STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING ______ B. WING ______	C 07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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E 000	Initial Comments An unannounced recertification and complaint survey was conducted on 7/17/22 through 7/20/22. The facility was found in compliance with the requirement 483.73, Emergency Preparedness. Event #R3E11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification, complaint and extended survey was conducted on 7/17/22 through 7/20/22. Past noncomplaince was identified at CFR 483.45 at F760 at a scope and severity K. The tag F760 constituted substandard quality of care beginning on 11/14/21 and removed on 3/9/22. Immediate jeopardy was identified at CFR 483.45 at tag 756 at a scope and severity of K beginning 11/14/21 and removed 7/20/22. Two of the 13 complaint allegations were substantiated resulting in federal citations at F756 (Intake #NC00186895) and F688 (Intake #NC00188489).	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to place a resident's call light within reach for 1 of 1	F 558	F-558 (1) How corrective action will be	8/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/08/2022

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 558 Continued From page 1

residents reviewed for accommodation of needs (Resident #7).

The findings included:

Resident #7 was originally admitted to the facility on 10/11/21 with diagnoses that included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and muscle weakness.

A significant change in status MDS assessment dated 4/13/22 indicated Resident #7 had moderately impaired cognition with no behaviors present. She required extensive to total assistance from staff to complete Activities of Daily Living (ADLs) tasks.

Resident #7's active care plan, last reviewed 5/23/22, included a focus area for risk for falls related to deconditioning, gait/balance problems, weakness, incontinence and anxiety with a fear of falling. An intervention was to be sure the resident's call light was within reach and encourage her to use it for assistance as needed. The resident needs prompt response to all requests for assistance.

On 7/17/22 at 2:00 PM, an observation and interview occurred with Resident #7 while she was lying in bed watching TV. The call light was lying on the floor under her bed out of reach. Resident #7 stated, "I don't know how long I haven't had it but would like to have it pinned to the bed or something". Stated she would yell out when she needed something.

Another observation was made on 7/18/22 at 12:00 PM. Resident #7 was lying in bed watching

F 558

accomplished for resident(s) found to have been affected:
Residents #7's call light was ensured to be in place by the Director of Nursing on 7/20/2022.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
On 7/20/2022 the Administrator conducted an audit of all residents to ensure that all resident call lights were within reach. Audit revealed that all resident call lights were within reach. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/22/2022 the Director of Nursing, Assistant Director of Nursing and the Unit Manager initiated re-educated to the nursing department to ensure the resident call lights are within reach each time they enter the room. Education included agency staff, all shifts, and weekends. Any nursing staff not educated will receive education prior to their next shift. Education completed on 8/7/2022.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:
A monitor sheet will be done by the

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F 558	Continued From page 2 TV. Her call light remained under the bed out of reach. When asked how she would request assistance, she stated she would use the call light when she could reach it, otherwise she let staff know when they entered the room, when they were passing by or by yelling out for assistance. Resident #7 was observed on 7/19/22 at 9:21 AM, lying in bed with her eyes closed. The call light was observed coiled under the bed not within her reach. Nurse Aide (NA) #3 observed Resident #7's call light on the floor out of reach on 7/19/22 at 2:20 PM. She was assigned to Resident #7 and stated the call light was utilized by Resident #7, but it slid off the bed frequently due to her frequent leg movements. She retrieved the call light and placed it across Resident #7's lap. At the time of the observation there was no clip present on the call light cord. On 7/20/22 at 10:25 AM, Resident #7 was observed lying in bed watching TV. The call light was observed on the floor to the right side of the bed not within reach. The Administrator and Director of Nursing (DON) were interviewed on 7/20/22 at 2:40 PM. The DON stated Resident #7's call light was in the floor frequently due to her sliding her legs around in the bed. They stated it was their expectation for the call light to be within reach at all times.	F 558	Administrator, DON, or designee to monitor and ensure that all resident call lights are observed to be within reach along with resident interviews. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		8/8/22

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F 623	Continued From page 3	F 623		

Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

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

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F 623	Continued From page 4 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623		

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Continued From page 5

must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview with the responsible party (RP), resident and staff, the facility failed to notify the resident and or the responsible party (RP) in writing of the reason for the discharge to the hospital for 4 of 4 sampled residents reviewed for hospitalizations (Residents # 36, #20, #46 and #13).

Findings included:

1. Resident #36 was admitted to the facility on 5/19/21.

Review of the nurse's notes revealed that Resident #36 had been admitted to the hospital on 11/25/21 and on 5/23/22.

The nurse's note dated 11/25/21 at 9:07 AM revealed that Resident #36 was sent to the emergency room (ER) due to change in mental status, coughing and wheezing. The resident's blood pressure was 89/64.

F 623

F-623

(1) How corrective action will be accomplished for resident(s) found to have been affected:
Residents #36, #13, #20, and #46 had the proper written notification requirements for the reason of a hospital transfer sent to the resident and/or responsible party by the social worker on 7/29/2022.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
Social worker conducted and audit on 7/21/2022 of all residents that were transferred and discharged in the last 30 days. Audit revealed that 7 additional residents were affected. As a result, a written notification for the reason of a hospital transfer was provided to the resident and/or responsible party not

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F 623	Continued From page 6 The nurse's note dated 12/2/21 at 2:29 PM revealed that Resident #36 was readmitted back to the facility. The nurse's note dated 5/23/22 at 4:30 PM indicated that Resident #36 was sent to ER due to change in mental status, tremors, and slurred speech. The nurse's note dated 5/27/22 at 5:12 PM revealed that Resident #36 was readmitted back to the facility. The quarterly Minimum Data Set (MDS) assessment dated 6/1/22 indicated that Resident #36's cognition was intact. The Social Worker (SW) was interviewed on 7/17/22 at 2:21 PM. The SW stated that she was not responsible for notifying the resident or the RP in writing when a resident was discharged to the hospital. She added that she thought that nursing might have been responsible for the written notification. Nurse #4 was interviewed of 7/19/22 at 10:40 AM. The nurse stated that she normally calls the responsible party (RP) when a resident was discharged to the hospital. She reported that she didn't know that the facility has to notify the resident or the RP in writing of the reason for the discharge. The Unit Manager (UM) was interviewed on 7/19/22 at 10:45 AM. The UM stated that she had not been notifying the resident or the RP in writing when a resident was discharged to the hospital.	F 623	previously provided. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 7/20/2022 the Administrator re-educated the Social Service Director regarding the requirement to provide the resident and/or responsible party a written notification of the reason for a hospital transfer. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents and/or responsible parties are provided a written notification of the reason for a hospital transfer. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 623	Continued From page 7 The Administrator was interviewed on 7/19/22 at 3:00 PM. The Administrator stated that he had been the administrator of the facility for over 3 weeks, and he expected the SW to be responsible for notifying the resident and or the RP in writing of the reason for the discharge to the hospital. Resident #36 was interviewed on 7/20/22 at 9:05 AM. The resident stated that he had been admitted to the hospital twice and he had not received any letter from the facility about his discharge to the hospital. 2. Resident #20 was admitted to the facility on 5/6/21. Review of the nurse's note dated 5/3/22 at 4:50 PM revealed that Resident #20 was sent to the emergency room (ER) due to abdominal distention and gastrostomy (G) tube displacement. The nurse's note dated 5/11/22 at 5:36 PM revealed that Resident #20 was readmitted back to the facility. The significant change in status Minimum Data Set (MDS) assessment dated 5/23/22 indicated that Resident #20 was comatose. The Social Worker (SW) was interviewed on 7/17/22 at 2:21 PM. The SW stated that she was not responsible for notifying the resident or the RP in writing when a resident was discharged to the hospital. She added that she thought that nursing might have been responsible for the	F 623	The facility alleges compliance on 8/8/2022	

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written notification.

Nurse #4 was interviewed of 7/19/22 at 10:40 AM. The nurse stated that she normally calls the responsible party (RP) when a resident was discharged to the hospital. She reported that she didn't know that the facility has to notify the resident or the RP in writing of the reason for the discharge.

The Unit Manager (UM) was interviewed on 7/19/22 at 10:45 AM. The UM stated that she had not been notifying the resident or the RP in writing when a resident was discharged to the hospital.

The Administrator was interviewed on 7/19/22 at 3:00 PM. The Administrator stated that he had been the administrator of the facility for over 3 weeks, and he expected the SW to be responsible for notifying the resident and or the RP in writing of the reason for the discharge to the hospital.

Attempted to interview the RP of Resident #20 but was unsuccessful.

3. Resident #46 was admitted to the facility on 6/7/19.

Review of the nurse's note dated 6/4/22 at 1:45 PM revealed that Resident #46 was discharged to the hospital due to low oxygen saturation. He was readmitted back to the facility on 6/9/22.

The quarterly Minimum Data Set (MDS) assessment dated 6/16/22 indicated that Resident #46's cognition was intact.

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The Social Worker (SW) was interviewed on 7/17/22 at 2:21 PM. The SW stated that she was not responsible for notifying the resident or the RP in writing when a resident was discharged to the hospital. She added that she thought that nursing might have been responsible for the written notification.

Nurse #4 was interviewed of 7/19/22 at 10:40 AM. The nurse stated that she normally calls the responsible party (RP) when a resident was discharged to the hospital. She reported that she didn't know that the facility has to notify the resident or the RP in writing of the reason for the discharge.

The Unit Manager (UM) was interviewed on 7/19/22 at 10:45 AM. The UM stated that she had not been notifying the resident or the RP in writing when a resident was discharged to the hospital.

The Administrator was interviewed on 7/19/22 at 3:00 PM. The Administrator stated that he had been the administrator of the facility for over 3 weeks, and he expected the SW to be responsible for notifying the resident and or the RP in writing of the reason for the discharge to the hospital.

Resident #46 was interviewed on 7/20/22 at 9:10 AM. The resident stated that he could not remember if the facility had given him a letter about his admission to the hospital.
4. Resident #13 was admitted to the facility on 4/21/22.

An Admission Minimum Data Set (MDS)

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F 623	Continued From page 10 assessment dated 4/27/22 indicated Resident #13 had moderately impaired cognition. Resident #13's medical record revealed she was transferred to the hospital on 7/9/22 for evaluation of mental status changes. There was no documentation that a written notice of transfer was provided to the resident and/or responsible party (RP) for the reason for the transfer. The medical record only indicated the RP was notified via phone. Resident #13 was pending to return to the facility during the course of the survey. On 7/19/22 at 10:35 AM, an interview occurred with Nurse #4, who stated she sent a copy of the face sheet, any Do Not Resuscitate (DNR) information, physician orders, medication and treatment administration records and the Bed Hold policy when a resident was transferred to the hospital. She called the RP by phone to notify them of the change and reason for the hospital transfer. She was unaware of anything sent in writing. The Social Worker (SW) was interviewed on 7/19/22 at 2:21 PM and stated she had been employed at the facility since January 2022. When asked if she sent written notification of the reason for hospital transfer to the resident and/or RP, she stated she did not and thought the nurses sent it. The SW acknowledged being aware of the regulation but had not been instructed to do this task when hired. On 7/19/22 at 3:00 PM, the Business Office Manager was interviewed and stated she was unaware a written reason for hospital transfer to the resident and/or RP was needed.	F 623		

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F 623	Continued From page 11 The Administrator was interviewed on 7/19/22 at 3:05 PM and explained he had been employed at the facility for 3 weeks and was not aware the written reason for hospital transfer was not being completed. He added normally the Social Worker would be responsible for this task. The Administrator stated he would expect the resident and/or RP to be notified in writing for the reason of the hospital transfer per the regulation. On 7/19/22 multiple attempts were made to contact Nurse #10 who was assigned to Resident #13 at the time of her discharge to the hospital on 7/9/22, without success.	F 623		
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.	F 636		8/8/22

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THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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(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.
(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

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facility failed to complete an admission Minimum Data Set (MDS) assessment within 14 days of admission for 1 of 4 newly admitted residents whose MDS were reviewed (Resident #121).

Findings included:

Resident #121 was admitted to the facility on 7/1/22.

Review of the MDS revealed Resident #121 did not have an admission MDS assessment completed as of 7/19/22.

The MDS Nurse was interviewed on 7/19/22 at 12:10 PM. The MDS Nurse reviewed Resident #121's assessments and stated she was working on his admission MDS assessment, but it was not completed and was still in progress. She stated the resident was admitted on 7/1/22 and should have the admission assessment already completed. She reported that she was behind with her MDS assessments since she did not have any help.

The Director of Nursing (DON) was interviewed on 7/20/22 at 2:38 PM. The DON stated she expected the MDS assessments to be completed as required. She added that a new MDS Nurse will be starting this week.

