STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING _____ B. WING _____	C 09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/19/22 through 9/22/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# UH0S11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/19/22 through 9/22/22. Event ID#UH0S11 7 of the 23 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated: NC187894, NC186931, NC191638, NC191413, NC190953, NC190842, NC186055, NC185642 & NC183324.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to assess and obtain Physician orders for the self-administration of an as needed (prn) inhaler and a scheduled inhaler for 1 (Resident #23) of 1 residents reviewed for the self-administration. The findings included: Resident #23 was admitted on 8/2/19 with a diagnosis of Chronic Obstructive Pulmonary	F 554	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F554	10/14/22

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

Electronically Signed | 10/07/2022

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F 554	Continued From page 1 Disease (COPD). Her quarterly Minimum Data Set (MDS) dated 7/6/22 indicated she was cognitively intact. Review of Resident #23's care plan edited on 7/25/22 read she request to keep her prn inhaler at the bedside. Interventions included to evaluate for her continued ability to self-administer the inhaler at least quarterly. An observation was completed on 9/19/22 at 11:32 AM. Resident #23 was in bed and lying on her over the bed table were observed 2 inhalers (Combivent and Ventolin). They were not in original box indicating the prescribers directions for use. Resident #23 stated she was allowed to keep both inhalers at her bedside due to her COPD. Review of Resident #23's September 2022 Physician orders included an order dated 7/22/22 for Combivent Respimat 2 puffs for inhalation three times daily for COPD and another order dated 9/12/22 for Ventolin 2 puff for inhalation every 6 hours as needed for wheezing or shortness of breath. There were no orders for the self-administration of either inhalers. An interview was completed on 9/21/22 at 10:40 AM with MDS Nurse #1. She stated Resident #23 had been assessed previously on 4/7/21 for the self-administration of her Ventolin inhaler but when she went out to the hospital on 9/22/21, the self-administration order was discontinued. MDS Nurse #1 stated previously the process for residents who self-administrated any medication were assessed by the previous Director of Nursing (DON) to ensure the resident was safe to	F 554	Residents affected Nurse #8 completed a medication self-administration assessment on Resident #23 on 09-21-22. This assessment determined that Resident #23 was able to self-administer her scheduled inhaler and her PRN (as needed) inhaler per physician order. A physician order to self-administer the scheduled inhaler and the PRN inhaler was obtained on 9-21-22 by Nurse #8. Resident #23 did not suffer any adverse effects from the alleged deficient practice. Residents with potential to be affected The Director of Nursing (DON) completed a 100% review of all residents in the facility on 9-23-22 to determine if any other residents were self-administering medications. No other residents were determined to be self-administering their medications. No other residents suffered any adverse effects from the alleged deficient practice. Systemic Changes The DON and the Staff Development Coordinator (SDC) will educate all licensed nursing staff on the policy regarding self-administration of medications. This education included the following: " Residents requesting to self-administer medications must have a medication self-administration assessment observation completed to determine if they are able to self-administer medications.	

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F 554	Continued From page 2 self-administer and aware of the need to safely store the medication. She stated she was uncertain if the current DON was responsible for obtaining the order and completing the self-administration assessment. An interview was completed on 9/21/22 at 2:37 PM with Nurse #8. She stated Resident #23 administered her own inhalers and kept them at her bedside. She stated she was not aware who was responsible to assess and obtain Physician orders for the self-administration of medications. An interview as completed on 9/21/22 at 2:40 PM with the DON. She stated she had been the facility DON since December 2021 and was informed yesterday by MDS Nurse #1 that the previous DON completed the self-administration assessments and obtained the Physician order. She stated she had not been doing it. An interview was completed on 9/22/22 at 10:30 AM with the Administrator and the DON. Both stated it was their expectation that a self-administration assessment be completed anytime a resident request to self-administer any medication, routinely reassess and obtain a Physician order. An interview was completed on 9/22/22 at 10:50 AM with the Medical Director. He stated it was his expectation that the facility complete and routinely reassess and obtain an order for the safety of Resident #23's self-administration of her inhalers.	F 554	" A physician order must be obtained for the resident to self-administer medications. This will be completed by 10-7-22. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to duty by the DON/SDC or Registered Nurse Supervisor. Any newly hired licensed nurse will be educated by the Staff Development Coordinator during orientation. Monitoring An audit tool was developed that contained the following: " Is the Medication Self-administration Assessment Observation completed? " Is there a physician□s order to self-administer the medication? The DON and Registered Nurse Supervisor will audit 100% of residents who request to self-administer medications weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will determine the need for further monitoring. All results will be brought to our monthly Quality Assurance and Performance Improvement Committee meeting monthly x 3 months by the DON.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize	F 565		10/14/22

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F 565	Continued From page 3	F 565		

and participate in resident groups in the facility.
(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.
(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.
(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.
(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
(A) The facility must be able to demonstrate their response and rationale for such response.
(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident, and staff interviews, the facility failed to communicate the facility's efforts to address group concerns verbalized during Resident Council meetings and

Filing of this plan of correction
Does not constitute admission that
The deficiencies alleged did in fact
Exist. The plan of correction is filed in

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F 565	Continued From page 4 to resolve repeat concerns for 4 of 4 consecutive months (May 2022, June 2022, July 2022, and August 2022). Findings included: Resident Council minutes dated 05/25/22 indicated residents had voiced concerns related to items listed on the meal ticket was not served, and condiments not provided on the meal trays. There was no evidence of the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. Resident Council minutes dated 06/23/22 indicated residents had voiced concerns related to Nursing Assistants (NAs) not returning to assist with requests and having more diabetic snacks available. There was no evidence of the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. Resident Council minutes dated 07/20/22 revealed a repeated concern of items listed on the meal ticket was not served. There was no evidence of the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. Resident Council minutes dated 08/20/22 indicated residents had voiced concerns related to being hurried by NAs when using the restroom and noodles being served without an accompanying side or entrée. There was no evidence of the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. The facility's concern log revealed no	F 565	Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F565 Resident affected On 10-07-22, the Activity Director (AD) will call a Resident Council meeting and review all of the concerns that have been presented during Resident Council meetings for May, June, July and August, 2022. The AD will advise the Resident Council of the resolutions to these concerns that were presented during those months. Residents with potential to be affected No residents were adversely affected by the alleged deficient practice. Systemic changes The Corporate Nurse Consultant will educate the Administrator and AD on Resident Council policy and procedures to ensure that concerns presented from Resident Council are documented on a Grievance Form as a Resident Council group concern. In addition, the education will include the AD□s responsibility to advise the Resident Council members each month of the resolutions to the previous months concerns. This education will be completed on 10-07-22. Monitoring An audit tool was developed to include the following: " Were concerns presented at Resident	

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F 565	Continued From page 5 documented concerns from the Resident Council from May 2022 through August 2022. On 09/21/22 at 9:25AM an interview was conducted with the Resident Council group which consisted of 7 of 8 residents that participated in Resident Council regularly (Residents #76, #32, #18, #30, #11, #16 and #42). The group stated they did not receive feedback from staff when group concerns were voiced. They further voiced they have complained multiple times regarding snacks not being delivered or offered to them, call lights not answered in a timely manner, not receiving ice/water consistently, and not being able to choose the time of their scheduled shower. The residents present for the Resident Council interview expressed verbalize the same things every month, but nothing gets resolved. During an interview on 09/20/22 at 4:39PM the Activities Director (AD) revealed that when she received a complaint during the Resident Council meeting, she would write the grievance up with the resident name that first voiced the complaint. The AD further explained she did not document the complaint as a group grievance. The AD would then provide the individual grievance to the department that it related to. The responsible department would address the issues on the grievance and return the grievance forms to the Social Worker. The facility's response to the concerns voiced during the previous meeting were not reviewed or discussed during the following month's meeting. She was not aware of any repeat concerns voiced at the Resident Council meetings. An interview with the Social Worker on 09/21/22 at 2:26PM revealed that if a complaint was made	F 565	Council documented on a grievance form? " Was there documentation that the resolutions to the previous months concerns were addressed with the Resident Council? The Administrator will complete these audits monthly x 3 months. The results of these audits will determine the need for further monitoring. All results will be brought to our monthly Quality Assurance and Performance Improvement Committee meeting monthly by the Administrator.	

