one should be wetting through their clothing waiting on care.	F 550		
F 559 SS=B	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to provide a resident	F 559	On 08/02/2022 Resident #38 has been discharged from facility per request.	8/4/22

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F 559	Continued From page 6 written notification explaining the reason for a room change and failed to provide the resident with the opportunity to see the new room location and meet the new roommate prior to the room change for 1 of 1 sampled resident (Resident #38). Findings included: Resident #38 was admitted to the facility on 04/26/22. The admission Minimum Data Set (MDS) dated 05/03/22 assessed Resident #38 with moderate impairment in cognition. The MDS indicated Resident #38 could make herself understood and was able to understand others. Review of Resident #38's medical record revealed she was moved from room 105 to room 502 on 06/09/22. There was no evidence in the medical record that Resident #38 was provided a written notice of the room change. During an interview on 06/27/22 at 12:42 PM, Resident #38 stated when she was moved to room 502, she was not informed she would be changing rooms until the day she was moved. Resident #38 added she was not provided the opportunity to see the new room location or meet her new roommate prior to the move. Resident #38 stated she was not informed why she was moving to a new room and when she asked the SW, she was told it was because she had requested to move. Resident #38 voiced she never asked to move to another room. A staff progress note written by the Admissions Director on 06/29/22 at 12:30 PM read in part,	F 559	On 7/13/22 an audit was conducted by facility social worker on all transfers in the past 30 days. No other resident's were affected. To prevent this from re-occurring, The Administrator or social worker will complete the saber room change notice, provide a copy to resident, tour the desired room, and meet new roommate prior to room change. To monitor and maintain ongoing compliance beginning 08/01/22, a room change binder will be maintained and kept at the social services office. The room change binder will be taken and reviewed monthly in the QAPI meeting at which time the committee will determine further action needed. Completion date is 08/04/22	

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F 559	Continued From page 7	F 559		

"Late entry: When Admissions Director spoke to Resident #38 regarding room change to 502 on 06/09/22 she was agreeable and requested to be placed on a list for 200 hall. Was explained she was 3rd in line and she was agreeable. Social Worker (SW) will assist as needed."

During an interview on 06/29/22 at 11:24 AM, the SW explained the Admissions Director completed resident room changes and typically typed up a notice to give to staff to make them aware of the room change and notified the resident and/or family. The SW stated the rooms located on 100 Hall, where Resident #38 previously resided, were reserved for residents newly admitted to the facility that require isolation related to COVID-19 and/or rehab services. She added residents were informed upon admission if they needed a long-term bed, they would have to move to a room on another hall; however, if the resident did not want to move to a particular room, they could remain in the room on 100 Hall until another room was available. The SW recalled when Resident #38 resided on 100 Hall, she did not like having so many new roommates and had requested a more permanent room on another hall. The SW was not sure if the Admissions Director discussed the room change with Resident #38 or took her to see room 502 and meet her new roommate prior to the room change on 06/09/22.

During an interview on 06/29/22 at 5:22 PM, the Admissions Director recalled on 06/09/22 she had discussed the room change with Resident #38. The Admissions Director explained she did not take Resident #38 to see the room, meet her new roommate or provide her with a written notice prior to the room change since Resident #38 had been agreeable to the move.

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F 559	Continued From page 8 During an interview on 07/01/22 at 11:20 AM, the Administrator stated when contemplating a room change, staff were expected to discuss the room change with the resident and take the resident to tour the new room prior to the move to see if the resident had any concerns. The Administrator added residents should be given the choice as to whether or not they wanted to change rooms.	F 559		
F 561 SS=B	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561		8/4/22

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F 561	Continued From page 9 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews the facility failed to honor a resident's preference for their scheduled shower days for 1 of 6 residents (Resident #34) reviewed for Activities of Daily Living (ADL). The findings included: Resident #34 was admitted to the facility on 1/21/22 with diagnosis which included muscle weakness. Review of Resident #34's quarterly Minimum Data Set (MDS) dated 5/4/22 revealed Resident #34 was cognitively intact and required limited assistance and set up only with bathing. Review of the bathing schedule for the facility revealed Resident #34 was scheduled for showers on Tuesdays and Fridays during the second shift. Review of Resident #34's bathing chart revealed no evidence Resident #34 received a shower on any Sunday in the month of June 2022. An interview conducted with Resident #34 on 6/28/22 at 8:50 AM revealed she had gone to dialysis on Mondays, Wednesdays, and Fridays. Resident #34 further revealed she received showers on Tuesdays and Fridays on second shift but preferred an additional shower on Sundays before her dialysis appointment on Monday. Resident #34 stated she had requested multiple times to receive a shower on Sundays	F 561	Resident #34 was interviewed on 07/21/2022 for shower preference. Shower preference was updated on the shower schedule and was updated on the care plan. To identify other resident's that have the potential to be affected. All resident's upon admissions and /or families were interviewed for shower choices, and changes can be made as requested. On 07/21/2022 unit managers updated shower schedule per request from residents and /or families. To prevent this from re-occurring by 08/04/22 the DON or designee will educate facility staff nurses and nursing assistants, agency nurses and nursing assistants, on expectations that resident's will receive showers based on preferences. If residents refuse showers on scheduled day they must notify the nurse. If schedule needs to be changed, staff will notify unit manager to adjust schedule for residents. Any new hires, in house staff and agency staff will be educated in orientation. To monitor and maintain ongoing compliance, the DON or designee will randomly check 5 residents documentation of showers in PCC for compliance. Results of random audits will be documented 5x a week for 2 weeks 2x	

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F 561	Continued From page 10 but rarely got one. An interview conducted with Nurse Aide (NA) #10 on 6/29/22 at 11:50 AM revealed Resident #34 had requested for showers on Sundays. NA #10 further revealed Resident #34 needed little assistance with showers but they were unable to give the shower on Sundays due to a shortage of staffing on weekends. An interview conducted with NA #3 on 6/30/22 at 10:15 AM revealed Resident #34 had requested to receive a shower on Sunday before her dialysis appointments on Monday. NA #3 further revealed several Sundays Resident #34 did not receive a shower because there was not enough staff. NA #3 stated she had failed to report to the Unit Manager that Resident #34 preferred a shower on Sundays. An interview conducted with the Unit Manager on 6/30/22 at 2:05 PM revealed she was not aware Resident #34 had requested for an additional shower on Sundays. The Unit Manager further revealed Resident #34 needed little assistance and she expected for Resident #34 to receive an additional shower on Sundays if it was preferred. An interview conducted with the Administrator on 7/1/22 at 12:35 PM revealed she was unaware Resident #34 had not received showers on Sundays. The Administrator further revealed she expected for Resident #34 to receive a shower on Sunday if it was preferred and she would add Sundays to Resident #34's shower schedule.	F 561	a week for 2 weeks and 1x a week for 8 weeks. Results of the audits will be reported to the QAPI meeting for 3 months at which the committee will determine further action needed. Completion Date 08/04/22	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 565		8/4/22

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F 565	Continued From page 11 §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to document, resolve and communicate the facility's efforts to address	F 565	Administrator and RDCS participated in resident council on 07/14/2022 to address resident concerns. Minutes were taken	

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F 565	Continued From page 12 repeated concerns voiced during Resident Council meetings for 7 of 7 residents who regularly attended the monthly meetings (Residents #10, #13, #16, #29, #34, #39, and #72). Findings included: During a Resident Council group interview conducted on 06/30/22 at 2:33 PM, residents all reported an ongoing issue with the resolution of concerns voiced during Resident Council meetings. The residents all stated they felt facility staff did not address their concerns as they had to bring up the same issues month after month. The residents all agreed the main issues they repeatedly brought up during monthly Resident Council meetings were regarding the quality of food served and staffing, such as having to wait long periods of time for assistance with toileting and not receiving bathing assistance regularly. The facility's grievance/concern logs for the period July 2021 through June 2022 were reviewed. Concerns filed on behalf of the members of the Resident Council were recorded as follows: September 2021 related to laundry, October 2021 related to meals and laundry, April 2022 related to food, laundry, call lights and restorative nursing, and May 2022 related to melted ice cream on meal trays, medication administration and not receiving fresh ice water during each shift. The Resident Council minutes for the period July 2021 through June 2022 were reviewed and revealed no documentation of concerns voiced by residents attending the monthly meeting. In addition, there was no documentation indicating	F 565	during this meeting. A grievance form was completed for all grievances and given to appropriate staff member to address. All resolutions were documented on grievance forms, reviewed in next resident council. I To identify other resident's who have the potential to be affected a review of the prior month's resident council minutes and grievance log was reviewed to ensure all concerns were followed and resolution was provided. To prevent this from reoccurring, the Administrator or designee will provide education to all in facility staff by 8/4/22, and agency staff on facility grievance process. All new hires including new agency staff will be educated during orientation. Activities Director and assistant will be educated by administrator by 8/4/22 on the resident council process, resident council notes, and follow up process for resident council. To monitor and maintain ongoing compliance, the facility Administrator or designee will audit Resident council minutes to ensure all concerns are documented and resolved monthly to review resolution for the previous month. All new grievances will be reviewed daily during morning meeting by the administrator/designee stand up 5x a week for 2 weeks, then 2x a week for 2 weeks and then weekly for 8 weeks. Results of the audits will be reported in the QAPI meeting for 3 months at which	

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F 565	Continued From page 13 the facility's response to concerns investigated were discussed with the members during subsequent Resident Council meetings. During an interview on 06/30/22 at 3:33 PM, the Activity Director (AD) confirmed either she or the Activities Assistant attended and recorded the minutes for the Resident Council monthly meetings. The AD explained when residents voiced concerns and/or issues during the monthly meetings, she wrote them on a concern form and delivered the form to the Social Worker or Administrator who distributed them to the appropriate department manager to investigate. She explained once the resolution to the concern was provided to her, she reviewed it with the Resident Council at the next scheduled meeting. The AD confirmed the residents who regularly attended Resident Council meetings brought up the same concerns month-to-month, mainly related to staffing and food. The AD shared she did not write down the specific concerns or resolution on the monthly minutes but did verbally discuss with the residents what was or had been done to address their concerns. During an interview on 07/01/22 at 11:20 AM, the Administrator explained resident concerns voiced during Resident Council meetings were submitted to her or the SW on a concern form, given to the appropriate department manager to address, and resolution discussed with the members of the Resident Council at the next monthly meeting. The Administrator stated she was aware of the repeated concerns residents had voiced related to food and care not being provided timely and voiced the residents should not have to bring up the same concerns over and over. She explained a lot of the resident concerns dealt with staffing	F 565	the committee will determine further action needed. Completion Date 8/4/22	

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F 565	Continued From page 14 and they were actively hiring Nurse Aides but were not having as much luck finding Nurses. The Administrator stated she would expect for the minutes to include what concerns were voiced or resolved from meeting to meeting.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility	F 578		8/4/22

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F 578	Continued From page 15 may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain accurate advanced directives throughout the medical record for 1 of 13 sampled residents reviewed for advanced directives (Resident #60). Findings included: Resident #60 was admitted to the facility on 05/20/22 with multiple diagnoses that included atrial fibrillation (an irregular, often rapid heart rate), coronary artery disease (heart disease), and adult failure to thrive. Review of Resident #60's physician's orders revealed an active order for a DNR code status effective 05/20/22. The admission Minimum Data Set (MDS) assessment dated 05/26/22 assessed Resident #60 with intact cognition. Resident #60's advanced directive care plan, last reviewed/revised on 06/06/22, revealed his wishes would be honored relative to a Do Not Resuscitate (DNR) code status. A Full Measures document, dated and signed by	F 578	Resident #60's medical record was reviewed, advanced directives were updated immediately by medical director to reflect resident□s desire to be a full code and MDS updated care plan, social worker updated code status binder. Resident did not suffer any negative outcomes as a result. All residents are at a potential risk to be affected. Therefore all resident□s advanced directives were audited on 7/14/2022 by facility social worker. Care plans were reviewed and updated as needed by social worker on 7/14/22. No residents were affected by this deficient practice. To prevent this from reoccurring, all facility licensed nurses and agency nurses will be educated by facility DON or designee by 8/4/2022 that each resident has correct desired advanced directive and admissions checklist to capture code status. Admitting nurse will verify code status on admission per discharge order, facility social worker will validate advanced directives with residents and	

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F 578	Continued From page 16 Resident #60 on 06/06/22, read in part "this resident does not currently have a DNR order in effect and is to receive Full Measures, meaning if the resident were to need emergency medical treatment, facility staff is to provide resuscitative, life-sustaining and/or life-support services." Review of Resident #60's Electronic Medical Record (EMR) on 06/28/22 at 4:50 PM revealed his code status was listed as "DNR" on the profile page. Review of the Code Status notebook located at the nurses' station on 06/30/22 at 5:00 PM revealed a Full Measures document for Resident #60 with an effective date of 06/06/22. During an interview on 06/30/22 at 6:12 PM, Unit Manager (UM) #2 explained when residents were admitted to the facility, an order for code status was entered into the resident's EMR based off the information received from the hospital. She added the Admissions Director would later review code status with the resident and/or their representative when completing the admission paperwork, scan the updated form for DNR or Full Measures into the resident's EMR, place a hard copy in the Code Status notebook and notify the UM or nurse to enter a physician's order. UM #2 confirmed the active physician's order for Resident #60's DNR code status dated 05/20/22 conflicted with the Full Measures document signed by Resident #60 on 06/06/22 and filed in the Code Status notebook. The UM #2 explained if the EMR and Code Status notebook conflicted, nursing staff would follow the code status with the most recent effective date. UM #2 was unaware of the conflicting code status orders for Resident #60 and stated his code status should have been	F 578	families on admissions and ensure physicians order, care plan and code status binder are all correct. New hires and agency staff will be educated in orientation. To monitor and maintain on going compliance, DON/designee will audit all new admissions for 2 weeks, then will randomly audit 2 admissions per week for 2 weeks and then one admission per week for 8 weeks. Administrator will present to the QAPI committee for the next 3 months and the committee will modify to ensure the facility remains in compliance. completion date 08/04/22	

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updated on 06/06/22 to reflect his wishes for Full Measures.

During an interview on 06/30/22 at 6:49 PM, the Admissions Director explained when a resident admitted to the facility, the admitting nurse entered the resident's code status into their EMR based on the paperwork received from the hospital. When she met with the resident and/or their representative to complete the admission paperwork, their preference for code status was discussed and new documents were filled out according to the resident's wishes. She then scanned the signed code status documents into the resident's EMR, filed an updated copy in the Code Status notebook located at the nurses' station and informed the administrative team via group text message for the appropriate nurse/manager to update the resident's code status order in the EMR. The Admissions Director could not recall for certain if she had sent a group text message on 06/06/22 informing the administrative team Resident #60's code status changed to Full Measures per his request.

During an interview on 06/30/22 at 6:30 PM, the Administrator stated the initial order for a resident's code status was entered into their EMR based off the information received from the hospital; however, a resident could decide to change their code status at any time and their preferences would be honored. The Administrator stated Resident #60's code status should have been updated in both his EMR and the Code Status notebook to accurately reflect his code status preference when he signed the Full Measures paperwork on 06/06/22.

During a follow-up interview on 07/01/22 at 11:20

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F 578	Continued From page 18 AM, the Administrator stated it was her expectation the code status in a resident's EMR and the Code Status notebook matched and were consistent with the resident's preferences.	F 578		
F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		8/4/22

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F 580	Continued From page 19 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, and interviews with staff, family member, Wound Physician Assistant (PA) and Nurse Practitioner, the facility failed to notify the physician or Nurse Practitioner when a sacral pressure ulcer was identified on Resident #36 on 3/3/22 and when the pressure ulcer deteriorated on 3/10/22. The facility failed to notify the Wound PA of two wound culture swabs being discarded by the laboratory. Resident #36 was later diagnosed on 4/13/22 with sacral osteomyelitis. In addition, the facility failed to notify Resident #36's family member when her pressure ulcer deteriorated on 3/10/22. This failure was for 1 of 3 residents reviewed for notification of changes (Resident #36). Immediate Jeopardy began on 3/3/22 when the facility failed to notify the physician or Nurse Practitioner and obtain treatment orders for new pressure ulcer identified on Resident #36. The immediate jeopardy was removed on 7/3/22 when	F 580	Facility failed to notify the physician or nurse practitioner when a sacral pressure ulcer was identified on Resident #36. The nurse who completed the admission assessment on resident #36 did not notify the physician or nurse practioner of the pressure ulcer or obtain treatment orders. Resident□s wound deteriorated over seven days to a stage 4 and there was no notification to the physician or nurse practitioner. Facility completed a total body skin assessment and record review on all current residents on 7-1-2022 by the unit managers to find no missed notifications or deterioration of resident□s wounds, pressure sores or changes in skin integrity. An assessment of Resident #36 revealed	

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the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective.

The findings included:

Resident #36 was initially admitted to the facility on 4/23/19 with diagnoses that included Parkinson's disease, muscle weakness, spinal stenosis, atherosclerotic heart disease, hypertension and history of transient ischemic attack and cerebral infarction. She was recently re-admitted on 3/3/22 from the hospital due to acute encephalopathy and advanced Parkinson's disease.

An Admission Skin Evaluation completed by Nurse #1 on 3/3/22 indicated Resident #36 had an open area to sacrum and left lower buttock with treatment in place.

An interview with Nurse #1 on 6/28/22 at 3:10 PM revealed she observed an open area on Resident #36's sacrum on 3/3/22 which was much smaller in size than her current pressure ulcer and a raw area on the left lower buttock. Nurse #1 characterized the open area as a stage 1 pressure ulcer because it was slightly opened and required a treatment, so she applied zinc oxide and covered it with a foam dressing to both sacrum and left lower buttock. Nurse #1 stated she thought the pressure ulcer required a different treatment, but she could not remember if she had notified the physician or the Nurse Practitioner about the pressure ulcer and she did on 7-2-2022, that there was no further deterioration on the wound, treatment orders in place per physician order, resident being followed by the local wound care clinic.

" Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

Regional Director of Clinical Services (RDCS) completed education to Director of Nursing (DON) and unit managers (UM) on 7-1-2022. The facility process is as follows: a. licensed nurse completes admission skin assessment, and weekly skin assessment in electronic medical record. B. If any deterioration of skin area or new area observed, the licensed nurse notifies and documents physician or nurse practitioner immediately and obtains treatment orders. C. Licensed nurse is to complete notification and documentation of responsible party. D. Notification of DON and/or unit managers by calling or tiger texting (which is a secure web-based communication).
All licensed nurses including agency nurses were in serviced by 7/2/2022 from DON or unit manager on completing and documenting admission skin assessments and weekly skin assessments. Licensed nurses are responsible for immediate notification of physician or nurse practitioner when they observe any deteriorating wound/pressure ulcer, new wounds/pressure ulcers, or

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F 580	Continued From page 21 not obtain an order. Resident #36's Treatment Administration Record for March 2022 indicated no treatment orders for Resident #36's sacral pressure ulcer until 3/10/22 when Unit Manager #1 initiated the following treatment order: Cleanse area to coccyx with wound cleanser. Apply (brand name) occlusive dressing and cover with foam every 3 days. An interview with Unit Manager (UM) #1 on 6/30/22 at 3:20 PM revealed she couldn't remember if she had been made aware of an open area on Resident #36's sacrum upon her re-admission to the facility on 3/3/22 and she was not sure if she had checked her re-admission orders. UM #1 stated she remembered Resident #36's family member telling her to make sure they kept an eye on her sacrum because an area on her sacrum had opened when she came back from the hospital. UM #1 stated she didn't get around to assessing Resident #36's sacrum until 3/10/22 when Nurse Aide (NA) #1 reported to her that Nurse #3 had been asking her to apply a foam dressing to Resident #36's sacrum and buttocks without the nurse checking the area first. UM #1 stated she observed necrotic tissue covering the ulcer, but she couldn't tell how big it measured. The ulcer did have some drainage but did not have foul odor. UM #1 stated she thought the nurses could initiate wound care orders without consulting with the physician first and she decided on the occlusive dressing based on her previous experience with wound care. UM #1 further stated she did not notify the physician, the Nurse Practitioner, or the Wound Physician Assistant (PA) and just included Resident #36 in the list of residents to be seen by the Wound PA on his next visit at the facility.	F 580	significant change in condition and obtaining physician orders for treatments. Facility requires that all licensed nurses or agency licensed nurses notify and document significant changes in resident□s condition, new wounds or changes in pressure ulcer condition. Licensed nurses are responsible for notification and documentation of responsible party. Licensed nurses are responsible for notification to DON/UM via call or tiger texting. Nurse aides including agency nurse aides have been in serviced by 7/2/2022 by DON/designee on reporting any change in resident condition; such as skin conditions, poor intake, no urine output, observation of new areas to skin, mental status changes, physical abilities, and breathing changes to the licensed nurse immediately. DON is responsible for tracking nurses and nurse aides including agency that have received education. The DON/UM are responsible for providing education to current nurses and nurse aides who were not in serviced by 7/2/2022. Nurses and nurse aids will not be allowed to work until they receive education. New nurses and nurse aides hired after 7/2/2022 will receive education during orientation. Beginning the week of 7/4/22 the DON or designee will review five random resident□s medical record per week for any change in resident condition; such as skin conditions, poor intake, no urine output, observation of new areas to skin,	

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F 580	Continued From page 22 An interview with Nurse #3 on 6/30/22 at 1:59 PM revealed she couldn't remember doing a skin evaluation on Resident #36, but she had seen her sacral wound progress from being a quarter-sized stage 1 pressure ulcer to being covered with a black necrotic tissue. Nurse #3 stated she didn't think she was the first nurse who had discovered the black necrotic tissue, so she didn't think about reporting this to anybody. A phone interview with Resident #36's family member on 6/27/22 at 4:33 PM revealed she didn't find out about Resident #36's worsened pressure ulcer until 3/14/22 when a nurse aide asked her if she had seen Resident #36's bottom recently. Resident #36's family member stated, "it looked terrible, it had an odor and looked deep." She said she informed UM #1 that she wanted the wound clinic to look at Resident #36, but she was told that they were going to get the in-house wound care provider to look at her. A phone interview with the Wound Physician Assistant (PA) on 6/30/22 at 4:56 PM revealed he did not get consulted when an open area was first noted on Resident #36's sacrum on 3/3/22 nor when they started treatment on Resident #36's sacral pressure ulcer on 3/10/22 when it got worse. On 3/31/22, he noted an increase in drainage, so he did a wound culture and sensitivity after he debrided the wound. He was informed at the facility when he came back on 4/7/22 that the laboratory had discarded the swab from the week before because they used the wrong tube, so he obtained another one due to the wound's continued decline and it had started undermining. (Undermining is a closed passageway under the surface of the skin that is	F 580	mental status changes, physical abilities, and breathing changes to ensure any negative changes have been communicated to the physician/nurse practitioner. DON or designee will report results of the audits to the QAPI committee for 3 months at which time the committee will determine further actions needed. Completion date 8/4/22	

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open only at the skin surface. It involves a significant portion of the wound edge). When he came back on 4/14/22, he found out that Resident #36 had been to the Wound Center, so he discharged her from her care. He didn't hear back about the last wound culture and sensitivity done on 4/7/22 and assumed it was discarded again by the laboratory. He said if he obtained the result from the first wound culture sooner, it could have made a difference in treating Resident #36's pressure ulcer if the infection was superficial.