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(1) How corrective action will be accomplished for resident(s) found to have been affected:
Resident #121’s admission minimum data set was completed on 7/20/2022 by the minimum data set coordinator.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
A 30-day focused review was completed by the Minimum Data Set Coordinator on 8/2/2022 regarding the timely completion of an admission data set assessment within 14 days. Focused review revealed 5 additional assessments were not completed within 14 days of admission and were thus therefore completed by the Minimum Data Set Coordinator. This focused review was subsequently audited by the Director of Nursing on 8/3/2022 and verified to be accurate. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/20/2022 the Director of Clinical Reimbursement provided re-education to the Minimum Data Set Coordinators regarding the requirement for timely completion of an admission minimum data set assessment within 14

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F 636	Continued From page 14	F 636	days of admission. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Director of Nursing, or designee to monitor and ensure that all newly admitted residents will have a completed admission minimum data set within 14 days. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Director of Nursing or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of alarms (Resident #32), Hospice	F 641	F-641 (1) How corrective action will be accomplished for resident(s) found to	8/8/22

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(Resident #41) and falls (Resident #70). This was for 3 of 19 resident records reviewed.

The findings included:

1. Resident #32 was admitted to the facility on 5/5/22 with diagnoses that included dementia.

The active physician orders for Resident #32 were reviewed and revealed an order dated 5/13/22 for a wander-guard to the ankle to decrease the risk for elopement. Check placement every shift.

Resident #32's care plan included a focus area that was initiated on 5/13/22 for elopement risk/wanderer related to cognitive impairment, wandering and exit seeking. The interventions included a wander-guard in place.

A quarterly Minimum Data Set (MDS) assessment dated 5/30/22 indicated Resident #32 had moderately impaired cognition and was not coded for a wander/elopement alarm.

On 7/17/22 at 5:00 PM, Resident #32 was observed while she was lying in bed. A wander-guard bracelet was visible to her ankle.

An interview was conducted with the MDS Nurse on 7/20/22 at 1:42 PM. She reviewed the MDS assessment dated 5/30/22 and confirmed the wander/elopement alarm was not coded. She stated it was an oversight not to have coded the wander/elopement alarm for Resident #32 as she was aware one was in place.

The Administrator and Director of Nursing were interviewed on 7/20/22 at 2:40 PM and indicated

F 641

have been affected:
Resident #70, #41, and #32, were corrected and coded accurately on the minimum data set by the Minimum Data Set Coordinator on 7/20/2022.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
A focused review was completed by the Minimum Data Set Coordinator on 7/31/2022 regarding the accuracy of coding on the minimum data set in accordance with the resident assessment instruments for all residents over the past 3 months to include falls, hospice, and alarms. Focused review revealed 4 additional coding discrepancies. All corrections were made as indicated by the Minimum Data Set Coordinator. This focused review was subsequently audited by the Director of Nursing on 8/1/2022 and verified to be accurate. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/20/2022 the Director of Clinical Reimbursement provided re-education to the Minimum Data Set Coordinators regarding the need for accurate coding on the minimum data set to reflect falls, hospice, and alarms.

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it was their expectation for the MDS assessment to be coded accurately.

2. Resident #41 was admitted to the facility on 4/5/19 with diagnoses that included pressure ulcer of the right upper back and muscle weakness.

A physician's order dated 5/29/22 indicated an admission to Hospice care.

A Significant Change in Status Minimum Data Set (MDS) assessment dated 6/6/22 revealed Resident #41 was marked yes for a prognosis of less than six months but not coded with receiving Hospice care.

An interview was conducted with the MDS Nurse on 7/20/22 at 1:42 PM, she confirmed she was aware Resident #41 received Hospice care and confirmed Hospice was not marked on the MDS assessment dated 6/6/22. She stated it was an oversight.

The Administrator and Director of Nursing were interviewed on 7/20/22 at 2:40 PM and indicated they were unaware of any coding issues for the MDS assessments. Both further stated, it was their expectation for the MDS assessment to be coded accurately.
3. Resident #70 was admitted to the facility on 6/22/22 with multiple diagnoses including dementia.

Review of the nurse's notes and the incident reports revealed that Resident #70 had falls on 6/22/22 at 6:14 PM, on 6/26/22 at 11:21 PM and on 6/28/22 at 12:18 AM.

F 641

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:
A monitor sheet will be done by the Director of Nursing or designee to monitor and ensure that all falls, hospice, and alarms were coded accurately on the minimum data set. This monitoring process will take place weekly for 4 weeks then monthly for 2 months.

Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 8/8/2022

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F 641	Continued From page 17 The admission Minimum Data Set (MDS) assessment dated 6/29/22 indicated that Resident #70 had severe cognitive impairment and he had no falls since admission/entry or reentry. The MDS Nurse was interviewed on 7/20/22 at 2:00 PM. The MDS Nurse reviewed the nurse's notes and verified that Resident #70 had falls on 6/22/22, 6/26/22 and 6/28/22. She indicated that the admission MDS assessment dated 6/29/22 was coded wrong under falls. She stated that she would complete a correction MDS to reflect the 3 falls with no injury under the fall section of the MDS. The Director of Nursing (DON) was interviewed on 7/20/22 at 2:38 PM. The DON stated that she expected the MDS assessment to be coded accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655		8/8/22

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F 655	Continued From page 18 (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews and record review, the facility failed to complete a Baseline Care Plan 48 hours after admission for 3 (Resident #171, Resident #121 and Resident #176) of 7 residents reviewed for care planning. The findings included: 1. Resident #171 was admitted on 7/16/22 for a pelvic fracture.	F 655	F-655 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #171, #121, and #176's baseline care plan was completed on 8/2/2022 by the Unit Manager.	

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Review of the electronic medical record (EMR) did not include documented evidence of a Baseline Care Plan.

An interview was completed on 7/18/22 at 10:50 AM with Resident #171. He stated to date, nobody at the facility had discussed his care or goals with him or his Responsible Party (RP).

An interview was completed on 7/20/22 at 10:30 AM with Nurse #1. She stated she completed Resident #171's admission but was not aware that she needed to complete a baseline care plan within 48 hours.

An interview was completed on 7/20/22 at 1:42 PM with the Minimum Data Set (MDS) Nurse. She stated it was the responsibility of the floor nurses to complete the baseline care plan for new admissions within 48 hours from admission. The MDS Nurse confirmed Resident #171 did not have a baseline care plan and she did not know if the agency nurse (Nurse #1) was aware of the need to complete the baseline care plan.

An interview was completed on 7/20/22 at 2:35 PM with the Director of Nursing (DON). She stated it was her expectation that the admitting nurse start a baseline care plan on admission and the floor nurses to ensure it was completed and reviewed with Resident #171 and his RP within 48 hours.

2. Resident # 121 was admitted to the facility on 7/1/22.

Review of Resident #121's medical records

F 655

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
Unit Manager conducted and audit on 8/3/2022 of all resident baseline care plans in the last 30 days for timely completion. Audit revealed that 15 baseline care plans required corrections to be complete. All were corrected and completed on 8/3/2022 by the Unit Manager.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/22/2022 the Director of Nursing, Assistant Director of Nursing and the Unit Manager initiated re-educated to the licensed nurses regarding the need to have a baseline care plan completed within 48 hours of admission. Education included agency staff, all shifts, and weekends. Any licensed nurse not educated will receive education prior to their next shift. Education completed on 8/7/2022.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:
A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all new admissions have their baseline care plan completed within 48 hours of admission. This monitoring process will take place

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revealed that there was no baseline care plan developed as of 7/19/22.

The MDS Nurse was interviewed on 7/19/22 at 12:10 PM. The MDS Nurse stated that she was not responsible for developing the baseline care plan. She reported that the admitting nurse was responsible for developing the baseline care plan within 48 hours of admission. The MDS Nurse reviewed the resident's medical records and verified that there was no baseline care plan developed for Resident #121. She indicated that the nurse who admitted the resident was an agency nurse, and the agency nurse might not be aware that she has to develop the baseline care plan on admission.

The Director of Nursing (DON) was interviewed on 7/20/22 at 2:40 PM. The DON stated the nurses were responsible for developing the baseline care plan on admission. She explained she was not sure if the agency nurses had been educated on baseline care plans.

3. Resident #176 was admitted on 7/7/2022 with diagnoses that included diabetes type two and end stage renal disease requiring dialysis.

The resident's Minimum Data Set (MDS) was in progress and not yet completed.

Hospital discharge records included an emergency room encounter dated 6/20/2022. The resident's list of active diagnoses included diabetes and end stage renal disease.

The resident's active orders included a physician's order for dialysis on Tuesday,

F 655

weekly for 4 weeks then monthly for 2 months.

Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 8/8/2022

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F 655	Continued From page 21 Thursday, and Saturday related to end stage renal disease. The order had a start date of 7/7/2022. The resident's baseline care plan was dated 7/8/2022 and indicated the resident was not a diabetic and did not require dialysis. On 7/19/2022 at 11:37 AM an interview was conducted with the MDS nurse. She stated the baseline care plan was completed on 7/8/2022 by the admitting nurse, Nurse #3. When questioned as to the resident's diagnosis of diabetes and end stage renal requiring dialysis she stated it was an error. She further stated the resident was a diabetic and did receive dialysis. An interview was conducted with Nurse #3 on 7/19/2022 at 12:25 PM. He stated he did not recall if he completed the baseline care plan for Resident #176. There were several admissions on 7/7/2022 and they all came around the same time. He stated if he did complete the baseline care plan, it was an oversight. Resident #176 had a diagnosis of diabetes and received dialysis. An interview was conducted with the Director of Nursing (DON) on 7/20/2022 at 2:40 PM. She stated it was her expectation all baseline care plans are completed and accurate.	F 655		
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	F 656		8/8/22

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F 656	Continued From page 22 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to develop the	F 656	F-656	

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THE GREENS AT PINEHURST REHAB & LIVING CENTER	**205 RATTLESNAKE TRAIL** **PINEHURST, NC 28374**

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Continued From page 23

comprehensive care plan for 3 (Resident #59, Resident #5 and Resident #3) of 19 residents reviewed for care planning. The findings included:

1. Resident #59 was admitted on 6/21/22 with diagnoses of Metabolic Encephalopathy, Diabetes and Dysphagia.

The 5-day Minimum Data Set dated 7/8/22 indicated that Resident #59 had moderate cognitive impairment and required extensive to total assistance with her activities of daily living. She was also coded as incontinent of bladder and bowel.

Resident #59's comprehensive care plan included two identified areas of concern: little to no involvement in activities on 6/23/22 and for a nutritional risk on 6/29/22.

An interview was completed on 7/20/22 at 1:42 PM with the Minimum Data Set (MDS) Nurse. She confirmed Resident #59 did not have a comprehensive care plan and she stated one should have been completed. The MDS Nurse stated she did not identify that Resident #59 did not have a comprehensive care plan until 7/18/22 when it was identified during the recertification survey. She stated it was an apparent oversight due to her workload.

An interview was completed on 7/20/22 at 2:35 PM with the Director of Nursing (DON). She stated the previous Administrator delegated some of the care planning to other staff rather than the MDS Nurse because she reported that she could not complete the scheduled MDS assessments and care planning. The DON stated the MDS Nurse had not identified that Resident #59 did not

F 656

(1) How corrective action will be accomplished for resident(s) found to have been affected:
Resident #59, #5, and #41's comprehensive care plan was updated on 7/20/2022 by the Minimum Data Set Coordinator.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
A 30-day focused review was completed by the Minimum Data Set Coordinator on 8/2/2022 regarding the timely development of comprehensive care plans. Focused review revealed 5 additional comprehensive care plans were not completed within 21 days of admission and were thus therefore completed as indicated by the Minimum Data Set Coordinator. This focused review was subsequently audited by the Director of Nursing on 8/3/2022 and verified to be accurate. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/20/2022 the Director of Clinical Reimbursement provided re-education to the Minimum Data Set Coordinators regarding the requirement to develop the comprehensive care plan.