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F 565	Continued From page 6 in Resident Council the Activities Director would write the grievance form up with the individuals name who was making the original complaint. She stated if more than one individual was voicing a concern, the AD would write a separate grievance for each person. Group grievances were not captured during the Resident Council meeting. The grievance was then given to the department head that was responsible for the area of concern and then returned to her after completion for filing. She stated there was not a separate binder dedicated to Resident Council meetings, only individual grievances. Interview with the Director of Nursing (DON) and the Administrator on 09/22/22 at 10:31AM revealed that their expectation was for the AD to fill out a grievance for each person that had a complaint/grievance and distribute them to the department head to address. If more than 1 resident complained, then a grievance for each individual resident was to be filled out. The grievances should be resolved and then reviewed at the next Resident Council meeting. They were not aware of any repeat concerns voiced at the Resident Council meetings.	F 565		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other	F 585		9/23/22

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F 585	Continued From page 7	F 585		

residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process,

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receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

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F 585	Continued From page 9 (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record reviews and resident, family and staff interviews, the facility failed to provide a written grievance response summary for 5 of 8 residents reviewed for grievances (Residents #33, #62, #23, #36 and #68). The findings included: A review of the facility grievance policy, dated 11/28/16, included, in part, "the resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the administrator, or his or her designee. The resident will be offered a copy of the written grievance decision". 1. Resident #33 was originally admitted to the facility on 7/4/22. An admission Minimum Data Set (MDS) assessment dated 7/7/22, indicated Resident #33 had severe cognitive impairment. Review of the facility grievance logs from November 2021 until September 2022 indicated one grievance was initiated on 7/18/22 for Resident #33, by the responsible party (RP), regarding dissatisfaction with the room. The form indicated the Social Worker (SW) spoke with the family member with a resolution on 7/19/22 and was signed by the Administrator on 7/19/22. The form indicated a verbal resolution was provided.	F 585	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F 585 Residents affected by the alleged deficient practice The following grievance decisions were given to the resident or mailed to the Responsible Party (RP) on 09/23/2022 by the Social Worker. • Resident #33, grievance dated 7-18-22 (mailed to RP) • Resident #62, three grievances dated 3-17-22 – (mailed to RP) • Resident #23 grievances dated 7-26-22, 8-2-22 and 9-11-22 were given to the resident • Resident #36 grievances dated 2-24-22, 3-28-22 and 5-25-22 were given to the resident • Resident #68 grievances dated 05-23-22, 07-01-22, 08-30-22, 09-02-2022, and 09-15-2022 (mailed to RP) Residents #33, #62, #23, #36, and #68 were not adversely affected by the alleged deficient practice. Residents with the potential to be affected	

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F 585	Continued From page 10 There was no indication a written summary was provided, offered, or requested by/to the RP. On 9/21/22 at 9:41 AM, an interview was conducted with the SW, who stated she logged all the grievance forms, and concerns were investigated by the appropriate department head. She went on to explain after the department head completed the investigation they would call/or speak with the person filing the grievance and provided the resolution verbally. A written copy was only provided to the ones that requested it, but she couldn't remember anyone that had requested a copy recently. A phone interview occurred with Resident #33's RP on 9/21/22 at 3:22 PM, who stated she had received verbal resolution of the past grievance concern but had not been offered or provided a summary in writing. The Administrator was interviewed on 9/22/22 at 10:33 AM and stated he was unaware a written summary of the grievance was not being provided at all times. The Administrator added, it was his expectation for the facility to adhere to the regulatory guidance regarding written grievance response summaries. 2. Resident #62 was admitted to the facility on 3/11/22. A quarterly MDS assessment dated 8/4/22 indicated Resident #62 was cognitively intact. Review of the facility grievance logs from November 2021 until September 2022 indicated three grievance forms were initiated by the RP for Resident #62 on 3/17/22 regarding missing items,	F 585	The grievance log for September was reviewed by the Social Worker on 9-23-22 to ensure that written grievance decisions were offered and provided to the resident/representative and that this was documented on the grievance form. All individuals who wrote a grievance in the month of September were either hand delivered or mailed a copy of the grievance decision by Social Worker on 9-23-22. No resident was adversely affected by the alleged deficient practice. Systemic changes The Corporate Nurse Manager educated the Administrator on the grievance process on 09-23-22. This education included the regulation that the resident/representative must be offered/provided with a written copy of the grievance decision when the grievance decision is issued. The Administrator educated the Social Worker on 9-23-22 to ensure that the resident/representative is offered and provided a copy of the grievance decision when the grievance decision is issued. This can either be hand delivered or mailed to the resident/representative. Monitoring An audit tool was developed which included the following: • Was the resident/representative offered a written copy of the grievance	

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facility communication and room changes. The forms indicated the appropriate department heads spoke with the RP on 3/21/22 regarding the resolutions and were signed by the Administrator on 3/21/22. The forms indicated only a verbal resolution was provided. There were no indications written summaries were provided, offered, or requested by/to the RP/resident.

On 9/21/22 at 9:41 AM, an interview was conducted with the SW, who stated she logged all the grievance forms, and it was investigated by the appropriate department head. She went on to explain after the department head completed the investigation they would call/or speak with the person filing the grievance and provided the resolution verbally. A written copy was only provided to the ones that requested it, but she couldn't remember anyone that had requested one recently.

On 9/21/22 at 2:00 PM, an interview occurred with Resident #62 who stated he had not received anything in writing regarding the concerns his RP had voiced.

A phone interview occurred with Resident #62's RP on 9/21/22 at 3:19 PM, who stated she could only recall getting verbal notification of the grievance resolutions.

The Administrator was interviewed on 9/22/22 at 10:33 AM and stated he was unaware a written summary of the grievance was not being provided at all times. The Administrator added, it was his expectation for the facility to adhere to the regulatory guidance regarding written grievance response summaries.

decision?
- Was this documented on the grievance form?

Administrator will audit 50% of all grievances weekly for four weeks, then 25% monthly for 2 months to ensure compliance with the plan of correction. The results of these audits will determine the need for further monitoring.

All results will be brought to the Quality Assurance and Performance Improvement Committee meeting monthly by the Administrator.

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3. Resident #23 was admitted on 8/2/19 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

Her quarterly Minimum Data Set dated 7/6/22 indicated she was cognitively intact and exhibited no behaviors.

Review of the facility grievance list included written intakes on behalf of Resident #23 on 7/26/22, 8/2/22 and 9/11/22. The grievance form indicated Resident #23 was provided verbal investigation findings and actions but nothing was provided in writing.