An interview with Unit Manager (UM) #1 on 6/30/22 at 3:20 PM revealed the first time the Wound PA obtained the wound culture; she was notified by the laboratory that they had to discard it because they couldn't run it due to it being too dry. UM #1 did not notify the Wound PA until the next week when he came back and performed a second wound culture. UM #1 was again informed by the laboratory that they had to discard it because they used the wrong swab. UM #1 did not think to notify the Wound PA about the wound culture not being done a second time, but she called the laboratory twice to request for the appropriate culture swabs.

An interview with the Nurse Practitioner (NP) on 6/29/22 at 3:10 PM revealed she became aware of Resident #36's sacral pressure ulcer on 4/11/22 when her family member texted her and asked her if Resident #36 could be seen by the Wound Center. The NP checked the electronic results for the laboratory and found wound cultures on 4/1/22 and 4/8/22 that were originally ordered but had been marked out. The NP stated the facility had been having problems with laboratory tests getting missed and not getting

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followed through. The NP also stated she was aware that Resident #36's pressure ulcer progressed quickly but she was not aware that Resident #36 did not have a treatment order for the wound prior to the Wound PA seeing her. The NP stated the facility physician usually ordered a treatment for a newly identified wound until the resident was seen by the Wound PA, but she was not sure why she didn't get notified of Resident #36's pressure ulcer that was noted on 3/3/22. The NP stated the nurses should have notified her on 3/3/22 when they noted a pressure ulcer on Resident #36's sacrum so a treatment could have been started while they were waiting for her to be seen by the Wound PA.

The Report of Consultation from the Wound Center dated 4/13/22 for Resident #36 indicated a stage 4 pressure ulcer to the sacrum which measured 2.2 cm in length, 2 cm in width and 2.1 cm in depth. Treatment was changed to skin prep to peri wound, antimicrobial gel wet to dry using 2 inch rolled gauze to pack wound, cover with 4x4 gauze, abdominal pad, and tape. Change daily and as needed for soiled or loose dressing. Referral to an Infectious Disease specialist. Bone culture and pathology done. Prescription for (brand name) antibiotics sent to the facility. Facility to order pressure relief cushion and specialty air mattress.

An Infectious Disease Visit Note dated 4/25/22 in Resident #36's medical record indicated Resident #36 was seen for sacral osteomyelitis. Bone biopsy was positive for Morganella. (Morganella is a species of gram-negative bacteria known to be a causative organism of opportunistic infections in wound infections.) Intravenous antibiotics were ordered. Resident #36 was

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currently using a wound vac (vacuum-assisted closure of a wound), had gotten an air mattress, and was waiting on a pressure relief cushion for her wheelchair.

The Administrator was notified of Immediate Jeopardy on 7/1/22 at 1:03 PM.

The facility provided the following IJ Removal Plan with the correction date of 7/3/22.

*Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
Facility failed to notify the physician or Nurse Practitioner when a sacral pressure ulcer was identified on Resident #36. The nurse who completed the admission assessment on Resident #36 and did not notify the physician or Nurse Practitioner of the pressure ulcer or obtain treatment orders. Resident #36's wound deteriorated over seven days to a stage 4 and there was no notification to the physician or Nurse Practitioner.

Facility completed a total body skin assessment and record review on all current residents on 7/1/22 by the unit managers to find no missed notifications or deterioration of residents' wounds, pressure sores or changes in skin integrity.

An assessment of Resident #36 revealed on 7/2/22, that there was no further deterioration on the wound, treatment orders in place per physician order, resident being followed by the local wound care clinic.

*Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete.
Regional Director of Clinical Services (RDCS) completed education to Director of Nursing (DON) and unit managers (UM) on 7/1/22. The facility process is as follows: a. Licensed nurse completes admission skin assessment, and weekly skin assessment in electronic medical record; b. If any deterioration of skin area or new area observed, the licensed nurse notifies and documents physician or Nurse Practitioner immediately and obtains treatment orders, c. Licensed nurse is to complete notification and documentation of responsible party, d. Notification of DON and/or unit managers by calling or tiger texting (which is a secure web-based communication).

All licensed nurses including agency nurses were in-serviced by 7/2/22 from DON or unit manager on completing and documenting admission skin assessments and weekly skin assessments. Licensed nurses are responsible for immediate notification of physician or Nurse Practitioner when they observe any deteriorating wound/pressure ulcer, new wounds/pressure ulcers, or significant change in condition and obtaining physician orders for treatments. Facility requires that all licensed nurses or agency licensed nurses notify and document significant changes in residents' condition, new wounds, or changes in pressure ulcer condition. Licensed nurses are responsible for notification and documentation of responsible party. Licensed nurses are responsible for notification to DON/UM via call or tiger texting.

Nurse aides including agency nurse aides have been in-serviced by 7/2/22 by DON/designee on

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reporting any change in resident condition, such as skin conditions, poor intake, no urine output, observation of new areas to skin, mental status changes, physical abilities, and breathing changes to the licensed nurse immediately.

DON is responsible for tracking nurses and nurse aides including agency that have received education. The DON/UM are responsible for providing education to current nurses and nurse aides who were not in-serviced by 7/2/22. Nurses and nurse aides will not be allowed to work until they receive education.

New nurses and nurse aides hired after 7/2/22 will receive education during orientation.

Beginning the week of 7/4/22, the DON or designee will review five random resident's medical record per week for any change in resident condition, such as skin conditions, poor intake, no urine output, observation of new areas to skin, mental status changes, physical abilities, and breathing changes to ensure any negative changes have been communicated to the physician/Nurse Practitioner.

The alleged date of IJ removal is 7/3/22.

The credible allegation for the immediate jeopardy removal was validated on 7/7/22 with a removal date of 7/3/22.

A review of in-service education records from 7/1/22 to 7/2/22 revealed education was provided to nurses and nurse aides on topics that included reporting any changes in the residents' baseline condition such change in vital signs, change in activity, and change in daily habits to the nurse.

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F 580	Continued From page 28 Any new orders, changes in residents' conditions, reports, skin integrity issues and laboratory results that have not been addressed need to be communicated timely to the physician/Nurse Practitioner, family, and the Director of Nursing. Interviews with the nursing staff revealed they had been educated on when to report a resident's change in condition as well as who to report the change in condition to. They also verbalized the different signs of changes and what observations to look for while working with the residents at the facility. The nurses stated they had been educated on notifying the physician of changes such as a new pressure wound or open area, any signs of wound infection and any wound deterioration. The laboratory book was observed at the nurses' station, and it included an audit tool that included information on the resident's name, laboratory test order date, laboratory test ordered, date the results were obtained, any critical laboratory test results and the date and time the medical provider was notified.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a	F 583		8/4/22

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F 583	Continued From page 29 private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect the private health information for 1 of 7 sampled residents (Resident #17) for medication administration by leaving confidential medical information unattended and exposed in an area accessible to the public on 1 of 4 medication carts (100 hall). The findings included: A continuous observation was made on 6/29/22 from 8:30 AM to 8:36 AM of an unattended medication cart (100 hall medication cart) parked in the hallway in front of Resident #233's room.	F 583	Resident #17's private health information was corrected immediately by logging off the computer at the time it was identified on 100 Hall All resident's are at a potential risk to be affected by this practice. An Audit was performed on 07/04/2022 by the DON to ensure all resident's private health information was not unattended or exposed in an area accessible to the public from the medication cart. To prevent this from re-occurring all staff,	

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F 583	Continued From page 30 Nurse #7 left the MAR (Medication Administration Record) visible on the medication cart computer when she went into Resident #233's room. During the observation, the MAR for Resident #233 showed a picture of the resident, her room number, list of her medications and diagnoses on the computer screen which were exposed for others to read and were not covered up. During this time, a housekeeper was observed in the hallway right next to Resident #233's door. On 6/29/22 at 8:37 AM, Nurse #7 exited Resident #233's room and stood in front of the 100 hall medication cart. Nurse #7 stated she knew she shouldn't have left the computer screen open, but she had to go into Resident #233's room and talk to the resident about letting the nurse aides get her up. Nurse #7 stated she realized that she had to maintain privacy and confidentiality of Resident #233's medical information and to not leave it exposed for other people to read. An interview with the Administrator on 7/1/22 at 3:41 PM revealed she had expected the nurses to maintain confidentiality of medical records by minimizing the computer screen or locking it before stepping away from it.	F 583	all new hires and new agency staff will be educated by 08/04/2022 regarding patient rights and confidentiality by Administrator or designee. During routine rounds the leadership staff will monitor for compliance. To monitor and maintain compliance administrator or designee will observe and monitor to ensure health information is protected from the public view. Administrator/DON will conduct random audits to ensure HIPAA compliance is in place. This will be completed 5x a week for 2 weeks then 2x a week for 2 weeks, then 1x a week for 8 weeks. Administrator will present to the QAPI committee for the next 3 months and the committee will modify to ensure the facility remains in compliance. Date of compliance is August 4, 2022	
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic	F 626		8/4/22

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F 626	Continued From page 31 leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accept a resident back into the facility upon her arrival from the hospital, resulting in the resident being transported back to the hospital that was located approximately 1 ½ hours from the facility for 1 of 2 sampled residents reviewed (Resident #379). Findings included:	F 626	Resident was admitted to the facility on November 11th, 2022 To ensure all other residents were not affected by this deficient practice, an audit was done by the facility social worker beginning 07/15/22 over the last 30 days of new admissions by the Admissions Director. No additional issues were identified.	

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F 626	Continued From page 32 Resident #379 was admitted to the facility on 09/03/21 with multiple diagnoses that included adult failure to thrive, severe-protein calorie malnutrition, and burns involving 60-69 percent (%) of body surface with 50-59% 3rd degree burns. The admission Minimum Data Set (MDS) dated 09/10/21 assessed Resident #379 with intact cognition. The MDS noted Resident #379 reported frequent pain at a level of 9 (numerical rating scale of 1 to 10 with ten being the most severe) that made it hard for her to sleep at night and limited her day-to-day activities due to the pain. Review of Resident #379's medical record revealed she was discharge to the hospital on 10/07/21. A hospital discharge summary dated 11/09/21 read in part, "A Percutaneous Endoscopic Gastrostomy (PEG tube which is the placement of a feeding tube through the skin and the stomach wall directly into the stomach) was recommended in the temporary short-term until her oral intake improved. Resident #379 and family member in agreement and PEG tube placed on 11/08/21. Diet at discharge: soft-mechanical diet with tube feeds. Will discharge to Skilled Nursing Facility (SNF) on Tuesday, 11/09/21." A hospital progress note dated 11/10/21 read in part, "Resident #379 was discharged on 11/09/21 to the SNF. On arrival to the SNF, she was sent back to us due to the PEG-tube. The SNF stated they could not manage her PEG-tube."	F 626	Facility nursing home administrator educated on 7/13/22 the Admissions Director, Medical Records and DON on Admission/Readmission communication of orders including specialty diets or specialty equipment between the hospital and the facility. DON or designee will be conducting audits on new admissions to monitor and maintain ongoing compliance to ensure there are no issues on timely transfer from the hospital to the facility. The audit will be conducted on all new admissions for 2 weeks and randomly conducted on 2 admissions for the following 2 weeks and 1 admission for the next 8 weeks. Results of audits will be reported to the quality assurance and improvement committee for three months at which the committee will determine any other actions necessary. QAPI committee will monitor to assure facility remains in compliance. Completion date is 8/4/22	

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Review of Resident #379's medical record revealed she was readmitted to the facility from the hospital on 11/11/21.

Resident #379 discharged to the community on 01/23/22 and was unable to be interviewed.

During an interview on 06/29/22 at 5:22 PM, the Admissions Director revealed the Corporate Hospital Liaison reviewed Resident #379's discharge referral on 11/09/21 and approved her for readmission but did not notify anyone at the facility. The Admissions Director was notified by the Hospital Case Manager the afternoon of 11/09/21 that Resident #379 was returning to facility and she had a PEG tube. The Admissions Director recalled the former Director of Nursing (DON) instructed her to notify the Hospital Case Manager the facility would not be able to accept Resident #379 back as they did not have the supplies or formula to manage Resident #379's PEG tube feedings. When she spoke to the Hospital Case Manager to let her know they could not accept Resident #379 back at this time, the Hospital Case Manager stated they would have to accept her since she was already enroute back to the facility and the Admissions Director informed the Hospital Case Manager they would have to send Resident #379 back to the hospital when she arrived. The Admissions Director stated when Resident #379 arrived at the facility, the former DON met Emergency Medical Services (EMS) outside and informed them the facility wasn't able to accept Resident #379 back and they would have to transport her back to the hospital. The Admissions Director explained the facility purchased PEG tube supplies from their medical equipment company and they weren't able to get the supplies Resident #379 needed on

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11/09/21. She added a few days later, they received the supplies and Resident #379 returned to the facility. The Admissions Director stated it was never the facility's intention not to accept Resident #379 back to the facility and the only reason her return to the facility was delayed was because they were not informed in time of her pending discharge from the hospital for them to order the necessary supplies for Resident #379's tube feedings.

A telephone attempt on 06/29/22 at 7:53 PM for interview with the former DON was unsuccessful.

A telephone attempt on 07/01/22 at 3:16 PM for interview with the Corporate Hospital Liaison was unsuccessful.

During an interview on 07/01/22 at 3:45 PM, the Administrator revealed on 11/09/21 the Corporate Hospital Liaison had approved Resident #379's return from the hospital without notifying the facility. When the former DON reviewed the discharge summary and noticed Resident #379 had a PEG tube, the Corporate Hospital Liaison was informed they would need to delay Resident #379's readmission for a day or so to allow them the time to get the necessary supplies and formula Resident #379 would need. The Administrator explained by the time they had notified the Corporate Hospital Liaison and she spoke to the Hospital Case Manager, Resident #379 was already enroute back to the facility. The Administrator confirmed the former DON met EMS outside upon their arrival and informed them Resident #379 would need to go back to the hospital which was located approximately 1 ½ hours from the facility. The Administrator was unaware of the order on the discharge summary

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F 626	Continued From page 35 indicating Resident #379 could have a mechanical soft diet with tube feedings. The Administrator stated had she known that on 11/09/21, Resident #379 would have been allowed to return to the facility and there would have been no reason for them to send her back to the hospital.	F 626		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications.	F 636		8/4/22

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F 636	Continued From page 36 (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment within 14 days of the Assessment Reference Date (ARD) for 1 of 3 sampled residents reviewed for Resident Assessments (Resident #31). Findings included:	F 636	The facility failed to complete an MDS comprehensive assessment within 14 days of the ARD. Resident #31 MDS was completed and modified on 03/14/2022 Audit was conducted of the last 30 days to check for late completions on 07/15/2022. No other late completions were identified.	

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F 636	Continued From page 37 Resident #31 was admitted to the facility on 02/01/22. Review of Resident #31's electronic medical record revealed an admission MDS assessment with an ARD of 02/08/22. The MDS assessment was noted as completed on 03/07/22. During an interview on 06/30/22 at 9:35 AM, the MDS Coordinator stated they realized there was an issue with MDS assessments not being completed on time during a COVID-19 outbreak at the facility. The MDS Coordinator explained they got behind when a lot of residents on the assisted living hall tested positive for COVID-19 and were moved to a skilled hall which created a lot more MDS assessments that had to be completed. The MDS Coordinator reviewed Resident #31's admission MDS dated 02/08/22 and confirmed it was not completed within the regulatory time frame. During an interview on 07/01/22 at 11:20 AM, the Administrator stated she would expect for MDS assessments to be completed within the regulatory timeframe.	F 636	Regional Director of Reimbursement educated MDS nurses on 7/27/22 on completion of assessments according to calendar guidelines. To monitor and maintain on going compliance, beginning 08/01/2022 an audit will be conducted on MDS completion within the ARD. Audits will be for all MDS assessments that are due according to calendar for 2 weeks. Two random assessments will be audited for 2 weeks and 1 randomly audited for 8 weeks. Administrator will present the results of the audits to the QAPI committee for three months, The QAPI will modify as appropriate to ensure the facility remains in compliance. Completion date 8/4/21	
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 reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments to reflect a	F 641	Regional reimbursement director confirmed with the state RAI office that MDS for pressure ulcer for resident #36	8/4/22

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F 641	Continued From page 38 pressure ulcer for 1 of 3 residents reviewed for wound care (Resident #36) and the Pre-Admission Screening and Resident Review (PASRR) level for 3 of 3 residents reviewed (Resident #14, Resident #379, and Resident #50). The findings included: 1. Resident #36 was admitted to the facility on 4/23/19 with diagnoses that included Parkinson's disease and muscle weakness. An Admission Skin Evaluation completed by Nurse #1 on 3/3/22 indicated Resident #36 had an open area to sacrum and left lower buttock with treatment in place. The annual Minimum Data Set (MDS) assessment dated 3/9/22 indicated Resident #36 was at risk of developing pressure ulcers/injuries, had moisture-associated skin damage but no pressure ulcers. The Care Area Assessment (CAA) dated 3/23/22 for pressure ulcer/injury indicated "Resident #36 had been seen by the wound doctor for her skin breakdown. These areas of moisture had history of actual breakdown. The areas were not coded as pressure ulcer during this assessment. However, after this ARD (Assessment Reference Date), it was noted to be worse. According to the wound doctor, there is now an unstageable ulcer." An interview with Nurse #1 on 6/28/22 at 3:10 PM revealed she observed an open area on Resident #36's sacrum on 3/3/22 which was much smaller in size than her current pressure ulcer and a raw	F 641	did not need to be modified related to there was no documentation in the medical record to support coding as pressure ulcer on the MDS up until midnight of the ARD. The moisture wound was coded, and not until after the ARD was past the supporting documentation was noted in the medical record and therefore a significant change MDS was completed on 4/29/22. modification and care plans reflecting Level II PASARR's which consisted for residents #379, #14 and #50 were immediately corrected. Audit of the last 30 days ARD's with current pressure ulcers showed that they were coded accurately. Audit of Level II PASARR's for MDS and completion and care plan were completed for the all resident's on 7/12/2022 by social worker Education was provided by the Regional Reimbursement Nurse to MDS/social services and activities on 7/27/22. Audits for ARD's will be completed for 3 random resident's a week for 12 weeks to assure Level II PASARR and pressure ulcers coding is complete. Administrator will bring results to the QAPI committee monthly for three months and committee will modify plans as needed to assure facility is in compliance. Completion date 8/4/22	

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F 641	Continued From page 39	F 641		

area on the left lower buttock. Nurse #1 characterized the open area as a stage 1 pressure ulcer because it was slightly opened and required a treatment.

An interview with the MDS Coordinator on 7/7/22 at 1:19 PM revealed when she had seen the skin evaluation completed by Nurse #1 on 3/3/22 about the open area on Resident #36's sacrum, she left a note for one of the unit managers, but she couldn't remember which one, in order to verify if the open area was a pressure ulcer. The MDS Coordinator stated she couldn't recall if the unit manager got back to her with an answer. She further stated this issue was something she would normally question and ask the nurse about, but she didn't ask Nurse #1 because she didn't always work at the facility. She explained that when she completed the CAA right before she transmitted the 3/9/22 MDS, she saw a note from the wound doctor about Resident #36 having an unstageable ulcer. The MDS Coordinator stated she didn't go back and code the pressure ulcer on the MDS because she wasn't sure if the open area observed on 3/3/22 was the same unstageable ulcer seen by the wound doctor on 3/17/22.

An interview with the Administrator on 7/7/22 at 2:41 PM revealed the MDS Coordinator should have coded Resident #36's pressure ulcer on her MDS if the pressure ulcer started on 3/3/22 and it was within the 7-day look back period.

2. Resident #14 was admitted to the facility on 03/22/22 with multiple diagnoses that included anxiety, depression, and psychotic disorder.

A North Carolina Medicaid Uniform Screening

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F 641	Continued From page 40	F 641		

Tool (NC MUST) document dated 03/22/22 revealed Resident #50 had a Level II PASRR with an expiration date of 04/29/22.

The admission Minimum Data Set (MDS) dated 03/28/22 revealed Resident #14 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

During an interview on 06/30/22 at 11:40 AM, the Social Worker (SW) revealed she was responsible for completing the PASRR section on MDS assessments. The SW confirmed Resident #14 had a Level II PASRR as indicated on the determination letter dated 03/22/22. The SW explained she did not realize it needed to be coded on the MDS as a Level II PASRR if the PASRR was only for a 30, 60 or 90 day period and had to be reevaluated through the PASRR process when a longer period was needed. The SW stated it was a misunderstanding of the process and a modification would be submitted to accurately reflect Resident #14 had a Level II PASRR.

During an interview on 07/01/22 at 11:20 AM, the Administrator stated she would expect for MDS assessments to be coded appropriately and accurately reflect a resident's PASRR status.

3. Resident #379 was admitted to the facility on 09/03/21 with multiple diagnoses that included anxiety, depression, and post-traumatic stress disorder.

An undated North Carolina Medicaid Uniform Screening Tool (NC MUST) document revealed Resident #379 had a Level II PASRR with an

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F 641	Continued From page 41	F 641		

expiration date of 12/22/21.

The admission Minimum Data Set (MDS) dated 09/10/21 revealed Resident #379 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

The re-admission Minimum Data Set (MDS) dated 11/18/21 revealed Resident #379 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

During an interview on 06/30/22 at 11:40 AM, the Social Worker (SW) revealed she was responsible for completing the PASRR section on MDS assessments. The SW confirmed Resident #379 had a Level II PASRR. The SW explained she did not realize it needed to be coded on the MDS as a Level II PASRR if it the PASRR was only for a 30, 60 or 90 day period and had to be reevaluated through the PASRR process when a longer period was needed. The SW stated it was a misunderstanding of the process and a modification would be submitted to accurately reflect Resident #379 had a Level II PASRR.

During an interview on 07/01/22 at 11:20 AM, the Administrator stated she would expect for MDS assessments to be coded appropriately and accurately reflect a resident's PASRR status.

4. Resident #50 was admitted to the facility on 08/14/17 with multiple diagnoses that included dementia, schizophrenia, and bipolar disorder.