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F 656	Continued From page 24 have a comprehensive care plan until it was identified during the current recertification survey. 2. Resident #5 was admitted on 1/24/20 with a diagnosis of a left wrist contracture. The quarterly Minimum Data Set (MDS) dated 4/20/22 indicated Resident #5 had severe cognitive impairment and she was coded for range of movement impairment of one side of her upper extremity. Review of Resident #5's July 2022 Physician orders included an order dated 7/21/20 for the application of a left resting hand splint to be upon waking and removed at bedtime. Observations were completed of Resident #5 on 7/18/22 at 3:20 PM, 7/19/22 at 9:22 AM and 7/20/22 at 8:37 AM. On all occasions her left wrist was contracted and she was not wearing her hand splint. Review of Resident #5's comprehensive care plan last revised 6/13/22 did not include a care plan for her left wrist contracture and the intervention of splinting. Review of the undated Care Guide utilized by the Nursing Assistants also did not include any documentation regarding her contracture or splinting. An interview was completed on 7/20/22 at 1:42 PM with the Minimum Data Set (MDS) Nurse. She stated Resident #5 should be care planned for her left wrist contracture but she obviously missed it. The MDS Nurse stated she did not know if the care plan automatically generated the Care Guide for the aides to follow but then the	F 656	(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents have a developed comprehensive care plan by day 21 of admission. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	

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F 656	Continued From page 25 MDS Nurse went on to say she had to ability to check and enter the information regarding Resident #5's splint orders in so that the aides would know to apply her splint from reading her Care Guide. An interview was completed on 7/20/22 at 2:35 PM with the Director of Nursing (DON). She stated Resident #5's comprehensive care plan should have included the care area for her contractures and splinting. The DON stated MDS Nurse had not identified that Resident #5 did not have a care plan for her contractures until it was identified on 7/20/22 during the current recertification survey. 3. Resident #41 was admitted to the facility on 4/5/19. A physician's order dated 5/29/22 indicated an admission to Hospice care. A Significant Change in Status Minimum Data Set (MDS) assessment dated 6/6/22 revealed Resident #41 was marked yes for a prognosis of less than six months. Resident #41's active care plan, last revised 6/15/22, made no reference to Hospice care. An interview was conducted with the MDS Nurse on 7/20/22 at 1:42 PM, she confirmed being aware Resident #41 received Hospice care and stated it was an oversight. The Administrator and Director of Nursing were interviewed on 7/20/22 at 2:40 PM and indicated	F 656		

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F 656	Continued From page 26 it was their expectation for Resident #41's care plan to be comprehensive and felt it was an oversight not to have included Hospice care.	F 656		
F 686 SS=E	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 record review, observation, Wound Provider and staff interviews, the facility failed to complete pressure ulcer treatments as ordered (Residents #41, #58 and #36) and failed to provide a specialized wheelchair cushion as ordered (Resident #36) for 3 of 5 residents reviewed for pressure ulcer care. The findings included: 1. Resident #41 was admitted to the facility on 4/5/19 with diagnoses that included a pressure ulcer to the mid back. A review of the Wound Provider's progress note dated 4/19/22 indicated Resident #41's mid back	F 686	F-686 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #41, #58, and #36's pressure ulcer treatments were completed as ordered on 8/3/2022. On 7/20/22 the Director of Rehab took resident #36's cushion to him however he refused it stating that it made him sit to high. A different cushion was offered by the Director of Rehab and resident #36 refused this one as well. (2) How corrective action will be	8/8/22

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F 686	Continued From page 27 pressure ulcer measured 2 centimeters (cm) in length, 1.4 cm in width and 0.4 cm in depth. The wound stage had changed from unstageable to a Stage 3 due to debridement that had been completed. Resident #41's active care plan, last revised 5/23/22, included a focus area for a pressure ulcer to the mid back and was at risk for further impaired skin integrity/pressure ulcer development related to a history of pressure ulcers, impaired bed mobility, debility, weakness and incontinence. A review of the Wound Provider's progress note dated 5/31/22 indicated Resident #41's mid back pressure ulcer measured 1.8 cm in length, 1.6 cm in width and 0.7 cm in depth. The wound stage had changed to a Stage 4 pressure ulcer. The single wound had improved tissue types but was complicated by known osteomyelitis (an infection of the bone). There would be no aggressive measures of treatment for the osteomyelitis per the responsible party and primary care physician, as the resident was on Hospice care. A Significant Change in Status Minimum Data Set (MDS) assessment dated 6/6/22 indicated Resident #41 had severe cognitive impairment and displayed no behaviors or rejection of care during the 7 day look back period. She required extensive to total assistance with Activities of Daily Living (ADLs) and was coded with one Stage 4 pressure ulcer. A review of the Wound Provider's progress note dated 6/28/22 revealed Resident #41's mid back pressure ulcer measured 1.6 cm in length, 1.3 cm in width, 0.7 cm in depth and was classified as a	F 686	accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: An audit was completed on 8/3/2022 by the Unit Manager to ensure that all pressure ulcer treatments were provided as ordered and that all specialized wheelchair cushions are provided as indicated. Audit revealed that there were not any additional residents affected. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 7/22/2022 the Director of Nursing, Assistant Director of Nursing and the Unit Manager initiated re-educated to the licensed nurses regarding the completion of pressure ulcer treatments as ordered that includes specialized wheelchair cushions along with notifying therapy of any new specialized wheelchair cushions orders. Education included agency staff, all shifts, and weekends. Any licensed nurse not educated will receive education prior to their next shift. Education completed on 8/7/2022. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all pressure ulcer	

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Stage 4. The single wound presented with stable dimensions, overall appearance, and no acute decline.

The Wound Provider's progress note dated 7/12/22 indicated Resident #41's mid back stage 4 pressure ulcer measured 2.2 cm in length, 1.6 cm in width, 0.7 cm in depth and no signs of infection.

Resident #41's physician orders included the following wound care orders:
"   An order dated 5/10/22 to 7/12/22 that read to cleanse the mid back wound with normal saline/wound cleanser and pat dry. Apply Dakin's (an antiseptic solution with anti-infective properties) 0.5% (full strength) moistened gauze and secure with super absorbent dressing once a day and as needed.
"   An order dated 7/13/22 that read to cleanse the mid back wound with normal saline and pat dry. Apply Dakin's 0.25% (half strength) moistened gauze and secure with a super absorbent dressing once a day and as needed.

The nursing progress notes from 5/1/22 until 7/18/22 were reviewed and indicated Resident #41 had no episodes of refusing wound care but did often refuse to turn and reposition for pressure relief.

a) The June 2022 Treatment Administration Record (TAR) revealed wound care to Resident #41's mid back pressure ulcer was not initialed as completed on 6/9/22, 6/14/22 and 6/27/22.

Multiple phone attempts were made on 7/19/22 and 7/20/22 to reach Nurse #9, which were unsuccessful. She was scheduled to work from

F 686

treatments as ordered are completed by observation and verification form the treatment administration record. Specialized wheelchair cushions will be verified in place by observation and the medication administration record. This monitoring process will take place weekly for 4 weeks then monthly for 4 months.

Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 8/8/2022

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7:00 AM to 7:00 PM with Resident #41 on 6/9/22, 6/14/22 and 6/27/22.

b) The July 2022 TAR was reviewed and indicated Resident #41's wound care to her mid back pressure ulcer was not initialed as completed on 7/4/22 and 7/15/22.

An interview occurred with Nurse #1 on 7/19/22 at 12:31 PM, who was familiar with Resident #41. She was scheduled for the 7:00 AM to 7:00 PM shift on 7/4/22 and 7/15/22 and explained nursing staff were responsible for completing wound care as ordered. The July 2022 TAR was reviewed and stated if the entry was not initialed it meant she didn't get to the wound care that day. Nurse #1 further stated she had reported this to the oncoming nurse so the wound care could be completed as ordered.

Multiple phone calls were made to Nurse #8 on 7/19/22 and 7/20/22 without success. She was scheduled to work with Resident #41 from the 7:00 PM to 7:00 AM shift on 7/4/22.

Multiple phone attempts were made on 7/19/22 and 7/20/22 to reach Nurse #7 without success. She was scheduled to work from 7:00 PM to 7:00 AM on 7/15/22 for Resident #41's hall.

On 7/18/22 at 11:41 AM, wound care observation occurred with Nurse #4 for Resident #41. A pressure ulcer was noted to the mid back and was the size of a dime. Nurse #4 indicated the Wound Provider measured wounds weekly. There was no drainage or odor present. Nurse #4 cleansed the wound and completed the wound care as ordered.

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A phone interview was conducted with the Wound Provider on 7/20/22 at 11:45 AM who was familiar with Resident #41. He was unaware wound care had not been completed as ordered for Resident #41 but had not seen a decline in her wound status during his weekly assessments. The Wound Provider added he would expect the facility to provide wound care as prescribed.

An interview occurred with the Director of Nursing (DON) on 7/20/22 at 2:40 PM, who stated the former treatment nurse last worked at the facility on 6/14/22 and was unaware Resident #41 had missed several days of wound care to her mid back pressure ulcer. She added it was her expectation for the wound care to be completed as ordered.

2. Resident #58 was admitted to the facility on 5/19/22 with diagnoses that included an unstageable pressure ulcer to the right hip.

A review of the active physician orders revealed an order dated 5/31/22 to cleanse the right hip with wound cleanser or normal saline and pat dry. Apply Santyl (a topical medication used to allow wound healing) and Dakin's (an antiseptic solution with anti-infective properties) moistened gauze. Secure with a super absorbent dressing once a day and as needed.

A review of the Wound Provider's progress note dated 6/7/22 indicated Resident #58 was admitted to the facility with an unstageable pressure ulcer to the right hip. On assessment the pressure ulcer measured 9.5 centimeters (cm) in length, 6.2 cm in width and 1.0 cm in

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F 686	Continued From page 31	F 686		

depth, with no signs of infection.

The Wound Provider's progress note dated 6/21/22 revealed Resident #58's right hip pressure ulcer measured 8 cm in length, 4.1 cm in width and 0.8 cm in depth. There was no signs of acute infection or decline.

A Significant Change in Status Minimum Data Set (MDS) assessment dated 6/22/22 indicated Resident #58 had moderately impaired cognition and displayed no behaviors or rejection of care. She required extensive assistance from staff for Activities of Daily Living (ADLs) and was coded with one unstageable pressure ulcer that was present on admission.

A review of the Wound Provider's progress note dated 6/28/22 indicated Resident #58's right hip pressure ulcer measured 8 cm in length, 4.6 cm in width and 0.7 cm in depth. The pressure ulcer was classified as a Stage 3.

The Wound Provider's progress note dated 7/5/22 indicated Resident #58's right hip pressure ulcer measured 8.5 cm in length, 5 cm in width and 2.8 cm in depth. There was noted deterioration in the size and overall depth and questioned whether it was related to underlying osteomyelitis. Orders for further testing was provided.

Resident #58's active care plan, last reviewed 7/11/22, included a focus area for an actual pressure ulcer to the right hip and was at risk for further pressure ulcer development/skin impairment related to impaired bed mobility, weakness and incontinence.

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F 686	Continued From page 32 A review of the Wound Provider's progress note dated 7/12/22 revealed Resident #58's right hip pressure ulcer measured 8.3 cm in length, 5 cm in width and 2.4 cm in depth. There were no signs of acute infection. The nursing progress notes from 5/19/22 until 7/18/22 were reviewed and indicated Resident #58 had no episodes of refusing wound care. a) The June 2022 and July 2022 Treatment Administration Records (TARs) were reviewed and revealed Resident #58's wound care to her right hip was not initialed as completed on 6/14/22, 6/17/22, 6/22/22, 6/27/22, 6/28/22, 7/1/22, and 7/3/22. A phone interview occurred with Nurse #6 on 7/20/22 at 10:07 AM, who was scheduled for the 7:00 AM to 7:00 PM shift on 6/14/22, 6/17/22, 6/22/22, 6/27/22, 6/28/22, 7/1/22, and 7/3/22 for Resident #58. The June 2022 and July 2022 TARs were reviewed. Nurse #6 stated the Treatment Nurse left unexpectant in early June 2022 and she tried to do the wound care when she was able but thought the managers or the 7:00 PM to 7:00 AM nursing staff would complete them when she didn't. Nurse #6 stated if the wound care was not initialed as completed it meant she didn't get to it that day. b) The June 2022 and July 2022 TARs were reviewed and revealed Resident #58's wound care to her right hip pressure ulcer was not initialed as completed on 6/21/22, 6/29/22, 7/11/22 and 7/15/22. An interview occurred with Nurse #1 on 7/19/22 at 12:31 PM, who was familiar with Resident #58.	F 686		

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She was scheduled for the 7:00 AM to 7:00 PM shift on 6/21/22, 6/29/22, 7/11/22 and 7/15/22 and explained nursing staff were responsible for completing wound care as ordered. Nurse #1 reviewed the June 2022 and July 2022 TARs and she stated if the entry was not initialed it meant she didn't get to the wound care that day.

Multiple attempts were made to observe Resident #58's wound care on 7/18/22, 7/19/22 and 7/20/22 that were unsuccessful.

A phone interview was conducted with the Wound Provider on 7/20/22 at 11:45 AM who was familiar with Resident #58. He was unaware wound care had not been completed as ordered for Resident #58 and had seen no indication to this during his weekly assessments. He added there was a concern for underlying osteomyelitis with tests pending. The Wound Provider added he would expect the facility to provide wound care as prescribed.

An interview occurred with the Director of Nursing (DON) on 7/20/22 at 2:40 PM, who stated the former treatment nurse last worked at the facility on 6/14/22 and was unaware Resident #58 had missed wound care to her right hip pressure ulcer. She added it was her expectation for the wound care to be completed as ordered.
3 a. Resident # 36 was admitted to the facility on 5/19/21 with multiple diagnoses including non-traumatic intracerebral hemorrhage and hemiplegia affecting the right dominant side. The quarterly Minimum Data Set (MDS) assessment dated 6/1/22 indicated that Resident #36's cognition was intact, and he had pressure ulcers. The assessment further indicated that the resident needed extensive assist with bed

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F 686		F 686		

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mobility, and he was totally dependent with transfers.

Resident #36's care plan dated 5/16/22 was reviewed. The care plan problem was resident has actual pressure ulcers related to impaired mobility due to hemiplegia. The goal was for the resident's pressure ulcers to show signs of healing. The approaches included to follow facility's protocol for treatment and to monitor/document location, size, and treatment to skin injury/pressure ulcers.

Review of the physician's orders for Resident #36 revealed that on 2/1/22 there was an order for a (name of the cushion) cushion (a pressure relief cushion that is made of soft and flexible air cells) to electric wheelchair when up and out of bed. The order was written by the previous treatment nurse, who no longer works at the facility.