An interview was completed on 9/20/22 at 4:30 PM with Resident #23. She confirmed the Social Worker (SW) completed grievances on her behalf for the dates listed above. Resident #23 stated she did not receive anything in writing about her grievance, but the SW did follow up with her verbally.

An interview was completed on 9/21/22 at 9:41 AM with the SW. She stated she was responsible for keeping up with and assigning the grievances to the appropriate department head to investigate and intervene. After the investigation, the department head would follow up with the person filling the grievance and if the person filing the grievance wanted a copy of the investigation findings, action/resolution, a copy the grievance form was given to him/her. The SW stated she did not provide a copy of the grievance investigations with resolutions to Resident #23.

An interview was completed on 9/22/22 at 10:30 AM with the Administrator. He stated he thought the SW was providing a written response to each

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grievance, but he recently found out she only provided the written resolution if it was requested.
4. Resident #36 was admitted on 3/15/2017 with diagnoses that included chronic kidney disease.

Resident #36's quarterly Minimum Data Set (MDS) dated 7/13/2022 indicated the resident was cognitively intact.

The facility's grievance log for February 2022 through August 2022 revealed Resident #36 filed the following grievances:

On 2/24/2022 Resident #36 filed a grievance regarding food. She stated the food was bland and did not have any seasoning. She also stated dietary had failed to provide snacks for residents.

On 3/28/2022 Resident #36 filed a grievance regarding food. She stated the meat served to her was tough and dry.

On 5/25/2022 Resident #36 filed a grievance regarding condiments with meals. She stated the kitchen did not put condiments on the meal trays for residents. Meals were served without any condiments.

An interview was conducted with Resident #36 on 9/19/2022 at 11:14 AM. She stated she did not get a written resolution for the grievances she filed regarding food and the food had not changed nor had the facility provided snacks as requested.

On 9/21/2022 at 9:41 AM an interview was conducted with the Social Worker (SW). She stated she maintains the grievance log and all the grievance forms. The grievance form was given

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to the appropriate department head to investigate and resolve. After the investigation, the department head contacted the person filling the grievance. If the person filing the grievance wanted a copy of the investigation and findings, action/resolution, a copy of the grievance form was given to them. She did not recall anyone requesting a copy of the grievance form.

On 9/21/2022 at 9:58 AM an interview was conducted with the Director of Nursing (DON). She stated the SW gave her grievance forms. She investigated the grievance. After the investigation, she would call the person who filed the grievance and discuss the result of her investigation and what actions were taken. The DON did not provide a written copy of the grievance to the complainant and did not know regulations stipulated a written copy should have been provided.

5. Resident #68 was admitted to the facility on 1/21/16 with multiple diagnosis including dementia. The quarterly Minimum Data Set (MDS) assessment dated 8/24/22 indicated that Resident #68 had severe cognitive impairment.

Review of the facility's grievance log revealed that Resident #68's family member had reported 5 grievances in the last 4 months.

The grievance reporting forms revealed that on 5/23/22, a family member had reported a grievance regarding lack of activities of daily living (ADL) care, on 7/1/22 regarding food/dietary concerns, on 8/30/22 regarding lack of ADL care, 9/2/22 regarding lack of ADL care and on 9/15/22 regarding lack of ADL care.

The grievance reporting forms dated 5/23/22,

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8/30/22 and 9/2/22 revealed that investigation findings, action/resolution and the grievance decision were reported/given to the person filing the grievance verbally on 5/25/22, and 9/4/22.

The grievance reporting forms dated 7/1/22 and 9/15/22 revealed that investigation findings, action/resolution and the grievance decision were reported to the person filing the grievance on 5/25/22, and 9/4/22. The report did not indicate whether the forms were reported/given verbally or in writing.

A family member of Resident #68 was interviewed on 9/21/22 at 9:36 AM. The family member stated that she had reported grievances to the facility staff on 5/23/22, 7/1/22, 8/30/22, 9/2/22 and 9/15/22. She indicated that a staff member had called and told her what actions were taken to correct her grievances. She stated that she had never received any responses in writing regarding her grievances and she would prefer to have a copy of the grievance report with the resolution.

The Social Worker (SW) was interviewed on 9/21/22 at 9:41 AM. The SW stated that she was responsible for the grievance and keeps all the grievance forms. She reported that the grievance form was given to the department head (depends on the type of grievance) to investigate and to resolve the grievance. The department head would call the person filing the grievance and discuss the resolution. After the investigation, the completed form was returned to the SW for filing. If the person filing the grievance wants a copy of the grievance form, a copy is provided.

The Director of Nursing (DON) was interviewed

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F 585	Continued From page 16 on 9/21/22 at 9:58 AM. The DON stated that the SW was responsible for the grievance. The SW gives her the grievance form if the grievance was related to nursing. She then investigates and takes action to resolve the grievance. She calls the person filing the grievance. She submitted back the completed grievance form to the SW. The Administrator was interviewed on 9/22/22 at 10:23 AM. The Administrator stated that he expected the SW to provide a copy of the completed grievance form to the person filing the grievance. He indicated that he was not aware that the SW was not providing a written copy of the grievance form with the resolution to the person filing the grievance.	F 585		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews, the facility failed to provide treatments as ordered by the physician for a non-pressure related surgical wound on the left hip for 1 of 2 residents reviewed for wounds (Resident #236). The findings included:	F 684	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care.	10/14/22

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F 684	Continued From page 17 Resident #236 was admitted on 9/8/2022 with diagnoses that included stage 3 pressure injury to the sacrum, deep tissue injury (DTI) to the right great toe, and non-pressure related surgical wound to the left hip. The resident's Minimum Data Set (MDS) was not available. Resident #236's baseline care plan dated 9/12/2022 had a focus for pressure injury, stage 3, to the sacrum, deep tissue injury to the right great toe, and non-pressure related surgical wound to the left hip. The resident's active physician's orders revealed an order dated 9/8/2022 to clean surgical wound to right hip with normal saline, pack with Dakins soaked gauze, and cover with dry dressing twice daily. Resident #236's September 2022 Medication Administration Record (MAR) was reviewed and revealed the wound care to the resident's left hip had not been documented as completed or refused on the following dates: 9/8/2022 (7:00 PM to 7:00 AM) 9/9/2022 (7:00 PM to 7:00 AM) 9/10/2022 (7:00 PM to 7:00 AM) Review of nursing progress notes did not indicate Resident #236 refused wound care treatment on 9/8/2022, 9/9/2022 or 9/10/2022. On 9/19/2022 at 10:56 AM an interview was conducted with Resident #236. He stated wound care to his left hip was not completed twice daily. Attempts to contact Nurse #10, assigned to	F 684	F684 Resident Affected: Resident #236 did have his treatments completed, as ordered, by the assigned licensed nursing staff after the clarification of the doctor□s order was received on 9-11-22. The wound doctor and treatment nurse completed a full assessment of all wounds on resident #236 on 9-22-22. None of the wounds worsened as a result of the alleged deficient practice. Residents with Potential to be Affected: The Director of Nursing (DON), Minimum Data Set (MDS) nurse #1, MDS Nurse #2 and Registered Nurse Supervisor audited 100% of all current treatment orders on 9-22-22 to ensure that all treatments were completed as ordered. There were no additional residents affected by the alleged deficient practice. Systemic changes: All licensed nursing staff will be educated by the DON or the Staff Development Coordinator (SDC) to ensure that they contact the doctor to clarify treatment orders. If the doctor is unable to be reached the nurses must contact the DON or the RN Supervisor to get clarification. This will be completed by 10-14-22. Any licensed nurse on PRN status or out on leave will be educated by the DON or SDC on this process prior to returning to duty. Any newly hired licensed nursing staff will be educated by the SDC on this process during orientation. Monitoring:	