A North Carolina Medicaid Uniform Screening Tool (NC MUST) document dated 08/08/17

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F 641	Continued From page 42 revealed Resident #50 had a Level II PASRR with no expiration date. The annual Minimum Data Set (MDS) dated 05/10/22 revealed Resident #50 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. During an interview on 06/30/22 at 11:40 AM, the Social Worker (SW) confirmed she was responsible for completing the PASRR section on MDS assessments. The SW confirmed Resident #50 had a Level II PASRR. The SW explained she did not realize it needed to be coded on the MDS as a Level II PASRR when dementia was the primary diagnosis. The SW stated it was a misunderstanding of the process and a modification would be submitted to accurately reflect Resident #50 had a Level II PASRR. During an interview on 07/01/22 at 11:20 AM, the Administrator stated she would expect for MDS assessments to be coded appropriately and accurately reflect a resident's PASRR status.	F 641		
F 656 SS=D	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	F 656		8/4/22

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F 656	Continued From page 43 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop comprehensive, individualized care plans that addressed Preadmission Screening and Resident Review (PASRR) Level II status for 2 of 3 sampled residents reviewed for PASRR (Resident #14 and #379).	F 656	Care plans were immediately developed addressing PASARR level 2 status for residents 14 and 379 A 100% audit on 7/12/22 by social worker of PASRR's found no other resident affected by this deficient practice.	

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F 656	Continued From page 44 Findings included: 1. Resident #14 was admitted to the facility on 03/22/22 with multiple diagnoses that included anxiety, depression, and psychotic disorder. A North Carolina Medicaid Uniform Screening Tool (NC MUST) document dated 03/22/22 revealed Resident #14 had a Level II PASRR with an expiration date of 04/29/22. A PASRR Level II Determination Letter for Resident #14 dated 04/29/22 indicated she had a Level II PASSAR with an expiration date of 07/28/22 and noted nursing facility placement was appropriate for a 90-day period. Review of Resident #14's active care plans, last reviewed/revised 06/21/22, revealed no care plan that addressed her Level II PASRR status. During an interview on 06/30/22 at 11:40 AM, the Social Worker (SW) revealed she was responsible for developing PASRR care plans for residents with a Level II PASRR. The SW confirmed Resident #14 had a Level II PASRR as indicated on the determination letter dated 04/29/22. The SW explained she did not realize it was considered a Level II PASRR when the PASARR was only effective for a 30, 60 or 90 day period and had to be reevaluated through the PASRR process when a longer period was needed. The SW verified a Level II PASRR a care plan was not developed for Resident #14 and stated it was a misunderstanding of the process. During an interview on 07/01/22 at 11:20 AM, the	F 656	Education was provided by Regional Reimbursement nurse to MDS and Social Worker on 7/27/22 and any new staff hired after 07/27-2022 will be educated on the requirement for comprehensive person-centered care plans for PASRR status. To prevent this from reoccurring, the facility social worker will audit all resident's for PASARR's beginning 08/01/2022 for new admissions and updates 5x a week for 2 weeks 2x a week for 2 weeks and weekly for 8 weeks. Current residents will be reviewed during Resident Review meeting to ensure that there are no significant changes in condition. The facility social worker will report results of the audits to the Quality Assurance and Performance Improvement meeting for 3 months at which time the committee will determine further action needed. Date of completion 8/4/22.	

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F 656	Continued From page 45	F 656		

Administrator stated it was her expectation that residents with a Level II PASRR would have care plans developed that reflected their PASRR needs.

2. Resident #379 was admitted to the facility on 09/03/21 with multiple diagnoses that included anxiety, depression, and post-traumatic stress disorder.

An undated North Carolina Medicaid Uniform Screening Tool (NC MUST) document revealed Resident #379 had a Level II PASRR with an expiration date of 12/22/21.

A PASRR Level II Determination Notification letter for Resident #379, with an effective date of 12/28/21 and no expiration date, revealed nursing facility placement was appropriate with specialized services that consisted of individual/group psychotherapy.

Review of Resident #379's care plans, last reviewed/revised 12/30/21, revealed no care plan that addressed her Level II PASRR status or the specialized services needed as described in the PASRR Level II Determination Notification letter.

Resident #379 discharged to the community on 03/01/22.

During an interview on 06/30/22 at 11:40 AM, the Social Worker (SW) revealed she was responsible for developing PASRR care plans for residents with a Level II PASRR. The SW confirmed Resident #379 had a Level II PASRR as indicated on the determination letter dated 12/28/21. The SW explained, initially, Resident #379's PASARR had an expiration date and she

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F 656	Continued From page 46 did not realize it was considered a Level II PASRR when the PASARR was only effective for a 30, 60 or 90 day period and had to be reevaluated through the PASRR process when a longer period was needed. The SW verified a Level II PASRR care plan was not developed for Resident #379 and stated it was a misunderstanding of the process. During an interview on 07/01/22 at 11:20 AM, the Administrator stated it was her expectation that residents with a Level II PASRR would have care plans developed that reflected their PASRR needs.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		8/4/22

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AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 47 §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, Certified Occupational Therapy Assistant (COTA), Physical Therapy Assistant (PTA), and staff interviews, the facility failed to provide a maintenance program to prevent a decline in the ability to ambulate for 2 of 2 sampled residents (Resident #58 and Resident #39) reviewed for maintaining activities of daily living. The findings included: 1. Resident #58 was admitted to the facility on 11/11/19 with diagnoses which included osteoarthritis, and rheumatoid arthritis. Resident #58's quarterly MDS dated 05/24/22 revealed she was moderately cognitively impaired, required extensive assistance of 1 staff for transfers, did not walk in her room, walked in corridor with limited assistance of 1 staff member, and used a walker and wheelchair for mobility.	F 676	Resident #58 and #39 were immediately screened by rehab for maintenance plans from therap. Last 30 days of discharges from therapy were audited by the director of rehab (DOR) or designee on 07/21/22 for potential maintenance plans for restorative nursing care (for example ambulation, ROM, etc). The DON or Designee will complete education by 8/4/2022 to the facility nurses and nurse aides, agency nurses and nurse aides. New staff nurses and agency will receive education in orientation. Residents who are discharging from skilled therapy, that will remain in the community, will be reviewed by the MDS nurse or designee for the need for a restorative program. Once determined the need for a restorative	

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F 676	Continued From page 48 Observation and interview on 06/27/22 at 10:34 AM of Resident #58 revealed her in her room sitting in her wheelchair. Resident #58 stated she would like for the facility to have a restorative program so she could walk in the hallway daily with her walker. She said she had not asked anyone to assist her because she knew they were busy and short staffed and didn't have time to help her ambulate in the hallway. Interview on 06/29/22 at 8:07 AM with the COTA revealed there had not been a restorative program at the facility for over a year and said residents had not maintained their mobility once discharged from therapy. She stated the progress the residents had made with therapy had all diminished due to not having a restorative program. The COTA further stated therapy had written up programs for each resident to follow with restorative but the carry over was not there from therapy to restorative. She indicated Resident #58 did well in therapy and would get to the point she could ambulate 125 to 150 feet in the hallway with her walker and then when she was discharged there was no maintenance program to keep her going. The COTA further indicated if restorative was working with her after therapy, she could be walking in the hall with her walker instead of being in her wheelchair all day. According to the COTA the resident was last discharged from therapy on April 29, 2022. Interview on 06/29/22 at 5:14 PM with Nurse Aide (NA) #12 revealed she was often assigned to Resident #58 from 7:00 AM to 7:00 PM. She stated when they had a restorative program the resident was able to walk in the hallway the length of the hallway with her walker but stated since the facility no longer had a restorative program, she	F 676	program, the MDS nurse will communicate and assign program for the restorative aide. If needed MDS nurse and or therapy department will develop a restorative program based on the residents needs/ abilities. MDS and or therapy will educate the restorative assistant based on the residents individualized plan of care. The director of therapy or designee will audit the discharging residents who will be staying in the community after their skilled stay to ensure a review was completed, the MDS nurse communicates to restorative aide the need for restorative programing. These audits will be completed 5x a week for 2 weeks then 2x a week for 2 weeks, then 1x a week for 8 weeks. The MDS nurse will present to the QAPI committee for the next 3 months and the committee will modify to ensure the facility remains in compliance. Date of completion is 8/4/22	

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F 676	Continued From page 49	F 676		

doesn't walk but just sat in her wheelchair. NA #12 stated with their current workload there was not enough time in their shift to walk residents.

Interview on 06/29/22 at 5:35 PM with Nurse #12 revealed she was the permanent nurse assigned to the resident during day shift from 7:00 AM to 3:00 PM. She stated Resident #58 had done well ambulating with her walker when they had a restorative program and was able to walk the length of the hallway and walk to the bathroom. Nurse #12 further stated when the program was stopped the resident quit asking to walk because the NAs were too busy to help her. She indicated the resident would probably do well with a restorative program and would be able to ambulate with her walker instead of sitting in her wheelchair all day.

Interview on 07/01/22 at 10:34 AM with PTA revealed he had worked with Resident #58 multiple times and stated she had done well with ambulating with her walker. He stated the resident was transferring with minimum to moderate assistance depending on the day and how her knees were feeling that day and was ambulating about 100 to 125 feet with her walker. The PTA further stated if there was a restorative program it would prolong her ability to ambulate, and she would not need therapy as often. He indicated a restorative or maintenance program would be beneficial for her to continue ambulating with her walker.

Interview on 07/01/22 at 11:31 AM with the Administrator and Regional Director of Clinical Services (RDCS) revealed there had not been a maintenance or restorative program in place at the facility for about a year due to staffing. The

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F 676	Continued From page 50	F 676		

Administrator stated they relied on the NAs to ambulate the residents and maintain their abilities. The Administrator further stated the Nurses could also assist with ambulating residents. The Administrator indicated they were staffing about 90% of positions with agency staff and it posed a problem when they were not engaged with the residents like full time staff. She indicated they had hired 26 new NAs and they were beginning to look at promoting a NA to a lead position to be able to get restorative back in place. The Administrator further indicated corporate was looking at incorporating restorative in with therapy.

2. Resident #39 admitted to the facility on 04/28/21 and readmitted on 12/11/21 with diagnoses which included muscle weakness.

Review of her annual Minimum Data Set (MDS) assessment dated 05/05/22 revealed she was cognitively intact, required extensive assistance of 2 staff members with transfers, did not walk in her room or the corridor, and used a wheelchair for mobility.

Observation and interview on 06/27/22 at 10:34 AM of Resident #39 revealed her in her room sitting in her wheelchair talking with her roommate. She stated she had been walking with assistance to the bathroom but since physical therapy had discharged her no one would walk with her to the bathroom. Resident #39 stated the Nurse Aides (NAs) came in and got her up with the sit to stand lift and then put her in the wheelchair and that is where she remained for the day. Resident #39 further stated "no one has time to assist me with walking to the bathroom."

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F 676	Continued From page 51	F 676		

Interview on 06/29/22 at 8:40 AM with Certified Occupational Therapy Assistant (COTA) revealed Resident #39 had been on the caseload for therapy and was recently discharged on May 31, 2022, with the recommendation for a maintenance program with nursing. The COTA stated Resident #39 had been walking 30 feet with contact guard assistance (required hand contact on the resident because of occasional loss of balance) once she was lifted with the sit to stand. She further stated once Resident #39 was up on her feet she did well with walking to the bathroom but said there was no maintenance program with nursing and the residents did not maintain their abilities once they were discharged from therapy. The COTA explained there had not been a maintenance or restorative program at the facility for over a year due to staffing.

Interview on 06/29/22 at 5:14 PM with Nurse Aide (NA) #12 revealed she was often assigned to Resident #39 from 7:00 AM to 7:00 PM. She stated when they had a restorative program the resident was able to walk with 2 staff assist to the bathroom but stated since the facility no longer had a restorative program, she doesn't walk but just sat in her wheelchair. NA #12 further stated she and the other NAs working on the halls did not have time to walk residents with all the other responsibilities they were assigned.

Interview on 06/29/22 at 5:35 PM with Nurse #12 revealed she was the permanent nurse assigned to the resident during day shift from 7:00 AM to 3:00 PM. She stated Resident #39 had done well ambulating to and from the bathroom when they had a restorative program. Nurse #12 further stated when the program was stopped the

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F 676	Continued From page 52	F 676		

resident stopped asking to be walked to the bathroom and just started transferring from her wheelchair to the toilet. She indicated the resident would probably do well with a restorative program and would be able to ambulate to and from the bathroom instead of sitting in her wheelchair all day and just transferring to and from the toilet.

Interview on 07/01/22 at 10:34 AM with Physical Therapy Assistant (PTA) revealed he had worked with Resident #39 and said she was recently discharged from therapy on May 31, 2022. He said once she was up on her feet, she was able to walk 30 feet with contact guard assistance. He stated that enabled her to walk to the bathroom and back with assistance instead of being in her wheelchair all day. The PTA further stated if there was a maintenance program such as restorative that would have prolonged her ability to ambulate to the bathroom and would have maintained her walking. He indicated a maintenance or restorative program would be beneficial for Resident #39.

Interview on 07/01/22 at 11:31 AM with the Administrator and Regional Director of Clinical Services (RDCS) revealed it had been about a year since they were able to offer a maintenance or restorative program due to overall staffing issues with Nurse Aides. The Administrator and RDCS stated they relied on the NAs to ambulate the residents and maintain their abilities. The Administrator further stated the Nurses could also assist with ambulating residents. The Administrator indicated they were staffing about 90% of positions with agency staff and it posed a problem when they were not engaged with the

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F 676	Continued From page 53 residents like full time staff. She further indicated they had hired 26 new NAs and they were beginning to look at promoting a NA to a lead position to be able to get restorative back in place. The Administrator explained that corporate was looking at incorporating restorative in with therapy.	F 676		
F 684 SS=E	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 record review, and interviews with staff and the Nurse Practitioner, the facility failed to obtain culture swabs from the laboratory needed to collect a specimen for a wound culture ordered by the physician for a resident with a suspected wound infection for 1 of 3 residents reviewed for quality of care (Resident #70). The findings included: Resident #70 was admitted to the facility on 8/23/21 with diagnoses that included hypertension and diabetes. The quarterly Minimum Data Set (MDS) assessment dated 6/6/22 indicated Resident #70 was severely cognitively impaired, required	F 684	Culture was immediately obtained on resident #70, resident remains in the community. 100% audit of all cultures for the last 30 days were reviewed on 7/28/22 and no other resident□s were affected. To prevent this from reoccurring, the Director of Nursing or designee will provide education to licensed nursing staff and licensed agency staff by 8/4/22 on the expectation of collecting labs timely and monitoring for expired lab supplies. Any new facility licensed nurses and agency staff will receive this education during orientation.	8/4/22

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F 684	Continued From page 54 extensive physical assistance with activities of daily living and had no skin conditions. The Physician Orders dated 6/17/22 in Resident #70's medical record indicated orders for: culture wound to left shoulder for infected boil/cyst, warm compress daily for 3 days to cyst on left shoulder and Doxycycline 100 mg (milligrams) give 1 tablet by mouth two times a day for wound infection for 10 days. A progress note dated 6/23/22 at 7:12 PM by Nurse #7 indicated no adverse reactions to Doxycycline 100 mg by mouth twice a day x 10 days related to wound infection. Continue to await laboratory to provide swabs to collect culture and sensitivity to boil to left shoulder. An interview with Nurse #7 on 6/30/22 at 12:44 PM revealed when she worked with Resident#70 on 6/23/22, she was told by the nurse before her that the swab that was collected for her wound culture was discarded because they used the wrong culture swab. Nurse #7 was told that laboratory was supposed to be sending the right swab for them to use. A phone interview with Nurse #4 on 6/29/22 at 10:11 PM revealed she worked night shift from 11:00 PM on 6/26/22 to 7:00 AM on 6/27/22 and received report that they still needed to do a wound culture on Resident #70's boil on her left shoulder. Nurse #4 stated she was unable to obtain the wound culture because the swabs that were available were all expired. Nurse #4 stated that she observed a whole box of expired culture swabs, and she went ahead and discarded them. She told the phlebotomist who came in early that morning that the facility was waiting on the	F 684	Beginning the week of 08/01/2022, the DON or designee will complete an audit of wound supplies to ensure no supplies are expired, and timeliness of lab results. This will be completed 5x a week for 2 weeks then 2x a week for 2 weeks, then 1x a week for 8 weeks. The DON will present to the QAPI committee for the next 3 months and the committee will modify to ensure the facility remains in compliance. Date of completion 8/4/22	

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F 684	Continued From page 55	F 684		

laboratory to bring them the right culture swabs. Nurse #4 said the phlebotomist told her that she wasn't aware of this but that she would bring them some the next day.

A progress note dated 6/28/22 at 3:21 PM by Nurse #2 indicated a wound culture for boil to left shoulder was obtained and placed in refrigerator.

An interview with Nurse #2 on 7/7/22 at 12:45 PM revealed when she obtained the wound culture on Resident #70 on 6/28/22, the boil had already dried so she just rubbed the tip of the swab on the skin where the boil was.

An interview with the Nurse Practitioner (NP) on 6/30/22 at 10:40 AM revealed she had seen Resident #70 on 6/17/22 and she had observed a boil on her left shoulder. The NP stated when she touched it she had expressed some pus coming out of it which was why she had ordered a warm compress, wound culture, and Doxycycline. The NP stated she did not expect the wound culture to be done before the antibiotic therapy, but she had expected it to have been done within 1-2 days of when she had given the order. The NP looked at the laboratory results on the laboratory website and noted that Resident #70's wound culture was done on 6/28/22 with partial results received on 6/30/22. The NP stated the facility had a system-wide problem with the laboratory and there was no excuse for a wound culture to be done after antibiotic therapy was completed.

An interview with the Administrator on 7/1/22 at 3:41 PM revealed the Director of Nursing was supposed to oversee obtaining the laboratory supplies and she didn't know what happened with

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F 684	Continued From page 56 the culture swabs.	F 684		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews with resident, family member, staff, Wound Physician Assistant (PA) and Nurse Practitioner, the facility failed to assess, obtain treatment orders from the physician, and identify deterioration of the pressure ulcer which resulted in a serious adverse outcome. Resident #36's open area on her sacrum deteriorated from an open area to an unstageable pressure injury with necrotic tissue in a week (from 3/3/22 to 3/10/22). The facility also failed to have two wound cultures processed on Resident #36's sacral pressure ulcer resulting in delayed treatment for osteomyelitis. In addition, the facility failed to provide pressure ulcer care as ordered by the Wound PA for Resident #11. These failures were for 2 of 3 residents reviewed for pressure ulcers (Resident #36 and Resident #11).	F 686	" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; Resident #36 readmitted on 3-3-2022 and had an identified wound/pressure ulcer without physician notification or ordered treatment. The facility failed to assess, obtain treatment orders from physician, identify deterioration of the pressure ulcer, and process a wound culture which resulted in a serious adverse outcome. A culture was ordered by physician and completed however not resulted by lab twice from an expired swab and dry specimen. The facility failed to follow up on lab results and did not ensure lab	8/4/22

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F 686	Continued From page 57 Immediate Jeopardy began on 3/3/22 when the facility failed to provide the necessary care and services for a pressure ulcer that deteriorated in condition. The immediate jeopardy was removed on 7/3/22 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Example #2 was cited at a scope and severity level of D. The findings included: 1. Resident #36 was initially admitted to the facility on 4/23/19 with diagnoses that included Parkinson's disease, muscle weakness, spinal stenosis, atherosclerotic heart disease, hypertension and history of transient ischemic attack and cerebral infarction. She was recently re-admitted on 3/3/22 from the hospital due to acute encephalopathy and advanced Parkinson's disease. An Admission Skin Evaluation completed by Nurse #1 on 3/3/22 indicated Resident #36 had an open area to sacrum and left lower buttock with treatment in place. A Weekly Skin Evaluation completed by Nurse #2 on 3/4/22 indicated Resident #36 had a wound to sacrum and left lower buttock with treatment in place. The annual Minimum Data Set (MDS) assessment dated 3/9/22 indicated Resident #36	F 686	supplies were not expired. Facility completed a full body skin assessment and record review on all current residents on 7-1-2022 by the unit managers. Resident #36 was the only identified resident who has suffered an adverse outcome related to non-compliance. The Regional Director of clinical services (RDCS) audited lab supplies to ensure appropriate supplies on hand. An assessment of Resident #36 revealed on 7-2-2022, no further deterioration of pressure ulcer, treatment orders in place per physician order, resident being followed by local wound care clinic. " Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The Regional Director of Clinical Services (RDCS) educated the Director of Nursing (DON) and nurse unit managers (UM) of the existing/revised process of labs on 7-2 -2022. Process is as follows for labs: a. licensed nurse records lab order in electronic medical record. B. Notification of Responsible Party (R.P.) of order, C. Licensed nurse completes lab requisition in facility lab book, D. Licensed nurse completes patient log in facility lab book E. Phlebotomist from lab obtains specimen, F. Licensed nurse receives results via lab fax, G. Licensed nurse checks off in facility lab book on patient log, H. Licensed nurse notifies physician	

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was cognitively intact, had no rejection of care behaviors and required extensive physical assistance with bed mobility, locomotion, and toilet use. Resident #36 had impairment on one side of her upper extremities and used a wheelchair. The MDS further indicated Resident #36 was frequently incontinent of urine, but she was always continent of bowel. Resident #36 was at risk of developing pressure ulcers/injuries, had moisture-associated skin damage but no pressure ulcers.

An interview with Resident #36 on 7/1/22 at 10:04 AM revealed when staff came to change her and got her up out of bed this morning, she was wet and had to be changed. Resident #36 stated staff did check in on her during the night to see if she was wet, but she did not recall the name of the nurse aide or the time they came in. She stated she looked up at the clock on the wall and said she had waited for about 30 minutes this morning for them to come change her. Resident #36 stated she typically went to the bathroom before going to bed in the evening which could be anywhere from 6:30 PM to 9:00 PM depending on how long staff took to help her in bed. She was assisted with incontinence care and to bed around 7:30 PM the night before. Resident #36 further stated staff would get her up in the morning before breakfast, she would stay up through lunch, staff would lie her down after lunch, get her up about 30 minutes before supper, and then put her to bed between 6:30 PM to 9:00 PM. Resident #36 stated she never refused to lie down in bed and stated it felt good to get off her bottom for a while. She also did not refuse assistance with positioning on her side in bed and stated staff did come in and offer to turn her. Resident #36 stated she has had a pressure

of abnormal lab results or places within normal limits labs in physician box and notifies R.P. Location of lab supplies for blood specimens are located in medication rooms, in addition to lab supplies for urine samples. Wound culture supplies are located in DON office in cabinet. If a physician or nurse practitioner orders a wound culture, the licensed nurse will obtain the culture, place in lab refrigerator, complete the lab requisition and complete the patient log in the facility lab book. Results are received via lab fax. In addition, the DON/designee are responsible for tracking lab results beginning 7/4/2022. If a licensed nurse is contacted by the lab about a problem, the licensed will be responsible for notifying physician and reentering the order and obtaining sample. Any pressure ulcers or skin conditions that are referred to wound physician are communicated via order and requested resident information are communicated by DON and or UM. No Licensed nurse can initiate treatments without a physician order.