Resident #36 had a doctor's orders dated 7/13/22, to clean the ulcers on the right and left ischium with Dakin's solution (used to clean the wounds to prevent infection) and to apply crushed Flagyl (an antibiotic used to treat infection) 500 milligrams (mgs) tablet to wound bed and to clean the sacral ulcer with normal saline and to apply collagen powder (helps stimulates tissue growth) and silver alginate (used in treatment of at risk or infected chronic wounds).

Resident #36 was observed up in wheelchair on 7/18/22 at 9:40 AM. He was in the smoking area and his wheelchair did not have a cushion on it.

Resident #36 was observed during the dressing change on 7/18/22 at 11:30 AM. The resident had 3 pressure ulcers, on the right and left

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F 686	Continued From page 35 ischium and on the sacrum. The ulcers were deep with necrotic tissue, moderate amount of serous drainage with no odor noted. The Unit Manager (UM) provided the treatment to the resident. She cleaned the right and left ischium pressure ulcers with Dakin's solution and applied crushed Flagyl to the wound bed. She also cleaned the sacral ulcer with normal saline and applied collagen powder and silver alginate. Resident #36 was observed in bed on 7/19/22 at 3:10 PM. He reported that he was paralyzed from waist down and he has pressure ulcers. He stated that he needed a cushion when he was out of bed to help relieved the pressure on his bottom. He stated that he had been asking for a cushion from the therapist, but nothing had been done about it. Nurse #5, assigned to Resident #36, was interviewed on 7/20/22 at 8:50 AM. The nurse reported that Resident #36 preferred to stay out of bed on his wheelchair every day. He went out to smoke most of the time and would not go back to bed. He indicated that the resident had an order for a chair cushion, and he thought the therapist was working on getting him one. Nurse #5 further stated that he had not seen a cushion on his wheelchair. The Rehabilitation (Rehab) Director was interviewed on 7/20/22 at 9:55 AM. He reported that the therapy department was responsible for ordering the chair cushion for the resident. The Rehab Director stated that nobody had informed him that Resident #36 had an order for a chair cushion. He stated that he remembered the resident asking him for the cushion, but he was never informed that he had an order for it. He	F 686		

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indicated that he would assess the resident and see what type of cushion fits for him.

The Wound Provider was interviewed on 7/20/22 at 11:56 AM. He stated that he had been following Resident #36's pressure ulcers on a weekly basis for quite some time. His ulcers were chronic and were unavoidable due to his medical condition being paralyzed on his lower extremities and his non-compliance with care. He preferred to stay out of bed most of the time and he was educated on the importance of offloading his bottom to help heal his ulcers. The Wound Provider indicated that the resident would benefit using a chair cushion.

The Director of Nursing (DON) was interviewed on 7/20/22 at 2:38 PM. The DON stated that Resident #36 had an order for a chair cushion on 2/1/22. The order was written by the previous treatment nurse, who no longer works at the facility. The previous treatment nurse did not inform the therapy department, who was responsible for assessing the resident and for ordering the chair cushion.

b. Resident #36 had a physician's order dated 1/26/22 to clean the pressure ulcers on the right ischium and sacrum with normal saline (NS) and to pack with silver alginate and cover with super absorbent dressing. On 6/8/22, the treatment to the right ischium was changed to collagen powder and silver alginate, and to the to the left ischium, the treatment was changed to Santyl (used to remove dead tissue from wounds) and calcium alginate (used on wounds with moderate to heavy exudates). On 7/13/22, the treatment o

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the left and right ischium was changed to clean with Dakin's solution and to apply crushed Flagyl 500 milligrams (mgs) tablet to wound bed.

Resident #36 was observed during the dressing change on 7/18/22 at 11:30 AM. The resident had 3 pressure ulcers, on the right and left ischium and on the sacrum. The ulcers were deep with necrotic tissue, moderate amount of serous drainage with no odor noted. The Unit Manager (UM) provided the treatment to the resident. She cleaned the right and left ischium pressure ulcers with Dakin's solution and applied crushed Flagyl to the wound bed. She also cleaned the sacral ulcer with normal saline and applied collagen powder and silver alginate.

Review of the April 2022 Treatment Administration Records (TARs) revealed that on 4/2/22, 4/3/22, 4/16/22, 4/17/22, 4/29/22 and 4/30/22, there were no nurse's initials to indicate that the treatment to the right ischium and sacrum was provided to the resident. There were no notes to indicate that the resident had refused the treatment.

Review of the June 2022 TARs revealed that on 6/3/22, 6/6/22, 6/10/22, 6/11/22, 6/12/22, 6/16/22, 6/18/22, 6/20/22 and 6/23/22, there were no nurse's initials to indicate that the treatment to the right and left ischium and sacrum was provided to the resident. There were no notes to indicate that the resident had refused the treatment.

Review of the July 2022 TARs revealed that on 7/1/22, 7/3/22, 7/4/22, 7/7/22, 7/8/22, 7/10/22, 7/11/22, 7/12/22 and on 7/14/22, there were no nurse's initials to indicate that the treatment to the left and right ischium and sacrum was provided to

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F 686	Continued From page 38 the resident. There were no notes to indicate that the resident had refused the treatment. Attempted to call Nurse #10, who was assigned to Resident #36 on 7/8/22, 7/10/22 and 7/14/22 but was unsuccessful. Nurse #5, who was assigned to Resident #36 on 7/7/22, 7/11/22 and 7/12/22, was interviewed on 7/20/22 at 8:50 AM. The nurse reported that at times the treatment was not provided since he did not have the time to do it. He added that at times Resident #36 had refused treatments and at times he assumed that there was a treatment nurse who will provide the treatment to the residents. Nurse #5 indicated that he should have made a note whenever the resident had refused treatment, but he did not. The Wound Provider was interviewed on 7/20/22 at 11:56 AM. He stated that he had been following Resident #36's pressure ulcers on a weekly basis for quite some time. His ulcers were chronic and unavoidable due to his medical condition being paralyzed on his lower extremities and his non-compliance with care. He preferred to stay out of bed most of the time and he was educated on the importance of offloading his bottom to help heal his ulcers. The Wound Provider indicated that he was aware that Resident #36 had refused dressing change, but he expected the nursing staff to try to provide the treatment as ordered and to document if refused. The Director of Nursing (DON) was interviewed on 7/20/22 at 2:39 PM. The DON stated that the previous treatment nurse was not doing her job as treatment nurse. She was not providing the treatments to the residents as ordered. She quit	F 686		

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F 686	Continued From page 39 on 6/27/22 but had not been at the facility since 6/14/22. The DON indicated that she expected the nurses to provide the treatment as ordered and to document when the resident refused treatment.	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 observations, staff interviews and record review, the facility failed to follow and implement Physician orders for a left resting hand splint for 1 (Resident #5) of 1 residents reviewed for range of motion. The findings included: Resident #5 was admitted on 1/24/20 with a diagnosis of a left wrist contracture. Review of Resident #5's July 2022 Physician	F 688	F-688 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #5's left resting hand splint was verified to be worn by resident per physician orders by the Director of Nursing on 7/20/2022.	8/8/22

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orders included an order dated 7/21/20 for the application of a left resting hand splint to be upon waking and removed at bedtime.

The quarterly Minimum Data Set (MDS) dated 4/20/22 indicated Resident #5 had severe cognitive impairment and she was coded for range of movement impairment of one side of her upper extremity.

Review of Resident #5's comprehensive care plan last revised 6/13/22 did not include a care plan for her left wrist contracture and the intervention of splinting.

An observation was completed on 7/17/22 at 2:00 PM. Resident #5 was sitting up in bed with a left wrist contracture. The left resting hand splint was observed on top of her dresser in her room. Also observed taped to her closet door for the instructions on the application of her hand splint.

An observation was completed on 7/18/22 at 3:20 PM. Resident #5 was sitting up in bed without her ordered splint. The left resting hand splint was observed on top of her dresser in her room.

An interview was completed on 7/19/22 at 9:10 AM with Nursing Assistant (NA) # 5. She stated she was under the impression that Resident #5's hand splint was applied before bedtime and removed in the morning and she did not recall ever applying it. NA #5 stated Resident #5 was not known to refuse care.

An observation was completed on 7/19/22 at 9:22 AM. Resident #5 was sitting up in bed without her ordered splint. The left resting hand splint was observed on top of her dresser in her room.

F 688

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
An audit was completed on 8/5/2022 by the Minimum Data Set Coordinator to ensure that all residents that have splints are applied and implemented per physician orders along with having a corresponding care plan. Audit revealed that there were not any additional residents affected. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/22/2022 the Director of Nursing, Assistant Director of Nursing, and the Unit Manager initiated re-education to the nursing staff regarding the process of splint application and removal per physician's orders. Education included agency staff, all shifts, and weekends. Any nursing staff not educated will receive education prior to their next shift. Education completed on 8/7/2022.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:
A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents that have been assessed for contracture

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An interview was completed on 7/19/22 at 12:30 PM with NA #3. She stated Resident #5's splint at bedtime so she did not recall ever applying it on her shift.

An interview was completed on 7/19/22 at 12:40 PM with NA #2. She stated she was under the impression that her hand splint was only worn at night.

An observation was completed on 7/19/22 at 12:42 PM. Resident #5 sitting up in a wheelchair beside her bed. She was not wearing her splint. The left resting hand splint was observed on top of her dresser in her room.

An observation was completed on 7/20/22 at 8:37AM. Resident #5 was sitting up in bed without her splint. The left resting hand splint was observed on top of her dresser in her room.

An interview was completed on 7/20/22 at 2:04 PM with the Rehabilitation Director. He stated Resident #5 was not on the therapy caseload for splinting. He stated once a splint was provided, fitted and a splinting program was established, the application of the splints was turned over to the floor aides after receiving education and able to correctly apply the splint. The Rehabilitation Director stated Resident #5's left resting hand splint instructions were posted in her room and it was up to the nursing department to determine what shift they assigned the splinting to be completed.

An interview was completed on 7/20/22 at 2:35 PM with the Director of Nursing (DON). She stated Resident #5's left resting hand splint was

F 688

management requiring the utilization of a splint are following implemented physician orders through observation. This monitoring process will take place weekly for 4 weeks then monthly for 2 months.

Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 8/8/2022

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F 688	Continued From page 42 ordered to be worn from when she woke up until she went to bed every day. She stated she was not aware that Resident #5's splint was not being applied but it was her expectation that Resident #5's splinting orders be followed.	F 688		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview with the resident and staff, the facility failed to obtain an order for the care of the urostomy (surgically created opening in the abdominal wall through which urine passes) and failed to have the urostomy supplies (night drainage bag and pouch) that fit for 1 of 1 sampled resident reviewed for ostomy (Resident # 9). Findings included: Resident #9 was admitted to the facility on 5/28/21 with multiple diagnoses including urinary retention and uterine prolapse. The annual Minimum Data Set (MDS) assessment dated 4/27/22 indicated that Resident #9's cognition was intact, and she has an ostomy. Resident #9's care plan dated 5/16/22 was	F 691	F-691 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #9's urostomy order was obtained by the Director of nursing on 7/23/2022 and the correct supplies were available. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: The Director of nursing conducted and audit on 7/21/2022 of all residents that have a urostomy. Audit revealed that there were not any additional residents affected. The systemic changes stated below have been put in place to prevent	8/8/22

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reviewed. The care plan problem was "resident has a urostomy related to uterine prolapse and urinary retention". The goal was "resident will show no signs/symptoms of urinary infection through review date". The approaches included to monitor for signs/symptoms of discomfort on urination and frequency, monitor and document for pain/discomfort due to urostomy and to monitor/record/report to physician for signs/symptoms of urinary tract infection (UTI). The care plan did not include what, who, how often and how to care for the urostomy.

Review of the physician's orders for Resident #9 revealed no order for the care of the urostomy.

Review of the treatment administration records (TARS) from 1/2022 through 7/19/22 was conducted. There was no documentation that the urostomy site was cleaned, the wafer or the pouch were changed and emptied.

Resident #9 was observed on 7/17/22 at 9:30 AM. She was up in wheelchair in her room. The floor under her wheelchair was wet. The resident stated that her urostomy was leaking between the pouch and the tubing of the drainage bag.

Resident #9 was observed on 7/18/22 at 10:05 AM up in wheelchair in her room. Her urostomy pouch was connected to a drainage bag and the drainage bag was in a wash basin under her bed. The resident stated that the connection between the pouch and the drainage bag was leaking. She reported that the tip of the drainage tubing would not fit into the end of the pouch. The resident indicated that the facility knew about the leaking but had not done anything.

F 691

any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/22/2022 the Director of Nursing, Assistant Director of Nursing and the Unit Manager initiated re-educated to the licensed nurses regarding the need for obtaining an order for the care of a urostomy along with ensuring that the proper supplies are available. Education included agency staff, all shifts, and weekends. Any licensed nurse not educated will receive education prior to their next shift. Education completed on 8/7/2022.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:
A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that through observation, all resident's with a urostomy have the proper orders and supplies available. This monitoring process will take place weekly for 4 weeks then monthly for 2 months.

Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification

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The Assistant Director of Nursing (ADON) was interviewed on 7/19/22 at 11:10 AM. Th ADON stated that she didn't know why Resident #9 did not have an order for the urostomy including how to care for it. She was not aware that the pouch did not fit the drainage bag and was leaking.