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F 684	Continued From page 18 Resident #236 on night shift 9/8/2022 were not successful. Nurse #10 documented she did not complete wound care because wound care order did not specify what strength of Dakins solution to use on the wound. On 9/21/2022 at 1:28 PM a telephone interview was conducted with Nurse #9. She stated she was assigned to Resident #236 on 9/9/2022 and she did not complete the wound treatment to the left hip because there was no clarification to what strength of Dakins solution to use on the wound. She further stated she did not call anyone or look at the resident's discharge summary for clarification. Attempts to contact Nurse #7, assigned to Resident #236 on night shift 9/10/2022 were not successful. Nurse #7 documented she did not complete wound care due to "waiting on clarification". On 9/22/2022 at 10:33 AM an interview was conducted with the Director of Nursing (DON). She stated to her knowledge there was only one strength of Dakins solution on the treatment cart. She further stated she expected nursing staff to call her or the treatment nurse immediately if wound care orders needed clarification.	F 684	An audit was developed to monitor for the following: " Does any treatment order require clarification by the physician? " Have all treatments been completed as ordered? The treatment nurse and the RN Supervisor will be auditing 100% of any new treatment order weekly x 4 weeks, then 50% weekly x 4 weeks, then 50% monthly x 1 month. The results of these audits will determine the need for further monitoring. Results of this audit will be brought to our monthly Quality Assurance and Performance Improvement Committee meeting monthly x 3 months by the Treatment Nurse.	
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	F 686		10/14/22

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F 686	Continued From page 19 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, observations and interviews, the facility failed to ensure alternating pressure reducing mattresses were set according to the residents' weights for 3 of 10 residents (Residents #236, #78 and #68) reviewed for pressure injuries. The findings included: 1. Resident #236 was admitted on 9/8/2022 with diagnoses that included stage 3 pressure injury to the sacrum, deep tissue injury (DTI) to the right great toe, and non-pressure related injury to the left great toe. The resident's Minimum Data Set (MDS) was not available. Resident #236's baseline care plan dated 9/12/2022 had a focus for pressure injury, stage 3, to the sacrum. The resident's medical record included a visit summary by the Wound Care Physician dated 9/14/2022. The summary indicated Resident #236 had a full thickness injury to the sacrum that measured .05 x .05 x 0.2 centimeters (cm). The etiology of the injury was pressure, and it was stage 3.	F 686	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F686 Resident Affected The treatment nurse set the alternating pressure reducing mattress to the accurate setting according to the residents weight for Resident #236, Resident #78, and Resident #68 on 09-20-22. Residents with Potential to be Affected On 09-20-22, The Director of Nursing (DON) and the Registered Nurse Supervisor (RN Supervisor) checked 100% of all residents on alternating pressure reducing mattresses to ensure that the mattress setting was set according to the residents weight. One other residents air mattress was found to be set to the incorrect setting for the residents weight. The setting was	

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F 686	Continued From page 20 During a wound care observation on 9/20/2021at 11:50 AM the resident was on an alternating pressure reducing mattress. The mattress was set on 250 pounds (lbs). After the wound care observation, the treatment nurse was interviewed. When asked how the alternating pressure reducing mattress should be set, she stated it should be set to the resident's weight. The treatment nurse observed the mattress to be set at 250 lbs. and stated she thought the resident was 250 lbs. She stated she checked the mattress for function, but she did not check the settings. She further stated the nursing supervisor was responsible for making sure the mattresses were set correctly according to the resident's weight. Resident #236's medical record indicated he was weighed on 9/16/2022 and was 188.7 lbs. On 9/20/2022 at 3:50 PM an interview was conducted with the nursing supervisor. She stated she was responsible for checking the alternating pressure reducing air mattresses for proper settings. She further stated she completed a check weekly. She checked the mattresses last week but had not checked them this week. She did not know why or how the mattress settings got changed. An interview was conducted with the Wound Care Physician on 9/21/2022 at 11:55 AM. He stated the alternating pressure reducing mattresses should be set according to the resident's weight unless the manufacturer's recommendations stated otherwise.	F 686	immediately corrected to be set according to the resident□s weight by the DON. Systemic Changes All licensed nursing staff & Certified Nursing Assistants (CNA□s) will be educated by 10-7-22 by the Staff Development Coordinator (SDC). This education will include that all residents on alternating pressure reducing mattresses must have their mattresses set according to their weight. The RN Supervisor was also educated by the DON to ensure all alternating pressure reducing mattresses are checked weekly to ensure that the mattress is set to the correct setting according to the resident□s weight. Any licensed nursing staff and CNA□s out on leave or PRN status will be educated by the SDC prior to returning to duty. Any newly hired licensed nurse or CNA□s will be educated by the SDC during orientation. Monitoring An audit tool was developed and included the following: " Is the alternating pressure reducing mattress set to the resident□s current weight? The treatment nurse will audit 50% of all residents on alternating pressure reducing mattresses weekly x 4 weeks, then 25% monthly x 2 months. The results of these audits will determine the need for further monitoring. This audit was started on 9-23-22. All results will be brought to our monthly	

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F 686	Continued From page 21 On 9/22/2022 at 10:33 AM, an interview was conducted with the Director of Nursing (DON). She stated the staff may have turned the settings up when they provided incontinence care and forgot to place them back on the correct setting when they were done. She stated she expected the alternating pressure reducing mattresses to be set according to the resident's weight. 2. Resident #78 was admitted to the facility on 10/23/18 with diagnoses that included intracerebral hemorrhage and a pressure ulcer of the sacral region. Resident #78's active physician orders included an order dated 7/26/19 for a pressure relieving specialty mattress. Assess for inflation and proper functioning twice a day. Resident #78's weight on 7/13/22 was 145.2 pounds (lbs.). A quarterly Minimum Data Set (MDS) assessment dated 7/17/22 indicated Resident #78 had severely impaired decision-making skills. She was coded with one stage 4 pressure ulcer and had a pressure reducing device to the bed. Resident #78's weight on 9/16/22 was 152.0 lbs. On 9/19/22 at 10:00 AM, an observation was made of Resident #78 while she was lying in bed. The alternating pressure reducing mattress machine was set at 350 lbs. per weight setting. The machine had settings of 50 lbs., 100 lbs., 150 lbs., 200 lbs., 250 lbs., 300 lbs., and 350 lbs. and indicated to set according to the resident's weight per pounds. Resident #78 was observed lying in bed on	F 686	Quality Assurance and Performance Improvement Committee meetings monthly x 3 months by the Treatment nurse.	

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9/20/22 at 10:00 AM. The alternating pressure reducing mattress machine was set at 350 lbs.

On 9/20/22 at 2:45 PM, an interview occurred with the Treatment Nurse and Nurse #6, who stated when they checked the alternating pressure reducing mattresses, they were ensuring the lines were connected and the machine was functioning properly but was unaware of the weight settings. Both nurses verified the weight was set at 350 lbs. and should have been set according to Resident #78's weight.

An interview was conducted with the Wound Care Physician on 9/21/22 at 11:55 AM. He stated the alternating pressure reducing mattresses should be set according to the resident's weight unless the manufacturer's recommendations stated otherwise.

