STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT GASTONIA	969 COX ROAD GASTONIA, NC 28054

(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 9/26/22 through 10/3/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #2XUS11.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness	E 001		11/11/22

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

Electronically Signed | 11/10/2022

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E 001	Continued From page 1 program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on policy review and Administrator interview, the facility (1) failed to have a written policy or plan for means of providing information about the facility's occupancy needs and its ability to provide assistance to the Incident Command Center or designee, (2) failed to have a written policy and procedure for maintaining documentation of emergency preparedness training to new and existing staff, individuals under contract and volunteers and (3) failed to provide documentation that they participated in a full-scale exercise or a tabletop exercise within the past one year. This had the potential to affect all residents in the facility. The findings included: 1. Review of the facility's Emergency Preparedness (EP) Plan revealed no written plan or policy for communicating information about the facility's occupancy needs or the facility's ability to provide assistance to other facilities with the Incident Commander during an emergency event.	E 001	E001 □ Regarding the alleged deficient practice of failure to develop and maintain a comprehensive emergency preparedness program as evidenced by: a. failed to have a written policy or plan for means of providing information about the facility's occupancy needs and its ability to provide assistance to the Incident Command Center b. failed to have a written policy and procedure for maintaining documentation of emergency preparedness straining to new and existing staff, individuals under contract and volunteers c. failed to provide documentation that they participated in a full-scale exercise or a tabletop exercise within the past one year. On 11/09/2022, the facility administrator established a written plan for means to provide information regarding the facility□s occupancy needs and its ability to provide assistance to the Incident Command Center, developed a written	

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E 001	Continued From page 2 An interview conducted with the Administrator on 9/29/22 at 3:00 PM and a phone interview on 9/30/22 at 9:31AM revealed the previous administration had no plan or policy in the EP manual. She stated she has been administrator at this facility since July 2022. She stated the Administrator was responsible for the EP plan and there was no written plan or policy in place for providing the information to the Incident Command Center. 2. Review of the facility's Emergency Preparedness (EP) Plan revealed no written plan or policy for maintaining documentation of emergency preparedness training to new and existing staff, individuals under contract and volunteers. An interview conducted with the Administrator on 9/29/22 at 3:00 PM and a phone interview with the administrator on 9/30/22 at 9:31AM revealed the previous administration had no plan or policy in the EP manual. She stated she has been administrator at this facility since July 2022. She confirmed the Administrator is responsible for the EP plan and there was no written plan or policy in place for maintaining documentation of emergency preparedness training to new and existing staff, individuals under contract and volunteers. 3. Review of the facility's Emergency Preparedness (EP) Plan revealed no documentation that the facility participated in a full-scale exercise or tabletop exercise within the past one year. The review revealed documentation of a full-scale exercise in 2020.	E 001	policy and procedure for maintaining documentation of Emergency Preparedness training to new and existing staff, individuals under contract and volunteers. This plan will be reviewed annually and as needed per the Quality Assurance and Performance Improvement (QAPI) Committee recommendations. On 11-03-2022 the facility participated in a tabletop exercise in preparation for an emergency. On 11-02-2022 education was provided by the Administrator to the Maintenance Director on Emergency Preparedness, required documentation, coalition planning, all staff training, and necessity of mock planning exercises. On 11-02-2022, education was provided to the Human Resources Director, Maintenance Director, Director of Nursing (DON), and the Assistant Director of Nursing (ADON) regarding maintaining documentation of Emergency Preparedness training to new and existing staff, individuals under contract and volunteers by the Administrator. Education was provided to all staff regarding emergency preparedness by the Administrator, DON, and ADON, beginning on 11/08/2022 and completed by 11/10/2022. Education will be provided to all newly hired or contracted staff and volunteers upon hire. The administrator will audit training records for 5 staff members each week for 4 weeks, then3 staff members each week for 4 weeks to ensure documentation of Emergency	

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E 001	Continued From page 3 An interview conducted with the Administrator on 9/29/22 at 3:00 PM and a phone interview on 9/30/22 at 9:31AM revealed she has been administrator at this facility since July 2022. She stated the Administrator was responsible for the EP plan and there was no documentation of a full-scale exercise or tabletop exercise within the past year.	E 001	Preparedness training. Administrator or DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Administrator or DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/26/22 through 10/3/22. Event ID# 2XUS11. The following intakes were investigated NC:00190982, NC 00191043, NC 00193033, NC 00192931 and NC 00187586. Six of the 12 complaint allegations were substantiated resulting in deficiencies (F689, F668 and F677). This statement of deficiency was issued late due to State server maintenance.	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:	F 558		11/11/22

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F 558	Continued From page 4 Based on observations, record review, resident, and staff interviews, the facility failed to provide a specialty/adaptive call bell for 1 of 1 resident reviewed for accommodation of needs (Resident #8). The findings included: Resident #8 was admitted to the facility on 10/19/2010 with diagnoses including diabetes, hemiplegia and high blood pressure. The most recent quarterly Minimum Data Set (MDS) dated 9/12/2022 assessed Resident #8 as cognitively intact and able to make decisions about his care. Resident #8 needed assistance with bed mobility, toileting and was always incontinent of bladder and bowel. The care plan last revised on 6/17/22 identified Resident #8 as having a self-care performance deficit related to history of a stroke, upper extremity contractures and hemiplegia. The care plan stated in part, "I utilize a pancake call bell. Keep within reach of hands or elbows." An observation and resident interview were conducted on 09/27/22 at 10:28 AM. Resident #8 was observed with contractures of both arms and both hands. A push button call bell was observed on the floor at the head of bed. He stated he wanted a call bell but could not use a push button call bell. He stated he needed the call bell that he could press but has been yelling out to get help when he needed it. An observation on 09/28/22 at 7:58 AM revealed the resident was lying in bed with his eyes closed and had no needs at that time. A push button call	F 558	F558 - Regarding the alleged deficient practice of failure to provide a specialty/adaptive call bell for 1 of 1 resident reviewed for accommodation of needs as evidenced by: a. Failure to have adaptive call light in place for resident #8 Resident #8 was provided the required pancake call light. The facility determined that all residents that use adaptive call lights have the potential to be affected by the alleged deficient practice; nursing staff conducted a facility wide audit of adaptive call lights on November 7, 2022 to ensure appropriate call lights are in place. Facility administrator provided education to the housekeeping supervisor, maintenance director, social services director & assistant, minimum data set (MDS) nurse, director of nursing (DON), and assistant director of nursing (ADON) regarding necessity of ensuring adaptive call lights are moved with resident in the event of room moves on 11/03/2022. Education for nursing and housekeeping staff began on 11/08/2022 with completion by 11/10/2022 Education will be provided to newly hired or contracted nursing staff upon hire prior to receiving an assignment. The DON or ADON will conduct audits for placement of adaptive call lights on three residents who use them three times per week for a period of four weeks; then the DON or ADON will conduct audits for placement of adaptive call lights on three residents who use them weekly for a period of four weeks.	