Nurse #5, assigned to Resident #9, was interviewed on 7/20/22 at 8:50 AM. The nurse stated that Resident #9 would call if her urostomy wafer or pouch needed to be changed. He added that the resident's husband did most of the urostomy care for the resident when he comes to visit. The nurse did not know why there was no order for the care of the urostomy. He reported that there was no documentation on the TARs about what, who, how often and how to care for the urostomy.

Resident #9 was observed on 7/20/22 at 1:30 PM. She was up in wheelchair in her room. Her urostomy pouch was connected to the drainage bag. The tip of the drainage tubing was connected to the pouch with a tape around it. The resident stated that she preferred to use the drainage bag so the nurse's aide would not empty the pouch so often. The resident reported that she used the tape to connect the drainage tubing to the pouch so it would not leak. She indicated that the facility did not have the pouch and drainage bag that fit.

The Director of Nursing (DON) was interviewed on 7/20/22 at 2:41 PM. The DON verified that Resident #9 did not have an order for the urostomy including the care. She expected residents with ostomy to have a physician's order including how to care for it. The DON indicated that she was informed that the resident refused to

of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 8/8/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT PINEHURST REHAB & LIVING CENTER	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 691	Continued From page 45 use the urostomy supplies available at the facility.	F 691		
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 reviews, observations, resident and staff interviews, the facility failed to obtain a Physician's order for a resident's use of continuous oxygen (Resident #62) and failed to administer oxygen as ordered (Resident #7). This was for 2 of 3 residents reviewed for respiratory care. The findings included: 1. Resident #62 was initially admitted to the facility on 6/6/22. She returned to the hospital on 6/6/22 until 6/16/22 for a condition unrelated to respiratory. Her diagnoses included chronic obstructive pulmonary disease (COPD) and emphysema. Review of the hospital discharge summary dated 6/16/22 revealed Resident #62 was previously on chronic oxygen at home and had been weaned down to 3 liters of oxygen via nasal cannula during the hospitalization.	F 695	F-695 (1) How corrective action will be accomplished for resident(s) found to have been affected: Residents #62's oxygen orders were obtained by the Director of Nursing on 7/19/2022. Resident #7's oxygen was adjusted to the prescribed rate by nurse #4 on 7/19/2022 (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: The Unit Manager conducted and audit on 8/4/2022 of all residents that have oxygen to ensure that orders were obtained and that all residents are administered oxygen per physician orders including the oxygen rate. Audit revealed that there were not any additional residents affected. The systemic changes stated below have been	8/8/22

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F 695	Continued From page 46 A Physician's progress note dated 6/20/22 read that Resident #62 had COPD and was dependent on oxygen. The Admission Minimum Data Set (MDS) assessment dated 6/23/22 indicated Resident #62 was cognitively intact and was coded with the use of oxygen. Resident #62's active care plan included a focus area initiated on 6/30/22 for diagnosis of emphysema/COPD and was at risk for respiratory distress. Review of Resident #62's nursing progress notes from 6/16/22 until 7/18/22 revealed she was using oxygen continuously. A review of Resident #62's June 2022 and July 2022 Physician orders did not include any orders for oxygen. In an observation on 7/17/22 at 2:50 PM, Resident #62 was sitting up in bed watching TV with oxygen running at 3 liters flow via concentrator. She stated she used oxygen at home due to COPD/emphysema. Resident #62 was observed lying in bed watching TV on 7/18/22 at 2:15 PM. Oxygen was being used at 3 liters via a concentrator. In an interview on 7/19/22 at 11:30 AM, the Director of Nursing (DON) stated Resident #62 required continuous oxygen for her COPD. The DON verified there was no order for her continuous oxygen and stated there should have been an order written for it when she was admitted from the hospital. She felt it was an	F 695	put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 7/22/2022 the Director of Nursing, Assistant Director of Nursing and the Unit Manager initiated re-educated to the licensed nurses regarding the need for obtaining an order for the use of oxygen and administering oxygen/rate as ordered. Education included agency staff, all shifts, and weekends. Any licensed nurse not educated will receive education prior to their next shift. Education completed on 8/7/2022. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that through observation, any resident with oxygen has the proper orders and that the rate is administered per physician order. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification	

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F 695	Continued From page 47 oversight. 2. Resident #7 was admitted to the facility on 10/11/21 with diagnoses that included congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Review of Resident #7's active Physician orders included an order dated 4/6/22 for oxygen at 2 liters via nasal cannula continuously. A Significant Change in Status Minimum Data Set (MDS) assessment dated 4/13/22 indicated Resident #7 had moderately impaired cognition and was coded as using oxygen. Resident #7's active care plan, last reviewed 5/23/22, included a focus area for oxygen therapy. The interventions included oxygen per physician orders. A review of the July 2022 Medication Administration Record (MAR) revealed an entry for oxygen at 2 liters per minute continuously every shift for oxygen therapy. The form had a daily check mark and staff initials. On 7/17/22 at 2:00 PM, Resident #7 was observed lying in bed watching TV with oxygen on via nasal cannula. The oxygen regulator on the concentrator was set at 2.5 liters flow when viewed horizontally, eye level. Resident #7 was observed lying in bed watching TV on 7/18/22 at 12:00 PM and stated she wore oxygen all the time. The oxygen regulator on the concentrator was set at 2.5 liters flow when viewed horizontally, eye level. The oxygen	F 695	of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	

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F 695	Continued From page 48 concentrator was noted to not be within Resident #7's reach. On 7/19/22 at 9:21 AM, Resident #7 was observed lying in bed with her eyes closed. The oxygen regular on the concentrator was set at 2.5 liters flow when viewed horizontally at eye level. An observation was made with Nurse #4 of Resident #7's oxygen concentrator on 7/19/22 at 2:31 PM. She stated the oxygen regulator on the concentrator was set at 3 liters when viewed standing and 2.5 liters flow when viewed horizontally at eye level. Nurse #4 verified Resident #7 should be using oxygen at 2 liters and adjusted the flow. Additionally, Nurse #4 stated Resident #7 did not adjust her the oxygen concentrator. During an interview with the Director of Nursing on 7/20/22 at 2:40 PM, she indicated it was her expectation for oxygen to be delivered at the ordered rate.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident, staff, Consultant Pharmacist, Pharmacist #1, Nurse Practitioner (NP) and Medical Director (MD) interviews, observations and record review, the facility failed to obtain and	F 697	F-697 (1) How corrective action will be accomplished for resident(s) found to	8/8/22

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F 697 Continued From page 49

administer prescribed medications to treat pain for a newly admitted resident (Resident #171) with a left acetabulum (the socket part of the hip ball and socket joint) fracture and a pelvic fracture. This lack of pain medication resulted in observed evidence of pain and a reported pain numerical level of 10 out of 10. This was for 1 of 2 residents reviewed for pain. The finding included

Resident #171 was admitted on 7/16/22. There was no Minimum Data Set (MDS) assessment information except for the entry MDS and there was no documented evidence of a baseline care plan.

Review of Resident #171's admission orders dated 7/15/22 included an order for a pain assessment every shift, Oxycodone (opioid) 5 milligrams (mgs) every 6 hours for moderate to severe pain for 5 days. His orders also included orders for Tylenol (analgesic) 1000 mgs every 6 hours as need for pain and Gabapentin (anticonvulsant used to treat nerve pain) 500 mgs at bedtime for pain.

An interview with Resident #171 was attempted on 7/17/22 at 2:20 PM. He appeared angry, restless and complained of pelvic pain described as 10 out of 10 in intensity. He stated he fell at home and fractured his pelvis in several places. Resident #171 stated he was supposed to be admitted to the facility on 7/15/22 but for some reason, his admission was postponed till 7/16/22 at around 1:00 PM. Resident #171 stated he was medicated for pain at the time of his hospital discharge so his pain was controlled when he arrived at the facility. He stated the nurses told him that his pain medication would arrive until

F 697

have been affected:
Residents #171 was given the prescribed pain medication on 7/17/2022 by his nurse.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
The Director of nursing conducted and audit on 7/21/2022 of all residents that were admitted over the past 30 days to ensure that they received their prescribed medications for pain. Audit revealed no other residents were affected. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/22/2022 the Director of Nursing, Assistant Director of Nursing and the Unit Manager initiated re-education to the licensed nurses regarding obtaining and administering prescribed medications to treat pain for newly admitted residents on the weekend. Education included agency staff, all shifts, and weekends. Any licensed nurse not educated will receive education prior to their next shift. Education completed on 8/7/2022.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:

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F 697	Continued From page 50 later on 7/16/22 but apparently that didn't happen. He stated the only thing he had received for pain since his admission was Tylenol and one dose of his Oxycodone at around 10:00 AM this morning. Review of Resident #171 electronic medication administration record (MAR) revealed on 7/16/22 he reported a pain level of 6 out of 10 on the 7:00 AM to 7:00 PM and the 7:00 PM to 7:00 AM shifts. The MAR indicated Resident #171 did not receive his prescribed Oxycodone, Tylenol or Gabapentin on 7/16/22 and according to a documented nursing note dated 7/17/22 at 9:43 AM, the first dose of Oxycodone was administered. The MAR indicated the next administered dose of his Oxycodone was on 7/17/22 at 3:19 PM and again at 9:00 PM. A dose of Tylenol was also administered on 7/17/22 until 10:49 PM. Review of Resident #171's electronic medical record (EMR) read his that vital signs on 7/16/22 and 7/17/22, his blood pressure remained at 116/84 and his highest recorded pulse rate was 107. An interview was completed on 7/20/22 at 9:13 AM with the Unit Manager (UM). She stated Resident #171 was expected to be admitted the evening of 7/15/22. She stated she stayed at the facility until 11:00 PM waiting for his arrival when the hospital called and stated there was a delay and he would arrive at the facility for admission the next morning on 7/16/22. The UM stated she already had Resident #171's hard prescription for his Oxycodone and orders for his home medications. She stated she faxed the Oxycodone prescription to the pharmacy and entered all his additional medication orders. The UM explained that the way their EMR system was set up it would not let her activate Resident #171's orders because he had not been assigned	F 697	A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that through observation and resident interviews, any newly admitted resident received their prescribed medications to treat pain if indicated. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	

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F 697	Continued From page 51	F 697		

a room and another nurse still had to review the orders when he arrived for the second review for accuracy then activated. The UM stated the admitting nurse would have to go into the EMR and activate the orders in order for the pharmacy to begin processing the prescriptions. She stated she was the manager on call for 7/16/22 and 7/17/22 and she did not receive any calls regarding Resident #171. The UM stated apparently the facility did not provide any education to the agency nurses on the process of activating the orders and no education on the how to correctly access the Pixis (an automated medication dispensing system present at the facility with a supply of commonly prescribed medications) while waiting for his pain medications to arrive from the pharmacy. She stated when a medication was retrieved from the Pixis, it required calling the pharmacy and obtaining a code to access the medications along with a second nurse entering a code as well to verify the correct medication, dose and number of pills were retrieved for the correct resident.

Review of the undated Pixis medication inventory read there were 15 capsules of Gabapentin and 11 Oxycodone available in the Pixis.