On 7-1-2022 the RDCS also completed education with DON and unit managers on the process of notification. Notification process is as follows: A. licensed nurse complete admission skin assessment, and weekly skin assessment in electronic medical record as it is assigned as triggered by electronic medical records system. B. If any deterioration of skin area or new area observed, the licensed nurse notifies physician or nurse practitioner immediately, and obtains

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F 686	Continued From page 59 ulcer to her sacrum for a long time and it hurt. She said it felt like something was sticking her all the time. An interview with Nurse #1 on 6/28/22 at 3:10 PM revealed she observed an open area on Resident #36's sacrum on 3/3/22 which was much smaller in size than her current pressure ulcer and a raw area on the left lower buttock. Nurse #1 characterized the open area as a stage 1 pressure ulcer because it was slightly opened and required a treatment, so she applied zinc oxide and covered it with a foam dressing to both sacrum and left lower buttock. Nurse #1 stated she thought the pressure ulcer required a different treatment, but she could not remember if she had notified the physician or the Nurse Practitioner about the pressure ulcer and she didn't get an order. Nurse #1 also stated she didn't think she had to complete a wound assessment because wound assessments were usually completed by the Unit Managers whenever they rounded with the Wound Physician Assistant. Nurse #1 further stated Resident #36 always had an issue with her sacral area and they had struggled to keep it intact because Resident #36 liked to sit up in her wheelchair during the day, but she was adamant about having her naps and usually lied down in bed after lunch. Resident #36 also had sensitive skin. Prior to her hospitalization, Resident #36 often rang her call light, was continent of both urine and bowel and walked to the bathroom with staff assistance. After coming back from the hospital on 3/3/22, Resident #36 got a little weaker, but she was still ambulatory. Nurse #1 also stated Resident #36 did not refuse to be turned to her side but often preferred to lie flat on her back.	F 686	treatment orders. C. Completes notification of responsible party (R.P.). D. Reports to the DON and/or unit managers by calling or tiger texting (which is a secure web-based communication). The DON/unit managers along with Wound Nurse Practitioner are responsible for weekly wound/pressure ulcer measurements and assessments. A comprehensive list of wounds will be maintained by the DON/unit managers. Licensed nurses including agency nurses were in serviced 7-2-2022 by the DON and unit managers on facility process for labs, facility process for notification, location of lab supplies, responsibilities and of admission and weekly skin assessments, completing weekly wound assessment. Notification process is as follows: A. licensed nurse complete admission skin assessment, and weekly skin assessment in electronic medical record as it is assigned as triggered by electronic medical records system. B. If any deterioration of skin area or new area observed, the licensed nurse notifies physician or nurse practitioner immediately, and obtains treatment orders. No Licensed nurse can initiate treatments without a physician order. C. Completes notification of responsible party (R.P.). D. Reports to the DON and/or unit managers by calling or tiger texting (which is a secure web-based communication). If any changes in resident conditions, including skin, deterioration (change in size, appearance skin color, smell, drainage, redness) of wounds/pressure sores, physical or	

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F 686	Continued From page 60 An interview with Nurse #2 on 6/28/22 at 3:36 PM revealed she completed a skin check on Resident #36 on 3/4/22 and observed a foam dressing on her sacrum. Nurse #2 stated she knew Resident #36 had a pressure ulcer on her sacrum, but she did not remove the dressing to assess the wound underneath. Nurse #2 stated she did not have a reason as to why she did not complete a wound assessment on Resident #36's sacral pressure ulcer. Nurse #2 further stated back in February 2022 prior to Resident #36's hospitalization, staff used to roll Resident #36's wheelchair to the bathroom and assisted her to use the commode but when she came back from the hospital, Resident #36 had a decline and they often had to provide incontinence care to her, but she never refused to be turned on her side while in bed. The Braden Scale Pressure Ulcer Risk Assessment dated 3/10/22 for Resident #36 indicated she was at moderate risk for developing pressure ulcers due to slightly limited sensory perception, very moist skin, very limited mobility, chairfast, adequate nutrition and problem with friction and shear. Complete lifting without sliding against sheets was impossible. Resident #36's Treatment Administration Record for March 2022 indicated no treatment orders for Resident #36's sacral pressure ulcer until 3/10/22 when Unit Manager #1 initiated the following treatment order: Cleanse area to coccyx with wound cleanser. Apply (brand name) occlusive dressing and cover with foam every 3 days. An interview with Unit Manager (UM) #1 on 6/30/22 at 3:20 PM revealed she couldn't remember if she had been made aware of an	F 686	mental changes the Licensed nurse must report findings to physician immediately. Facility process for labs is as follows: a. licensed nurse records lab order in electronic medical record. B. Notification of Responsible Party (R.P.) of order, C. Licensed nurse completes lab requisition in facility lab book, D. Licensed nurse completes patient log in facility lab book E. Phlebotomist from lab obtains specimen, F. Licensed nurse receives results via lab fax, G. Licensed nurse checks off in facility lab book on patient log, H. Licensed nurse notifies physician of abnormal lab results or places within normal limits labs in physician box and notifies R.P. Location of lab supplies for blood specimens are located in medication rooms, in addition to lab supplies for urine samples. Wound culture supplies are located in DON office in cabinet. If a physician or nurse practitioner orders a wound culture, the licensed nurse will obtain the culture, place in lab refrigerator, complete the lab requisition and complete the patient log in the facility lab book. Results are received via lab fax. The nurse aides, including agency nurse aides will be in serviced by 7-2-2022 by DON/designee on reporting any changes in resident□s condition including skin, (such as: redness, drainage, open areas, odor, temperature, and complaints of pain) to the licensed nurse immediately. DON is responsible for tracking nurses and nurse aides including agency that have received education. The DON/UM are responsible for providing education to	

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F 686	Continued From page 61 open area on Resident #36's sacrum upon her re-admission to the facility on 3/3/22 and she was not sure if she had checked her re-admission orders. UM #1 stated all her treatment orders probably got discontinued because there were no orders from the hospital for any treatment to her sacral wound. UM #1 stated Nurse #1 should have initiated a treatment when she observed an open area to Resident #36's sacrum on 3/3/22 and she should have completed a wound assessment. UM #1 stated she remembered Resident #36's family member telling her to make sure they kept an eye on her sacrum because an area on her sacrum had opened when she came back from the hospital. UM #1 stated she didn't get around to assessing Resident #36's sacrum until 3/10/22 when Nurse Aide (NA) #1 reported to her that Nurse #3 had been asking her to apply a foam dressing to Resident #36's sacrum and buttocks without the nurse checking the area first. UM #1 stated she observed necrotic tissue covering the ulcer, but she couldn't tell how big it measured. The ulcer did have some drainage but did not have foul odor. UM #1 stated she thought the nurses could initiate wound care orders without consulting with the physician first and she decided on the occlusive dressing based on her previous experience with wound care. UM #1 further stated she did not notify the physician, the Nurse Practitioner, or the Wound Physician Assistant (PA) and just included Resident #36 in the list of residents to be seen by the Wound PA on his next visit at the facility. UM #1 stated she did not think about documenting an assessment or complete measurements of Resident #36's pressure ulcer on 3/10/22 because she was going to be seen by the Wound PA the next week. An interview with Nurse #3 on 6/30/22 at 1:59 PM	F 686	current nurses and nurse aides who were not in serviced by 7/2/2022. Nurses and nurse aides will not be allowed to work until they receive education. New nurses and nurse aides hired after 7/2/2022 will receive education during orientation. The DON/unit managers are responsible for tracking labs and notification of physician during clinical morning meeting beginning the week of 7/4/22. The facilities inter-disciplinary team (IDT) will continue to conduct a weekly resident review of all residents with pressure sores to discuss and document pressure ulcers. The DON will present the results of the audits to the QAPI committee monthly for 3 months and the committee will modify plans as needed to ensure the facility remains in compliance. Date of Completion 8/4/22	

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revealed she couldn't remember doing a skin evaluation on Resident #36, but she had seen her sacral wound progress from being a quarter-sized stage 1 pressure ulcer to being covered with a black necrotic tissue. Nurse #3 denied ever handing a foam dressing to the nurse aides and asking them to place it on Resident #36's sacrum. She recalled placing a dressing according to the treatment record whenever the nurse aides told her Resident #36's dressing was off. She also stated she didn't think she was the first nurse who had discovered the black necrotic tissue, so she didn't think about reporting this to anybody.

A phone interview with Nurse Aide (NA) #1 on 6/29/22 at 10:19 AM revealed she took care of Resident #36 on the day shift, but she always came in early to help the night shift aides get the residents up in the mornings. NA #1 stated there were multiple times when she would come in early that she would see Resident #36's call light on and her bed would be soaked from urine. At those times, Resident #36 was still continent of urine and whenever she asked Resident #36 if the staff had come to check on her, she told her that they came in and turned her light off, thinking that she was asleep and didn't come back. NA #1 stated there were multiple times when she would come in and observed Resident #36 without a dressing to her sacrum and her clothes would be soaked from drainage from her wound. Whenever she asked the night shift nurse aides, they couldn't tell her anything as to why Resident #36 did not have a dressing on to her sacrum. NA #1 stated Resident #36 always had a soft, boggy, purplish red spot on her sacrum that would close and re-open, but she had no clue as to how she got the "hole" on her sacrum which

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had a lot of drainage and smelled really bad. NA #1 reported there had been some nurses who had handed her a dressing to put on Resident #36's sacrum and she did it in order to help out, but she got written up for it when she reported this to UM #1. She also stated that Resident #36 never refused to lie down after lunch and never refused to be turned and repositioned in bed.

A phone interview with Nurse #4 on 6/27/22 at 7:44 PM revealed she worked with Resident #36 on the night shift, but she didn't remember having to replace her sacral pressure ulcer dressing. Nurse #4 stated she relied on the nurse aides to report to her if her dressing had come off whenever they did their incontinence rounds. Resident #36 usually got up after Nurse #4 had already left, and Resident #36 never refused to be turned and repositioned to her sides when in bed. Nurse #4 stated she had concerns about the nurses not completing skin assessments and wound assessments which were usually scheduled for the day and evening shifts. She stated she would often see alerts on the electronic medical record that they were past due and some of them would even be over 15 days late. Nurse #4 further stated she reported this to UM #1 and the DON, but she wasn't sure if anything had been done about it.

The Wound Evaluation and Management Reports in Resident #36's medical record indicated she was seen by the Wound Physician Assistant (PA) on the following dates:
3/17/22 - "Unstageable pressure ulcer to the sacrum measured 2.5 cm (centimeters) in length, 1.5 cm in width and 0.3 cm in depth. The pressure ulcer was covered with excessive necrotic tissue and had mild serous drainage.

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Will treat with sodium hypochlorite solution moistened gauze and foam daily. No signs of acute infection."
3/24/22 - "Unstageable pressure ulcer to the sacrum measured 2.5 cm in length, 1.5 cm in width and 1.5 cm in depth. The pressure ulcer was covered with excessive yellowish necrotic tissue and had mild serous drainage. Wound had remained stable in diameter but increased in depth. No signs of acute infection. Wound was debrided with scalpel. Wound depth increased to 15 mm (millimeters). Will change treatment to collagenase, filling the narrow wound with the collagenase and covering with calcium alginate and foam daily."
3/31/22 - "Unstageable pressure ulcer to the sacrum measured 2.5 cm in length, 1.5 cm in width and 1.8 cm in depth. The pressure ulcer was covered with excessive yellowish necrotic tissue. Wound had remained stable in size, but depth had increased due to debridement. Patient had moderate drainage, so a wound culture and sensitivity was taken. Awaiting results. Wound debrided with scalpel removing necrotic tissue. Will order a low air loss mattress and discuss with therapy to get her set up with a pressure relief cushion."
4/7/22 - "Unstageable pressure ulcer to the sacrum measured 3 cm in length, 1.5 cm in width and 2 cm in depth. Wound now had undermining of 20 mm at 12 o'clock position. Wound culture and sensitivity had an unknown issue last week, so it was redone this week. No exposed bone present at this time. Mild odor and mild drainage present, no erythema or pain. Wound debrided with scalpel. Less necrotic tissue present this week than before. Treated wound with sodium hypochlorite solution moistened gauze, lightly packed in the wound and foam daily."

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A phone interview with the Wound Physician Assistant (PA) on 6/30/22 at 4:56 PM revealed he did not get consulted when an open area was first noted on Resident #36's sacrum on 3/3/22 nor when they started treatment on Resident #36's sacral pressure ulcer on 3/10/22 when it got worse. The Wound PA stated he would not have recommended to use the occlusive dressing that was started on 3/10/22 because he didn't typically use it on the sacrum, and it was not appropriate treatment for the unstageable ulcer that was present on 3/10/22. He stated if the facility provided consistent treatment to Resident #36's pressure ulcer, it would have made a difference in preventing the pressure ulcer from worsening. The Wound PA stated Resident #36's pressure ulcer could have been avoided if the facility provided the appropriate treatment and took preventive measures such as offloading and regular skin checks. The Wound PA further stated he expected the nurses to perform skin checks by looking at all surfaces of the skin from head to toe and paying particular attention to skin folds and creases which were susceptible to fungal infections. The Wound PA also stated if a dressing was present, the nurses were supposed to remove the dressing so they could visualize and assess the wound underneath especially for residents who were not currently being treated by him. On 3/31/22, he noted an increase in drainage, so he did a wound culture and sensitivity after he debrided the wound. He was informed at the facility when he came back on 4/7/22 that the laboratory had discarded the swab from the week before because they used the wrong tube, so he obtained another one due to the wound's continued decline and it had started undermining. (Undermining is a closed

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passageway under the surface of the skin that is open only at the skin surface. It involves a significant portion of the wound edge). When he came back on 4/14/22, he found out that Resident #36 had been to the Wound Center, so he discharged her from her care. He didn't hear back about the last wound culture and sensitivity done on 4/7/22 and assumed it was discarded again by the laboratory. He said if he obtained the result from the first wound culture sooner, it could have made a difference in treating Resident #36's pressure ulcer if the infection was superficial. But he couldn't say it would have made a difference if the infection had already reached the bone. And he didn't see any exposed bone after debridement, so he didn't think to do a bone biopsy. The Wound PA stated Resident #36's pressure ulcer was avoidable.

An interview with Unit Manager (UM) #1 on 6/30/22 at 3:20 PM revealed the first time the Wound PA obtained the wound culture; she was notified by the laboratory that they had to discard it because they couldn't run due to it being too dry. UM #1 did not notify the Wound PA until the next week when he came back and performed a second wound culture. UM #1 was again informed by the laboratory that they had to discard it because they used the wrong swab. UM #1 did not think to notify the Wound PA about the wound culture not being done a second time, but she called the laboratory twice to request for the appropriate culture swabs. No one from the laboratory sent any of the swabs that she had requested.

An interview with the Nurse Practitioner (NP) on 6/29/22 at 3:10 PM revealed she became aware of Resident #36's sacral pressure ulcer on

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4/11/22 when her family member texted her and asked her if Resident #36 could be seen by the Wound Center. The NP checked the electronic results for the laboratory and found wound cultures on 4/1/22 and 4/8/22 that were originally ordered but had been marked out. The NP stated the facility had been having problems with laboratory tests getting missed and not getting followed through. The NP also stated she was aware that Resident #36's pressure ulcer progressed quickly but she was not aware that Resident #36 did not have a treatment order for the wound prior to the Wound PA seeing her. The NP stated the facility physician usually ordered a treatment for a newly identified wound until the resident was seen by the Wound PA, but she was not sure why she didn't get notified of Resident #36's pressure ulcer that was noted on 3/3/22. The NP stated the nurses should have notified her on 3/3/22 when they noted a pressure ulcer on Resident #36's sacrum so a treatment could have been started while they were waiting for her to be seen by the Wound PA.

The Report of Consultation from the Wound Center dated 4/13/22 for Resident #36 indicated a stage 4 pressure ulcer to the sacrum which measured 2.2 cm in length, 2 cm in width and 2.1 cm in depth. Treatment was changed to skin prep to peri wound, antimicrobial gel wet to dry using 2 inch rolled gauze to pack wound, cover with 4x4 gauze, abdominal pad, and tape. Change daily and as needed for soiled or loose dressing. Referral to an Infectious Disease specialist. Bone culture and pathology done. Prescription for (brand name) antibiotics sent to the facility. Facility to order pressure relief cushion and specialty air mattress.

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An Infectious Disease Visit Note dated 4/25/22 in Resident #36's medical record indicated Resident #36 was seen for sacral osteomyelitis. Bone biopsy was positive for Morganella. (Morganella is a species of gram-negative bacteria known to be a causative organism of opportunistic infections in wound infections.) Intravenous antibiotics were ordered. Resident #36 was currently using a wound vac (vacuum-assisted closure of a wound), had gotten an air mattress, and was waiting on a pressure relief cushion for her wheelchair.

An observation of wound care was made on 7/1/22 at 2:43 PM on Resident #36 and performed by Nurse #3 and assisted by Nurse Aide (NA) #2. Resident #36 was turned towards her left side while NA #2 stood facing Resident #36 and supported her trunk. Nurse #3 sprayed wound cleanser into the sacral pressure ulcer which measured approximately 2 cm (centimeters) in length, 3 cm in width and 2 cm in depth. The wound bed had beefy red granulation tissue with 20% slough (yellow/white material in the wound bed consisting of dead cells). The skin surrounding the wound was red. Nurse #3 applied skin prep barrier to the surrounding skin and well over towards the right buttock. Nurse #3 cut a piece of green foam that fit exactly into the wound bed and applied it to the wound. She cut a plastic drape in half, cut, and measured a hole to fit the foam and applied it to cover Resident #36's buttocks and sacral area. She cut another piece of green foam approximately 6 inches long and 1 inch wide to serve as a bridge to the foam covering the wound. Nurse #3 placed the bridge over the plastic drape and covered it with another piece of plastic drape. She cut a small piece of the drape at the top and placed the track pad with

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the tubing towards Resident #36's sacrum. She secured the track pad with another piece of tape and then coiled the tubing into a circle and taped it to Resident #36's right hip. Nurse #3 connected the tubing to the canister that was placed inside the wound vac and turned the machine on. The wound vac was set at 125 mmHg (millimeters Mercury).

The Administrator was notified of Immediate Jeopardy on 7/1/22 at 1:03 PM.

The facility provided the following IJ Removal Plan with the correction date of 7/3/22.

*Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
Resident #36 readmitted on 3/3/22 and had an identified wound/pressure ulcer without physician notification or ordered treatment. The facility failed to assess, obtain treatment orders from physician, identify deterioration of the pressure ulcer, and process a wound culture which resulted in a serious adverse outcome. A culture was ordered by physician and completed however not resulted by lab. twice from an expired swab and dry specimen. The facility failed to follow up on lab. results and did not ensure lab. supplies were not expired.

Facility completed a full body skin assessment and record review on all current residents on 7/1/22 by the unit managers. Resident #36 was the only identified resident who has suffered an adverse outcome related to non-compliance. The Regional Director of Clinical Services (RDCS) audited lab. supplies to ensure appropriate supplies on hand.

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An assessment of Resident #36 revealed on 7/2/22, no further deterioration of pressure ulcer, treatment orders in place per physician order, resident being followed by local wound care clinic.

*Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
The Regional Director of Clinical Services (RDCS) educated the Director of Nursing (DON) and nurse unit managers (UM) of the existing/revised process of labs. on 7/2/22. Process is as follows for labs.: A. Licensed nurse records lab. order in electronic medical record. B. Notification of Responsible Party (RP) of order. C. Licensed nurse completes lab. requisition in facility lab. book. D. Licensed nurse completes "patient log" in facility lab. book. E. Phlebotomist from lab. obtains specimen. F. Licensed nurse receives results via lab. fax. G. Licensed nurse checks off in facility lab. book on "patient log." H. Licensed nurse notifies physician of abnormal lab. results or places "within normal limits" labs. in physician box and notifies RP. Location of lab. supplies for blood specimens are located in medication rooms, in addition to lab. supplies for urine samples. Wound culture supplies are located in medication rooms, in addition to lab. supplies for urine samples. Wound culture supplies are located in DON office in cabinet. If a physician or Nurse Practitioner orders a wound culture, the licensed nurse will obtain the culture, place in lab. refrigerator, complete the lab. requisition and complete the patient log in the facility lab. book. Results are received via lab. fax. In addition, the DON/designee are responsible for tracking lab. results beginning

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7/4/22. If a licensed nurse is contacted by the lab. about a problem, the licensed nurse will be responsible for notifying physician and reentering the order and obtaining sample. Any pressure ulcers or skin conditions that are referred to wound physician are communicated via order and requested resident information are communicated by DON and/or UM. No licensed nurse can initiate treatments without a physician order.

On 7/1/22, the RDCS also completed education with DON and unit managers on the process of notification. Notification process is as follows: A. Licensed nurse complete admission skin assessment, and weekly skin assessment in electronic medical record as it is assigned as triggered by electronic medical records system. B. If any deterioration of skin area or new area observed, the licensed nurse notifies physician or Nurse Practitioner immediately, and obtains treatment orders. C. Completes notification of responsible party (RP). D. Reports to the DON and/or unit managers by calling or tiger texting (which is a secure web-based communication). The DON/unit managers along with Wound Nurse Practitioner are responsible for weekly wound/pressure ulcer measurements and assessments. A comprehensive list of wounds will be maintained by the DON/unit managers.

Licensed nurses including agency nurses were in-serviced 7/2/22 by the DON and unit managers on facility process for labs., facility process for notification, location of lab. supplies, responsibilities and of admission and weekly skin assessments, completing weekly wound assessment. Notification process is as follows: A. Licensed nurse complete admission skin assessment, and weekly skin assessment in

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electronic medical record as it is assigned as triggered by electronic medical records system. B. If any deterioration of skin rea or new area observed, the licensed nurse notifies physician or Nurse Practitioner immediately, and obtains treatment orders. No licensed nurse can initiate treatments without a physician order. C. Completes notification of responsible party (RP). D. Reports to the DON and/or unit managers by calling or tiger texting (which is a secure web-based communication). If any changes in resident conditions, including skin, deterioration (change in size, appearance, skin color, smell, drainage, redness) of wounds/pressure sores, physical or mental changes the licensed nurse must report findings to physician immediately. Facility process for labs. is as follows: A. Licensed nurse records lab. order in electronic medical record. B. Notification of Responsible Party (RP) of order. C. Licensed nurse completes lab. requisition in facility lab. book. D. Licensed nurse completes "patient log" in facility lab. book. E. Phlebotomist from lab. obtains specimen. F. Licensed nurse receives results via lab. fax. G. Licensed nurse checks off in facility lab. book on "patient log." H. Licensed nurse notifies physician of abnormal lab. results or places "within normal limits" labs. in physician box and notifies RP. Location of lab. supplies for blood specimens are located in medication rooms, in addition to lab. supplies for urine samples. Wound culture supplies are located in DON office in cabinet. If a physician or Nurse Practitioner orders a wound culture, the licensed nurse will obtain the culture, place in lab. refrigerator, complete the lab. requisition and complete the patient log in the facility lab. book. Results are received via lab. fax.