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F 558	Continued From page 5 bell was on the floor at the head of the bed. An interview was conducted with assigned nurse #1 on 09/28/22 at 10:27 AM. He stated Resident #8 was not able to use a push button call bell or a pancake call bell. He stated Resident #8 called out when he needed something. An interview was conducted with the MDS nurse #1 and the Social Work Assistant on 9/28/22 at 11:08 AM. The MDS nurse stated Resident #8 was moved from the 400 hall to the 200 hall on 6/13/22. The Social Work Assistant stated she was sure Resident #8 had the pancake bell while he was on the 400 hall. The MDS nurse stated a bedside care plan meeting was held on 7/13/22. The call bell should have been assessed at that time and noticed that he did not have the appropriate pancake call bell at that time. He should have the pancake call bell for which he was care planned. An observation on 09/29/22 at 8:20 AM revealed the push button call light was switched to a pancake call bell but was on the floor at the head of the bed. The resident had no needs at the time of the observation. An interview with assigned nurse aide #1, who was very familiar with Resident #8, was conducted on 09/29/22 11:01 AM. She stated when Resident #8 was on the 200 hall before, he could use the pancake call bell with his elbow before he was moved to the 400 hall. When he was moved back to the 200 hall several months ago, the special pancake call light was not brought with him. She stated the push button call bell was replaced with the pancake call bell yesterday afternoon. She stated she placed the	F 558	DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	

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F 558	Continued From page 6 pancake call bell underneath his hands yesterday, but he was unable to press it. An interview with MDS nurse #1 was conducted on 9/29/2022 at 11:30 AM. She stated a pancake call bell was put into place on 9/28/22. Resident #8 demonstrated multiple times the ability to appropriately use the pancake call bell if the pancake call bell was placed underneath his wrists. An interview conducted with the Administrator on 9/29/22 at 4:11 PM revealed this was isolated to one person so she needed to know why his call light was on the floor and why it was not the right kind of call light. Resident #8 needed to have a call light he could use with his contractures. A phone interview was conducted with the Director of Nursing on 9/30/22 at 10:31 AM. She stated the pancake call light should have been transferred with Resident #8 to the 200 hall in June and is unsure why it was not sent. Staff should have realized it was not available and reported it.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health	F 561		11/11/22

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F 561	Continued From page 7 care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to accommodate a resident's request to be assisted out of bed at their preferred time of day for 1 of 7 residents reviewed for choices (Resident #106). Findings included: Resident #106 was admitted to the facility on 04/02/18 with multiple diagnoses that included unspecified convulsions, spinal stenosis (narrowing of the spine), and tobacco use. The annual Minimum Data Set (MDS) dated 09/06/22 assessed Resident #106 with intact cognition. She required total staff assistance of two staff members with transfers and displayed no rejection of care during the MDS assessment period.	F 561	F561 - Regarding the alleged deficient practice of failure to accommodate a resident's request to be assisted out of bed at their preferred time of day for 1 of 7 residents reviewed as evidenced by: a. Resident #106 observed still in bed in the afternoon on two occasions, after reporting her preference to be out of bed in the morning after breakfast. Resident #106□s Kardex was updated on 09/29/2022 with her preferred time to be assisted out of bed and noted out of bed per her preference in the morning after breakfast on 09/30/2022. All residents requiring staff assistance with transfers have the potential to be affected by this practice. On 11/08/2022 an audit was conducted of all residents requiring assistance with transfers by the	

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F 561	Continued From page 8 Review of Resident #106's care plans, last reviewed/revised on 09/20/22, revealed a plan of care that addressed her need for help with ADL. Interventions included: please assist with all ADL that I am unable to complete independently but encourage me to do as much as possible for myself and I transfer using a mechanical lift, please help me to the degree that I need. During an interview on 09/26/22 at 3:34 PM, Resident #106 was lying in bed, dressed in a nightgown. Resident #106 voiced she preferred to be up out of bed before lunchtime because she liked to go outside to smoke after eating lunch. Resident #106 revealed she was not assisted up out of bed today because there was only one Nurse Aide (NA) on the hall. A subsequent observation conducted on 09/28/22 at 12:50 PM revealed Resident #106 was sitting up in bed, dressed in a nightgown, eating her lunch. A follow-up interview and observation was conducted with Resident #106 on 09/29/22 at 11:58 AM. Resident #106 was sitting up in bed and spoke with a slightly agitated, high-pitched tone. Resident #106 stated someone took her wheelchair out of the room yesterday and now no one can find it. She stated she didn't get assisted up out of the bed yesterday or so far today and wanted to get dressed and up in her wheelchair so she could go outside to smoke. During an interview on 09/29/22 at 12:00 PM, Nurse #3 confirmed Resident #106 liked to get up out of bed in the mornings so she could go outside to smoke and had been requesting to get	F 561	Assistant Director of Nursing to determine their preferred time to be assisted out of bed with this preference added to the CNA plan of care as needed, per audit findings. Resident preferences will be added to the CNA plan of care upon admission. Education provided to nursing staff regarding residents rights to choose their schedules by Administrator or Director of Nursing (DON) on 11/08/2022. Education to continue for nursing staff upon return to work, to be completed by 11/10/2022. Education will be provided to newly hired or contracted nursing staff by Administrator, Director of Nursing, or other member of nurse management team upon hire prior to receiving an assignment. Audit will be conducted by DON, Assistant Director of Nursing, or Infection Control Nurse of 5 residents requiring assistance to be transferred out of bed per week to ensure they are up, out of bed per their preference for 4 weeks, then 3 residents for 4 weeks. Administrator, DON, or Assistant Director of Nursing (ADON) will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Administrator, DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	

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F 561	Continued From page 9 up out of bed this morning but they hadn't been able to find her wheelchair. Nurse #3 stated NA #3 was aware Resident #106 wanted up out of bed and was looking for her wheelchair. During an interview on 09/29/22 at 12:20 PM, NA #3 confirmed Resident #106 preferred to be up out of bed after breakfast and was not assisted up out of bed yesterday because she couldn't find her wheelchair. NA #3 further stated Resident #106 had not been assisted up out of bed yet today because she hadn't had time to locate her wheelchair. During a follow-up interview at 12:30 PM, Nurse #3 reported they located Resident #106's wheelchair on the service hall and informed Resident #106 they would assist her up out of bed after lunch. During a telephone interview on 10/03/22 at 10:27 AM, the Administrator stated she spoke with NA #3 on 09/29/22 and was informed Resident #106 was not assisted up out of bed because they were unable to locate her wheelchair. The Administrator stated it only took her about "14 seconds" to find Resident #106's wheelchair where it was stored on the service hall. She explained, due to space, they placed the larger wheelchairs on the service hall and NA #3 had to have walked right by it after clocking in to work. The Administrator stated she would expect for residents to be assisted up out of bed when requested.	F 561		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing	F 640		11/11/22

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F 640	Continued From page 10	F 640		

requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an

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F 640	Continued From page 11 initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date for 1 of 4 sampled residents reviewed for discharge (Resident #91). Findings included: Resident #91 was admitted to the facility on 08/25/22. A nurse progress note dated 09/12/22 at 2:54 PM revealed Resident #91 discharged home with family at 2:30 PM. Review of Resident #91's medical record revealed the last completed MDS assessment was an admission dated 09/01/22. There was no discharge assessment completed or transmitted. During an interview on 09/29/22 at 9:08 AM, MDS Coordinator #1 explained she completed the appropriate MDS assessments when notified of discharges or deaths during morning clinical meetings. MDS Coordinator #1 confirmed there was no discharge MDS assessment completed for Resident #91. She stated it was an oversight and should have been completed within 14 days of Resident #91's discharge.	F 640	F640 □ Regarding the alleged deficient practice of failure to complete a discharge Minimum Data Set (MDS) assessment within 14 days of the discharge date as evidenced by: a) Discharge assessment not completed as of 09/29/2022 for resident #91, discharged from facility on 09/12/2022 On 09-29-2022 discharge MDS assessment for resident #91 was completed and submitted by the MDS coordinator; assessment was accepted on 09-30-2022. All residents who have discharged from the facility have the potential to be affected. An audit was conducted on 11-07-2022 by facility administrator to ensure all residents discharged from the facility in the last six months have had discharge MDS assessment completed and submitted within 14 days of discharge with no additional concerns. MDS nurse was educated by the Director of Nursing (DON) on 11/08/2022 regarding requirement for timely discharge assessment completion. Newly hired MDS nurses will be educated upon hire by Director of Nursing or Regional	