An interview was completed on 7/17/22 at 2:40 PM with Nurse #1. She stated she was an agency nurse who had worked at the facility a few months. She stated when Resident #171 arrived at the facility on 7/16/22, she faxed the hard prescription for his Oxycodone and reviewed the orders put in on 7/15/22. She stated on admission, he had been premedicated at the hospital and did not complain of uncontrolled pain and voiced felt discomfort with any movement. Nurse #1 stated around 3:00 or 4:00 PM,

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F 697	Continued From page 52 Resident #171 requested something for pain but his Oxycodone would not arrive from the pharmacy until later that evening so she gave him two Tylenol, called the pharmacy and verified receipt of the Oxycodone prescription and she sent a text to the on-call provider about his pain. Nurse #1 stated she forgot to document that she administered Tylenol on 7/16/22 around 4:00 PM. She stated at the end of her shift, Resident #171 did not report any unrelieved pain but she reported off to Nurse #2 that she had reached out to the pharmacy and a texted the on-call provider because his pain medications had not yet arrived. She stated when she came in again on 7/17/22 at 7:00 AM, Resident #171's medications had still not arrived so she and another nurse accessed the Pixis to retrieve a dose of Oxycodone and she administered it at 9:43 AM. Nurse #1 stated she was never educated on the process of accessing medications in the facility Pixis until 7/17/22 and she did not ask anyone to assist her with obtaining a Oxycodone from the Pixis on 7/16/22. An telephone interview was completed on 7/19/22 at 3:58 PM with Nurse #2. She stated she was an agency nurse and worked 7:00 PM to 7:00 AM on 7/16/22 with Resident #171. She stated Nurse #1 reported to her that none of Resident #171's pain medications had not arrived. Nurse #2 stated late on 7/16/22 Resident #171 verbalized pain at a 10 out of 10 so she resubmitted his prescription orders and again faxed the hard prescription for his Oxycodone to the pharmacy. She stated if the nurse did not know to hit the activate button in the EMR, the medication orders would not be activated for the pharmacy to process. She stated she hit the activate button in the EMR and called the pharmacy to confirm the orders would be processed and would arrive at the facility likely	F 697		

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F 697	Continued From page 53 the next morning due to the late activation of his medication orders in the EMR. She stated it was round this time at approximately 10:30 PM on 7/16/22 that she administer his Tylenol and again sometime after 6:00 AM but she forgot to document it in his EMR. Nurse #2 stated she never received a call or text from the on-call provider and she did not know how to access the Pixis. She stated she was under the impression none of the agency nurses could access the Pixis so she administered Resident #171 Tylenol every 6 hours for pain control. Nurse #2 stated Resident #171 was not happy with it but he agreed. Nurse #2 stated at 7:00 AM on 7/17/22 when Nurse #1 came in, she reported that he still had not received any Oxycodone. Nurse #2 stated before she left work she again called the pharmacy to see when Resident #171's medications would arrive and was told the orders were processed and enroute in the truck or with a transporter. Review of the pharmacy manifest dated 7/17/22 read Nurse #1 signed the manifest acknowledging received Resident #171's Oxycodone and Gabapentin at 1:27 PM. An interview and observation was completed on 7/18/22 at 10:50 AM with Resident #171. He stated his pain was much better until he repositioned himself in bed but eased off and controlled. An interview was completed on 7/18/22 at 9:47 AM with the NP. He stated he was at the facility Monday through Friday 7:00 AM to 1:00 PM. He stated he was not aware that Resident #171 did not received his prescribed pain medications until today. The NP stated on weekends, the nurses must call or video call the provider rather than	F 697		

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F 697	Continued From page 54 sending a text. The NP stated apparently the facility had not communicated or provided instructions to the agency staff on the process for the weekends. He stated that would explain why the facility never received a call or text from the on-call provider on 7/16/22. An interview was completed on 7/19/22 at 8:45 AM with the MD. She stated it was her expectation that Resident #171 received his prescribed pain medications timely after his admission but it appeared the be related to a knowledge deficit on behalf of the agency nurses not aware of the need to activate the medication orders prompting the pharmacy to fill the prescription and agency staff not educated in access to the Pixis. An interview was completed on 7/19/22 at 9:05 AM with Nurse #3. He stated he started out as an agency nurse but had recently accepted a permanent position at the facility. He stated Resident #171 complained of pain on 7/18/22 during his 12 hour shift and he medicated him twice with his prescribed Oxycodone which Resident #171 stated was effective. Nurse #3 stated when entering orders into the EMR, two nurses have to review the orders and then hit an activate button in the EMR in order for the pharmacy to start processing any the prescriptions. He stated he did not think he was told that when he started but someone at some time must have told him the orders would not be proceed at the pharmacy until they were activated. He also stated someone told him on weekends to just call the on-call provider and not sent a text because when contacting a provider on the weekends there would be some degree of immediacy needed and when just sending a text	F 697		

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F 697	Continued From page 55 was viewed as less immediate. A telephone interview was completed on 7/19/22 at 11:10 AM with the Consultant Pharmacist. She stated the pharmacy did not utilize a local back up pharmacy for narcotic medications because of the need for a hard copy of the prescription. She stated all nurses were able to access the Pixis. The nurse would only need to call the pharmacy while at the Pixis with another nurse to obtain an access codes to retrieve the medication because two were required to verify and enter both access codes. This was a real-time method of record keeping and prevented possible medication diversion. A telephone interview was completed on 7/19/22 at 3:27 PM with Pharmacist #1. She stated the pharmacy could not process and medication orders until the facility confirmed or activated the orders in the EMR. She stated Resident #171's prescription orders to include his Oxycodone and Gabapentin were not activated to be processed until 7/16/22 at 10:32 PM. Pharmacist #1 confirmed only one dose of Oxycodone was obtained from the Pixis on 7/17/22 at 9:43 AM and no Gabapentin was retrieved. She stated the pharmacy had the ability to go ahead and deliver a 3 day emergency supply prior of opioids until the hard prescription was received as long as the pharmacy was faxed a copy of the hard prescription. She stated this was rarely done due to the availability in the Pixis. An interview was completed on 7/17/22 at 2:50 PM with Nursing Assistant (NA) #1. She confirmed she was assigned Resident #171 on 7/16/22. She stated he refused any assistance with his activities of daily living (ADLs) stating it	F 697		

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F 697	Continued From page 56 was too painful to move. She stated he only used his call bell so far today to request something for pain. Nurse #1 was aware of Resident #171's pain. A telephone interview was completed on 7/17/22 at 3:37 PM with NA #6. She confirmed she was assigned Resident #171 on 7/16/22 for second shift. She stated Resident #171 never complained of pain. A telephone interview was completed on 7/19/22 at 3:44 PM with NA #2. She verified she worked with Resident #171 on 7/17/22 on first shift. She stated he refused staff assistance with his ADLs stating his wife would assist him later in the day. She stated he displayed outward signs of pain in his facial expressions and vocalizations like groans but he never asked her to get the nurse about his pain. An interview was completed on 7/20/22 at 8:40 AM with the Director of Nursing (DON). She stated the floor nurses seldom do admissions because the Assistant Director of Nursing (ADON) and the UM did the admission paperwork during the week. The DON stated it was unusual to have an admission on a Saturday but in the event it happened, the Registered Nurse (RN) Supervisor would then complete the admission paperwork and process the Physician orders. The DON stated this past weekend, the RN Supervisor called out for Saturday and Sunday and Nurse #1 did not call the on-call UM for directions. The DON stated once the resident was assigned a room number and the nurse confirmed that the orders had been reviewed by two nurses, the nurse had to activate the orders to remove the orders from the que to be processed at the pharmacy. The DON stated	F 697		

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F 697	Continued From page 57 apparently Resident #171's medication orders were not activated by Nurse #2 until late Saturday night. Another interview was completed on 7/20/22 at 1:00 PM with Nurse #1. She stated she was not aware until 7/17/22 that anytime an order was entered into the EMR it had to be activated in order for the pharmacy to process and fill the prescription. She also stated she was not aware until 7/17/22 that she could have accessed the Pixis on 7/16/22 because she had never been shown or educated by the facility on the procedure for using the Pixis. An interview was completed on 7/20/22 at 2:35 PM with the DON. She stated Resident #171's acute pain should have been treated with his prescribed pain medications as ordered on 7/16/22. She also stated she expected any nurse with an issue obtaining a medication on the weekend to reach out to her, the ADON or the UM for instruction. The DON further stated the orientation of the agency nurses was not being done regarding the facility's processes and procedures to ensure they were knowledgeable in the procedures needed to effectively take care of the residents due to a recent significant turnover in the nursing management department.	F 697		
F 726 SS=G	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	F 726		8/8/22

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F 726	Continued From page 58 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)(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 staff interviews and record review, the facility failed to ensure 2 (Nurse #1 and Nurse #2) of 3 agency nurses interviewed were oriented to the facility processes and procedures regarding the following: contacting the on-call medical provider on the weekends, how to activate the Physician orders in the electronic medical record (EMR) in order for the pharmacy to process the orders and the use of the pharmacy Pixis (an automated medication dispensing system present at the facility with a supply of commonly prescribed medications). This was for 1 (Resident #171) of 2 residents reviewed for pain.	F 726	F-726 (1) How corrective action will be accomplished for resident(s) found to have been affected: Residents #171 was given the prescribed pain medication on 7/17/2022 by his nurse. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:	

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F 726	Continued From page 59 This resulted in uncontrolled pain for Resident #171 admitted with multiple fractured areas of his pelvis. The finding included: This citation is cross referred to F697-G: Based on resident, staff, Consultant Pharmacist, Pharmacist #1, Nurse Practitioner (NP) and Medical Director (MD) interviews, observations and record review, the facility failed to obtain and administer prescribed medications to treat pain for a newly admitted resident (Resident #171) with a left acetabulum (the socket part of the hip ball and socket joint) fracture and a pelvic fracture. This lack of pain medication resulted in observed evidence of pain and a reported pain numerical level of 10 out of 10. This was for 1 of 2 residents reviewed for pain.	F 726	The Director of nursing conducted and audit on 7/21/2022 of all residents that were admitted over the past 30 days to ensure that they received their prescribed medications for pain. Audit revealed no other residents were affected. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: To protect residents from similar occurrences, on 7/22/2022 the Director of Nursing, Assistant Director of Nursing and the Unit Manager initiated re-educated to the licensed nurses regarding obtaining and administering prescribed medications to treat pain for newly admitted residents. Education included agency staff, all shifts, and weekends. Any licensed nurse not educated will receive education prior to their next shift. Education completed on 8/7/2022. For agency and new nurses, a book was be placed at the nurses' station with directions/instructions for notification of physician/NP, obtain meds from pixis (statsafe) and activating orders for new residents. Agency staff will be educated and sign education record. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that through	

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F 726	Continued From page 60	F 726	observation and resident interviews, any newly admitted resident received their prescribed medications to treat pain if indicated. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. An additional monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure through observation and agency staff interviews, that any new agency nurse was properly trained on the process of ensuring that any newly admitted resident receive their prescribed medications to treat pain if indicated. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		8/8/22

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F 732	Continued From page 61 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews, the facility failed to ensure the daily nurse staffing sheets were completed for 10 of 30 days reviewed (6/17/2022 through 7/16/2022).	F 732	F-732 (1) How corrective action will be accomplished for resident(s) found to have been affected:	

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F 732	Continued From page 62 Findings included: Review of the daily nurse staffing sheets from 6/17/2022 through 7/17/2022 revealed there were no daily nurse staff sheets for weekends 6/18-6/19/2022, 6/25-6/26/2022, 7/2-7/3/2022, 7/9-7/10/2022, and 7/16/-7/17/2022. On 7/17/2022 at 1:00 PM the daily nurse staff sheet observed in the lobby of the facility was dated 7/15/2022. Upon entering facility on 7/18/2022 at 8:15 AM the staff posting in the lobby of the facility was dated 7/15/2022. The Director of Nursing (DON) was interviewed. She stated the scheduler is responsible for updating the staff posting and she was not in the facility at that time. She further stated the weekend receptionist was responsible for updating the nurse posting on the weekend and she was not sure why it was not done. On 7/19/2022 at 10:28 AM an interview was conducted with the Scheduler. She stated she completed the daily nurse staff sheets Monday through Friday, but she was not in the facility on the weekends. When asked who completed the daily nurse staffing sheets on the weekend, she stated since she has been in her position, the last month, and a half, no one had completed the daily nurse staff sheets on the weekends. She stated she was not aware it had to be completed on the weekends. The Scheduler stated she should have trained the weekend supervisor or the receptionist, but she had not done that yet. An interview was conducted with the Administrator on 7/20/2022 at 2:40 PM. He stated it was his expectation the daily nurse staff sheets	F 732	No residents were directly affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 7/22/2022 the Director of Nursing re-educated the scheduler and weekend receptionist regarding the daily nurse staffing information requirements and that all required areas must be filled out and posted daily. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that through observation including weekends, all of the required daily nurse staffing information is complete and displayed appropriately. This monitoring process will take place daily for 4 weeks and then monthly for 2 months. The Administrator, DON, or designee will report findings of the monitoring process	

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F 732	Continued From page 63 be completed 7 days a week, including weekends.	F 732	to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	
F 756 SS=K	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756		8/8/22

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F 756	Continued From page 64 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Pharmacy Consultant and the staff, the facility's Pharmacy Consultant failed to identify and to report drug irregularity to the Director of Nursing and or the Attending Physician regarding the facility's failure to transcribe and to administer the Keppra (antiseizure medication) to a resident as ordered upon readmission from the hospital (Resident #175). Resident #175 was discharged to the hospital on 11/9/21 due to possible stroke like symptoms and tremors and was readmitted back to the facility on 11/13/21 with a diagnosis of seizure disorder and was prescribed Keppra. Keppra was not transcribed by the admitting Nurse and therefore was not administered to the resident from 11/14/21 through 3/3/22. On 3/4/22, Resident #175 had seizure like activity and was sent to emergency room. The Pharmacy Consultant had reviewed Resident #175's drug regimens on 11/29/21, 12/27/21, 1/24/22 and 2/25/22 and did not identify the drug irregularity. This was for 1 of 6 sampled residents whose drug regimens were reviewed (Resident #175). Immediate jeopardy began on 11/29/21 when the Pharmacy Consultant failed to identify and to	F 756	F-756 (1) How corrective action will be accomplished for resident(s) found to have been affected: Residents #175 no longer resides in the facility. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: The Director of Nursing conducted an audit on 7/19/2022 of all residents to ensure that no other medication reconciliations were inaccurate, and no other medication errors were noted. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: Education was completed by the Vice	

F 756

Continued From page 65

report the drug irregularity regarding the Keppra for Resident #175. The immediate jeopardy was removed on 7/20/22 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of an E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure interventions put into place are effective related to drug regime review.

Findings included:

Resident #175 was originally admitted to the facility on 6/29/20 and was readmitted on 11/13/21 with multiple diagnoses including non-traumatic intracerebral hemorrhage and seizure disorder.