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The nurse aides, including agency nurse aides will be in-serviced by 7/2/22 by DON/designee on reporting any changes in resident's condition including skin, (such as: redness, drainage, open areas, odor, temperature, and complaints of pain) to the licensed nurse immediately.

DON is responsible for tracking nurses and nurse aides including agency that have received education. The DON/UM are responsible for providing education to current nurses and nurse aides who were not in-serviced by 7/2/22. Nurses and nurse aides will not be allowed to work until they receive education.

New nurses and nurse aides hired after 7/2/22 will receive education during orientation.

The DON/unit managers are responsible for tracking labs. and notification of physician during clinical morning meeting beginning the week of 7/4/22. The facilities interdisciplinary team (IDT) will continue to conduct a weekly resident review of all residents with pressure sores to discuss and document pressure ulcers.

The alleged date of IJ removal is 7/3/22.

The credible allegation for the immediate jeopardy removal was validated on 7/7/22 with a removal date of 7/3/22.

On 7/7/22, the facility's credible allegation was validated through record reviews and staff interviews. The facility provided education documentation for all staff on identifying and reporting a change in condition especially in skin integrity. In addition, the facility provided signed education sheets on performing and documenting

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weekly wound assessments, notification of the physician, Nurse Practitioner and wound doctor of new/worsening pressure ulcers, actions to take if new/deteriorating pressure ulcer observed and what changes in skin integrity to report, following up and processing of laboratory orders and reviewing laboratory process to ensure supplies were within date.

The nursing aides were interviewed and described the different signs of changes in skin integrity to be reported to the nurse during provision of care. The in-service also included reporting all changes in condition and signs of wound infection/wound deterioration to the nurse.

A skin/wound audit was completed on 7/2/22 for any unreported skin issues and the results were compared with the skin assessment documentation, if the physician was notified, if family was notified and if care plan was updated. This was verified through interviews with the Unit Managers and MDS Coordinator who completed the audits.

The RDCS completed an audit of all laboratory supplies on 7/1/22 wherein she removed and discarded expired laboratory supplies and validated that all current in house supplies were sufficient in quantity and there were no other expired supplies in house. She also completed a laboratory audit on 7/2/22 and checked all laboratory orders within the last 7 days if they had obtained the results and if the physician was notified of the results.

2. Resident #11 was admitted to the facility on 6/9/12 with diagnoses that included peripheral vascular disease, hypertension, and muscle

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weakness.

The quarterly Minimum Data Set (MDS) assessment dated 3/25/22 indicated Resident #11 was severely cognitively impaired, had no rejection of care behaviors and required extensive physical assistance with bed mobility and transfer. She had impairment to both sides of upper and lower extremities. The MDS further indicated Resident #11 had one stage 3 pressure ulcer, one stage 4 pressure ulcer, one deep tissue injury and one venous ulcer.

Resident #11's care plan revised on 4/7/22 indicated Resident #36 had impaired skin integrity to left heel, left leg and right leg. Interventions included consult with wound care provider as indicated, elevate heels off mattress per routine, inspect skin during routine care daily, pillows for positioning as needed, turn, and reposition during care rounds and as needed and treatment as indicated to impaired skin.

The Weekly Wound Assessment dated 6/23/22 indicated Resident #36 had a stage 4 pressure ulcer to the right lower extremity posterior that measured 13.5 cm (centimeters) in length, 3 cm in width and 0.5 cm in depth. The wound had moderate serous drainage with pink and red wound bed and faint odor. The wound had maceration to peri wound. She was seen and evaluated by the Wound Physician Assistant.

A physician order dated 6/24/22 indicated the following treatment for Resident #11's right lower leg pressure ulcer: Cleanse wound on right lower leg using wound cleanser, pat dry. Apply skin prep barrier to intact skin surrounding wound. Apply sodium hypochlorite-soaked gauze

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(squeeze out excess), place calcium alginate on gauze, cover with foam and secure with roll bandage and tape every day shift and as needed for soiling or displacement.

An observation of pressure ulcer care on Resident #11 was made on 6/29/22 at 12:53 PM performed by Nurse #5. Nurse #5 cleaned the wound to the right posterior leg with a gauze soaked with wound cleanser. She packed the wound with sodium hypochlorite-soaked gauze and covered it with calcium alginate. She covered it with a foam dressing, wrapped the ulcer with a roll bandage and secured it with tape. Nurse #5 did not apply skin prep barrier to the skin surrounding the wound.

An interview with Nurse #5 on 6/29/22 at 5:44 PM revealed she was nervous while performing wound care on Resident #11 and forgot to put skin prep barrier to the skin surrounding the wound. Nurse #5 stated she was not used to doing wound care and had worked at facilities where they had a treatment nurse. Nurse #5 also stated she did not see a skin prep barrier film on the bag where the supply clerk had placed the supplies to be used on Resident #11's pressure ulcer so it was easy to forget that it was part of the order.

An interview with the Wound Physician Assistant (PA) on 6/30/22 at 7:12 AM revealed he had ordered to apply skin prep around the edges of Resident #11's pressure ulcer to keep the peri wound intact and prevent maceration. The Wound PA stated Resident #11's pressure ulcer to her right lower leg had a lot of drainage that could damage the skin surrounding it if a skin prep barrier was not applied to it. He further

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F 686	Continued From page 77 stated he expected the nurses to follow his wound care orders as he had written. An interview with the Administrator on 7/1/22 at 3:41 PM revealed the nurse should have followed the order given by the Wound PA regarding treatment to the pressure ulcer on her right lower leg.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident, staff and the Nurse Practitioner, the facility failed to apply a left-hand splint for 1 of 2 residents reviewed for positioning (Resident #72). The findings included:	F 688	Orders were obtained immediately from the physician to discharge and discontinue splint on resident #72, due to resident refusing splint. Therapy conducted a 100% screen for splints on 7/20/22 to determine if the	8/4/22

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F 688	Continued From page 78 Resident #72 was admitted to the facility on 5/16/17 with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction affecting left non-dominant side. A physician order dated 1/2/20 in Resident #72's medical record indicated an order for nurse to ensure that left hand splint was applied every evening shift at bedtime. Document any refusals. Resident #72's Treatment Administration Record (TAR) for June 2022 revealed an order for: Apply left hand splint at bedtime. Nurse to ensure that left hand splint was applied every evening shift at bedtime. Document any refusals. It was documented as having been applied every night at 9:00 PM. No refusals were documented on the TAR. A review of the Progress Notes for June 2022 in Resident #72's medical record indicated no documented refusals of left hand splint application. The quarterly Minimum Data Set (MDS) assessment dated 6/5/22 indicated Resident #72 was moderately cognitively impaired, exhibited no rejection of care behaviors, required extensive physical assistance with activities of daily living and had impairment to both upper and lower extremities on the left side. Resident #72's care plan revised on 6/14/22 indicated Resident #72 had potential for decreased range of motion related to left hemiparesis and degenerative changes of	F 688	resident still required the use of the splint. Therapy and the MDS nurse completed a review of all splint orders and any identified concern were acted upon immediately. When therapy determines a need for a resident to wear a splint a therapy communication form will be completed by therapy and given to MDS nurses for restorative programing. The Director of Nursing or designee will provide education to both licensed nurses and nurse aides for splint application. This education will be done by 08/04/2022 All agency staff and new hires responsible for splint application, after 8/4/2022, will receive this same education. Beginning 8/1/2022, an audit of splint application and orders will be completed by the DON or designee 5x a week for 2 weeks then 2x a week for 2 weeks, then 1x a week for 8 weeks. DON will present to the QAPI committee for the next 3 months and the committee will modify to ensure the facility remains in compliance. Date of completion 8/4/22	

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bilateral shoulders. Interventions included left hand splint as directed, encourage compliance and OT (Occupational Therapy) evaluation and treatment as indicated for new splinting.

During an initial observation and interview with Resident #72 on 6/27/22 at 12:10 PM, Resident #72 was noted to have left-sided weakness with her left hand contracted in a closed-fist position. Resident #72 stated she was unable to move her left arm without assistance from her right arm and that staff was supposed to apply her splint to the left hand at bedtime, but they had not been doing it.

An interview with Resident #72 on 6/28/22 at 7:14 AM revealed staff did not apply her left hand splint at bedtime on 6/26/22 and 6/27/22. Resident #72 stated she didn't refuse to have her splint on and that the staff didn't even come and offer to apply it. Resident #72 stated her hand splint stayed at the foot of her bed the whole night.

An interview with Resident #72 on 6/29/22 at 5:40 AM revealed she was already up in her wheelchair because she wanted to get up early. Resident #72 reported that her left hand splint had not been applied from the night before. Resident #72 stated she was scheduled for a hand specialist appointment on 7/5/22 due to contracture at the joint on her left thumb. Resident #72 stated she was supposed to wear her left hand splint for 6 hours and then to remove it for 2 hours so she could get a break. She was supposed to wear it at night, but they hadn't always been applying it. Resident #72 further stated she remembered the COTA (Certified Occupational Therapy Assistant) doing

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an education with the nursing staff about her splint and she also posted instructions with pictures on her closet door on how to apply her splint. Resident #72 stated it didn't hurt when her left hand was opened for splint application, and she did not refuse to have it on.

An interview with the Certified Occupational Therapy Assistant (COTA) on 6/29/22 at 7:47 AM revealed they had recently worked with Resident #72 from 6/14/22 to 6/23/22 related to her splint to the left hand and arm. The COTA stated they had to pick Resident #72 back up on 6/14/22 because the Nurse Practitioner had given an order that Resident #72 needed a new orthotic splint due to contractures. The COTA stated Resident #72 didn't need a new splint because she had one which the staff had not been applying to her left hand. The COTA stated the problem with orthotics not being applied stemmed from the facility not having a restorative program to follow through on rehabilitation goals. As a result, the residents had to go through repeat cycle with therapy having to pick them up over and over for the same issues. The COTA further stated she was familiar with Resident #72 who complained to her all the time that nursing had not been applying her left hand splint as ordered. The COTA stated Resident #72 would wear her splint if a staff member put it on her. She said she did not notice any worsening in her left hand contracture from the time they last worked with her. She also did an education with the available nursing staff and showed them how to do the release on Resident #72's left hand so it was easier to apply her splint.

An interview with Nurse Aide (NA) #6 on 6/28/22 at 3:04 PM revealed she took care of Resident

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AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 81	F 688		

#72 on the night shift from 11:00 PM on 6/26/22 to 7:00 AM on 6/27/22. NA #6 stated she did not remember if Resident #72 had her left hand splint on that night, but Resident #72 didn't have it on when she got her up in the morning. NA #6 stated she didn't know Resident #72 was supposed to wear a splint to her left hand at night.

An interview with NA #4 on 6/29/22 at 5:45 AM revealed she was not sure why Resident #72 did not have her splint on when she worked with her on 6/28/22 on the night shift. NA #4 stated she sometimes saw Resident #72 wearing her left hand splint and sometimes not, but she didn't know who was responsible for applying it.

An interview with Nurse #8 on 6/29/22 at 7:00 AM revealed she worked with Resident #72 on 6/27/22 and 6/28/22 from 7:00 PM to 7:00 AM. Nurse #8 stated she thought the nurse aides were supposed to be applying Resident #72's left hand splint whenever she went to bed. Nurse #8 stated she couldn't remember if she had checked behind them to make sure her left hand splint was on. She knew they were supposed to remove it whenever they got her out of the bed, but she hadn't gotten around to checking if she even had the left hand splint on from the night before.

An interview with the Nurse Practitioner (NP) on 6/29/22 at 3:10 PM revealed she had written an order on 6/9/22 for Resident #72 to see a hand specialist for contracture to her left hand. The NP stated she didn't think Resident #72's current splint was good enough for her and she might need a new splint. The NP also stated Resident #72 would tell her all the time that nursing did not

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F 688	Continued From page 82 apply her left hand splint. The NP said she wasn't sure if she had been refusing or if staff forgot to come back and apply the splint to her left hand. An interview with the Administrator on 7/1/22 at 3:41 PM revealed the nurses should have applied Resident #72's left hand splint as ordered by the physician and documented accordingly.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with staff and the Nurse Practitioner, the facility failed to administer oxygen as prescribed by the physician for 1 of 2 residents reviewed for oxygen therapy (Resident #11). The findings included: Resident #11 was admitted to the facility on 6/9/12 with diagnoses that included obstructive hydrocephalus, hypertension, and anemia. Resident #11's care plan initiated on 3/25/21 indicated Resident #11 required oxygen as needed. Interventions included to administer	F 695	Resident #11 oxygen was immediately adjusted to the order rate of 1.5 LPM via nasal cannula. Resident remains in the community and has had no negative outcome. On 7/12/22 nursing conducted a 100% audit of oxygen orders and administration with no additional findings. DON/Designee will conduct education to all licensed nursing staff to ensure oxygen is being administered as ordered. Education will be done by 8-4-2022. Agency staff or newly hired staff after	8/4/22

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F 695	Continued From page 83 oxygen as ordered, monitor oxygen saturation as ordered and observe for signs and symptoms of dyspnea (shortness of breath). The quarterly Minimum Data Set (MDS) assessment dated 3/25/22 indicated Resident #11 was severely cognitively impaired, had impairment to both sides of the upper and lower extremities and used oxygen therapy while a resident at the facility. A physician order dated 4/8/22 for Resident #11 indicated oxygen therapy at 1.5 liters per minute via nasal cannula every shift. Resident #11's Treatment Administration Record (TAR) for June 2022 included an order for oxygen therapy at 1.5 liters per minute via nasal cannula every shift but there was no order to check oxygen saturation every shift. An observation of Resident #11 on 6/27/22 at 10:27 AM revealed Resident #11 sitting in a geriatric chair in her room with an oxygen tank behind her. Resident #11 had a nasal cannula on which was connected to the oxygen tank and the oxygen was set at 3 liters per minute. A second observation of Resident #11 on 6/28/22 at 8:45 AM revealed Resident #11 sitting in a geriatric chair in her room with a nasal cannula on her nose. The nasal cannula was connected to an oxygen concentrator which was running at 3.5 liters per minute. During an observation of care on Resident #11 on 6/29/22 at 5:45 AM, she did not have a nasal cannula on, and her oxygen concentrator was turned off. Resident #11 did not show any signs	F 695	8-4-2022, who responsible for oxygen administration will receive this same education. During routine rounds the leadership staff will monitor for compliance. Beginning 8-1-2022, the DON or designee will complete an audit of oxygen orders vs administration 5x a week for 2 weeks then 2x a week for 2 weeks, then 1x a week for 8 weeks. Administrator will present to the QAPI committee for the next 3 months and the committee will modify to ensure the facility remains in compliance. Date of compliance is August 4, 2022	

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F 695	Continued From page 84	F 695		

of respiratory distress.

An interview with Nurse Aide (NA) #4 and NA #5 on 6/29/22 at 7:20 AM revealed Resident #11 did not have her oxygen on all night, and they didn't know she was supposed to get oxygen on their shift.

An interview with Nurse #8 on 6/29/22 at 7:00 AM revealed she remembered checking Resident #11's oxygen saturation before midnight and it was between 93% and 95% but she couldn't remember if she had her oxygen on at that time. Nurse #8 stated she was not sure whether Resident #11 was supposed to receive continuous oxygen because it was not specified in the order. Nurse #8 checked Resident #11's oxygen saturation at 7:10 AM and it was 97% on room air. Nurse #8 stated she remembered the oxygen concentrator not being on when she came in at 7:00 PM the night before and she also remembered the nurse from the day before telling her that she had just changed Resident #11's oxygen tubing and nasal cannula.

An interview with Nurse #5 on 6/29/22 at 5:44 PM revealed she worked on 6/27/22 and 6/28/22 with Resident #11 but didn't remember looking at the rate at which her oxygen tank or oxygen concentrator had been set on. Nurse #5 stated she checked to make sure the oxygen tank had enough oxygen left and the humidifier on the concentrator had enough fluid. She also stated she changed Resident #11's oxygen tubing and nasal cannula on 6/28/22 and they probably forgot to switch her to her oxygen concentrator when they put her to bed the night before.

An interview with the Nurse Practitioner on

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F 695	Continued From page 85 6/29/22 at 3:33 PM revealed the nurses should administer Resident #11's oxygen according to the physician's order and they should let her know if oxygen was no longer needed so she could re-evaluate the resident and discontinue the order for oxygen. An interview with the Administrator on 7/1/22 at 3:41 PM revealed the nurses should have made sure Resident #11's oxygen was delivered per physician's order.	F 695		
F 698 SS=D	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 record review, resident interview, staff interviews, and dialysis staff, the facility failed to serve breakfast before dialysis for 1 of 1 resident reviewed for dialysis (Resident #34). Findings included: Resident #34 was admitted to the facility on 1/21/22 with diagnoses which included muscle weakness and dependence on renal dialysis. Review of Resident #34's quarterly Minimum Data Set (MDS) dated 5/4/22 revealed Resident #34 was cognitively intact and required limited assistance for majority of Activities of Daily Living (ADL).	F 698	Resident #34 diet ordered was immediately reviewed and care plan updated for preferences On 7/5/22 a 100% audit was completed on dialysis residents for meal preferences with no additional findings The facility administrator or designee educated the dietary and nursing department staff on providing meals prior to dialysis for residents based on the residents preference. This education will be completed by 8-4-2022 Agency staff and any new hires, after 8-4-2022, that are responsible for	8/4/22

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F 698	Continued From page 86 An interview conducted with Resident #34 on 6/28/22 at 8:50 AM revealed her dialysis schedule was Monday, Wednesday, and Fridays. Resident #34 further revealed she had missed breakfast at least four times in the last three months due to kitchen and nursing staff not being organized. An interview conducted with a Nurse from the dialysis center on 6/28/22 at 3:20 PM revealed Resident #34 had stated to dialysis staff that she had missed breakfast a few times. The dialysis Nurse further revealed Resident #34 did not have a low blood sugar but complained about facility staff being unorganized and being very hungry when she returned to the facility. An interview conducted with Nurse Aide (NA) #10 on 6/29/22 at 11:50 AM revealed Resident #34 had missed breakfast twice before her dialysis appointment in the last two months. NA #10 further revealed dietary staff were supposed to serve Resident #34 breakfast at 7:00 AM on dialysis days and would consistently forget. An interview conducted with the Dietary Manager on 6/30/22 at 5:30 PM revealed she was aware Resident #34 had missed breakfast before going to dialysis. The Dietary Manager further revealed Resident #34 was supposed to receive breakfast between 7:00 AM to 7:30 AM on dialysis days. The Dietary Manager stated there had been ongoing miscommunication between nursing and kitchen staff. An interview conducted with the Dietician on 6/29/22 on 2:50 PM revealed she had not been made aware Resident #34 had missed meals before dialysis. The Dietician further revealed she	F 698	providing meals to residents receiving dialysis, will receive this same education. During routine rounds the leadership staff will monitor for compliance. Beginning 8-1-2022, the Administrator or designees, will complete an audit of dialysis meals according to preferences 5x a week for 2 weeks then 2x a week for 2 weeks, then 1x a week for 8 weeks. Administrator will present to the QAPI committee for the next 3 months and the committee will modify to ensure the facility remains in compliance. Date of compliance is August 4, 2022	

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F 698	Continued From page 87 would expect Resident #34 to eat before dialysis so Resident #34 did not become weak. An interview conducted with the Nurse Practitioner (NP) on 6/29/22 at 4:00 PM revealed she had not been made aware Resident #34 had missed meals before dialysis. The NP further revealed she would expect Resident #34 to eat before dialysis so Resident #34 did not become weak and received full nutrition. An interview conducted with the Administrator on 7/1/22 at 12:35 PM revealed she was not aware Resident #34 had missed breakfast before dialysis. The Administrator further revealed she expected for Resident #34 to not miss any meals and dietary staff to be on time with meals.	F 698		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 725		8/4/22

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F 725	Continued From page 88 (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide sufficient nursing staff which resulted in personal hygiene and incontinence care not being performed (Residents # 39 and Resident #10). The facility failed to ensure a maintenance program for maintaining function was provided for 2 of 2 residents (Resident #58 and Resident #39) reviewed for Activities of Daily Living. The findings included: The tag was cross-referred to: F550: Based on observations, record reviews, resident and staff interviews, the facility failed to treat residents in a dignified manner when 1 of 4 residents (Resident #39) was not provided toileting before wetting herself, her clothing and the floor, and failed to provide incontinence care to 1 of 4 residents prior to the resident (Resident #10) wetting through her brief and through her clothing onto her bed pad. F676 Based on observations, record reviews, resident, Certified Occupational Therapy Assistant (COTA), Physical Therapy Assistant (PTA), and staff interviews, the facility failed to	F 725	Resident's #58 and #39 were immediately evaluated by therapy and both were picked up by therapy services to ensure no functional decline. facility immediately conducted skin checks for residents #10 and #39 and no additional issues were identified. On 7/21/22 therapy staff conducted an audit of the last 30 days discharged residents from therapy to ensure a maintenance program is place for all identified residents. On 7/18/2022, the facility social worker interviewed alert residents to determine if there were any further concerns with call light response and timely care. On 7/29/2022 a full sweep was complete by the DON and clinical team to ensure there were no incontinent concerns that were not being addressed. All concerns were addressed at the time of check. DON/designee will educate all staff responsible for providing timely incontinent care services, and timely response to call lights. Education also will include implementation of restorative	

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F 725	Continued From page 89 provide a maintenance program to prevent decline in the ability to ambulate for 2 of 2 sampled residents (Resident #58 and Resident #39) reviewed for maintaining activities of daily living. An interview was conducted on 6/29/2022 at 9:36AM with Nurse Aide (NA) #1. She stated she mainly worked on 400 and 500 halls. She revealed when the facility was short staffed, residents would not get put back to bed after lunch until 9:30-10:30PM, because Agency staff refused. NA #1 stated the facility used Agency staff to fill in the holes on the schedule and if they (agency staff) did not want to do something, they would refuse. She stated there had been a time, recently, where she was the only NA (second shift) assigned to 48 residents. NA #1 stated she was not able to complete her assignment on that day because there was not enough time or help to complete everything with so many residents. NA #1 indicated she had reported staffing issues to the Director of Nursing and the Administrator several times in the past few months. An interview with NA #11 was conducted on 6/30/2022 at 9:46AM. She stated there had been times when the facility was short-staffed especially since covid-19. She revealed staffing on the weekends was still bad because agency staff did not want to work weekends. Interview with NA #3 on 6/30/2022 at 10:37AM revealed she had worked at the facility through an agency. She stated on Monday, June 27, 2022, on 2nd shift, she had to work 5 hours by herself on the hall with residents that required extensive to total assistance by staff for their care.	F 725	program by 08/04/2022. Any agency staff or new hires after 8-4-2022 that will be responsible for restorative program or providing incontinent care services will receive this same education. All staff will receive education on answering of call lights during orientation. Beginning 8-1-2022, the Administrator or designee will randomly interview 5 resident's on call light response concerns weekly for 12 weeks. Director of nursing or designee will randomly observe 5 residents per week for potential functional decline for 12 weeks. The DON or designee will observe 5 residents per week for 12 weeks to ensure that their incontinent care needs are met. Results of audits will be reported to the Qauality Assurance and performance improvement meeting for three months at which time the committee will determine further action needed.	