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F 640	Continued From page 12 During a telephone interview on 10/03/22 at 10:06 AM, the Administrator stated she would expect for MDS assessments to be completed and transmitted within the regulatory timeframes.	F 640	Nurse Consultant. Director of Nursing (DON) or Assistant Director of Nursing (ADON) will audit 5 discharged residents every week for four weeks, then 3 of discharged residents every week for four weeks to ensure timely completion and submission of discharge MDS assessment. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee This plan of correction was completed on 11/11/2022	
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 and interviews with staff the facility failed to accurately complete the Minimum Data Set (MDS) assessments in the areas of pressure ulcers and Pre-Admission Screening and Resident Review (PASRR) for 2 of 4 residents reviewed for MDS accuracy (Resident #315 and #33). The findings included:	F 641	F641 - Regarding the alleged deficient practice of failure to submit assessment that accurately reflects residents status as evidenced by: a) Failure to correctly code Minimum Data Set assessment to reflect pressure ulcer for resident #315 b) Failure to correctly code Minimum Data Set assessment to reflect correct Pre-Admission Screening and Resident Review (PASRR) level for resident #33	11/11/22

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F 641	Continued From page 13 1. Resident #315 was admitted to the facility on 12/18/17. His diagnoses included diabetes mellitus, chronic kidney disease, and pressure ulcer of the lower back. Review of a "Head-to-Toe Check" dated 11/27/21 indicated an existing sacrum wound was present. Review of a weekly pressure ulcer record dated 12/21/21 for Resident #315 revealed an existing sacrum ulcer was present on admission with the date of onset as 08/16/20. Review of a discharge MDS dated 12/30/21 revealed Resident #315 did not currently have a pressure ulcer. An interview was conducted on 10/03/22 at 9:43 AM with MDS Nurse #1. MDS Nurse #1 revealed she was unable to find documentation to support Resident #315 was admitted with a stage 4 pressure ulcer and stated the coding was incorrect. MDS Nurse #1 revealed the assessments should have been coded to indicate one stage 4 pressure ulcer was facility acquired and needed to be modified. During an interview on 10/03/22 at 8:17 the Director of Nursing (DON) revealed she expected the MDS assessments to be accurate and Resident #315 ' s pressure ulcer be coded correct if facility acquired.	F 641	Beginning on 10/08/2022 and completed 11/08/2022 , Minimum Data Set (MDS) assessments were amended by MDS Coordinator to correct the noted areas of pressure ulcer (#315) and PASRR (#33). All residents with pressure ulcers and all residents with Level Two PASRRs have the potential to be affected. An audit was conducted by the Director of Nursing and Administrator on 11/08/2022 of the most recent MDS assessments for current residents with pressure ulcers & level two PASRRs to ensure accurate coding. MDS nurse was educated on 11/08/2022 by Director of Nursing (DON) regarding accurate assessment and coding of pressure ulcers and PASRRs. Newly hired MDS nurses will be educated upon hire to ensure Pressure Ulcers and PASRRs are reflected correctly on the MDS by Administrator, Director of Nursing or Regional MDS Consultant. Director of Nursing (DON) or Assistant Director of Nursing (ADON) will audit 5 residents with pressure ulcers (or 100% - whichever is greater) and 5 residents (or 100% - whichever is greater) with Level Two PASRRs every week for 4 weeks for accurate coding of pressure ulcers and PASRRs; then will audit 3 residents with pressure ulcers (or 100% - whichever is greater) and 3 residents (or 100% - whichever is greater) with Level Two PASRRs every week for 4 weeks for accurate coding of pressure ulcers and PASRRs DON or ADON will review the audits	

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F 641	Continued From page 14 2. a. Resident #33 was admitted to the facility on 06/06/22 and discharged to the community on 06/25/22. Her diagnoses included schizoaffective disorder bipolar type and anxiety disorder. Review of Resident #33's medical record revealed a North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document dated 05/09/22 that indicated Resident #33 had a Level II PASSR ending in an "E" with an expiration date of 05/27/22. Review of the North Carolina Skilled Nursing Facility Preadmission Screening and Resident Review (PASRR) authorization codes document revealed a PASRR ending in "E" indicated "Level II: 30-day rehabilitation services authorization only." The admission Minimum Data Set (MDS) dated 06/13/22 revealed Resident #33 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. During an interview on 09/29/22 at 9:08 AM, MDS Coordinator #2 explained she was instructed if the NC MUST inquiry was noted as "no" under the column "sent to Level II" then it was not considered a Level II PASRR and did not need to be coded as a Level II on MDS assessments. MDS Coordinator #2 confirmed Resident #33's MDS assessment dated 06/13/22 did not reflect she had a Level II PASRR and stated she coded the assessment based on what she was instructed and understood. During a telephone interview on 09/30/22 at 3:15 PM, the PASRR Representative revealed the last	F 641	monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	

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F 641	Continued From page 15	F 641		

PASRR review request they received from the facility for Resident #33 was in July 2022 at which time her PASSR was extended with an expiration date of 08/12/22.

During a telephone interview on 10/03/22 at 7:40 PM, the Administrator stated she would expect for MDS assessments to be coded correctly.

b. Resident #33 was readmitted to the facility on 07/14/22. Her diagnoses included schizoaffective disorder bipolar type and anxiety disorder.

Review of Resident #33's medical record revealed a NC MUST inquiry document dated 05/09/22 that indicated Resident #33 had a Level II PASSR ending in an "E" with an expiration date of 05/27/22.

Review of the North Carolina Skilled Nursing Facility Preadmission Screening and Resident Review (PASRR) authorization codes document revealed a PASRR ending in "E" indicated "Level II: 30-day rehabilitation services authorization only."

The admission MDS dated 07/21/22 revealed Resident #33 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability.

During an interview on 09/29/22 at 9:08 AM, MDS Coordinator #2 explained she was instructed if the NC MUST inquiry was noted as "no" under the column "sent to Level II" then it was not considered a Level II PASRR and did not need to be coded as a Level II on MDS assessments. MDS Coordinator #2 confirmed Resident #33's MDS assessment dated 07/21/22 did not reflect

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F 641	Continued From page 16 she had a Level II PASRR and stated she coded the assessment based on what she was instructed and understood. During a telephone interview on 09/30/22 at 3:15 PM, the PASRR Representative revealed the last PASRR review request they received from the facility for Resident #33 was in July 2022 at which time her PASSR was extended with an expiration date of 08/12/22. During a telephone interview on 10/03/22 at 7:40 PM, the Administrator stated she would expect for MDS assessments to be coded correctly.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 644		11/11/22