The hospital discharge summary dated 11/13/21 revealed that Resident #175 presented to the ER due to altered mental status. On arrival to the ER, the resident became unresponsive, and he had a witnessed seizure and was given a dose of Ativan (a sedative used to treat seizure disorder). The discharge summary indicated that Resident #175 was discharged back to the facility on 11/13/21 with a diagnosis of seizure disorder and Keppra 500 milligrams (mgs) 1 tablet by mouth twice a day was included on the discharge medications.

The nurse's note dated 11/13/21 at 4:01 PM revealed that Resident #175 was readmitted back with a new diagnosis of seizure disorder.

Resident #175's admission orders (11/13/21) were reviewed. Keppra was not listed on the admission orders.

F 756

President of clinical services of the facility's pharmacy on 07/19/2022 for all the facility pharmacy consultants who provide services to the facility on medication regimen reviews which included ensuring a thorough and complete review of resident's medications was completed within 31 days of admission/readmission. No other consultant pharmacist will provide services to facility prior to receiving education.

All new admits, readmitted residents, will be communicated by admissions email distribution to include the consultant pharmacists. Consultant pharmacist will meet with Director of nursing at each visit to identify residents with significant changes for medication regimen review to occur to ensure that orders were accurately transcribed and administered as directed by the provider/hospital in accordance with professional standards and appropriate medication use/dosage. The medication regimen review will also include review of the medications listed on hospital discharge summary for new admit/readmit residents.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Director of nursing will conduct an audit of 100% of admitted and readmitted residents to ensure accurate medication reconciliation occurs 5 times per week X 4 weeks. Director of nursing will audit two times weekly to include at least 2

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F 756	Continued From page 66 Resident #175's Medication Administration Records (MARs) from 11/14/21 through 3/3/22 were reviewed and Keppra was not administered to the resident. The nurse's note dated 3/4/22 at 9:19 AM indicated that Resident #175 was observed having seizure like activity lasting approximately 3 minutes. Few minutes later, the resident had another seizure activity. The NP, who was in the building, was notified and ordered to send the resident to the ER. This note was written by Nurse #4. The hospital discharge summary dated 3/7/22 revealed that Resident #175 presented to the ER on 3/4/22 after having 2 focal seizures. The resident had received a dose of Ativan and parenteral Keppra. The resident had a history of significant intracranial hemorrhage and on 11/2021 hospitalization he had seizures and was discharged on Keppra 500 mgs twice a day. It was unclear if the resident was receiving the Keppra at the facility. Review of Resident #175's monthly drug regimens were conducted. The Pharmacy Consultant had reviewed the resident's drug regimens on 11/29/21, 12/27/21, 1/24/22 and 2/25/22. The drug regimen reviews indicated that there were no drug irregularities noted and with no recommendations. The DON was interviewed on 7/18/22 at 2:35 PM. The DON indicated that after the resident was sent to the ER, she reviewed the resident's medical records and found out that the admitting nurse (previous DON) failed to transcribe the	F 756	admits/readmits X 4 weeks to ensure medication reconciliation occurs. Facility will continue to monitor to maintain substantial compliance throughout monitoring process. Any irregularity noted by the Pharmacy Consultant will be relayed to the facility's Director of Nursing and when applicable to the facility's medical director and the irregularity will be acted upon by the facility in a timely manner. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	

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Keppra when the resident was readmitted on 11/13/21. She reported that she developed an action plan for the medication error but not for the drug regimen review.

A follow up interview was conducted with the DON on 7/19/22 at 9:30 AM. The DON reported that she expected the Pharmacy Consultant to review the hospital discharge summary including the medications listed to ensure medications were transcribed accurately into the resident's electronic medical records.

The Pharmacy Consultant was interviewed by telephone on 7/19/22 at 11:01 AM. She stated that she was the Pharmacy Consultant assigned to conduct the monthly drug regimen review at the facility. She acknowledged that she had reviewed Resident #175's drug regimen on 11/29/21, 12/27/21, 1/24/22 and 2/25/22 with no irregularities noted. When asked if she had been reviewing the hospital discharge summary for new admit/readmit residents, she replied that normally she did not review the hospital discharge summary unless she had questions about the resident's medications. The Pharmacy Consultant reported that she was not aware that Resident #175 was readmitted on 11/13/21 on Keppra. She was also not aware that the Keppra was not transcribed and was not administered to the resident.

The administrator was notified on the immediate jeopardy on 7/19/22 at 3:22 PM.

On 3/20/22 at 11:20 AM, the facility provided the following credible allegation of immediate jeopardy removal.

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Alleged date of immediate jeopardy removal 7/20/22.

The Director of Nursing and the Pharmacy Consultant conducted an audit on 7/19/22 of all residents to ensure that no other medication reconciliation were inaccurate and no other medication errors were identified.

Education was completed by the Vice President of Clinical Services of the facility's pharmacy on 7/19/22 for the facility's Pharmacy Consultants who provide services to the facility on medication regimen reviews which included ensuring a thorough and complete review of resident's medications was completed within 31 days of admission/readmission. No other Pharmacy Consultant will provide services to the facility prior to receiving the education.

All new admit/readmit residents will be communicated by admissions email distribution to include the Pharmacy Consultants. Consultant Pharmacists will meet with the Director of Nursing at each visit to identify residents with significant changes for medication regime review to occur to ensure that orders were accurately transcribed and administered as directed by the provider/hospital in accordance with professional standards and appropriate medication use/dosage. The medication regimen review will also include review of the medications listed on hospital discharge summary for new admit/readmit residents.

Any irregularities noted by the Pharmacy Consultants will be relayed to the facility's Director of Nursing and when applicable to the facility's medical director and the irregularity will

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F 756	Continued From page 69 be acted upon in a timely manner. The Director of Nursing and the facility Administrator were provided in-service education and worked in conjunction with the Regional Director of Operation to this plan. On 7/20/22, the credible allegation of immediate jeopardy removal was validated by onsite verification. Review of the Pharmacy Consultants sign in sheets for the in-service conducted on 7/19/22 on complete and accurate drug regimen review and the review of the audit conducted by the Director of Nursing and the Pharmacy Consultants on 7/19/22 of all resident's medications to ensure no other residents had inaccurate medication reconciliation and no significant medication errors. Interview with the admission Director, DON, and the Unit Managers revealed that they received the in-service on the new system regarding the drug regimen review. The facility's date of Immediate Jeopardy removal of 7/20/22 was validated.	F 756		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview with the Nurse Practitioner and the staff, the facility failed to administer the Keppra (an antiseizure medication) to a resident as ordered from the hospital (Resident #175). Resident #175 was	F 760	Past noncompliance: no plan of correction required.	

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discharged to the hospital due to tremors and altered mental status on 11/9/21 and was discharged back to the facility on 11/13/21 with a diagnosis of seizure disorder and was prescribed Keppra. Resident #175 did not receive the Keppra from 11/14/21 through 3/3/22 and on 3/4/22, Resident #175 had seizure activity and was sent to the emergency room. The resident had received a dose of Ativan and parenteral (intravenous) Keppra. Resident #175 was readmitted back to the facility on 3/7/22. This was for 1 of 4 sampled residents who were admitted/readmitted and were reviewed for medication errors.

Findings included:

Resident #175 was originally admitted to the facility on 6/29/20 and was readmitted on 11/13/21 with multiple diagnoses including non-traumatic intracerebral hemorrhage and seizure disorder.

Review of the nurse's note dated 11/9/21 at 8:00 AM revealed that Resident #175 had tremors, the Nurse Practitioner (NP) was notified, and the resident was sent to the emergency room (ER). This note was written by Nurse #6, who was no longer employed by the facility.

The hospital discharge summary dated 11/13/21 revealed that Resident #175 presented to the ER due to altered mental status. On arrival to the ER, the resident became unresponsive, and he had a witnessed seizure and was given a dose of Ativan (a sedative used to treat seizure disorder). The discharge summary revealed that Resident #175 was discharged back to the facility on 11/13/21 with a diagnosis of seizure disorder and

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Keppra 500 milligrams (mgs) 1 tablet by mouth twice a day was included on the discharge medications.

The nurse's note dated 11/13/21 at 4:01 PM revealed that Resident #175 was readmitted back with a new diagnosis of seizure disorder. The note was written by the previous Director of Nursing (DON).

Resident #175's admission orders (11/13/21) were reviewed. Keppra was not listed on the admission orders. The admission orders were transcribed by the previous DON.

Resident #175's Medication Administration Records (MARs) from 11/14/21 through 3/3/22 were reviewed and Keppra was not administered to the resident.

The quarterly Minimum Data Set (MDS) dated 11/20/21 indicated that Resident #175 had severe cognitive impairment and he had a diagnosis of seizure disorder.

The nurse's note dated 3/4/22 at 9:19 AM indicated that Resident #175 was observed having seizure like activity lasting approximately 3 minutes. Few minutes later, the resident had another seizure. The NP, who was in the building, was notified and ordered to send the resident to the ER. This note was written by Nurse #4.

The hospital discharge summary dated 3/7/22 revealed that Resident #175 presented to the ER on 3/4/22 after having 2 focal (partial) seizures (a seizure that begins in one part of the brain). The resident had received a dose of Ativan and

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parenteral Keppra. The resident had a history of significant intracranial hemorrhage and on 11/2021 hospitalization he had seizures and was discharged on Keppra 500 mgs twice a day. It was unclear if the resident was receiving the Keppra at the facility.

The DON was interviewed on 7/18/22 at 2:35 PM. The DON stated that she was called to Resident #175's room by Nurse #4 on 3/4/22. The resident was having seizures. The DON reported that the resident had 2 episodes of seizure activity that day. The first seizure activity, the NP was notified, and he ordered Keppra 500 mgs by mouth every 12 hours. Few minutes later, the resident had another seizure and more severe than the first one, the NP was notified, and the resident was sent to the ER. The DON indicated that after the resident was sent to the ER, she reviewed the resident's medical records and found out that the admitting nurse (previous DON) failed to transcribe the Keppra when the resident was readmitted on 11/13/21. She reported that she developed an action plan for the medication error.

The NP was interviewed on 7/19/22 at 8:36 AM. The NP reported that he was at the facility on 11/9/21 when he was informed that Resident #175 was having stroke like symptoms. He ordered to send the resident to the ER. He added that Resident #175 was readmitted back to the facility on 11/13/21 and he saw the resident on 11/14/21. He stated that he did not read the hospital discharge summary when the resident was readmitted, and he should have but he missed it. The NP indicated that the admitting nurse should have verified the medications listed on the hospital discharge summary with the

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on-call physician since the resident was admitted after 4 PM. The NP reported that on 3/4/22 at 8:00 AM, he was called to the resident's room and the resident was having seizure like activity. He ordered Keppra. At 8:44 AM (same day), the resident had tremors again and he ordered to send the resident to the ER.

A follow up interview was conducted with the DON on 7/19/22 at 9:30 AM. The DON reported that she expected the admitting nurse to verify the medications listed on the hospital discharge summary with the physician/on-call physician or the NP on admission/readmission. She also expected the NP to read the hospital records on admission/readmission to ensure orders were not missed.

Attempted to call the previous DON, who transcribed the admission orders for Resident #175 on 11/13/21 but was unsuccessful.

Nurse #4 was interviewed on 7/20/22 at 10:35 AM. Nurse #4 stated that she was assigned to Resident #175 on 3/4/22. She was called to the resident's room, and she observed the resident having seizures. She informed the NP and he ordered Keppra. Few minutes later, the resident had another seizure, the NP ordered to send the resident to ER.

The Administrator and the DON were notified of the Immediate Jeopardy on 7/19/22 at 3:22 PM.

The facility provided the following corrective action plan:

Corrective action that will be accomplished:
Resident #175 was transferred to the hospital on

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3/4/22 due to seizure activity.
Resident #175 returned to the facility on 3/7/22 with order for Keppra 1000 mgs twice a day.

Identification of other residents:
The Director of Nursing and the Unit Managers completed an audit on 3/8/22 for all residents that were admitted or readmitted from 8/1/21 through 3/7/22 to validate that orders were transcribed as ordered upon admission.

Measures for systemic change:
The Regional Clinical Director completed education on 3/7/22 for the Director of Nursing regarding facility protocol for reconciliation of medications upon admission/readmission.

The Director of Nursing and or Unit Managers completed education on 3/8/22 for current licensed nurses regarding facility protocol for reconciliation of medications upon admission. Licensed nurses that were not working will be educated upon return to work prior to accepting an assignment. Newly hired licensed nurses will be educated during new hire orientation.

The process includes upon admission, the licensed nurse will review the discharge summary and will notify the physician or NP to verify the orders. The licensed nurse will transcribe the orders into the electronic medical records. A second nurse will review the orders to validate that the orders are input accurately into the electronic medical record. The Unit Manager and or the nursing supervisor will review the orders within 24 hours of admission to validate that physician orders are transcribed accurately into the electronic medical records.

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How corrective action will be monitored:
The Director of Nursing and or Unit Managers will audit admission orders within 24 hours of admission x 4 weeks then weekly x 2 months to validate that orders were transcribed accurately into the electronic medical records. The Director of Nursing will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance.

The Director of Nursing will review the plan during the monthly QAPI meeting, and the audits will continue at the discretion of the QAPI committee.