On 9/22/2022 at 10:33 AM, an interview was conducted with the Director of Nursing (DON). She stated the staff may have turned the settings up when they provided incontinence care and forgot to place them back on the correct setting when they were done. She stated she expected the alternating pressure reducing mattresses to be set according to the resident's weight.

3. Resident #68 was admitted to the facility on 1/21/16 with multiple diagnosis including dementia and basal cell carcinoma of skin. The quarterly Minimum Data Set (MDS) assessment dated 8/24/22 indicated that Resident #68 had severe cognitive impairment and she needed extensive assistance with bed mobility. The assessment further indicated that the resident had stage 3 and unstageable pressure ulcers and she weighed 97 pounds (lbs.).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 23	F 686		

Resident #68 had doctor's orders dated 9/12/22 to clean area to the right hip and coccyx with normal saline, apply calcium alginate and cover with dry dressing daily.

Resident #68's care plan dated 9/19/22 was reviewed. One of the care plan problems was unstageable pressure ulcers to the left hip and coccyx. The goals were for the pressure ulcers to decrease in size and not to exhibit signs of infection.

Resident #68 was observed in bed on 9/19/22 at 10:47 AM and at 4:05 PM and on 9/20/22 at 9:45 AM. She had an alternating pressure relieving mattress and the weight setting was at 350 lbs.

The Treatment Nurse was interviewed on 9/20/22 at 3:45 PM, She stated that the Registered Nurse (RN) Supervisor was responsible for checking the pressure relieving mattress for proper functioning. She reported that Resident #68's pressure relieving mattress was supposed to be set according to the resident's weight.

The RN Supervisor was interviewed on 9/20/22 at 3:50 PM. She verified that she was responsible for checking the pressure relieving mattress for proper functioning. She reported that she checks the pressure relieving mattresses weekly but did not get the chance to check them this week. The RN Supervisor indicated that Resident #68's pressure relieving mattress should have been set according to her weight.

The Director of Nursing was interviewed on 9/22/22 at 10:38 AM. The DON indicated that she expected the pressure relieving mattress to

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F 686	Continued From page 24 be set according to the manufacturer's instruction. She stated that Resident #68's pressure relieving mattress should have been set according to her weight. She added that nursing assistants might have turned the knob of the pressure relieving mattress to firm during care and forgot to turn it back to the correct setting.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to obtain a Physician's order for a resident's use of continuous oxygen (Residents #33 and #68). This was for 2 of 2 residents reviewed for respiratory care. The findings included: 1. Resident #33 was initially admitted to the facility on 7/4/22 with the most recent readmission date of 9/9/22. Her diagnoses included chronic obstructive pulmonary disease (COPD) and coronary artery disease. An admission Minimum Data Set (MDS) assessment, dated 7/7/22, indicated Resident	F 695	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F695 Resident affected On 09-21-22, the Registered Nurse Supervisor (RN Supervisor) contacted the Medical Director and obtained a physicians order for Resident #33 for oxygen at 2 liters per minute via nasal cannula to be used continuously. On 09-	10/14/22

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F 695	Continued From page 25 #33 had severe cognitive impairment. Review of the nursing progress notes revealed on 8/21/22, Resident #33 had low oxygen saturations and was started on oxygen at 2 liters flow by nasal cannula. On 8/22/22 Resident #33 was sent to the Emergency Room (ER) for further evaluation of shortness of breath and increased fatigue and was admitted to the hospital and readmitted to the facility on 8/29/22. Review of the August 2022 physician orders included an order for oxygen at 2 liters via nasal cannula to maintain oxygen saturations above 90% every shift, as needed. The order was dated 8/21/22 and discontinued on 8/29/22. There were no orders for oxygen at 2 liters from 8/29/22 to 8/31/22. Review of the hospital discharge summary dated 8/29/22 revealed Resident #33 would be on 2 liters of oxygen due to COPD. A nursing progress note dated 9/4/22 indicated Resident #33 was transferred to the hospital for a condition unrelated to her COPD and was readmitted to the facility on 9/9/22. Review of the hospital discharge summary dated 9/9/22 indicated Resident #33 was on 2 liters of oxygen due to her COPD. A review of the September 2022 physician orders did not include an order for the use of oxygen at 2 liters. A review of Resident #33's medical record revealed physician progress notes dated 9/15/22 and 9/19/22 indicated oxygen was in place at 2	F 695	21-22, the RN Supervisor contacted the Medical Director and obtained a physicians order for Resident #68 for oxygen at 3 liters per minute via nasal cannula to be used continuously. Resident #33 and Resident #68 were not adversely affected by the alleged deficient practice. Residents with potential to be affected On 09-21-22, the Director of Nursing (DON) and the RN Supervisor audited 100% of all residents in the facility that were using oxygen to ensure that there was a physicians order for its use. During this audit all residents using oxygen had a physicians order for its use. No other resident was adversely affected by the alleged deficient practice. Systemic changes All licensed nursing staff will be educated by the DON or RN Supervisor by 10-14-22 on the following: "A physicians order must be obtained to administer oxygen to any resident. Any licensed nursing staff out on leave or PRN status will be educated by the Staff Development Coordinator (SDC) prior to returning to duty. Any newly hired licensed nursing staff will be educated by the SDC during orientation. Monitoring An audit tool was developed which included the following: "Is there a physicians order for the use of oxygen? The RN Supervisor will audit 50% of residents that are using oxygen weekly for	

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F 695	Continued From page 26	F 695		

liters.

In an observation on 9/19/22 at 9:40 AM, Resident #33 was lying in bed with oxygen running at 2 liters via concentrator.

Resident #33 was observed lying in bed watching TV on 9/20/22 at 3:05 PM. Oxygen was being used at 2 liters via a concentrator.

In an interview on 9/20/22 at 3:50 PM, the Clinical Care Coordinator (CCC) stated oxygen could be initiated as needed per standing orders when a resident was in need, however the physician should be notified after oxygen was started and an order written for the use of oxygen. She stated Resident #33 was using oxygen continuously. After reviewing Resident #33's medical record, the CCC confirmed an order for oxygen was not in place and felt like it had fallen off the physician orders due to recent hospitalizations.

2. Resident #68 was admitted to the facility on 1/21/16 with multiple diagnosis including dementia and basal cell carcinoma of skin. The quarterly Minimum Data Set (MDS) assessment dated 8/24/22 indicated that Resident #68 had severe cognitive impairment.

Review of Resident #68's doctor's orders revealed that there was no order for the use of oxygen.

A nurse's note dated 9/9/22 at 6:59 PM revealed that Resident #68's oxygen saturation was 83% at bedtime and oxygen at 2 liters (L) per minute was administered via nasal canula (written by Nurse # 4). Nurse #4 was interviewed on 9/21/22 at 11:18 AM. She verified that she was assigned to Resident #68 on 9/9/22 and remembered

four weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will determine the need for further monitoring. This audit was started on 9-23-22.

All results will be brought to our monthly Quality Assurance and Performance Improvement Committee meeting monthly x 3 months by the RN Supervisor.