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F 644	Continued From page 17 Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) before the expiration date for 1 of 1 resident reviewed with a Level II PASRR (Resident #33). Findings included: Resident #33 was admitted to the facility on 07/14/22 with diagnoses that included schizoaffective disorder bipolar type and anxiety disorder. Review of Resident #33's medical record revealed a NC MUST (online system used for PASRR screenings) inquiry document dated 05/09/22 that indicated Resident #33 had a time-limited Level II PASSR ending in an "E" with an expiration date of 05/27/22. Review of the North Carolina Skilled Nursing Facility Preadmission Screening and Resident Review (PASRR) authorization codes document revealed a PASRR ending in "E" indicated "Level II: 30-day rehabilitation services authorization only." The Minimum Data Set (MDS) admissions assessment dated 07/21/22 revealed Resident #33 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability. During a telephone interview on 09/30/22 at 3:15 PM, the PASRR Representative revealed the last PASRR review request they received from the facility for Resident #33 was in July 2022 at which time her PASSR was extended with an expiration date of 08/12/22.	F 644	F644 □ Regarding the alleged deficient practice of failure to request a Pre-Admission Screening and Resident Review (PASRR)before the expiration date as evidenced by: a. Resident #33 level two PASRR noted with an expiration date of 08/12/2022 and had not been renewed as of 09/30/2022 On 09/30/22 an updated PASSR request was submitted for resident #33 and was obtained on 10/06/22. All residents with limited PASRRs have the potential to be affected. An audit was conducted of all limited PASRRs on 10/05/2022 by the minimum data set (MDS) coordinator to ensure that all were unexpired and valid, all expired PASRRs completed by the Business Office. On 11/08/2022, the facility administrator provided education to team members who participate in the PASRR renewal process: business office manager (BOM), assistant business office manager (ABOM), admissions coordinator, marketing director, social services director, and social services assistant regarding timely updating/renewal of limited PASRRs. Newly hired team members who will participate in the PASRR process will be educated on the PASRR process by the administrator or business office manager upon hire. Business Office Manager (BOM) or Assistant Business Office Manager (ABOM) will audit 5 residents (or 100% - whichever is greater) with limited PASRRs every week for 4 weeks to ensure PASRRs are unexpired or updated, then will audit 3 residents (or 100% - whichever	

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F 644	Continued From page 18 During a telephone interview on 10/03/22 at 10:06 AM, the Administrator explained the Business Office Manager was responsible for requesting PASRR screenings when needed and prior to the expiration date, if applicable. The Administrator explained Resident #33's expired Level II PASRR just got missed and a request for review was submitted on 09/30/22.	F 644	is greater) with limited PASRRs every week for 4 weeks to ensure PASRRs are unexpired or updated. BOM or ABOM will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. BOM or ABOM will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/10/2022	
F 661 SS=B	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident	F 661		11/11/22

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F 661	Continued From page 19 representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a recapitulation of stay for 3 of 4 residents reviewed for a planned discharge to the community (Residents #363, #365, and #366). This practice had the potential to affect other residents who discharged from the facility. Findings included: 1. Resident #363 was admitted to the facility on 06/09/22 and discharged to the community on 07/08/22. The admission Minimum Data Set (MDS) assessment dated 06/24/22 assessed Resident #363 with severe impairment in cognition. Review of Resident #363's medical record revealed a discharge summary dated 07/06/22 that included a discharge plan and location, diagnoses, vital signs, and attached list of medications. There was no documentation that included all the components of the recapitulation of stay, such as course of illness, treatments and pertinent laboratory and radiology results, and a final summary of the resident's status at discharge. During an interview on 09/28/22 at 4:19 PM, the	F 661	F661 □ Regarding the alleged deficient practice of failure to complete a recapitulation of stay for 3 of 4 residents reviewed for a planned discharge to the community as evidenced by: a. Residents #363 #365, and #366 noted with discharge summaries that did not include documentation reflecting all components of the recapitulation of stay, such as course of illness and treatments, pertinent laboratory and radiology results, and a final summary of the resident's status at discharge Discharge summaries were completed for residents #363, #365, AND #366 on 11/08/2022. All residents discharged to the community have the potential to be affected. As of 09/30/2022, all residents scheduled for discharge to the community are reviewed during regularly scheduled Interdisciplinary Team (IDT) meeting to ensure completion of a comprehensive discharge summary; this process for routine IDT review will continue for all residents scheduled for discharge. On 11/03/2022, education was provided to Interdisciplinary Team (IDT) who participate in the discharge summary to include: Social Services Director, Social	

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F 661	Continued From page 20 Social Worker (SW) stated a recapitulation of resident stay was documented as a Bridge to Home Discharge Summary (summary of a resident's stay while in the skilled nursing facility) assessment in the resident's medical record. The SW explained when a resident was ready to discharge, he initiated the Bridge to Home Discharge Summary assessment and completed his section, then emailed the other department managers for them to complete their sections. The SW stated he was not sure who was responsible for ensuring the Bridge to Home Discharge Summary assessment was completed and stated he tried to follow-up when he could. The SW reviewed Resident #363's Bridge to Home to Discharge Summary assessment dated 07/06/22 and confirmed it was not complete and did not contain all the required components. During a telephone interview on 10/03/22 at 10:06 AM, the Administrator explained the Bridge to Home Discharge Summary assessment was a new form that was implemented when the new corporation took over in July 2022. The Administrator stated staff were still getting used to using the new form and the department managers overlooked completing their sections of the Bridge to Home Discharge Summary assessment. 2. Resident #365 was admitted to the facility on 07/27/22 and discharged to the community on 08/16/22. The admission Minimum Data Set (MDS) assessment dated 08/03/22 assessed Resident #365 with severe impairment in cognition. Review of Resident #365's medical record	F 661	Services Assistant, Therapy Manager, Dietary Tech, Activities Director, Activities Assistant, Director of Nursing (DON), Assistant Director of Nursing (ADON) by the Administrator to ensure Discharge Summary is completed with required components prior to resident□s discharge from facility. Newly hired members of the IDT who participate in the discharge summary will be educated upon hire by the Administrator or Director of Nursing. Facility administrator will conduct an audit of 5 residents discharged to the community each week for 4 weeks to ensure comprehensive completion of discharge summaries, and then will conduct an audit of 3 residents discharged to the community each week for 4 weeks to ensure comprehensive completion of discharge summaries. Administrator or DON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Administrator or DON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	

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F 661	Continued From page 21	F 661		

revealed a discharge summary dated 08/12/22 that included a discharge plan and location, vital signs, diet, and rehabilitation progress. There was no documentation that included all the components of the recapitulation of stay, such as course of illness and treatments, pertinent laboratory and radiology results, and a final summary of the resident's status at discharge.

During an interview on 09/28/22 at 4:19 PM, the Social Worker (SW) stated a recapitulation of resident stay was documented as a Bridge to Home Discharge Summary (summary of a resident's stay while in the skilled nursing facility) assessment in the resident's medical record. The SW explained when a resident was ready to discharge, he initiated the Bridge to Home Discharge Summary assessment and completed his section, then emailed the other department managers for them to complete their sections. The SW stated he was not sure who was responsible for ensuring the Bridge to Home Discharge Summary assessment was completed and stated he tried to follow-up when he could. The SW reviewed Resident #365's Bridge to Home Discharge Summary assessment dated 08/12/22 and confirmed it was not complete and did not contain all the required components.

During a telephone interview on 10/03/22 at 10:06 AM, the Administrator explained the Bridge to Home Discharge Summary assessment was a new form that was implemented when the new corporation took over in July 2022. The Administrator stated staff were still getting used to using the new form and the department managers overlooked completing their sections of the Bridge to Home Discharge Summary assessment.

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F 661	Continued From page 22	F 661		

3. Resident #366 admitted to the facility on 06/04/22 and discharged to the community on 09/12/22.

The quarterly Minimum Data Set (MDS) assessment dated 09/07/22 assessed Resident #366 with intact cognition.

Review of Resident #366's medical record revealed a discharge summary dated 09/09/22 that included a discharge plan and location, vital signs, diet, and rehabilitation progress. There was no documentation that included all the components of the recapitulation of stay, such as course of illness and treatments, pertinent laboratory and radiology results, and a final summary of the resident's status at discharge.