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F 725	Continued From page 90	F 725		

An interview was conducted with Unit Manager (UM) #1 on 6/30/2022 at 4:03PM. She revealed on Sunday, 6/26/2022, when she arrived at work for first shift, there had been 5 call outs. She stated the call outs left the facility with only 1 NA upstairs and 4 downstairs, and she had to pull 2 NAs from downstairs to upstairs so they would have at least 1 NA per hall. UM stated each one of those NAs performed showers, personal care, incontinence care, turned and repositioned residents, assisted residents to the bathroom, assisted residents with feeding, passed, and picked up trays and answered call lights, by themselves on their assigned hall. She stated she assisted the NAs and much as she could, but everything that needed to be done was not done. She indicated she had reported staffing issues to the Director of Nursing and the Administrator on several occasions in the past couple of months.

Interview with the Staffing Coordinator on 7/1/2022 at 8:37AM revealed she had been at this position for 2 years and she was also a NA. She stated the facility had been short-staffed recently, but she reached out to different Staffing Agencies to help find coverage. She stated the facility currently has 7 open Nurse positions and 8 open Nurse Aide positions. The Staffing Coordinator stated she helped on the floor when needed and helped cover the weekends when staffing was short. For recruitment, the facility has advertised in newspapers and on-line, offered sign-on bonuses, and increased staff pay. She stated Unit Managers and the Director of Nursing had assisted on the floor when necessary.

An interview was conducted with the Administrator and Regional Director of Clinical Services (RDCS) on 7/1/2022 at 11:27AM. The

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F 725	Continued From page 91 Administrator stated she was aware of the staffing challenges in the facility, the staffing shortages had been reported to her by hall staff, unit managers, and the Director of Nursing. She revealed she was tasked with finding staff and had to utilize Staffing Agencies to cover the open shifts. She stated Agency staff sometimes did not show up for the shifts they had signed up for and this presented problems for the facility. Administrator stated Unit Managers and Department Managers assisted with answering call lights and doing what they could for the residents. All staff, including herself, had to answer call lights. Administrator indicated she offered bonuses to staff who worked an extra shift or agreed to stay over their shift to assist. She revealed the facility did not have a Restorative Program and relied on nursing staff to ambulate residents. RDCS stated the facility had recently hired 26 Nurse Aides. The Administrator stated staff had come to her about not being able to do their jobs and about the long hours they had to work. She stated the facility was actively recruiting staff to fill the open positions. She stated her expectation was for the facility to have enough staff to take care of the needs of the residents.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 726		8/4/22

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F 726	Continued From page 92 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, observation and interviews with family member, staff and Wound Center staff, the facility failed to provide training to ensure 2 of 7 nurses (Nurse #2 and Nurse #3) were competent and demonstrated skills in providing care to 1 of 1 resident (Resident #36) reviewed for wound vac (vacuum-assisted closure of a wound) application. The findings included: Resident #36 was initially admitted to the facility on 4/23/19 with diagnoses that included Parkinson's disease, muscle weakness, spinal stenosis, atherosclerotic heart disease,	F 726	Competencies related to wound vacs were immediately conducted for Nurse #2 and nurse #3. On 7/11/22 100% audit of resident□s with wound vacs was conducted to ensure appropriate applications were being done. To prevent future occurrences no licensed staff will care for a wound vac without competency being completed. DON/designee provided education and competiency for wound vac applications (donning and doffing, vac failure, etc) will be completed by 8/4/22 for all licensed	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 93 hypertension and history of transient ischemic attack and cerebral infarction. She was recently re-admitted on 3/3/22 from the hospital due to acute encephalopathy and advanced Parkinson's disease. A physician order dated 4/22/22 in Resident #36's medical record indicated an order for wound vac to wound continuously at 125 mmHg (millimeter Mercury) and to change wound vac in the evening every Monday, Wednesday, and Friday. Resident #36's care plan revised on 4/26/22 indicated Resident #36 had potential for skin breakdown related to weakness, impaired mobility, and episodes of bladder incontinence. She had a history of moisture-associated skin damage to buttocks/sacrum and now had a stage 4 pressure wound to the sacrum. Interventions included wound vac as directed. Wound vac, also known as vacuum-assisted closure of a wound, is a type of therapy to help wounds heal. It is a therapeutic technique using a suction pump, tubing, and a dressing to remove excess exudate (drainage) and promote healing in acute or chronic wounds. The Significant Change Minimum Data Set (MDS) assessment dated 4/29/22 indicated Resident #36 was cognitively intact, had no rejection of care behaviors and required extensive physical assistance with bed mobility, locomotion, and toilet use. Resident #36 had impairment on one side of her upper extremities and used a wheelchair. The MDS further indicated Resident #36 was frequently incontinent of urine, but she was always continent of bowel. Resident #36 was at risk of developing pressure ulcers/injuries and had one stage 4 pressure	F 726	nurses. Any nurses not educated will not be able to perform this practice. New hires and agency nurses will be educated prior to performing this procedure. DON/designee will complete an audit on all wound vacs applications to ensure competent applications 3x a week for 2 weeks then 2x a week for 2 weeks, then 1x a week for 8 weeks. DON will present to the QAPI committee for the next 3 months and the committee will modify plan as appropriate to ensure the facility remains in compliance. Date of compliance is 8/4/22	

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ulcer.

A phone interview with Resident #36's family member on 6/30/22 at 8:19 AM revealed she went with Resident #36 to her Wound Center appointment on 6/27/22 and they noted that the wound vac was applied incorrectly when a barrier was not applied between the bridge foam and the skin which caused red areas to her left buttock. Resident #36's family member stated she had voiced her concerns to the Administrator about the nurses requiring more training and education on the application of wound vac, but she wasn't sure what was done about it. Prior to this, on 5/2/22 at around 5:00 PM, Resident #36's wound vac was not working because it had lost seal and needed to be re-applied. The nurse on the hall did not know how to change the wound vac. The Administrator got UM #1 to come and change the wound vac and UM #1 made a comment to her that the nurses at the facility could use more education and training on wound vac application. On 5/4/22, Resident #36's family member went with the resident to her appointment at the Wound Center and Wound Center staff had made a comment to her that they would suggest to the facility to consider training their nurses on wound vac application due to multiple issues observed with Resident #36's wound vac.

An In-service Sign-off Sheet dated 6/3/22 indicated an in-service was conducted by Unit Manager #1 and Unit Manager #2 on wound vac application with the objective of all nurses to be able to successfully apply and maintain wound vac. The sign-off sheet was signed by 6 nurses that included Nurse #3. Nurse #2 did not sign the sheet.

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An interview with Unit Manager (UM) #1 on 6/30/22 at 3:20 PM revealed she and UM #2 conducted an in-service on wound vac application to all nurses who could be assigned to Resident #36. UM #1 stated she talked to the nurses and provided them with a written step by step instructions on the procedure. On the day she conducted the in-service, Resident #36's wound vac was not scheduled to be changed so she didn't get to demonstrate the procedure but some of the nurses were able to watch her do the procedure on a later date. However, she did not watch any of the nurses return demonstrate and she did not evaluate their understanding and competency of the wound vac application.

An interview on 6/28/22 at 3:36 PM with Nurse #6 who was an agency nurse revealed she did not attend the in-service on wound vac on 6/3/22 but she had watched UM #1 do the procedure once on 6/16/22. Nurse #6 stated she had to change Resident #36's wound vac on 6/27/22 for the first time but prior to the procedure, UM #1 had talked her through as to what she needed to do. UM #1 did not watch her change Resident #36's wound vac dressing on 6/27/22.

An interview with Unit Manager (UM) #2 on 6/30/22 at 6:02 PM revealed she received a phone call on 6/27/22 from the Wound Center about Nurse #6 not having applied Resident #36's wound vac correctly. Nurse #6 didn't put enough foam on the wound and the foam that she applied didn't fill the hole completely. She also did not put skin prep barrier and clear tape under the bridge. UM #2 stated Nurse #6 was instructed on what she needed to do prior to the procedure but she didn't have time to check Resident #36's wound vac to make sure it was applied correctly. UM #2

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stated she told all the nurses who worked with Resident #36 to come get her if they needed help with Resident #36's wound vac application. She also stated it was hard to give instructions to agency nurses because of the high turnover with working at the facility and there was always a new nurse working on the hall. UM #2 stated the only time she received a phone call from the Wound Center was on 6/27/22 but Resident #36 always came back from her appointment with detailed instructions on how to do the wound vac dressing and it always indicated to consider wound vac in-service for facility staff.

An observation of wound care was made on 7/1/22 at 2:43 PM on Resident #36 and performed by Nurse #3 and assisted by Nurse Aide (NA) #2. Resident #36 was turned towards her left side while NA #2 stood facing Resident #36 and supported her trunk. Nurse #3 sprayed wound cleanser into the sacral pressure ulcer which measured approximately 2 cm (centimeters) in length, 3 cm in width and 2 cm in depth. The wound bed had beefy red granulation tissue with 20% slough (yellow/white material in the wound bed consisting of dead cells). The skin surrounding the wound was red. Nurse #3 applied skin prep barrier to the surrounding skin and well over towards the right buttock. Nurse #3 cut a piece of green foam that fit exactly into the wound bed and applied it to the wound. She cut a plastic drape in half, cut, and measured a hole to fit the foam and applied it to cover Resident #36's buttocks and sacral area. She cut another piece of green foam approximately 6 inches long and 1 inch wide to serve as a bridge to the foam covering the wound. Nurse #3 placed the bridge over the plastic drape and covered it with another piece of plastic drape. She cut a small piece of

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the drape at the top and when she was about to place the track pad, she asked NA #2 how she was supposed to position it. NA #2 told Nurse #3 she didn't know. Nurse #3 ended up placing the track pad with the tubing towards Resident #36's sacrum. She secured the track pad with another piece of tape and then coiled the tubing into a circle and taped it to Resident #36's right hip. Nurse #3 connected the tubing to the canister that was placed inside the wound vac and turned the machine on. It took a minute before suction was visible on the foam on Resident #36's sacral area but it was set at 125 mmHg.

An interview with Nurse #3 on 7/1/22 at 3:21 PM revealed that the length in which she cut the bridge foam was based on her observation from the dressing done at the Wound Center. Nurse #3 stated she always positioned the track pad with the tubing going towards Resident #36's sacrum because whenever she positioned it the other way, the tubing ended up getting kinked more.

A follow-up interview with Unit Manager (UM) #1 on 7/1/22 at 3:36 PM revealed after inspecting the wound vac dressing applied by Nurse #3, she noted that the bridge wasn't long enough because it was sitting at Resident #36's right buttock. UM #1 stated the bridge should be placed farther out all the way to the right hip so that when Resident #36 got turned towards her right side, she won't be laying on the track pad. At the same time, the track pad was applied backwards and should have been placed with the tubing going out and not towards Resident #36's sacrum. UM #1 also stated Nurse #3 shouldn't have coiled the tubing the way she did because this would cause the tubing to kink and potentially cut off the suction from the wound vac. UM #1 stated she had

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shown Nurse #3 several times how to change the wound vac dressing on Resident #36 but had not watched her return demonstrate. UM #1 said she never received a call from the Wound Center, but they always made it clear on the paperwork that Resident #36 came back with if they had issues with the wound vac. On 5/25/22, the Wound Center staff sent a "sample foam" that measured exactly how much foam they wanted placed on the wound. UM #1 stated the consult indicated that the facility staff needed to put more foam on the wound bed.

A phone interview with a Wound Center nurse on 6/30/22 at 2:41 PM revealed the Wound Center had recommended an in-service with the nurses at the facility regarding wound vac application due to multiple concerns observed whenever Resident #36 came to her Wound Center appointments. A lot of times, the nurses would forget to place a transparent drape in between the bridge foam and the skin causing more redness to intact skin. There were also times when they had applied the track pad directly on the sacrum on top of the foam which caused more pressure to the area. At other times, the tubing was positioned on the buttock which was not acceptable because this could cause more pressure areas on the buttocks. The Wound Center nurse stated this did not cause deterioration of the pressure ulcer or delay in healing, but it posed the potential to do so.

An interview with the Director of Nursing (DON) on 7/7/22 at 2:22 PM revealed he had heard nurses report to him that the Wound Center had issues with the way the wound vac was applied at the facility. He said the Unit Managers had done several in-services with the nurses especially the

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F 726	Continued From page 99 ones who were assigned to Resident #36 on how to change her wound vac dressing. They had reported to him that they watched the nurses return demonstrate wound vac application on Resident #36. An interview with the Administrator on 7/1/22 at 3:41 PM revealed all nurses on all shifts should be in-serviced and educated on Resident #36's wound vac application through hand-outs and sign-in sheets for accountability. The Administrator stated the nursing administrative team had an open-door policy for questions and nurses were expected to ask questions and say something to the DON or the unit managers if there was a procedure they weren't sure of. The Administrator also stated it was best practice to have the nurses be checked off on wound vac application to determine if they had retained any of the instructions provided to them.	F 726		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.	F 802		8/4/22

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F 802	Continued From page 100 §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to have sufficient dietary staff to ensure meals were delivered at the posted mealtimes. This failure had the potential to impact 80 of 82 residents who received oral nutrition. The findings included: Interview with Resident #58 (400 hall) on 6/27/2022 at 10:34 AM revealed the meal trays were not delivered at a consistent time. Resident #58 stated she did not receive her breakfast tray until 9:30 AM to 10:00 AM and the lunch tray did not arrive until 1:00 PM to 1:30 PM. Resident #58 further disclosed the dinner trays did not arrive until 6:00 PM to 6:30 PM. Interview with Resident #64 (500 hall) on 6/27/2022 at 10:53 AM revealed the mealtimes were not consistent. Resident #64 stated meals were at least an hour late every day. According to Resident #64, she had made the Administrator aware of the inconsistent mealtimes, but there had been no changes. Interview on 6/28/2022 at 7:30 AM with Nurse #12 revealed 4 or 5 dietary staff members quit a few months ago. Nurse #12 stated the lack of dietary staff meant the upstairs main kitchen was the only one staffed. The downstairs kitchen was no longer open due to lack of dietary staff to operate that kitchen. According to Nurse #12, meals were late every day (breakfast as late as	F 802	It is the policy of this facility to provide sufficient support personnel to safely and effectively carry out the functions of food and nutrition services. facility reviewed staffing schedules immediately to assure no residents would be negatively affected related to the deficient practice All residents in the facility have the potential to be affected by the alleged deficient practice. The dietary department has instituted oversight by temporary CDM until permanently filled. Depart managers and other personnel will assist dietary staff with meals until adequate staffing is obtained. Facility actively advertising and hiring dietary personnel. Beginning 7/4/22 education to all dietary staff was completed by the Regional Dietary Manager on timely meal service according to the posted meal times. Administrator/designee will complete an audit of timely meal service 5x a week for 2 weeks then 2x a week for 2 weeks, then 1x a week for 8 weeks. Administrator or designee will review staffing schedules daily to ensure appropriate staffing levels are in place to meet expected meal time delivery. This will be completed 5 times per week for 2 weeks, 2 times per week for 2 weeks then 1 times per week for 8	

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F 802	Continued From page 101 10:30 AM and lunch as late as 2:30 PM) because there were so few staff to work in the kitchen. Observation and interview with Resident #34 (500 hall) on 6/28/2022 at 8:59 AM revealed she was eating a breakfast meal she had ordered and had delivered from an outside restaurant. Resident #34 stated she did not like the dinner meal last night and was hungry. Interview with Resident #24 (500 hall) on 6/28/2022 at 9:05 AM revealed she sometimes did not receive her breakfast tray until after 10:00 AM and her lunch tray around 2:30 PM. Observation of a meal schedule was posted in the hallway beside the dining room door on 6/28/2022 at 5:04 PM. The scheduled mealtimes were as follows: " Breakfast - 7:45 AM " Lunch - 11:45 AM " Dinner - 4:30 PM The posting further indicated meals were served in the following order: " Upstairs dining room " Downstairs Assisted Diners " 100 hall " 200 hall " 300 hall " 400 hall - downstairs " 500 hall - downstairs A continuous observation of the lunch meal delivery on 6/28/2022 at 12:01 PM revealed the following: " 12:01 PM - residents assisted to upstairs dining room " 12:01 PM - overhead page indicated 100 and 200 hall dining carts were available for pick up	F 802	weeks. Administrator will present to the QAPI committee for the next 3 months and the committee will modify to ensure the facility remains in compliance. Date of completion is 8/4/22.	

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" 12:02 PM - 100 hall dining cart delivered to hall by Nurse Aide (NA)
" 12:05 PM - first dining room resident served
" 12:11 PM - 200 hall cart delivered to hall by NA
" 12:26 PM - overhead page indicated 300 hall dining cart was available for pick up
" 12:30 PM - 300 hall dining cart delivered to hall by NA
" 12:35 PM - overhead page indicated 400 and 500 hall dining carts were available for pick up
" 12:38 PM - 400 and 500 hall dining carts were taken to downstairs residents by NAs

A continuous observation of the dinner meal delivery on 6/28/2022 at 5:04 PM revealed the following:
" 5:23 PM - overhead page indicated 100 hall dining cart was available for pick up
" 5:38 PM - overhead page indicated 200 hall dining cart was available for pick up
" 5:44 PM - overhead page indicated 300 hall dining cart was available for pick up
" 5:56 PM - overhead page indicated 400 hall dining cart was available for pick up
" 6:07 PM - overhead page indicated 500 hall dining cart was available for pick up

An interview with the Certified Occupational Therapy Assistant (COTA) on 6/29/2022 at 8:19 AM revealed dietary staffing was very low which necessitated non-dietary staff to step up to help. The COTA stated she had worked in the kitchen to assist with making coffee on several occasions.

Interview with NA #1 on 6/29/2022 at 9:44 AM revealed mealtimes were erratic. The NA stated the inconsistency was related to very few staff in

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the kitchen.

Interview with the Registered Dietician (RD) #4 on 6/29/2022 at 1:13 PM revealed there was not enough dietary staff on a regular basis to keep the kitchen running smoothly and on time.

Interview with Cook #1 on 6/30/2022 at 11:18 AM revealed he did not have enough staff to maintain consistent meal delivery times. Cook #1 indicated he never knew how many staff would be in the kitchen on any given day. Cook #1 also disclosed at least 2 more staff were needed in the kitchen on a daily basis to make the schedule work. Cook #1 stated there had not been a reliable dishwasher since he had worked at the facility (1 month). Cook #1 revealed dietary staff pitched in to run the dishwasher when they could.

Interview with Unit Manager (UM) #1 on 6/30/2022 at 4:23 PM revealed meal delivery timing was very erratic due to low dietary staffing.

An interview with the Dietary Manager (DM) on 6/27/2022 at 9:41 AM revealed she was struggling to maintain staff. The DM indicated the previous DM and 4 or 5 of the dietary staff quit in November 2021. At that time, she was promoted to DM and made sure meals were prepared and menus followed. The DM revealed 3 or 4 dietary aides had since been hired, but none of them had maintained their employment, leaving the department understaffed. The DM disclosed having an understaffed kitchen staff meant meals were not served on time according to the schedule, but dietary staff were doing the best they could.

Interview with the facility Administrator on

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F 802	Continued From page 104 7/1/2022 at 11:19 AM revealed she was aware of low dietary staffing. The Administrator further disclosed she was aware NAs were scraping plates after meals. The Administrator indicated recruitment efforts were ongoing for dietary staffing.	F 802		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to honor food preferences for 2 of 2 sampled residents reviewed (Residents #24 and #50). Findings included: 1. Resident #24 was admitted to the facility on 02/01/21. The quarterly Minimum Data Set (MDS) dated 04/14/22 indicated Resident #24 was cognitively intact and required set-up help only with meals. A physician's order for Resident #24 dated 05/20/22 read, "magic cup (frozen nutritional supplement) two times a day on lunch and dinner	F 806	Tray cards for residents #24 and #50 were immediately reviewed and updated for dietary preferences Administrator or designee will conduct an audit by 7/15/22 to review resident's preferences in PCC and ensure meal tickets are updated to reflect resident food preferences. Education for all dietary staff related to resident preferences was completed by Regional Dietary Manager starting on 7/11/22. During routine rounds the leadership staff will monitor for compliance. Nursing staff educated on to check tray cards when passing trays to	8/4/22

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F 806	Continued From page 105 tray." During interviews on 06/27/22 at 12:18 PM and 06/28/22 at 9:05 AM, Resident #24 revealed she was only able to eat certain food items due to gastroesophageal reflux disease (GERD; occurs when stomach acid frequently flows back into the tube connecting your mouth and stomach). Resident #24 stated she was not able to eat most of the meals served because the food was either too spicy, had no taste at all or she was served items she did not like and as a result had lost weight. Resident #24 indicated the Dietary Manager (DM) and Registered Dietician (RD) were both aware of her food preferences but she still received food items she could not eat. An observation of the lunch meal on 06/27/22 at 1:09 PM revealed Resident #24 received an orange cream magic cup, chocolate cupcake and a vegetable medley. A review of the meal ticket that was on her meal tray revealed a standing order for one magic cup - berry only and her dislikes included chocolate, vegetable blend, broccoli, and cauliflower. An observation of the lunch meal on 06/28/22 at 1:06 PM revealed Resident #24 received an orange cream magic cup, Salisbury steak with gravy, creamed corn, and diced potatoes. A review of the meal ticket that was on her meal tray revealed a standing order for one magic cup - berry only and a note that read, "no gravy per resident's request." An observation of the supper meal on 06/28/22 at 6:15 PM revealed Resident #24 received 2 grilled cheese sandwiches and no magic cup with her meal. A review of the meal ticket that was on her	F 806	ensure meal served matches tray card. Interim Dietary manager to randomly audit trays to assure they match tray cards for preferences. This will be completed 5x a week for 2 weeks then 2x a week for 2 weeks, then 1x a week for 8 weeks. Administrator will present to the QAPI committee for the next 3 months and the committee will modify to ensure the facility remains in compliance. Date of completion is 8/4/22.	

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F 806	Continued From page 106	F 806		

meal tray revealed a standing order for one magic cup - berry only.

An observation of the lunch meal on 06/29/22 at 1:03 PM revealed Resident #24 received stew, roll, brussels sprouts, and an orange cream magic cup. A review of the meal ticket that was on her meal tray revealed a standing order for one magic cup - berry only and her dislikes included brussels sprouts.