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F 695	Continued From page 27 starting the oxygen due to low oxygen saturation. Nurse #4 reported that the facility has a standing order to start the oxygen at 2L per minute. She also indicated that she should have written the order for the use of the oxygen, but she forgot. Resident #68 was observed in bed on 9/19/22 at 10:47 AM and at 4:05 PM on oxygen at 3L/ minute via nasal canula. On 9/20/22 at 3:40 PM, MDS Nurse #1 observed and verified that Resident #68 was on oxygen at 3L per minute. Interview with the Registered Nurse (RN) Supervisor was conducted on 9/20/22 at 3:50 PM. She stated that the facility has a standing order for the use of oxygen. She indicated that the nurses could start the oxygen using the standing order, but the nurse must notify the physician and must write an order for the use of the oxygen including how many liters of oxygen per minute. The RN Supervisor reviewed Resident #68's doctor's orders and verified that that was no order for the use of the oxygen. She stated that she would ensure an order was written for the use of the oxygen for Resident #68. The Director of Nursing (DON) was interviewed on 9/22/22 at 10:38 AM. The DON stated that nurses were expected to write an order for the use of oxygen. She revealed that the facility has a standing order to use oxygen at 2L per minute via nasal canula and could be titrated, but it needs to have a doctor's order.	F 695		
F 732 SS=B	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	F 732		10/14/22

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F 732	Continued From page 28 must post the following information on a daily basis: (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 review and staff interview, the facility failed to ensure the nurse staffing data that were posted daily were accurate for 7 of 30 days	F 732	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact	

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F 732	Continued From page 29 reviewed. Findings included: The daily nurse staffing data, and the daily nursing assignments were reviewed from 8/20/22 through 9/20/22 with the Human Resources (HR) staff. The daily staffing data, and the daily nursing schedule did not match on 7 (8/27/22, 8/28/22, 9/3/22, 9/4/22, 9/6/22, 9/17/22 and 9/18/22) of 30 days reviewed. 8/27/22 -2 Registered Nurses (RNs) on nurse staffing data - 1 RN on schedule 8/28/22 - 2 RNs on nurse staffing data - 1 RN on schedule 9/3/22 - 2 RNs on nurse staffing data - 1 RN on schedule 9/4/22 - 2 RNs on nurse staffing data - 1 RN on schedule 9/6/22 - 2 RNs on nurse staffing data - 1 RN on schedule 9/17/22 - 2 RNs on nurse staffing data - 1 RN on schedule 9/18/22 - 2 RNs on nurse staffing data - 1 RN on schedule The HR staff member was interviewed on 9/22/22 at 8:40 AM. She stated that she was responsible for completing and posting the nurse staffing data daily except on Saturday and Sunday. She indicated that she completes the nurse staffing form for the weekend and the RN Supervisor was supposed to check for accuracy before posting. She verified that the nurse staffing data on 8/27/22, 8/28/22, 9/3/22, 9/4/22, 9/6/22, 9/17/22 and 9/18/22 were not accurate on the number of RNs in the building.	F 732	Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F732 Resident affected The following daily staffing hours postings were corrected by the Human Resources Coordinator (HRC) on 09-23-22: 8-27-22, 8-28-22, 9-3-22, 9-4-22, 9-6-22, 9-17-22 and 9-18-22. No resident was adversely affected by the alleged deficiency. Residents with the Potential to be affected On 10-06-22, The Administrator audited 100% of the daily staffing hours postings from 09-20-22 through 10-05-22 to ensure that the postings accurately reflected actual staff working in the facility on those dates. There were no additional inaccuracies discovered. No resident was affected by the alleged deficient practice. Systemic Changes The HRC and all licensed registered nurses will be educated by the Administrator on the process for posting the daily staffing hours to ensure that the postings are accurate and reflect the staff working in the facility on the day of the posting. This education will be completed by 10-7-22. Any licensed registered nursing staff out on leave or PRN status will be educated by the HRC prior to returning to duty. Any newly hired licensed registered nursing staff will be educated by the HRC during orientation.	

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F 732	Continued From page 30 The Administrator was interviewed on 9/22/22 at 10:23 AM. He reported that currently, he did not have a weekend RN Supervisor. He will ensure that the RN working on the weekend will be responsible for checking the nurse staffing data for accuracy before posting.	F 732	Monitoring An audit tool was developed and included the following: Are the posted daily staffing hours accurate? The Administrator will audit 50% of the daily staffing hours postings weekly x 4 weeks, then monthly x 2 months. The results of these audits will determine the need for further monitoring. This audit started on 9-23-22. All results will be brought to our monthly Quality Assurance and Performance Improvement Committee meeting monthly x 3 months by the Administrator.	
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.	F 812		10/14/22

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F 812	Continued From page 31 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the vent filters and sprinkler pipe under the kitchen exhaust hood were free of grease buildup. The failure had the potential to affect food served to the residents. The findings included: An initial kitchen tour was completed on 9/19/22 at 9:15 AM with Dietary Manager (DM) #1. She stated she was filling in for DM #3 who was out on medical leave. The exhaust hood over the cooking surfaces revealed amber to dark brown grease build up on the vent filters. Also observed on the sprinkler pipe located to the far right of the hood over the fryer was what appeared to be several suspended drops of dark brown grease suspended from the pipe. There was a label on this end of the exhaust hood. DM #1 stated the label indicated the hood was last professionally cleaned in May 2022 and due again November 2022. Another interview was completed on 9/19/22 at 12:15 PM with DM #1. She stated she took down the vent filters and cleaned them since our previous observation. She stated in her facility, she took the vent filters down every 2 weeks and cleaned them whether they were dirty or not because 6 months was too long to go in between cleaning. Another observation was completed on 9/21/22 at 11:12 AM with the Dietary District Manager (DDM). The vent filters were clean and free of	F 812	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F812 Residents affected: The hood vents were taken down by the Maintenance Director and Dietary manager on 9-19-22 and the vent filters and sprinkler pipes under the exhaust hood were cleaned and put back in place by the Maintenance Director. The fire suppression system was cleaned by the Maintenance Director on 9-20-22. Residents with potential to be affected: All residents have the potential to be affected by the alleged deficient practice. There were no residents adversely affected by the alleged deficiency. Systemic changes The Dietary manager will educate all of kitchen staff regarding the following: " hood vents, vent filters and sprinkler pipes will remain free of grease buildup and will be cleaned biweekly. This will be completed by 10-07-22. The Dietary manager posted a hood cleaning	

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F 812	Continued From page 32 obvious grease buildup. The sprinkler pipe appearance over the fryer was unchanged. The DDM stated his contract agency were not allowed to touch the sprinkler pipes or sprinkler heads. He stated the vent filters were professionally cleaned every 6 months and should be cleaned as needed for grease buildup in between professional cleanings. An interview was completed on 9/21/22 at 4:20 PM with the Administrator. He stated the dietary department were contracted and he was not aware that the vent filters and sprinkler pipe over the fryer had significant grease buildup on 9/19/22 but he felt the failure was due to the lack of consistent leadership. He stated he asked his Maintenance Supervisor (MS) to check the exhaust hood and vent filters monthly. An interview was completed on 9/22/22 at 8:20 AM with MS. He stated he added checking the vent filters on the exhaust hood to his weekly computer generated list of items to do to ensure they were clean. MS stated he also cleaned the sprinkler pipe over the fryer as well. A telephone interview was completed on 9/22/22 at 8:32 AM with DM #3. She stated she went out on medical leave on 9/1/22 and prior to her leave, she cleaned the vent filters weekly.	F 812	schedule on 9-20-22. Any kitchen staff out on leave or PRN status will be educated by the Dietary Manager prior to returning to duty. Newly hired kitchen staff will be educated by the Dietary Manager during orientation. Monitoring An audit was developed and included the following: " Are the vent filters, hood vents and sprinkler pipes free of grease buildup? The Maintenance director will audit the hood vents, vent filters and sprinkler pipes biweekly x 3 months to ensure that they stay clean. This audit started on 9-20-22. The results of these audits will determine the need for further monitoring. The Maintenance director will bring all results to the monthly Quality Assurance and Performance Improvement Committee meetings monthly x 3 months for review and further recommendations.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in	F 842		10/14/22