During an interview on 09/28/22 at 4:19 PM, the Social Worker (SW) stated a recapitulation of resident stay was documented as a Bridge to Home Discharge Summary (summary of a resident's stay while in the skilled nursing facility) assessment in the resident's medical record. The SW explained when a resident was ready to discharge, he initiated the Bridge to Home Discharge Summary assessment and completed his section, then emailed the other department managers for them to complete their sections. The SW stated he was not sure who was responsible for ensuring the Bridge to Home Discharge Summary assessment was completed and stated he tried to follow-up when he could. The SW reviewed Resident #366's Bridge to Home Discharge Summary assessment dated 09/09/22 and confirmed it was not complete and did not contain all the required components.

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F 661	Continued From page 23 During a telephone interview on 10/03/22 at 10:06 AM, the Administrator explained the Bridge to Home Discharge Summary assessment was a new form that was implemented when the new corporation took over in July 2022. The Administrator stated staff were still getting used to using the new form and the department managers overlooked completing their sections of the Bridge to Home Discharge Summary assessment.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide dependent residents with their preferred method of bathing and number of showers per week (Residents #47 and #33) for 2 of 3 residents reviewed for Activities of Daily Living (ADL). Findings included: 1. Resident #47 was admitted to the facility on 07/20/22 with multiple diagnoses that included a condition in which the immune system that attacks the nerves, respiratory failure, and heart disease. 2. A concern form dated 09/12/22 filed by Resident #47's family member revealed she did not receive her scheduled shower the previous Friday. The concern was investigated by the Director of	F 677	F677 □ Regarding the alleged deficient practice of failure to provide dependent residents with their preferred method of bathing and number of showers per week for 2 of 3 residents reviewed as evidenced by: a. Residents #47 and #33 did not receive shower per their schedule or preference On 11/08/2022, Kardex for resident #47 and resident #33 were updated to reflect current preferences for bathing method and number of showers per week. On 11/08/2022, residents 47 and 33 were interviewed by the facility administrator, and shower documentation was reviewed to validate they have received showers per their preference. All dependent residents have the potential	11/11/22

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F 677	Continued From page 24 Nursing and read in part, "interviewed Resident #47 who stated she did not get a shower on Friday. Arrangements made to have staff give her a shower on 09/13/22. Shower given on 09/14/22." Review of Resident #47's care plans, last reviewed/revised on 09/19/22, revealed a plan of care that addressed an ADL self-care performance deficit related to disease process, requiring staff assistance to complete ADL task and risk for decline in physical function. Interventions included: two-person assist with the use of a mechanical lift for transfers and bari-bed and grab bars to aid with independence. The 5-day Prospective Payment System (PPS) assessment dated 09/20/22 assessed Resident #47 with intact cognition. She required total staff assistance of one staff member for bathing and displayed no rejection of care during the assessment period. Review of the Nurse Aide (NA) weekly shower schedule sheets provided by the facility revealed the following: " 08/01/22 to 08/05/22: Resident #47 was not listed on the schedule as receiving a shower. " 08/15/22 to 08/19/22: Resident #47 was not listed on the schedule as receiving a shower. " 08/22/22 to 08/26/22: Resident #47 was not listed on the schedule as receiving a shower. Review of the NA daily shower assignment schedules provided by the Director of Nursing (DON) on 09/28/22 at 2:56 PM, for the period 09/21/22 to 09/24/22, read in part, "please ensure showers are completed. A bed bath is not a	F 677	to be affected. An audit was conducted by the Director of Nursing on 10/11/2022 of all residents who require assistance with the activity of bathing to identify preference of method and frequency, with appropriate follow-up per findings, to include updating of residents' Kardex completed by 10/12/2022. Resident preference for bathing method and frequency will be determined at time of admission. On 11/08/2022, DON(Director of Nursing) & ADON(assistant Director of Nursing) provided in-service education to nursing staff regarding provision of bathing services per residents preferred methods and frequency. Education of nursing staff to continue upon to return to work, to be completed by 11/10/2022. Education for newly hired or contracted nursing staff will be provided by DON, ADON or charge nurse upon hire, prior to receiving assignment. DON or ADON will conduct random audits of all residents who are dependent for showers per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks to ensure bathing provided per preference of method and frequency. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee.	

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F 677	Continued From page 25	F 677	This plan of correction was completed on 11/11/2022	

shower." Resident #47 was not listed on the daily assignment schedules to receive a shower.

The undated Master Shower Schedule (MSS) provided by the DON on 09/28/22 at 2:56 PM revealed Resident #47 was scheduled to receive showers on Tuesdays and Fridays.

Review of the NA September 2022 bathing documentation report provided by the facility for Resident #47 revealed she received a daily bed bath. There were no showers documented as provided.

During an observation and interview on 09/26/22 at 3:29 PM, Resident #47 was lying in bed, her hair disheveled and there was a brown colored substance underneath the middle finger of her left hand. Resident #47 stated she was supposed to receive 2 showers per week but at best, only gets one.

During a follow-up observation and interview on 09/29/22 at 3:45 PM, Resident #47 was lying in bed, her hair disheveled and there was a brown colored substance underneath the middle finger of her left hand. Resident #47 stated she was supposed to get showers on Tuesdays and Fridays every week but had not received one this past week nor had her roommate who was scheduled to receive showers on the same day as her. Resident #47 stated she preferred showers instead of bed baths and the "bed baths" she received daily was basically just cleaning her up after an incontinence episode and did not include washing her hair. Resident #47 stated her hair tended to get oily when not washed which made her feel "bad." Resident #47 couldn't recall the date but stated the last time she received a

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shower was after she had her husband file a grievance. Resident #47 looked at her left hand and confirmed her fingernails were dirty. She stated staff had not cleaned her fingernails and she wasn't able to get them clean enough herself.

During interviews on 09/27/22 at 8:45 AM and 09/29/22 at 12:20 PM, NA #3 revealed she was typically assigned to the bottom half of 400 Hall. NA #2 stated there were a lot of residents who required extensive to total staff assistance with ADL on 400 Hall which made it difficult to get all resident care done, including showers. NA #3 explained she had to prioritize resident care, such as meals and incontinence care, and unfortunately, showers would not get provided. NA #3 stated all of her assigned residents received a partial bed bath daily, which she described as washing the face, armpits, and peri-area, and every now and then she might have time to give the resident a complete bed bath. NA #3 stated she was usually able to provide Resident #47 at least one shower per week but she had not been able to provide her a shower this past week.

During an interview on 09/29/22 at 2:11 PM, NA #4 revealed she was typically assigned to the top half of 400 Hall. NA #4 explained a lot of residents on the 400 Hall required extensive to total staff assistance with ADL and at least half of them required transfers with the use of a mechanical lift. NA #4 stated she and NA #3 worked together to assist with resident transfers and did their best to make sure the residents were kept clean as possible. NA #4 stated she was not always able to provide her assigned residents with their scheduled showers but did give them a "good bed bath." NA #4 explained

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some days her assigned residents would get a partial bed bath and other days a complete bed bath which she described as washing the resident head-to-toe. NA #4 stated although she realized a bed bath did not compensate for a complete shower, residents did get some sort of bathing activity daily.

During an interview on 09/28/22 at 2:56 PM and follow-up telephone interview on 10/03/22 at 10:27 AM, the DON stated the only resident shower schedules they had were the ones provided for the period 08/01/22 to 08/26/22 and 09/21/22 to 09/24/22. The DON explained the daily assignment shower schedule was recently created after they found a "glitch" in the NA point of care documentation system where the shower activity task was not populating for NA staff to enter when a shower was provided. The DON stated NA staff were instructed to initial the daily shower schedule when completed but it was still a new process and they likely forgot. The DON could not explain why Resident #47 was not listed on the shower assignment schedules and was unaware of any recent complaints from Resident #47 about not receiving her preferred number of showers each week. In addition, the DON stated she had not been notified by NA staff of showers not being provided.