The facility's alleged corrective action plan was verified by the following:

On 7/19/22, the facility's corrective action plan was validated onsite by record review, and staff interview.
Review of the audit conducted on 3/8/22 of all residents who were admitted/readmitted from 8/1/21 through 3/7/22.

Interview with nursing staff revealed that they had received an in-service on how to reconcile orders on admission. They must verify medications listed on the hospital discharge summary with the physician or the NP. The admitting nurse will transcribe the orders into the electronic medical records. A second nurse will review the medical records and the hospital discharge summary to validate that orders were transcribed accurately.

Interview with the Unit Managers revealed that they must review the orders and the hospital discharge summary within 24 hours of admission to validate that orders were transcribed accurately into the electronic medical records.

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F 760	Continued From page 76 Review of the sign in sheets of the in-service conducted on 3/7/22. Review of the monitoring conducted by the Unit Managers on admission orders of new admit/readmit residents to validate that admission orders were transcribed accurately. F760 was corrected on 3/9/22.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff and the Dietary Manager (DM), the facility failed to ensure that food items, in the walk in cooler, that had been opened were labeled and dated.	F 812	F-812 (1) How corrective action will be accomplished for resident(s) found to	8/8/22

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This was for 1 of 1 walk in coolers and had the potential to affect food served to residents.

The findings included:

On 7/3/2022 at 1:30 PM during an initial tour of the kitchen.
1. The DM identified the following items in the walk-in cooler:
One metal container of tuna salad that was not labeled or dated.
One metal container of sausage that was not labeled or dated.
One metal container of ground pork that was not labeled or dated.
One metal container of scrambled eggs that was not labeled or dated.
One metal pan of diced tomatoes that was not labeled or dated.
One metal pan of shredded lettuce that was not labeled or dated.
Four - 8 ounce (oz) cups of orange liquid were not labeled or dated.
One large metal bowl with white substance identified by the DM as whip topping, was not labeled or dated.
One gallon container of salad dressing was half empty and did not have an open date.
One gallon container of relish was half empty with no open date.
One gallon container of mustard was observed to be three quarters empty with no open date.

2. In the dry storage room there were two large white plastic four wheeled bins. Neither of the bins were labeled or dated. The DM stated one bin contained sugar and the other bin contained flour.

F 812

have been affected:
All residents have the potential to be affected by this alleged non-compliance.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
The Dietary Manager reviewed the refrigerator, freezer, and the nourishment room for accurate storing, dating, and labeling of food items on 7/21/2022. Review revealed that additional items were not labeled correctly and were discarded by the dietary manager. A Dietary audit of the refrigerator, freezer, and nourishment room was conducted by the Administrator on 7/22/22 to verify accuracy of the Dietary Manager's review that all items are now currently labeled and dated correctly. Audit revealed that all items were stored, labeled, and dated appropriately. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/22/2022 the Administrator re-educated the Dietary Manager including all dietary staff regarding the requirements for proper storing, dating, and labeling of food items. Any dietary staff member not educated will have the required education prior to

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F 812	Continued From page 78 An interview was conducted with the DM after the initial tour of the kitchen on 7/3/2022 at 2:00PM. He stated opened items in the cooler should have been labeled with contents and dated. He further stated the bins in the dry storage room should have been labeled with contents and dated. He stated he did not know why the items were not labeled or dated. An interview was conducted with the Administrator on 7/20/2022. She stated it was her expectation that opened items in the walk in cooler as well as the bins in the dry storage room should be labeled and dated.	F 812	their next shift (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: A monitor sheet will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that through observation, the refrigerator, freezer, and nourishment room have accurate storing, dating, and labeling of food. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. Any issues during monitoring will be addressed immediately. The Administrator or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced	F 867		8/8/22

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by:

Based on observations, staff interviews and record review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitoring interventions that the committee put into place for the annual recertification surveys dated 3/21/19 and 9/20/21. This was for three recited deficiencies in the areas of Resident Assessments, Comprehensive Resident Centered Care Plan and Pharmacy Services. The continued failure of the facility during three Federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included:

This citation is cross referenced to:

F641-Based on record review, observations and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately.

F656-Based on observations, staff interviews and record review, the facility failed to develop the comprehensive care plan.

F756-Based on record review and interviews with the Pharmacy Consultant and the staff, the facility's Pharmacy Consultant failed to identify and to report drug irregularity.

In an interview on 7/20/22 at 2:35 PM, the Administrator stated he was new to the facility and that there had been a large turnover in the nursing department and with nursing management. He stated it was obvious that the

F 867

F-867

(1) How corrective action will be accomplished for resident(s) found to have been affected:
F-641- Resident #70, #41, #32, were corrected and coded accurately on the minimum data set by the Minimum Data Set Coordinator on 7/20/2022.

F-656- Resident #59, #5, and #3's comprehensive care plan was updated on 7/20/2022 by the minimum data set coordinator.

F-756- Residents #175 no longer resides in the facility.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
F-641- A focused review was completed by the Minimum Data Set Coordinator on 7/31/2022 regarding the accuracy of coding on the minimum data set in accordance with the resident assessment instruments for all residents over the past 3 months to include falls, hospice, and alarms. Focused review revealed 4 additional coding discrepancies. All corrections were made as indicated by the Minimum Data Set Coordinator. This focused review was subsequently audited by the Director of Nursing on 8/1/2022 and verified to be accurate. The systemic changes stated below have been put in place to prevent any risk of affecting

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F 867	Continued From page 80 monitoring for compliance in the three repeated citations areas was lacking.	F 867	additional residents. F-656- A 30-day focused review was completed by the Minimum Data Set Coordinator on 8/2/2022 regarding the timely development of comprehensive care plans. Focused review revealed 5 additional comprehensive care plans were not completed within 21 days of admission and were thus therefore completed as indicated by the Minimum Data Set Coordinator. This focused review was subsequently audited by the Director of Nursing on 8/3/2022 and verified to be accurate. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. F- 756- The Director of Nursing conducted an audit on 7/19/2022 of all residents to ensure that no other medication reconciliations were inaccurate, and no other medication errors were noted. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: F-641- To protect residents from similar occurrences, on 7/20/2022 the Director of Clinical Reimbursement provided re-education to the Minimum Data Set Coordinator regarding the need for accurate coding on the minimum data set	

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F 867	Continued From page 81	F 867	to reflect falls, hospice, and alarms. F-656- To protect residents from similar occurrences, on 7/20/2022 the Director of Clinical Reimbursement provided re-education to the Minimum Data Set Coordinators regarding the requirement to develop the comprehensive care plan. F-756- Education was completed by the Vice President of clinical services of the facility's pharmacy on 07/19/2022 for all the facility pharmacy consultants who provide services to the facility on medication regimen reviews which included ensuring a thorough and complete review of resident's medications was completed within 31 days of admission/readmission. No other consultant pharmacist will provide services to facility prior to receiving education. All new admits, readmitted residents, will be communicated by admissions email distribution to include the consultant pharmacists. Consultant pharmacist will meet with Director of nursing at each visit to identify residents with significant changes for medication regimen review to occur to ensure that orders were accurately transcribed and administered as directed by the provider/hospital in accordance with professional standards and appropriate medication use/dosage. The medication regimen review will also include review of the medications listed on hospital discharge summary for new admit/readmit residents.	

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F 867	Continued From page 82	F 867	To protect residents from similar occurrences, on 8/4/2022 the Senior Director of Clinical Operations re-educated the QAPI committee on maintaining implemented procedures and monitoring interventions that the committee puts into place. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: F-641- A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all falls, hospice, alarms were coded accurately on the minimum data set. This monitoring process will take place weekly for 4 weeks then monthly for 4 months. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. F-656- A monitor sheet will be done by the Administrator, DON, or designee to monitor and ensure that all residents have a developed comprehensive care plan by day 21 of admission. This monitoring process will take place weekly for 4 weeks then monthly for 4 months.	

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F 867	Continued From page 83	F 867	Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. F-756- Director of nursing will conduct an audit of 100% of admitted and readmitted residents to ensure accurate medication reconciliation occurs 5 times per week X 4 weeks. Director of nursing will audit two times weekly to include at least 2 admits/readmits X 4 weeks to ensure medication reconciliation occurs. Facility will continue to monitor to maintain substantial compliance throughout monitoring process. Any irregularity noted by the Pharmacy Consultant will be relayed to the facility's Director of Nursing and when applicable to the facility's medical director and the irregularity will be acted upon by the facility in a timely manner. Any issues during monitoring will be addressed immediately. The Administrator, DON, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility	

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F 867	Continued From page 84	F 867	remains in substantial compliance F-867- A monitor sheet will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that all implemented QAPI procedures that were put into place are maintained. This monitoring process will take place weekly for 2 weeks then monthly for 6 months. Any issues during monitoring will be addressed immediately. The Administrator or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	
F 880 SS=D	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	F 880		8/8/22

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a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a 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.

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§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 review, observations, and staff interviews, the facility failed to place an unvaccinated newly admitted resident on transmission-based precautions for 1 of 3 (Resident #171) residents reviewed for transmission-based precautions.

The findings included:

Resident #171 was admitted to the facility on 7/16/2022 diagnosis of pelvic fracture.

Resident #171's electronic medical record indicated he was admitted on 7/16/2022. The resident did not have evidence of COVID-19 vaccination and the electronic medical record indicated he refused COVID-19 vaccnation. There was no documentation of recent COVID-19 infection.

During the initial tour of the facility on 7/17/2022 at 1:30 PM, Resident #171 was observed in his room. There was no transmission-based precaution sign on the door.

F 880

F-880

Root Cause analysis:
The Senior Director of Clinical Services discussed with the interdisciplinary committee team (that consists of but not limited to the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Minimum Data Set Coordinators, Social Service Director Rehabilitation Director, Maintenance Director, Environmental Service Director, and Activities Director) on 8/4/2022 to identify the root cause of this alleged non-compliance by utilizing the 5 whys:

Problem identified: The facility failed to place an unvaccinated newly admitted resident on transmission-based precautions.

1. Why? Licensed nursing staff was presumed to know that a newly admitted unvaccinated resident was to be placed

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On 7/17/2022 at 5:00 PM staff were observed placing transmission base precaution sign and a personal protective equipment (PPE) caddy on Resident #171's door.

An interview was conducted with the Director of Nursing (DON) on 07/17/22 at 5:07 PM. She stated Resident #171 should have been placed on transmission-based precautions on admission, 7/16/2022. She further stated when a resident was admitted, the unit managers got an email with vaccination status and were instructed to place the resident on transmission-based precautions if needed. The unit manager made sure the nurse or nurse assistant placed the sign and PPE caddy on the door. The DON stated she was on vacation last week and 7/17/2022 was the first day she had been in the facility. She stated the weekend supervisor would have been the person responsible for making sure the resident was on precautions, but that person did not work over the weekend. The DON placed the resident on transmission-based precautions when she realized he had not been placed on precautions.

On 7/20/2022 at 2:40 PM an interview was conducted with the Administrator. He stated it was his expectation that newly admitted residents without COVID-19 vaccinations be placed on transmission-based precautions.

F 880

on transmission-based precautions.

2. Why? Licensed nursing staff have not had any questions regarding the requirements for newly admitted unvaccinated residents and there have not been any observed newly admitted unvaccinated residents without transmission-based precautions.
3. Why staff as not had any questions? Education sessions have been conducted with staff on transmission-based precautions for a newly admitted resident that is unvaccinated.
4. Why have education sessions been done? So, staff know what precautions to take when a newly admitted resident that has not been vaccinated admits.
5. Why does staff need to know what level of isolation is required? To decrease the chance of spread and cross contamination.

Root cause analysis conducted revealed that even though education and training was provided, and that proper transmission-based precaution signage and proper PPE has been achieved through the facilities observation, the licensed nursing staff had an inadequate understanding of the required transmission-based precaution requirements for a newly admitted unvaccinated resident and a need for ongoing oversight and re-education is necessary.

(1) How corrective action will be accomplished for resident(s) found to have been affected

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Resident #171 was placed on transmission-based precautions by the Director of Nursing on 7/17/2022.

(2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:
The Director of Nursing conducted an audit on 7/17/2022 to determine if any other residents were affected. Audit revealed that additional residents were affected and were placed on transmission-based precautions right away by the Director of Nursing. The systemic changes stated below have been put in place to prevent any risk of affecting additional residents.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
To protect residents from similar occurrences, on 7/22/2022 the Director of Nursing, Assistant Director of Nursing and Unit Manager initiated re-educated the Licensed Nursing staff regarding unvaccinated newly admitted residents are to be placed on transmission-based precautions. Education included agency staff, all shifts, and weekends. Any licensed nurse not educated will receive education prior to their next shift. Education completed on 8/7/2022.

(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained:

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F 880	Continued From page 89	F 880	A monitor sheet will be done by the Administrator, Director of Nursing, or designee to monitor and ensure that newly admitted residents that are unvaccinated are placed on transmission-based precautions. This monitoring process will take place 5 times per week for 4 weeks, weekly for 4 weeks, then monthly for 3 months. Any issues during monitoring will be addressed immediately. The Administrator or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 8/8/2022	