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F 842	Continued From page 33	F 842		

accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

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F 842	Continued From page 34 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to have accurate medical records for 3 of 10 residents reviewed for wound care (Resident #286, #236 and #68). The findings included: 1. Resident #286 was admitted to the facility on 9/8/22 with diagnoses that included type 2 diabetes and osteomyelitis (infection of the bone). The baseline care plan dated 9/9/22 included surgical wound to right groin. Resident #286's active physician orders revealed an order dated 9/9/22, to cleanse the right groin	F 842	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F842 Resident Affected The Wound physician and the treatment nurse assessed all wounds on Resident #286, Resident #236, and Resident #68 on 9-22-22. No resident's wounds worsened due to the alleged deficient practice.	

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F 842	Continued From page 35 surgical wound with normal saline. Pack the wound with Dakin's (a solution with anti-infective properties) 0.5% soaked gauze and cover with a dry dressing twice a day. The September 2022 Medication Administration Record (MAR) was reviewed and revealed the right groin wound care had not been documented as completed or refused by the resident on the following days: - Day shift (7:00 AM to 7:00 PM) on 9/13/22, 9/15/22 and 9/16/22. - Evening shift (7:00 PM to 7:00 AM) on 9/9/22 and 9/11/22. Review of the nursing progress notes from 9/8/22 until 9/21/22 revealed Resident #286 did not refuse surgical wound care. A phone interview was completed with Nurse #5 on 9/21/22 at 11:25 AM, who scheduled for the day shift on 9/16/22. She explained wound care had been completed after the medication pass and Resident #286 had accepted. Nurse #5 stated she had forgotten to document the wound care as completed on the MAR. On 9/21/22 at 1:00 PM, an interview occurred with Nurse #6, who was scheduled for the day shift on 9/13/22 and 9/15/22. She reviewed the missing documentation for surgical care to Resident #286 and stated she recalled completing the wound care but had forgotten to document as completed on the MAR. On 9/21/22 at 1:23 PM, a phone interview was conducted with Nurse #9 who had been scheduled for the evening shift on 9/9/22. She was able to recall the surgical wound to Resident	F 842	Residents with Potential to be affected On 09-21-22, Minimum Data Set (MDS) nurse #1 and MDS nurse #2 audited the electronic treatment administration record (ETAR) for all pressure wounds in the facility for the week of 9-11-22 to 9-17-22. It was determined that 14 residents' treatments were not signed off as completed for all treatments provided. When interviewing nursing staff for the week of 9-11-22 to 9-17-22 it was determined that the treatments were completed as ordered but were not always documented as completed in the ETAR. The Wound Doctor observed all pressure wounds on these 14 residents on 9-22-22. No residents' wounds had worsened due to the alleged deficient practice. Systemic changes The Corporate Nursing Consultant will educate the treatment nurse and Staff Development Coordinator (SDC) on 10-7-22 on proper policy and procedures with regard to documenting completion of the treatment on the ETAR. The SDC will educate all licensed nursing staff on the policy and procedures with regard to documenting completion of treatments on the ETAR when completed. This will be completed by 10-14-22. Any licensed nurse out on leave or PRN status will be educated by the SDC or the treatment nurse prior to returning to duty. Any newly hired licensed nursing staff will be educated during orientation by the SDC.	

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F 842	Continued From page 36 #286's groin area and could not remember the resident refusing wound care. She verified the date in question and stated she forgot to sign the wound care as completed on the MAR. A phone interview took place on 9/22/22 at 7:45 AM, with Nurse #7 who had been scheduled for the evening shift on 9/11/22. She was able to recall completing Resident #286's wound care after the medication pass, but must have forgotten to document the surgical wound care as completed on the MAR. The Director of Nursing was interviewed on 9/22/22 at 10:33 AM, and indicated she expected the nursing staff to complete wound care as ordered ensuring it was documented as completed or refused by the resident. 2. Resident #236 was admitted on 9/8/2022 with diagnoses that included stage 3 pressure injury to the sacrum, deep tissue injury (DTI) to the right great toe, and non-pressure related injury to the left great toe. The resident's Minimum Data Set (MDS) was not available. Resident #236's baseline care plan dated 9/12/2022 had a focus for pressure injury, stage 3, to the sacrum, deep tissue injury to the right great toe, and non-pressure related injury to the left great toe. The resident's active physician's orders revealed an order dated 9/8/2022 to cleanse wound to left heel, cover with calcium alginate, and cover with dry dressing daily. He also had an active order dated 9/8/2022 to apply absorbase ointment (skin protectant and barrier cream) to the resident's	F 842	Monitoring An audit tool was developed and included the following: • Is the treatment documented as completed on the ETAR? • If no, was any refusal documented? The treatment nurse and the RN Supervisor will audit 25% of treatments weekly x 4 weeks, then 25% biweekly x 4 weeks, then 25% monthly x 1 month. The results of these audits will determine the need for further monitoring. All results will be brought to our monthly Quality Assurance and Performance Improvement Committee meeting monthly x 3 months by the treatment nurse.	

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F 842	Continued From page 37	F 842		

sacrum twice daily.

Resident #236's September 2022 Medication Administration Record (MAR) was reviewed and revealed the wound care to the resident's right heel and sacrum had not been documented as completed or refused for 9/10/2022 day shift.

Review of nursing progress notes did not indicate Resident #236 refused wound care treatment on 9/10/2022.

On 9/22/2022 at 9:08 AM an interview was conducted with the Director of Nursing. She stated she was assigned to Resident #236, day shift on 9/10/2022. She stated she completed the wound treatments but did not document them on the resident's MAR. It was an oversight. She further stated she expected wound care treatments to be completed or documented as completed.

3. Resident #68 was admitted to the facility on 1/21/16 with multiple diagnosis including dementia. The quarterly Minimum Data Set (MDS) assessment dated 8/24/22 indicated that Resident #68 had severe cognitive impairment.

Resident #68 had doctor's order dated 8/12/22 to paint deep tissue injury (DTI) to right 5th toe with betadine daily, on 8/19/22 to clean left dorsal foot with normal saline, apply xeroform and cover with transparent dressing daily, on 9/1/22 to paint left 1st toe with betadine daily and on 9/8/22 to clean right posterior heel wound with normal saline, apply calcium alginate (used to treat wounds with moderate to heavy exudates), cover with silicone foam dressing daily.