During an interview on 09/29/22 at 3:52 PM and follow-up telephone interview on 10/03/22 at 10:06 AM, the Administrator stated she was aware of a previous concern filed by Resident #47 related to not getting her scheduled shower and one was provided as part of the resolution. The Administrator stated just last week, a daily shower schedule was created for NA staff. The Administrator could not explain why Resident #47

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was not listed on the shower assignment schedules for 08/01/22 to 08/26/22 and 09/21/22 to 09/24/22. She stated they were revamping the system and it may not be the best system but she knew showers were being completed. The Administrator stated it was her expectation for NA staff to complete showers as scheduled for their assigned residents.

2. Resident #33 was admitted to the facility on 07/14/22 with multiple diagnoses that included chronic respiratory failure with hypoxia, diabetes, and anxiety disorder.

The admission Minimum Data Set (MDS) dated 07/21/22 assessed Resident #33 with intact cognition. She had an impairment on one side of the upper extremity, displayed no rejection of care during the MDS assessment period and required total staff assistance of one staff member for bathing.

Review of Resident #33's care plans, last reviewed/revised on 09/02/22, revealed a plan of care that addressed an ADL self-care performance deficit related to disease process, requiring staff assistance to complete ADL task and risk for decline in physical function. Interventions included: one-person assist to move between surfaces.

Review of the Nurse Aide (NA) weekly shower schedule sheets provided by the facility revealed the following:
" 08/01/22 to 08/05/22: Resident #33 was not listed on the schedule as receiving a shower.
" 08/15/22 to 08/19/22: Resident #33 was not listed on the schedule as receiving a shower.
" 08/22/22 to 08/26/22: Resident #33 was not

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F 677	Continued From page 29	F 677		

listed on the schedule as receiving a shower. Review of the NA daily shower assignment schedules provided by the Director of Nursing (DON) on 09/28/22 at 2:56 PM, for the period 09/21/22 to 09/24/22, read in part, "please ensure showers are completed. A bed bath is not a shower." Resident #47 was not listed on the daily assignment schedules to receive a shower.

The undated Master Shower Schedule (MSS) provided by the DON on 09/28/22 at 2:56 PM revealed Resident #33 was scheduled to receive showers on Tuesdays and Fridays.

Review of the Nurse Aide (NA) September 2022 bathing documentation report provided by the facility for Resident #33 revealed she received a daily bed bath. There were no showers documented as provided.

During an observation and interview on 09/26/22 at 3:20 PM, Resident #33 was sitting in her wheelchair and dressed in a nightgown. Resident #33 voiced she preferred at least 2 showers per week and could not recall when she last received a shower. Resident #33 stated she preferred showers in lieu of a bed bath.

During a follow-up observation and interview on 09/28/22 at 1:35 PM, Resident #33 was sitting up in her wheelchair and dressed in clean clothing. Resident #33 stated she did not receive her scheduled shower on 09/27/22.

During interviews on 09/27/22 at 8:45 AM and 09/29/22 at 12:20 PM, NA #3 revealed she was typically assigned to the bottom half of 400 Hall. NA #2 stated there were a lot of residents who required extensive to total staff assistance with

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F 677	Continued From page 30	F 677		

ADL on 400 Hall which made it difficult to get all resident care done, including showers. NA #3 explained she had to prioritize resident care, such as meals and incontinence care, and unfortunately, showers would not get provided. NA #3 stated all of her assigned residents received a partial bed bath daily, which she described as washing the face, armpits, and peri-area, and every now and then she might have time to give the resident a complete bed bath. NA #3 stated she was usually able to provide Resident #33 at least one shower per week but she had not been able to provide her a shower this past week.

During an interview on 09/29/22 at 2:11 PM, NA #4 revealed she was typically assigned to the top half of 400 Hall. NA #4 explained a lot of residents on the 400 Hall required extensive to total staff assistance with ADL and at least half of them required transfers with the use of a mechanical lift. NA #4 stated she and NA #3 worked together to assist with resident transfers and did their best to make sure the residents were kept clean as possible. NA #4 stated she was not always able to provide her assigned residents with their scheduled showers but did give them a "good bed bath." NA #4 explained some days her assigned residents would get a partial bed bath and other days a complete bed bath which she described as washing the resident head-to-toe. NA #4 stated although she realized a bed bath did not compensate for a complete shower, residents did get some sort of bathing activity daily.

During an interview on 09/28/22 at 2:56 PM and follow-up telephone interview on 10/03/22 at 10:27 AM, the DON stated the only resident

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F 677	Continued From page 31 shower schedules they had were the ones provided for the period 08/01/22 to 08/26/22 and 09/21/22 to 09/24/22. The DON explained the daily assignment shower schedule was recently created after they found a "glitch" in the NA point of care documentation system where the shower activity task was not populating for NA staff to enter when a shower was provided. The DON stated NA staff were instructed to initial the daily shower schedule when completed but it was still a new process and they likely forgot. The DON could not explain why Resident #33 was not listed on the shower assignment schedules and was unaware of any complaints from Resident #33 about not receiving her preferred number of showers each week. In addition, the DON stated she had not been notified by NA staff of showers not being provided. During an interview on 09/29/22 at 3:52 PM and follow-up telephone interview on 10/03/22 at 10:06 AM, the Administrator stated she was aware of previous concerns from residents related to not getting their scheduled showers and just last week, a daily shower schedule was created for NA staff. The Administrator could not explain why Resident #33 was not listed on the shower assignment schedules for 08/01/22 to 08/26/22 and 09/21/22 to 09/24/22. She stated they were revamping the system and it may not be the best system, but she knew showers were being completed. The Administrator stated it was her expectation for NA staff to complete showers as scheduled for their assigned residents.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		11/11/22

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F 686	Continued From page 32 §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, observations, and interviews with the Physician's Assistant (PA) and staff the facility failed to follow treatment orders for a stage 4 pressure ulcer for 1 of 3 residents reviewed for pressure ulcer (Resident #102). The findings included: Resident #102 was admitted to the facility on 09/06/22 with diagnoses including a sacrum pressure ulcer and adult failure to thrive. Review of the admission Minimum Data Set (MDS) dated 09/13/22 assessed Resident #102 as being severely impaired cognitively and requiring extensive assistance with bed mobility. The MDS assessment of skin conditions indicated one stage 4 pressure ulcer was present on admission.	F 686	F686 - Regarding the alleged deficient practice of failure to provide services to treat a pressure ulcer as evidenced by: a. the facility failed to follow treatment orders for a stage 4 pressure ulcer for 1 of 3residents reviewed (#102) Dressing was applied per current physician order for resident #192 on 09/27/2022. All residents with pressure ulcers have the potential to be affected. An audit was conducted by facility wound nurse on 11/08/2022 of all residents with pressure ulcers to ensure treatments were in place per physician orders, with no additional deficiencies identified. On 11/08/2022, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) began providing inservicing regarding treatment of pressure ulcers per physician orders to licensed nurses, with education continuing upon return to work to be completed by 11/10/2022. All newly hired or contracted licensed nurses will be	