During an interview on 06/30/22 at 5:23 PM, the DM stated Resident #24 changed her food preferences frequently. The DM was unaware Resident #24 had been served an orange cream magic cup with her meals all week in addition to food items listed as a dislike or that she did not receive a magic cup with her supper tray on 06/29/22. She explained the dietary aides were supposed to be reading the meal tickets to ensure supplements were provided as ordered and residents weren't served foods that were listed as a dislike.

During an interview on 07/01/22 at 11:20 AM, the Administrator stated staff needed to be re-educated to remain diligent during food service and check the meal tickets to ensure supplements were provided as ordered and residents weren't served food listed as a dislike.

2. During an observation of the supper meal on 6/28/22 at 6:00 PM, Resident #36 was served two ham and cheese sandwiches with lettuce on them. A review of the meal ticket that was on the tray indicated Resident #36's dislikes included lettuce and salad.

An interview with Resident #36's family member

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F 806	Continued From page 107 on 6/28/22 at 6:15 PM revealed Resident #36's family members normally rotated during the lunch and supper meals to make sure Resident #36 got served food according to her preferences and the consistency that she would be able to eat. He stated he went ahead and removed the lettuce from the sandwiches and just set them aside on the plate instead of asking the kitchen staff for another plate. An interview was conducted with the Dietary Manager (DM) on 6/30/22 at 5:23 PM. The DM stated the dietary aides were supposed to be reading the cards or meal tickets to make sure they didn't serve the residents food that were on their dislikes list. She stated the dietary aides should have read Resident #36's meal ticket before serving her supper tray. An interview with the Administrator on 7/1/22 at 3:41 PM revealed the staff need to be re-educated on checking the meal tickets to prevent serving the residents any of their food dislikes and make sure staff remained vigilant during food service. The Dietary Manager also helped with looking at the meal tickets, but she wasn't always at the facility during the supper service.	F 806		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 835		8/4/22

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F 835	Continued From page 108	F 835		

by:
Based on observations, record reviews and interviews with resident, family member, staff, Wound Physician Assistant (PA) and Nurse Practitioner, the facility failed to provide effective leadership and implement effective systems to manage pressure ulcers, laboratory tests and physician notification. This failure affected 2 of 3 residents reviewed for administration (Resident #36 and Resident #11).

Immediate Jeopardy began on 3/3/22 when the facility failed to provide the necessary care and services for a pressure ulcer that deteriorated in condition that involved Resident #36. The immediate jeopardy was removed on 7/3/22 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective.

The findings included:

This tag is cross-referred to:

F-580: Based on record reviews, and interviews with staff, family member, Wound Physician Assistant (PA) and Nurse Practitioner, the facility failed to notify the physician or Nurse Practitioner when a sacral pressure ulcer was identified on Resident #36 on 3/3/22 and when the pressure ulcer deteriorated on 3/10/22. The facility failed to notify the Wound PA of two wound culture swabs being discarded by the laboratory. Resident #36 was later diagnosed on 4/13/22 with sacral osteomyelitis. In addition, the facility failed

I. Facility failed to provide effective leadership and implement systems to manage pressure ulcers, laboratory tests and physician notification

II. Regional team to include the Regional Vice President of Operations and the Regional Director of Clinical Services identified there were breakdowns in the execution of critical clinical services
a. Region team immediately provided oversight and education to the leadership staff.
b. Policies related to pressure ulcers and notification for change in condition were reviewed to assure they would be appropriate for the center and they were deemed to be appropriate. Issues related to pressure ulcers and notifications were not policy driven but issues were identified with implementation of the policy so education occurred. The center□s process for handling labs and laboratory supplies was reviewed and found to be inadequate so process was updated and put into place effective 7/2.
c. Education to the administrator and DON was provided by the Regional Vice President of Operations and the Regional Director of Clinical Services.
i. Education included policies, and implementing systems for oversight and execution of critical nursing systems identified in the immediate jeopardy. These were completed on 7/2/2022.
1. Education to the pressure ulcer policy was completed and implemented on 7/2/2022

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F 835	Continued From page 109 to notify Resident #36's family member when her pressure ulcer deteriorated on 3/10/22. This failure was for 1 of 3 residents reviewed for notification of changes (Resident #36). F-686: Based on observations, record reviews and interviews with resident, family member, staff, Wound Physician Assistant (PA) and Nurse Practitioner, the facility failed to assess, obtain treatment orders from the physician, and identify deterioration of the pressure ulcer which resulted in a serious adverse outcome. Resident #36's open area on her sacrum deteriorated from an open area to an unstageable pressure injury with necrotic tissue in a week (from 3/3/22 to 3/10/22). The facility also failed to have two wound cultures processed on Resident #36's sacral pressure ulcer resulting in delayed treatment for osteomyelitis. In addition, the facility failed to provide pressure ulcer care as ordered by the Wound PA for Resident #11. These failures were for 2 of 3 residents reviewed for pressure ulcers (Resident #36 and Resident #11). An interview with the Regional Director of Clinical Services (RDCS) on 6/30/22 at 6:59 PM revealed one of the factors that contributed to the facility's not having effective leadership was due to the facility's lack of Administrative nurses to help the Director of Nursing. The RDCS stated the facility had experienced a quick turnover of Administrative nurses including an Assistant Director of Nursing who was supposed to oversee the unit managers on the floor. They had recently hired 2 unit managers, but they sometimes got pulled to work on the hall and away from their Administrative duties. The Administrator was notified of Immediate	F 835	2. Education for updated process for laboratory testing and acquiring laboratory supplies was completed and implemented on 7/2/2022. 3. Notification for resident change in condition policy and procedure was educated and implemented on 7/2/2022. 4. Leadership education also included the company□s QAPI process and morning clinical meeting process. Completed 7/2/2022. III. Regional team member will participate in each QAPI meeting with the center for the next 3 months to assure appropriate issues are identified and follow-up is put into place. IV. Regional team member will participate in the center□s morning clinical meeting on a weekly basis for the next 30 days to assure meeting is thorough and captures any clinical issues that need to be addressed. V. Regional team member will review all audits and in-services related to this plan for the next three months on a weekly basis and repeat in-servicing as appropriate. VI. The Regional team will randomly audit 3 resident charts per week for the next three months to assure accuracy of pressure ulcer documentation, lab testing compliance and appropriate physician notification. VII. Regional team has set an expectation	

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F 835	Continued From page 110 Jeopardy on 7/1/22 at 1:03 PM. The facility provided the following IJ Removal Plan with the correction date of 7/3/22. I. Facility failed to provide effective leadership and implement systems to manage pressure ulcers, laboratory tests and physician notification. II. Regional team to include the Regional Vice President of Operations and the Regional Director of Clinical Services identified there were breakdown in the execution of critical clinical services. a. Regional team immediately provided oversight and education to the leadership staff. b. Policies related to pressure ulcers and notification for change in condition were reviewed to assure they would be appropriate for the center, and they were deemed to be appropriate. Issues related to pressure ulcers and notifications were not policy driven but issues were identified with implementation of the policy, so education occurred. The center's process for handling labs. and laboratory supplies was reviewed and found to be inadequate, so process was updated and put into place effective 7/2/22. c. Education to the Administrator and DON was provided by the Regional Vice President of Operations and the Regional Director of Clinical Services. d. Education included policies and implementing systems for oversight and execution of critical nursing systems identified in the immediate jeopardy. These were completed on 7/2/22. 1. Education to the pressure ulcer policy was completed and implemented on 7/2/22. 2. Education for updated process for	F 835	that the center will hold QAPI meetings monthly. Clinical morning meetings and daily stand-up meetings will be held daily Monday through Friday according to policy. VIII. Regional team will conduct a weekly leadership meeting that involves the Regional Vice President or designee, Regional Director of Clinical Services or designee, the facility Administrator and facility Director of Nursing for the next 3 months. Other regional or corporate staff will be invited as appropriate. This leadership meeting will review progress to the plan of correction for the current survey, review process or policy changes that have been implemented for effectiveness, and discuss any current issues needing addressed on a clinical level. The results of the audits will be presented to QAPI committee by Administrator or regional team for 3 months and the committee will modify to ensure the facility remains in compliance. Date of completion 8/4/22	

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laboratory testing and acquiring laboratory supplies was completed and implemented on 7/2/22.

3. Notification for resident change in condition policy and procedure was educated and implemented on 7/2/22.

4. Leadership education also included the company's QAPI process and morning clinical meeting process. Completed 7/2/22.

III. Regional team member will participate in each QAPI meeting with the center for the next 3 months to assure appropriate issues are identified and follow-up is put into place.

IV. Regional team member will participate in the center's morning clinical meeting on a weekly basis for the next 30 days to assure meeting is thorough and captures any clinical issues that need to be addressed.

V. Regional team member will review all audits and in-services related to this plan for the next three months on a weekly basis and repeat in-servicing as appropriate.

VI. The Regional team will randomly audit 3 resident charts per week for the next three months to assure accuracy of pressure ulcer documentation, lab. testing compliance and appropriate physician notification.

VII. Regional team has set an expectation that the center will hold QAPI meetings monthly. Clinical morning meetings and daily stand-up meetings will be held daily Monday through Friday according to policy.

VIII. Regional team will conduct a weekly

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leadership meeting that involves the Regional Vice President or designee, Regional Director of Clinical Services or designee, the facility Administrator and facility Director of Nursing for the next 3 months. Other regional or corporate staff will be invited as appropriate. This leadership meeting will review progress to the plan of correction for the current survey, review process or policy changes that have been implemented for effectiveness and discuss any current issues needing addressed on a clinical level.

Date of removal for alleged IJ is 7/3/22.

The credible allegation for the immediate jeopardy removal was validated on 7/7/22 with a removal date of 7/3/22.

A root cause analysis was completed by the Regional Vice President of Operations which identified the following root causes for the IJ concerns identified at the survey: new leadership, agency staffing and adherence to company systems.

The audit tools completed by the facility on skin status and laboratory results were reviewed. The physician/Nurse Practitioner were notified of results from the audits for additional follow-up as needed.

On 7/2/22, the Regional Vice President of Operations provided education with the new Administrator and Director of Nursing on identifying issues with immediate jeopardy cited and discussed with them the components of the regulations for F-580, F-686, and F-835. The education also included QA (Quality Assurance)

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F 835	Continued From page 113 roles and responsibilities, morning stand-up, clinical stand-up, pressure ulcer policy, policy on resident change in condition, laboratory process, correction plans and monitoring processes. Interviews with nurses and nurse aides revealed they received education on identifying any changes in resident condition including skin issues, changes in vital signs and daily habits and reporting these changes to the nurses and the medical providers. An ad hoc QAPI (Quality Assurance and Performance Improvement) meeting was conducted on 7/2/22 with the following key personnel in attendance: Administrator, Regional Director of Clinical Services, Regional Vice President for Operations, Nurse Practitioner and Director of Nursing. They discussed conducting weekly risk meetings to put practice back in place to ensure IDT discusses key resident conditions, makes recommendations and changes to care plans as needed.	F 835		
F 842 SS=B	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	F 842		8/4/22

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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

§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.

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F 842	Continued From page 115 §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 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 document a resident's change in condition requiring hospitalization for 1 of 1 sampled resident (Resident #67). The facility also failed to maintain accurate Treatment Administration Records (TAR) related to the application of hand splints and administration of oxygen for 2 of 3 sampled residents (Residents #11, and #72). The findings included: 1. Resident #67 was admitted to the facility on 05/21/22 with diagnoses that included diabetes and hemiplegia and hemiparesis (weakness or complete paralysis on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side. Review of Resident #67's medical record revealed she was sent out to the hospital on 06/19/22 for evaluation, admitted for treatment and returned to the facility on 06/24/22.	F 842	Resident #72 - Oxygen was adjusted per order resident remains in the facility no negative outcome Resident #11 - Splint orders were clarified resident remains in the facility with no negative outcome Resident # 67 - has re-admitted to the facility. To identify other residents that may have been affected by this issue, on 7/12/2022 residents who had oxygen orders were observe to ensure the order matched the liter flow. Residents that have orders for splints were clarified on 07/20/2022, any concerns were corrected. Residents who were discharged to the hospital in the last 30 days, were reviewed to ensure discharge notes included in medical record on 07/19/2022 To prevent this from re-occurring, DON /designee will educate the nursing	

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F 842	Continued From page 116 Review of Resident #67's nurse progress notes revealed no entry dated 06/19/22 describing Resident #67's change in condition, why she was transferred to the hospital, what time she left the facility or who was notified. The only nurse progress noted regarding Resident #67's hospital transfer was an entry dated 06/24/22 that read in part, "Resident #67 returned to the facility at 2:15 PM following hospitalization for altered mental status." During an interview on 07/01/22 at 10:10 AM, Unit Manger (UM) #1 stated when residents were sent out to the hospital for evaluation, nursing staff should enter a progress note that included a description of the resident's change in condition, reason for the hospital transfer, when the physician or Nurse Practitioner were notified, vitals, and what time the resident left the facility. UM #1 reviewed Resident #67's medical record and confirmed there was no progress note or assessment completed on 06/19/22 to indicate why or what time she was sent out to the hospital. During an interview on 07/01/22 at 11:20 AM, the Administrator stated she would have expected for the nurse to have documented Resident #67's change in condition in a progress note or assessment to indicate the reason for the hospital transfer, who all were notified, and the time she left the facility. 2. A physician order dated 1/2/20 in Resident #72's medical record indicated an order for nurse to ensure that left hand splint was applied every evening shift at bedtime. Document any refusals. Resident #72's Treatment Administration Record (TAR) for June 2022 revealed an order for: Apply	F 842	department on oxygen orders matching what liter flow resident is receiving; split application as ordered and requirement that residents who are discharge to the hospital have change of condition documentation included in the medical record. This education will be completed by 8-4-2022. Any new hires and agency staff after 8-4-2022, who are responsible for oxygen administration, splint application and documentation of change of condition, will receive this same education. Any nursing staff that cannot be reached with the initial education time frame will not take an assignment until they have received this education. To monitor and maintain ongoing compliance, beginning 8-1-2022, the DON/designee will audit 5 residents for 5 weeks, then 2 residents per week for 2 weeks then one resident per week for 8 weeks.. Splint orders will be reviewed 5x a week for 2 weeks 2x a week for 2 weeks and 1x a week for 8 weeks. The DON or designee will monitor residents who were sent to the hospital due to a change of condition to ensure there is appropriate documentation, 5x a week for 2 weeks 2x a week for 2 weeks and 1x a week for 8 weeks. Results of the audits will be reported to the QAPI meeting for 3 months at which the committee will determine further action needed to ensure the facility remains in compliance. Completion date 8/4/22	

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left hand splint at bedtime. Nurse to ensure that left hand splint was applied every evening shift at bedtime. Document any refusals. It was documented as having been applied at 9:00 PM on 6/26/22 by Nurse #9 and on 6/27/22 and 6/28/22 by Nurse #8. No refusals were documented on the TAR.

An interview with Nurse #8 on 6/29/22 at 7:00 AM revealed she worked with Resident #72 on 6/27/22 and 6/28/22 from 7:00 PM to 7:00 AM. Nurse #8 stated she thought the nurse aides were supposed to be applying Resident #72's left hand splint whenever she went to bed. Nurse #8 stated she couldn't remember if she had checked behind them to make sure her left hand splint was on. She knew they were supposed to remove it whenever they got her out of the bed, but she hadn't gotten around to checking if she even had them on from the night before. She couldn't remember why she had documented that Resident #72 had her splint on without checking it first.

A phone interview was attempted on 6/30/22 at 11:13 AM, 7/1/22 at 9:07 AM and 7/1/22 at 9:23 AM with Nurse #9 with no return call.

An interview with the Administrator on 7/1/22 at 3:41 PM revealed the nurses should have applied Resident #72's left hand splint as ordered by the physician and documented accordingly.

3. A physician order dated 4/8/22 for Resident #11 indicated oxygen therapy at 1.5 liters per minute via nasal cannula every shift.

Resident #11's Treatment Administration Record (TAR) for June 2022 included an order for oxygen

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therapy at 1.5 liters per minute via nasal cannula every shift. The TAR indicated that oxygen was administered to Resident #11 at 1.5 liters per minute on 6/27/22 and 6/28/22 on day shift by Nurse #5 and on 6/28/22 on the night shift by Nurse #8.

An interview with Nurse #5 on 6/29/22 at 5:44 PM revealed she worked on 6/27/22 and 6/28/22 with Resident #11 but didn't remember looking at the rate at which her oxygen tank or oxygen concentrator had been set on. Nurse #5 stated she checked to make sure the oxygen tank had enough oxygen left and the humidifier on the concentrator had enough fluid. Nurse #5 couldn't explain why she had documented giving Resident #11 oxygen at 1.5 liters per minute when it wasn't the rate it had been set at.

An interview with Nurse #8 on 6/29/22 at 7:00 AM revealed she remembered checking Resident #11's oxygen saturation before midnight and it was between 93% and 95% but she couldn't remember if she had her oxygen on at that time. Nurse #8 stated she was not sure whether Resident #11 was supposed to receive continuous oxygen because it was not specified in the order. Nurse #8 stated she remembered the oxygen concentrator not being on when she came in at 7:00 PM the night before and she also remembered the nurse from the day before telling her that she had just changed Resident #11's oxygen tubing and nasal cannula. Nurse #8 stated she couldn't remember why she had documented Resident #11 had received oxygen when it had been off the whole night shift.

An interview with the Administrator on 7/1/22 at 3:41 PM revealed the nurses should have made

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F 842	Continued From page 119 sure Resident #11's oxygen was delivered per physician's order and documented according to what they had administered to Resident #11.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		8/4/22

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F 880	Continued From page 120 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 when 8 of 8 staff members (Nurse #5, Nurse #10, Nurse	F 880	The facility failed to implement their infection control policies and the CDC recommended practices for COVID -19 when 8 staff members (nurse#5, nurse#10, nurse aide #5, nurse aide#4,nurse aide#7, nurse#11, nurse	

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F 880	Continued From page 121 Aide #5, Nurse Aide #4, Nurse Aide #7, Nurse #11, Nurse Aide #1 and Nurse Aide #2) failed to wear eye protective gear while providing care to 7 of 7 residents reviewed for infection control (Resident #1, Resident #60, Resident #232, Resident #11, Resident #14, Resident #9 and Resident #36). In addition, Nurse #5 failed to change gloves and perform hand hygiene during wound care on Resident #11 and Nurse #3 failed to perform hand hygiene and clean equipment used during wound care on Resident #14. These failures were for 2 of 3 residents reviewed for wound care (Resident #11 and Resident #14). These failures occurred during a COVID-19 pandemic. The findings included: 1. A review of the Centers for Disease Control and Prevention (CDC) COVID-19 Data Tracker on 6/27/22 indicated that the county where the facility was located had a high level of community transmission for COVID-19. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/2/22 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for HCP (Healthcare Personnel): *HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.	F 880	aide#1,nurse aide#2) failed to wear protective eyewear while providing care to 7 residents (resident numbers 1, 60, 232,11,14,9,36). In addition, Nurse#5 failed to change gloves and perform hand hygiene and clean medical equipment used during a wound care treatment for resident #14. Upon notification by the survey team of inappropriate PPE use, including lack of protective eyewear, appropriate PPE was made immediately available and re-in-servicing of the staff was initiated on 7-01-2022. Upon notification by the survey team of inappropriate hand hygiene by nursing staff during treatments, nursing leadership immediately began in-servicing nurses on appropriate infection control techniques related to hand hygiene during wound care on 07-01-2022 Upon notification by the survey team of inappropriate technique for cleaning medical equipment during treatments, nursing leadership immediately began in-servicing nurses on appropriate infection control techniques related to cleaning equipment during wound care on 07-01-2022 All staff and residents will be included in the monitoring process to ensure staff are adhering to proper infection control practices to minimize potential transmission of infections. To prevent this from re-occurring, the facility Infection Preventionist, will provide	

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F 880	Continued From page 122 The facility's policy entitled, "Recommended use of personal protective equipment (PPE) for Health care settings for Coronavirus Disease," dated 9/10/21 indicated when the community transmission level is red/high or orange/substantial, anyone on the COVID-free unit or green unit should wear an N95 mask and eye protection for patient care encounters. a. During an observation on the 200 hall on 6/27/22 at 4:01 PM, Nurse #5 administered medications to Resident #1 while wearing a KN95 mask and no eye protective gear. At 4:04 PM, Nurse #5 proceeded to Resident #60's room while carrying a medication cup. Nurse #5 was still wearing a KN95 mask and no eye protective gear. An interview with Nurse #5 on 6/27/22 at 4:12 PM revealed she had to wipe her goggles because there were fogging up and forgot to put them back on. Nurse #5 stated she knew she was supposed to wear eye protection with all resident care encounters. b. On 6/29/22 at 5:40 AM, Nurse #10 was observed pushing Resident #232 in her wheelchair in the hallway. Nurse #10 was wearing a surgical mask and no eye protective gear. An interview with Nurse #10 on 6/29/22 at 6:10 AM revealed she had left her face shield at the nurses' station when she started to push Resident #232 and she forgot to put it on. Nurse #10 knew she was supposed to wear eye protective gear when interacting with any of the residents at the facility.	F 880	education to all current staff by 8/4/2022,on following infection control practices, including proper PPE use, disinfecting of non-dedicated resident equipment during wound care, and proper hand hygiene during wound care. Education will be provided to new hires and agency staff after 08/04/2022. Monitoring will include the DON/designee, to randomly audit staff personal protective equipment (PPE) usage to ensure staff wearing appropriate PPE, disinfecting of non-dedicated resident equipment during wound care, and proper hand hygiene during wound care, 5x per week for 2 weeks, 2 times per week for 2 weeks and 1 time per week for 8 weeks beginning the week of 08/01/2022. The results of this monitoring will be discussed at the community QAPI committee meetings for review and further recommendations for the duration of the auditing. Date of completion 08/04/2022	

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c. During observation of care on Resident #11 on 6/29/22 at 5:40 AM, Nurse Aide (NA) #5 was observed exiting the room while wearing a surgical mask and no eye protective gear. At 5:45 AM, NA #5 re-entered Resident #11's room wearing a face shield and a surgical mask. NA #5 helped NA #4 provide incontinence care to Resident #11. NA #4 was observed wearing a surgical mask and no eye protective gear.

An interview with NA #5 and NA #4 on 6/29/22 at 5:50 AM revealed NA #5 didn't see any face shields at the front lobby when she had come in to work so she hadn't worn one all shift. NA #4 stated she had taken her goggles off because they had fogged up and forgot to put them back on. Both nurse aides stated they had been educated that they were supposed to wear eye protection while providing care to the residents.

d. NA #7 was observed exiting Resident #14's room on 6/29/22 at 5:58 AM. NA #7 was wearing a surgical mask with no eye protective gear.

An interview with NA #7 on 6/29/22 at 5:59 AM revealed she had just provided care to Resident #14 while wearing no eye protective gear. NA #7 stated she was told that they had to wear eye protection, but she took them off when she did her rounds because she got hot.

e. On 6/29/22 at 6:15 AM, Nurse #11 was observed administering medications to Resident #9 while wearing an N95 mask but no eye protective gear.