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F 842	Continued From page 38 Review of the September 2022 Treatment Administration Records (TARs) revealed that there was no nurse's initial to indicate that treatment was provided to Resident #68's pressure wounds on 9/9/22, 9/10/22, 9/12/22 and 9/16/22. The TARs revealed that Nurse #5 was assigned to Resident #68 on 9/9/22, 9/10/22 and 9/12/22 and the Treatment Nurse was assigned to the resident on 9/16/22. Nurse #5 was interviewed on 9/21/22 at 11:26 AM. She indicated that she was aware that nurses were responsible to provide the treatment when the Treatment Nurse was not available to provide the treatment. She verified that she was assigned to Resident #68 on 9/9/22, 9/10/22 and 9/12/22. She reported that she provided the treatment but missed to initial the TARs. The Treatment Nurse was interviewed on 9/21/22 at 11:30 AM. She reported that she was assigned to work on the floor on 9/16/22 and was assigned to the resident. She reported that she provided the treatments but forgot to the sign the TARs. The Director of Nursing (DON) was interviewed on 9/22/22 at 10:23 AM. The DON stated that she expected nursing to put their initials on the TARs to indicate that treatments were provided.	F 842		
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;	F 867		10/14/22

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F 867	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on record review, observation and Physician, resident and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedure and monitor interventions the committee put into place following the 4/8/21 recertification and complaint survey, 2/24/21 complaint survey and 8/22/19 recertification and complaint survey. This was for 5 deficiencies that were cited in the areas of Resident self-administration of medication, previously cited on 4/8/21 recertification and complaint survey, and recited on the current recertification and complaint survey of 9/22/22. In addition, Care Plan timing and revision, Respiratory/Tracheostomy care and Food Precurement, Store/Prepare/Serve-Sanitary were also cited during the recertification and complaint survey on 8/22/19 and Treatment/Services to Prevent/Heal pressure ulcers was cited on the complaint survey of 2/24/21 and recited on current recertification and complaint survey of 9/22/22. The duplicate citations during the 3 federal surveys of record showed a pattern of the facility ' s inability to sustain an effective QAPI program. Findings included: 1. F686 - Based on record review, observation and interview, the facility failed to ensure the alternating pressure reducing mattresses were set according to the residents' weights for 3 (Residents #236, #78 & #68) of 10 residents reviewed for pressure injuries. During a complaint survey of 2/24/21, the facility	F 867	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F867 "Root cause analysis: The Quality Assurance Performance Improvement (QAPI) failed to identify a reccurring issue in the following tags F686, F695, F812, and F554, and F657. Going forward the QAPI team will be focusing on the audit tools created in the Plans of Corrections (POCs). The QAPI team will be auditing the results of these audits monthly and making changes to the audits if there is not compliance with the POC. The audits tools created by the existing POCs time may have to be extended and the frequencies increased if the QAPI team see that the deficiency is not being corrected. To correct this deficiency the following items were completed "The QAPI policy was reviewed by the Administrator on 10-07-22. There were no changes required to the policy. "Facility QAPI committee members will be in-serviced by the Administrator and the Director of Nursing about the Quality Assurance Performance Improvement	

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F 867	Continued From page 40 failed to assess and to obtain a treatment order when the pressure ulcer was first identified for 1 (Resident #1) of 3 sampled residents reviewed for pressure ulcers. In an interview with the Administrator on 9/22/22 at 10:23 AM, he stated that the facility had experienced some challenges due to nursing shortages and turnover in management staff, which may have contributed to this repeat citation. 2. F695 - Based on record reviews, observations, resident, staff and Physician interviews, the facility failed to obtain a Physician's order for a resident's use of continuous oxygen (Residents #33 and #68). This was for 2 of 2 residents reviewed for respiratory care. During the recertification and complaint survey of 8/22/19, the facility failed to administer continuous oxygen as ordered for 1 (Resident #3) of 2 residents reviewed for respiratory care. In an interview with the Administrator on 9/22/22 at 10:23 AM, he stated that the facility had experienced some challenges due to nursing shortages and turnover in management staff. He added that the facility was utilizing agency nurses and nursing aides and he just hired a Staff Development Coordinator (SDC) who would be providing education to the staff. 3. F812 - Based on observation and staff interview, the facility failed to ensure the vent filters and sprinkler pipe under the exhaust hood were free of grease buildup. The failure had the	F 867	Committee, program and procedures by 10-14-22. QAPI committee members include: Medical Director, Pharmacy Consultant, Administrator, Director of Nursing, Minimum Data Set (MDS) nurses, Admission Coordinator, Social Worker, Business Office Manager, Staff Development Coordinator, Nursing Supervisor, Medical Records Manager, Maintenance Director, Housekeeping Supervisor, Dietary Manager, Treatment Nurse and Activities Director. "The in-service included: "Identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan, as necessary. "Committee members will understand how the QAPI Committee monitors issues and follows up with unresolved issues that have been identified. "A tool will be utilized to assist the QAPI committee. The tool, titled, QAPI Self-Evaluation, includes the following: o Does the QAPI committee have a current plan in place? o Does the committee identify who is responsible to oversee the plan/project? o Is the plan working? o If the plan is not working have changes been put in place to improve? o Is the outcome measurable? o Has the project been successful? o Can the plan be considered resolved?	

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F 867	Continued From page 41 potential to affect food served to the residents. During the recertification and complaint survey of 8/22/19, the facility failed to allow the meal trays to air dry before stacking together and ready for use for 14 meal trays observed. In an interview with the Administrator on 9/22/22 at 10:23 AM, he stated that the facility had a contracted dietary service. They are responsible for the sanitation in the kitchen including vent filters and sprinkle pipes under the exhaust hood. He reported that the Dietary Manager (DM) was on medical leave and there was no consistent DM in the kitchen to monitor. The Administrator indicated that the maintenance director would start to monitor and clean the exhaust hood routinely and as needed. 4. F554 - Based on observations, staff and resident interviews and record review, the facility failed to assess and obtain Physician orders for the self-administration of an as needed (prn) inhaler and a scheduled inhaler for 1 (Resident #23) of 1 resident reviewed for the self-administration. During the recertification and complaint survey of 4/8/21, the facility failed to assess and obtain a physician's order for the self-administration of an inhaler found in Resident #71's possession and failed to assess for the self-administration of an ointment for Resident #71. This was for 1 of 1 resident reviewed for self-administration of medications. In an interview with the Administrator on 9/22/22 at 10:23 AM, he stated that the facility had	F 867	"This tool was developed for a QAPI sub-committee to establish the successfulness of the QAPI projects and make recommendations as necessary. The sub-committee is made up of 3 members of the QAPI general Committee which will include the Director of Nursing, Staff Development Coordinator and the Administrator. Monitoring: "The Self-Evaluation tool will be completed by the sub-committee at scheduled meetings twice monthly prior to the next scheduled QAPI monthly meeting for 6 months. "Findings of the sub-committee will be addressed at the monthly QAPI meeting when all participants attend. "The Self-Evaluation tool will be utilized for 6 months; ongoing use of the tool will be determined by the prior 6 months of self-Evaluating the QAPI process. QAPI The results of the self-evaluation tool will be brought to the QAPI meeting monthly by the Administrator and reviewed by the QAPI team. The QAPI Team will make changes if necessary.	

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F 867	Continued From page 42	F 867		

experienced some challenges due to nursing and administrative staff turnover. He added that the turnover in the administrative staff might have contributed to this repeat citation.

5. F657 - Based on record review and staff interviews, the facility failed to review and revise the care plan in the area of falls. This was for 1 (Resident #139) of 11 residents reviewed for accidents.

During the recertification and complaint survey of 8/22/19, the facility failed to review and revise the care plan in the area of psychotropic medications for 1 (Resident #36) of 5 residents reviewed for unnecessary medications.

In an interview with the Administrator on 9/22/22 at 10:23 AM, he stated that the facility had experienced some challenges due to nursing and administrative staff turnover. He added that one of the MDS Nurses acted as the Director of Nursing (DON) temporarily until a full time DON was hired and this might have contributed to this repeat citation.