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F 686	Continued From page 33 Review of the current physician's order provided directions to cleanse the wound with wound cleanser and pack with a gauze soaked in a solution of 0.5% sodium hypochlorite (a topical antiseptic solution) and cover with a silicone bordered dressing. Review of the care plan initiated on 09/15/22 identified an existing pressure ulcer to the sacrum and Resident #102 remained at high risk for developing ulcers. Interventions included provide treatment as ordered and monitor for effectiveness. Review of Resident #102's wound evaluation dated 09/20/22 revealed the sacrum pressure ulcer measured 9 centimeters (cm) x 6 cm x 3 cm. An observation of wound care was made on 09/27/22 at 10:39 AM with the PA who provided the treatment order and the Wound Care Nurse. A border gauze not a silicone gauze dressing was in place with no date or initials to indicate who or when it was placed. The back of dressing was heavily soiled with a bloody drainage. There was no packed gauze to remove indicating the 0.5 % hypochlorite solution was not used. The wound bed had slough (non-viable tissue) and granulation (pink-red tissue that fills the wound when healing) tissue with no odor. The wound measured 8 cm x 6 cm x 1.9 cm indicating it was smaller in size. During an interview on 09/27/22 at 10:41 AM the	F 686	inserviced by Director of Nursing, Assistant Director of Nursing, or charge nurse upon hire. DON or ADON will conduct random audits of all residents with pressure ulcers per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks to ensure all pressure ulcers have correct dressing applied per physician order. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	

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F 686	Continued From page 34 PA revealed he expected the correct dressing would be in place and the treatment orders followed for consistency. The PA stated he wanted the correct dressing and treatments in place for him to know if it was effective or needed to be changed. The PA revealed Resident #102's stage 4 pressure had improved since his last assessment and described the wound bed as having 80 % granulation tissue and 10% slough, intact and smaller in size. An interview was conducted on 10/03/22 at 8:30 AM with the Director of Nursing (DON). The DON revealed it was her expectation treatment orders were followed as written and the correct dressing was in place for a pressure ulcer.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the Medical Doctor and staff the facility failed to provide care in a safe manner resulting in a resident falling from the bed to the floor and sustaining a fracture to the left ulna (forearm) for 1 of 2 residents reviewed for falls (Resident #315).	F 689	F689 Regarding the alleged deficient practice of failure to provide adequate supervision to prevent accidents as evidenced by: a. a resident falling from the bed to the floor during care and sustaining a fracture to the left ulna (forearm) for1 of 2 residents reviewed for falls	11/11/22

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F 689	Continued From page 35 The findings included: Resident #315 was readmitted to the facility on 12/18/17 with diagnoses including quadriplegia and bilateral below the knee amputations. The quarterly Minimum Data Set (MDS) dated 06/14/22 assessed Resident #315's cognition as intact and his functional status for activities of daily living as needing extensive 2-person assistance with bed mobility and total 2- person assistance with toilet use. One fall was coded with no injury. Review of a fall investigation dated 07/05/22 described Resident #315 fell during care and was transferred to the medical center for evaluation. New interventions recommended by the Interdisciplinary Team was to provide 2-person assistance with activities of daily living care as accepted. Review of the Nurse Practitioner (NP) progress note written on 07/05/22 revealed during personal care provided by the Nurse Aide (NA) Resident #315 rolled out of bed onto the floor. The NP instructed Resident #315 be sent to the emergency room for evaluation. Review of nurse progress note written on 07/05/22 revealed Resident #315 returned to the facility with his left arm, wrist, and hand wrapped with ace bandages and a new order for oxycodone (a opiate pain medication) 5	F 689	(Resident#315). Resident #315 was transferred to Emergency Department and received care for fracture. Certified Nursing Assistant (CNA) involved is no longer employed at the facility, and facility unable to provide corrective training at this time to this employee. All residents requiring assistance with bed mobility have the potential to be affected. On 11/09/2022, Director of Nursing conducted an audit of all residents who require assistance for bed mobility to ensure that appropriate level of assist is noted on CNA plan of care with updates made per findings. On 11/08/2022, education was provided to Certified Nursing Assistants on providing care in a safe manner and utilizing Kardex for bed mobility information by Director of Nursing and Assistant Director of Nursing, with education to continue upon return to work and completed by 11/10/2022. Education will be provided by a member of nurse management to all newly hired or contracted certified nursing assistants upon hire/contract prior to receiving assignment. DON or ADON will conduct random audits of care being provided to residents requiring assistance with bed mobility to ensure safe practice per the required level of assistance per the following schedule: 5 residents per week for 4 weeks, then 3 residents per week for four weeks. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance.	

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F 689	Continued From page 36 milligrams every 4 hours as needed for pain. Review of the NP progress note written on 07/06/22 revealed Resident #315 was being seen for a follow-up for a fractured arm and pain. The NP noted oxycodone 5 milligrams every 4 hours as needed for pain and Resident #315 was to follow-up with orthopedics on 07/08/22. During an interview on 09/29/22 at 12:37 PM the Medical Doctor (MD) revealed he spoke with Resident #315 about his fall. The MD indicated the NA was unsafe during care that resulted in Resident #315 falling from the bed onto the floor and sustained a fractured arm. An interview was conducted on 09/29/22 at 3:17 PM with NA #2, the staff member who was providing care for Resident #315 on 07/05/22 when he fell from the bed to the floor. NA #2 revealed she rolled Resident #315 away from her during incontinence care and that's when he leaned towards the edge of the bed and fell to the floor before she could grab him. NA #2 revealed she was trained to roll a resident towards her during care but was in a hurry getting him ready for an appointment and wasn't thinking. An attempt to interview the previous Staff Development Coordinator/Assistant Director of Nursing who signed the fall investigation dated 07/05/22 was unsuccessful. An interview was conducted on 10/03/22 at 8:17	F 689	DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	

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F 689	Continued From page 37 AM with the Director of Nursing (DON). The DON revealed she assumed the position of the Staff Development Coordinator and provided training for NA staff. She revealed NA staff were trained to roll a resident towards them when providing care for safety and prevent them from falling off the bed.	F 689		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the resident and staff the facility failed to arrange a consult with a Dermatologist for 1 of 2 residents reviewed for non-pressure skin conditions (Resident #23). The findings included: Resident #23 was admitted to the facility on 07/19/18 with diagnoses including diabetes mellitus and anxiety. Review of Resident #23's care plan revised on 07/11/22 identified he was at risk for skin breakdown and included the interventions to complete referrals from the Interdisciplinary Team as indicated, obtain lab and diagnostic work as ordered, and report results to the Medical Doctor.	F 745	F745 □ Regarding the alleged deficient practice of failure to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as evidenced by: a. the facility failed to arrange a consult with a Dermatologist for 1 of 2 residents reviewed for non-pressure skin conditions (Resident #23) Resident #23 was provided with Dermatology consult appointment on 10/25/2022. All residents with referrals for outside consults have the potential to be affected. On 11/08/2022, the Director of Nursing (DON) performed an audit on all orders/referral for consults in the last 3 months, to ensure appointments have been made, with no additional deficiencies identified.	11/11/22