An interview with Nurse #11 on 6/29/22 at 6:20 AM revealed she thought she only had to wear

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face shields or goggles when there was an active COVID-19 case in the building. Nurse #11 stated a staff member had signed her in at 11:00 PM and did not say anything to her about having to wear eye protection.

f. During an observation of incontinence care on Resident #36 on 7/1/22 at 7:56 AM, NA #1 and NA #2 were both wearing a surgical mask with no eye protective gear.

An interview with NA #1 and NA #2 on 7/1/22 at 8:00 AM revealed both nurse aides knew they were supposed to wear eye protection when working with the residents, but NA #2 forgot to obtain one when she came in and NA #1 left her goggles in the car and hadn't had a chance to get it.

An interview with the Regional Director of Clinical Services (RDCS) on 6/30/22 at 6:59 PM revealed the Director of Nursing (DON) was responsible for infection control at the facility but he was currently unavailable for interview. The RDCS who was covering for the DON stated they had provided education to the staff that because the county transmission level was still high, they required them to use an N95 mask and face shield or goggles during all resident care encounters. The RDCS stated it was hard to get agency staff to follow their infection control policies and some had given them attitude whenever they were told about they were supposed to do.

2. The Centers for Disease Control and Prevention (CDC) guidance entitled, "Hand Hygiene Guidance," last reviewed on 1/30/20 indicated the following information: Healthcare

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personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately after glove removal. Gloves are not a substitute for hand hygiene. Change gloves and perform hand hygiene during patient care, if moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs.

The facility's policy entitled, "Hand Hygiene/Handwashing Policy," last revised on 7/14/21 indicated the following statements: Hand washing is the most important component for preventing the spread of infection. Use of gloves does not replace the need for hand cleaning by either hand rubbing or hand washing. Perform hand hygiene: b. after removing gloves, d. after contact with body fluids or excretions, mucous membranes, non-intact skin and/or wound dressings and e. if moving from a contaminated body site to a clean body site during resident care.

a. An observation of wound care by Nurse #5 on Resident #11 was made on 6/29/22 at 12:53 PM. Resident #11 had just received a shower wherein her wound dressing to each leg had been removed. Nurse #5 was observed washing both hands prior to putting gloves on to start the procedure. Nurse #1 proceeded to wipe Resident #11's wound to the back of her right leg with wound cleanser-soaked gauze, packed it with sodium hypochlorite-soaked gauze and covered the wound with a piece of calcium alginate. Without removing her gloves and doing hand hygiene, Nurse #5 proceeded to do the same dressing to the back of Resident #11's left leg. Nurse #5 wrapped the left leg with a roll bandage

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and secured it with tape. Then she applied a foam dressing to cover the wound on the right leg and wrapped it with a roll bandage and secured it with tape while using the same pair of gloves. After the procedure, Nurse #5 removed her gloves and washed her hands in the sink.

An interview with Nurse #5 on 6/29/22 at 5:44 PM revealed she was nervous while performing wound care on Resident #11 and forgot to change her gloves and do hand hygiene after removing her gloves. Nurse #5 stated she knew she was supposed to have done one leg at a time to prevent cross-contamination of the wounds. She also stated she was not used to doing wound care and had worked at facilities where they had a treatment nurse.

An interview with the Regional Director of Clinical Services (RDCS) on 6/30/22 at 6:59 PM revealed the Director of Nursing (DON) was responsible for infection control at the facility but he was currently unavailable for interview. The RDCS who was covering for the DON stated Nurse #5 should have provided wound care to Resident #11 by doing one leg at a time and she should have changed her gloves and washed her hands in between.

b. An observation of wound care by Nurse #3, accompanied by Unit Manager (UM) #1, was made on 06/30/22 at 11:10 AM. Nurse #3 was observed washing both hands with soap and water, dried them and donned her gloves. Nurse #3 removed her scissors from her pocket and proceeded to cut the old dressing off Resident #14's right leg. After removing the old dressing from the right leg, she removed her gloves and donned a new pair of gloves without washing or

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sanitizing her hands. Nurse #3 proceeded to wipe the opened blister wound on Resident #14's right leg with wound cleanser-soaked gauze, and patted it dry with clean, dry gauze. With the same scissors that had not been cleaned after taking off the old dressing, Nurse #5 cut the PolyMem dressing (non-adherent dressing that facilitates healing, relieves pain, and reduces inflammation to the wound bed) to fit the area of the wound. Nurse #5 then cut the ABD pad (abdominal gauze pad that absorbs wound drainage) to fit the area of the wound and placed it over the PolyMem and wrapped the leg with a roll bandage and secured it with paper tape. Without removing her gloves or performing hand hygiene she moved to Resident #14's left leg and used the same scissors to cut off the old dressing on the left leg. Without removing her gloves or sanitizing her hands she proceeded to clean the opened blister wound on the back of Resident #14's left leg with wound cleanser-soaked gauze, and patted it dry with clean, dry gauze. With the same scissors that still had not been cleaned, she cut the PolyMem dressing to fit the area of the wound on the left leg and placed it on the wound and the remaining ABD pad over the wound bed and wrapped the leg and wound with roll bandage and secured it with paper tape. Nurse #5 then removed her gloves washed her hands with soap and water and removed the remaining dressing items from the resident's room.

An interview on 06/30/22 at 2:04 PM with Nurse #5 revealed she did not realize she had not cleaned her scissors after cutting the old dressings off the resident's leg and before cutting the PolyMem dressing. She stated she knew she was supposed to clean them but forgot. Nurse #5 further stated she knew she was supposed to

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F 880	Continued From page 128 sanitize or wash her hands when taking off gloves and before putting on new gloves but was nervous and forgot to do so. She indicated she should have changed gloves when she moved from the right leg to the left leg but had forgotten to do that as well. An interview on 06/30/22 at 4:17 PM with Unit Manager (UM) #1 revealed she noticed during the dressing change performed by Nurse #3 that she did not sanitize her hands between glove changes and that she had not cleaned her scissors after cutting off the old dressings and before cutting the dressing to fit Resident #14's wounds. UM #1 stated she also noticed Nurse #3 did not change her gloves or sanitize her hands when moving from the right leg wound to the left leg wound. An interview with the Regional Director of Clinical Services (RDCS) on 6/30/22 at 6:59 PM revealed the Director of Nursing (DON) was responsible for infection control at the facility but he was currently unavailable for interview. The RDCS who was covering for the DON stated Nurse #3 should have provided wound care to Resident #14 by cleaning her scissors after removing an old dressing and before cutting a new dressing to be placed on the wound area and she should have changed her gloves and washed her hands in between clean and dirty procedures and when moving from one wound area to the next wound area.	F 880		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility	F 888		8/4/22

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must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:

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F 888	Continued From page 130 (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical	F 888		

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exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the

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F 888	Continued From page 132 CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement their policy for all employees to be vaccinated or have an approved accommodation prior to employment and failed to have a process for tracking vaccination status for 3 of 5 staff members (Housekeeper #1, Housekeeper #2, and Nurse #14) reviewed for COVID-19 vaccination of facility staff. The facility was currently in outbreak status due to a staff member testing positive for COVID-19 on 06/23/22. All residents tested negative for COVID-19 on 06/24/22. The findings included: A review of the facility's "Employee COVID-19 Vaccination Policy" dated 05/21/21 and revised on 04/05/22 stated under the policy section that all employees were required to receive an FDA (Food and Drug Administration) authorized and/or approved COVID-19 vaccination as required by the Centers for Medicare and Medicaid Services (CMS), unless a reasonable accommodation from the requirement due to disability, medical condition, or sincerely held religious belief, practice or observance was requested and approved. Under the procedure section, the policy read in part, that all staff unless they receive an approved exemption (or a request is pending) or vaccine was temporarily delayed due to CDC (Centers for Disease Control and Prevention) recommendation (e.g., because of a recent COVID-19 infection) were to receive the first dose of the COVID-19 vaccine series before beginning employment. The policy further read,	F 888	Nurse #14, received her second dose on 07-01-2022 and house keeper #1 and housekeeper#2 no longer work at the facility. No residents were affected by this deficient practice. As of this submission nor at the time of the survey, the facility has not been in an outbreak status. 100% audit of staff vaccination was done and vaccination log updated by the human resource coordinator on 07-12-2022. There were no other negative findings. By 8/4/2022, education from Administrator to Human Resource Coordinator and the DON was completed regarding vaccination log updates and keeping current on all staff. By 8-4-2022, all staff who are not complete with their primary series, will receive education, by the director of nursing, on required vaccination status and timing of vaccine to be given to be in compliance. New hires and agency staff after 8-4-2022 will receive education before taking an assignment. Beginning 8-1-2022, the admin/designee will monitor staff vaccination log on all new hires each week for 12 weeks. Results of audits will be brought monthly to QAPI for three months at which time the committee will determine further action needed.	

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an employee who had received the first dose of a two-dose series but not the second dose must always wear an N95 and was required to be tested for COVID-19 twice weekly. After the employee received their second dose or a single dose of a one-dose series, they would follow the masking and testing rules of the facility. For a two-dose series, once an employee received the first dose of the COVID-19 vaccine the employee was required to then receive the second dose of the vaccine series timely per manufacturer guidelines. The employee would be removed from the schedule and placed on unpaid leave for failure to receive the second dose of the vaccine in a timely fashion. For applicants, they were notified of the vaccination policy prior to hire. After an offer of employment was made but prior to the individual starting work, the individual was required to provide proof of full vaccination or receive the first dose of COVID-19 vaccine series or request and receive an approved accommodation. The individual would not begin work until the first dose was received or an approved accommodation had been granted.

A review of the National Healthcare Safety Network (NHSH) data reported the week of 06/26/22 indicated 93.2% of the staff had completed COVID-19 vaccinations.

A review of the facility's COVID-19 Status for Providers listed 98 staff members and indicated one staff member was partially vaccinated and overdue for her second dose of a two-dose series (Nurse #14), two staff members were not vaccinated and had not applied for or received an accommodation (Housekeeper #1 and Housekeeper #2), and two staff members had received approved accommodations. The

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facility's vaccination rate with accommodations was 96.9%.

A phone interview on 06/30/22 at 10:45 AM with Nurse #14 revealed she had only had one dose of a two-dose series of COVID-19 vaccine. She stated her first dose was on 05/20/22 and she should have already gotten her second dose, but it had slipped her mind. Nurse #14 further stated she was scheduled to receive her second dose of the COVID-19 vaccination on 07/01/22 at the facility. She indicated she had worked at the facility with only one dose of the vaccine since 5/20/22 but stated she had worn an N95 mask and goggles while providing resident care.

A phone interview was attempted with Housekeeper #2 on 06/30/22 at 11:00 AM but her phone had been disconnected and the facility was unable to produce another contact number. Housekeeper #2 had not received any COVID-19 vaccinations according to the facility's records.

A phone interview on 06/30/22 at 11:10 AM with Housekeeper #1 revealed she was hired on 06/22/22 and had told the Director of Housekeeping during orientation that she was not vaccinated for COVID-19 but was willing to take the vaccination. She stated the Director of Housekeeping told her she could get her vaccine during the COVID-19 clinic at the facility. Housekeeper #1 further stated she had worked 6 days in a row since being hired and no one had said anything else to her until she was contacted by the Human Resources representative at the facility 06/29/22 and told she could not come back to work until she received her first vaccine on 07/01/22 at the facility. Housekeeper #1 indicated she had worn an N95 and goggles while

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F 888	Continued From page 135 working at the facility those 6 days. The Infection Preventionist (Director of Nursing) was not available for interview during the survey. An interview on 07/01/22 at 11:19 AM with the Administrator and Regional Director of Clinical Services (RDCS) revealed there was not a spreadsheet for staff like the one they had developed for residents which tracked vaccinations. The Administrator stated it was clear to her after this process of gathering pieces of information that it needed to be streamlined into a spreadsheet and one person given the responsibility of keeping up with the information. The RDCS indicated going forward they were going to put the information into a spreadsheet to help them keep track of everyone working in the building and to ensure they have everyone's vaccine status. According to the Administrator and the RDCS Housekeeper #1 and Housekeeper #2 should never have been hired prior to receiving their first dose of COVID-19 vaccine and said Nurse #14 should have been reminded her second dose of vaccine was overdue. The Administrator explained the scheduler was responsible for tracking vaccine status for agency staff, the Director of Nursing who served as the Infection Preventionist was responsible for tracking vaccine status for facility staff and the Human Resources representative was responsible for tracking vaccine status for vendors and providers.	F 888		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident;	F 914		8/4/22

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F 914	Continued From page 136 §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations, resident, and staff interviews, the facility failed to ensure resident privacy by not having a privacy curtain for 1 of 1 resident (Resident #58) reviewed for privacy. The findings included: Resident #58 was admitted to the facility on 11/11/19. Review of Resident #58's quarterly Minimum Data Set (MDS) assessment revealed she was moderately cognitively impaired. Observation and interview on 06/27/22 at 10:34 AM revealed Resident #58 had no privacy curtain around her bed. The resident stated it had been that way for a long time, maybe several months. She stated they had taken it down to wash it and never brought it back and hung it back up. Resident #58 stated she received bed baths in her room when the Nurse Aides (NAs) did not have time to take her for a shower and they pulled the curtain between the resident and her roommate but there was no curtain to pull around her bed on her side of the room. Observation on 06/28/22 at 8:30 AM revealed there was no privacy curtain around 401-W to allow for her privacy.	F 914	Resident #58 had a privacy curtain installed on 07-11-2022 100% audit on all privacy curtains was completed by Admissions Director on 7-21-2022. No other resident's were affected Education will be done on all current staff, on resident privacy curtains by 8-04-2022 by the Administrator or designee. All new hires and agency staff will receive this education prior to accepting an assignment. During routine rounds 5 days a week the leadership staff will monitor for compliance. The housekeeping director or designee, will complete an audit of all privacy curtains in resident rooms beginning 08/01/2022 will start for daily 5x a week for 2 weeks 2x a week for 2 weeks and weekly for 8 weeks. The administrator will take the results of the audits to QAPI committee for 3 months at which the committee will determine further action needed to ensure the facility remains in compliance.	

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F 914	Continued From page 137 Observation on 06/29/22 at 2:30 PM revealed there was no privacy curtain around 401-W to allow for her privacy. Observation on 06/30/22 at 9:20 AM revealed there was no privacy curtain around 401-W to allow for her privacy. Interview on 06/30/22 at 2:26 PM with the Director of Housekeeping revealed he expected all rooms to have privacy curtains around the beds and was not aware there was not a privacy curtain around Resident #58's bed. The Director of Housekeeping stated he depended on the housekeepers and other staff to make him aware of any rooms needing privacy curtains. He further stated "angel rounds" were made on residents each day by department heads and no privacy curtain is something they should have noticed and reported. The Director of Housekeeping indicated it was unacceptable for residents not to have privacy curtains. Interview on 07/01/22 at 11:31 AM with the Administrator revealed she was not aware Resident #58 did not have a privacy curtain around her bed. The Administrator stated privacy curtains was one of many things "angel rounds" were supposed to notice and report. She explained that angel rounds were rounds made by department heads to check on residents and ask how they were doing, if they needed anything, and a general look at their room to be sure it was clean and there were no needs expressed by the resident. The Administrator indicated housekeeping and other staff that are in and out of the room should have noticed and reported the resident not having a privacy curtain around her	F 914	Completion date 8/4/22	

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F 914	Continued From page 138 bed.	F 914		
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to implement an effective pest control program to control the presence of flies in the hallways and resident rooms. This was evident in 1 of 2 resident care halls downstairs (400-hall) and 1 of 12 rooms (room 405). The findings included: An observation on 06/27/22 at 12:16 PM revealed a fly in room 405 flying around both residents (Resident #39 and Resident #10) while they were eating their lunch. An observation on 06/28/22 at 11:37 AM revealed a fly in room 405 flying around the room while the residents were in their room talking with one another and watching TV. An observation and interview on 06/29/22 at 11:45 AM revealed a fly in room 405 flying around the room. Resident #39 and Resident #10 stated there was always a fly in their room and it tried to pitch on anything they were eating and both residents stated they were "aggravated" they had a fly in their room trying to get on their food. Resident #39 stated she had mentioned having a fly in their room to Nurse Aide (NA) #9 today.	F 925	The room for the resident in 405 was immediately inspected and exterminated by Maintenance Director on 07-01-2022. No further pests were noted. One silent insect bug control system installed on 7/22/22. An audit of the facility grounds, resident rooms and resident care areas was completed by the Maintenance Director on 7/01/2022 to find no other pest infestation. Education to all staff on pest control and what to do if any pests observed was conducted by administrator/designee by 8/4/22. During routine rounds the leadership staff will monitor for compliance 5 times a week. New staff and agency staff hired after 8-4-2022 will receive this education during orientation. Audit on all resident care areas will be done 5x a week for 2 weeks and 2x a week for 2 weeks and weekly for 8 weeks beginning 8-1-2022, by the housekeeping director or designee. Administrator will present to the QAPI committee for the next 3 months and the committee will	8/4/22

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Resident #39 indicated they had flies in the hall and in their room quite often but could not recall exactly how long they had been bothered with them.

An interview on 06/29/22 at 5:04 PM with NA #9 revealed she had seen flies in several of the rooms on the 400 hall and said Resident #39 had complained to her about flies in her room just today. NA #9 stated she had reported it to Nurse #12.

An observation on 06/29/22 at 3:50 PM revealed a fly in the 400-hall flying around outside the Assistant Director of Nursing's (ADON) office.

An interview on 06/29/22 at 3:59 PM with Unit Manager #1 revealed she had observed a fly in the 400-hall outside the ADONs office and observed the fly in the office.

A follow up interview on 06/30/29 at 4:12 PM with Unit Manager (UM) #1 revealed it had been reported to her on 06/29/22 by Nurse #12 there were several rooms on the 400-hall with flies in their room. One of the rooms mentioned was room 405 where Resident #39 and Resident #10 resided. UM #1 stated there were a lot of flies out where the employees go to smoke and there was a resident who often opened the door leading out to that smoking area. UM #1 further stated she suspected that was where the flies were coming from on the 400-hall. UM #1 indicated they had problems with flies especially in the summer, but they were treated and said it was probably time for another treatment with the pesticide company. She stated she discussed the reports of flies with the management team at their evening staff meeting on 06/29/22 and the Maintenance

modify to ensure the facility remains in compliance.

Date of completion is 8/4/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 140	F 925		

Director was going to spray the hall and rooms and if that didn't take care of the flies, he was going to contact the pesticide company for recommendations and treatment.

An interview on 07/01/22 at 9:52 AM with the Maintenance Director revealed he had been at the facility for 2 months in his role. He stated it had been reported to him during an evening staff meeting on 06/29/22 that there were flies observed on the 400 hall and in some of the resident rooms. The Maintenance Director further stated he had been on the 400 and 500 hall and only saw flies near the 500-hall exit door and had found a barrel of trash outside the door and took it to the dumpster and told staff to keep all trash away from the hallway doors. He indicated he had informed the department heads on 06/30/22 at a staff meeting if they saw any more flies to let him know and he could spray for them. The Maintenance Director further indicated there were no fly lights at the exit doors to the building to prevent them entering the building. He explained the facility had a contract with an insecticide company for monthly maintenance and if his spraying for the insects did not get rid of them, he would contact the company to come treat for flies.

An interview on 07/01/22 at 11:24 AM with the Administrator revealed she was not aware there were issues in the building with flies until it was mentioned in a staff meeting on 06/29/22 and the Maintenance Director was spraying the hall and would spray specific rooms for flies. She stated it was her expectation that observations of any insects be reported immediately to the Maintenance Director so he can take care of the issue immediately. The Administrator further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345222	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 141 stated any staff member could report sightings of insects to the Maintenance Director or the Maintenance Assistants so they could take care of the problem. She indicated she expected all halls and rooms to be free of all insects.	F 925		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345222	A. BUILDING: _____ B. WING _____	7/7/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 658	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to obtain a physician's order to discontinue a splint no longer utilized for 1 of 2 sampled residents (Resident #38). Findings included: Resident #38 was admitted to the facility on 04/26/22 with diagnoses that included hemiplegia and hemiparesis (weakness or complete paralysis on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side. The admission Minimum Data Set (MDS) dated 05/03/22 assessed Resident #38 with moderate impairment in cognition and displaying no behaviors or rejection of care. The MDS noted Resident #38 had impairment on one side of both the upper and lower extremities. Review of Resident #38's physician's order revealed the following active orders: 04/26/22: left hand splint - in the morning apply splint to left hand. 04/26/22: Left hand splint - every day and evening, check placement of left hand splint. Check skin integrity every 2 hours while left hand splint is in place. 04/27/22: left hand splint - at bedtime remove left hand splint. An observation of Resident #38 on 06/27/22 at 12:42 PM revealed her sitting up in her wheelchair out in the hall with no left hand splint in place. An observation and interview was conducted with Resident #38 on 06/28/22 at 8:40 AM. Resident #38 was observed sitting up on the side of her bed with no left hand splint in place. Observations of her room revealed no presence of a hand splint. Resident #38 confirmed she did not have a hand splint on her arm and stated she did not wear one. A subsequent observation at 9:25 AM revealed she was up in her wheelchair sitting out in the hall, well-dressed with no hand splint in place. An observation of Resident #38 on 06/29/22 at 1:02 PM revealed her sitting in her wheelchair out in the hall with no hand splint in place. During an interview on 06/29/22 at 10:22 AM, Nurse Aide (NA) #1 revealed she routinely provided care to Resident #38 during the day shift. NA #1 was not aware Resident #38 had an order to wear a left hand splint and stated there had not been one in her room to apply.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF DREXEL	307 OAKLAND AVENUE MORGANTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 658	Continued From Page 1

During an interview on 06/29/22 at 7:48 AM, the Certified Occupational Therapy Assistant (COTA) explained it was recommended Resident #38 wear a hand and elbow extension splint for preventative measures due to a previous stroke. The COTA stated although she still recommended Resident #38 wear the splint, Resident #38 refused to wear it and staff turned the splint back into her approximately one week after Resident #38's therapy services ended on 05/13/22.

During an interview on 06/29/22 at 3:59 PM, Unit Manager (UM) #1 was unaware Resident #38 had not worn a hand splint all week or that the hand splint was turned back into the therapy department in May of 2022 due to her repeated refusals to wear the splint. UM #1 reviewed Resident #38's physician orders and confirmed the orders for splint application and removal were still active. UM #1 stated nursing staff should have notified her when they were completing Resident #38's Treatment Administration Record that she did not have a splint in place or therapy staff when the splint was returned for the order to be discontinued.

During an interview on 07/01/22 at 11:20 AM, the Administrator stated Resident #38's order for splint application should have been discontinued when the splint was returned to the therapy department.