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F 745	Continued From page 38 Review of the quarterly Minimum Data Set (MDS) dated 07/14/22 assessed Resident #23 as being cognitively intact with no rejection of care behaviors. The MDS skin condition assessment indicated no issues were identified during the lookback period and treatments included the application of ointments and medications to areas other than the feet. A physician's order written on 08/19/22 revealed Resident #23 was referred to a Dermatologist for a chronic and generalized rash. During an interview and observation on 09/26/22 at 3:04 PM Resident #23 revealed he was referred to a Dermatologist for a rash. Resident #23's arms, chest, and abdomen had several small, circular in shape areas with no drainage. Resident #23 indicated his referral was made some time ago but to his knowledge hadn't been scheduled. An interview was conducted on 10/03/22 at 8:04 AM with the Director of Nursing (DON). The DON explained the person who received the physician's order was expected to notify the Unit Manager (UM) and the UM sent the necessary paperwork to get the appointments scheduled. The DON revealed she received the physician's order for the Dermatologist referral on 08/19/22 and was also the acting UM at that time. The DON revealed she should have followed the process in place and ensured the paperwork was sent and the Dermatologist appointment was scheduled for Resident #23.	F 745	On 11/08/2022 the DON & Assistant Director of Nursing (ADON) provided education to licensed nurses on process for following up on orders and referrals for outside consults with education to continue for licensed nurses upon return to work with completion by 11/10/2022. Newly hired or contracted nurses will be educated upon hire. The DON or ADON will conduct an audit of 5 orders or referrals for outside consults every week for 4 weeks to ensure appointments have been made, then will audit 3 orders or referrals for outside consults every week for 4 weeks to ensure appointments have been made. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	

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F 812 SS=F	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 staff interviews the facility failed to maintain a clean and sanitary kitchen to prevent ice build-up and repair a damaged door seal for 1 of 1 walk- in freezers, remove expired food ingredients stored ready for use in the dry in 1 of 1 dry storage rooms, cover and/or seal food left open to air in 1 of 1 walk-in refrigerators and not store staff food in resident food areas in 1 of 1 reach-in refrigerators. The facility also failed to repair leaking sink drains in the 3-compartment sink prevent standing water from accumulating on the kitchen floor, maintain clean ice coolers for 1 of 4 coolers (the 400-unit hallway), prevent the buildup of debris above the meal tray line, and maintain an intact ceiling above the clean dish area of the dish room. This	F 812	F 812 □ Regarding the alleged deficient practice of failure to maintain a clean and sanitary kitchen as evidenced by: a. damaged door seal on walk in freezer b. expired food ingredients stored in dry storage room c. food left uncovered, unsealed, and open to air in refrigerator d. staff food stored in resident food area e. failure to repair leaking sink drain f. allowing standing water to accumulate on kitchen floor g. failure to maintain one clean ice cooler of four inspected h. buildup of debris above meal tray line i. non-intact ceiling above clean dish	11/11/22

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F 812	Continued From page 40 practice had the potential to affect food served to residents. Findings included: 1. An observation conducted on 9/26/22 at 10:02 AM with a Dietary Aide revealed in the walk-in freezer had ice buildup of approximately 1.5 feet long hanging from an insulated pipe under the freezer fan box. Thawed and refrozen ice was on the top of one box of vanilla frozen nutritional treats and one box of ready care supplements. Observation of the freezer door revealed the lower right corner of the door was missing a section of the door seal approximately 6 inches long. The missing section of door seal contained ice buildup preventing the door from sealing. An interview the DM on 9/26/22 at 10:45 AM revealed that he was aware of the ice build up and had been cleaning the ice buildup every two days. 2. An observation conducted in the dry storage room on 9/26/22 at 10:10 AM with a Dietary Aide found 3 large plastic bins on wheels labeled flour, sugar, and thickener respectively all with written dates 8/8 - 9/8. The bins indicated the food supplies had expired. The DM indicated the marked dates on the 3 bins were incorrect and should have been dated when the new supplies arrived the last delivery day. 3. An observation in the walk-in refrigerator on 9/28/22 at 9:12 AM with the Dietary Manager revealed an open to air box of thawed raw sausage patties with a received date 9/21/22 and a thawed date 9/27/22. The DM stated at the same time of the observation that the cook had used the sausage for breakfast and should have closed or covered the box of sausage.	F 812	area of dish room Damaged freezer door seal was repaired on 09/30/2022 by a contracted vendor; expired food ingredients were removed on 09/27/2022 by the dietary manager; uncovered, unsealed food was discarded on 09/28/2022 by dietary manager; staff food was removed from resident food area on 09/28/2022 by dietary manager; sink drain was repaired on 10/19/2022 ; ice chest was removed from hall and cleaned on 09/28/2022 by housekeeping; standing water was removed and cleaned from floor on 09/28/2022 by dietary staff; debris build up was removed and cleaned above tray line on 09/28/2022 by maintenance director; the ceiling above the clean dish area was repaired on 10/26/2022 by the maintenance director. Audit of all kitchen areas was performed by Maintenance Director, Administrator and Dietary Manager on 10/27/2022 to ensure no further kitchen maintenance needs or sanitation concerns existed with no additional areas identified Education provided to dietary staff by facility administrator and dietary manager on 11/09/2022 regarding all areas of concern (removal of expired ingredients, covering and sealing food in refrigerator, proper storage of staff food, process for cleaning ice coolers, cleaning of debris, and process for reporting maintenance concerns), with education to continue upon return to work to be completed by 11/10/2022. Education will be provided to newly hired and contracted staff upon start of work. Education provided to Dietary Manager,	

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F 812	Continued From page 41 4. An observation in the kitchen reach-in refrigerator on 9/28/22 at 9:20 AM revealed a clear plastic zipped bag with lunch meat in it dated 9/26/22 stored with resident food. The DM indicated that it belonged to a dietary staff member and was taken home each day at end of shift and that staff food should not have been stored with resident food. 5. A kitchen observation on 9/28/22 at 9:30 AM conducted with the DM found the three-compartment sink to have leaking drains from each of the sinks. The left sink had a bowl underneath to collect the dripping water. The other two sink drains were dripping water onto the floor. The DM stated at that time that the Maintenance Director was aware of the leaking drains and was waiting on parts to arrive to fix them. 6. An observation conducted in the kitchen on 9/28/22 at 11:43 AM revealed standing brownish colored water around a floor drain located approximately 5 feet from the tray line. The Regional Dietary Consultant revealed at the same time, that the water was from the dish room and maintenance was made aware of the standing water in early August 2022 and kitchen staff should have swept the water into the drain. 7. An observation made on 400-unit hallway on 9/27/22 at 9:00 AM revealed an ice chest with black colored specks/debris visible on the inside walls of the cooler and small black colored specks/debris on some of the ice in the cooler. The ice chest was used to pass ice to residents on that hall earlier that day.	F 812	Maintenance Director, and Maintenance Assistant by facility administrator on 11/08/2022 regarding process for reporting maintenance concerns and importance of timely follow-up. Education to be provided by the Administrator to any newly hired or contracted Dietary Managers, Maintenance staff on timely repairs in the kitchen upon hire. Food storage areas (freezers, refrigerators, storage rooms) will be audited twice weekly for four weeks by dietary manager to ensure: no ice buildup in freezers, no expired ingredients in storage, no uncovered food items, and no staff food stored in resident food areas; then food storage areas (freezers, refrigerators, storage rooms) will be audited weekly for four weeks by dietary manager to ensure: no ice buildup in freezers, no expired ingredients in storage, no uncovered food items, and no staff food stored in resident food areas . All kitchen sink drains, and kitchen floors will be audited by maintenance director twice weekly for four weeks to ensure no leaks, clogs, or standing water exists; then weekly for four weeks to ensure no leaks, clogs, or standing water exists. All four facility ice chests will be audited by the Director of Nursing or Infection Control Nurse twice a week for four weeks, and then weekly for four weeks to ensure cleanliness. Meal tray line area and kitchen ceilings will be audited by dietary manager twice weekly for four weeks for cleanliness and freedom of debris and build up, then once weekly for four weeks for cleanliness and	

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F 812	Continued From page 42 An interview with a Nursing Aide at that time revealed the ice had been passed to residents on 400 unit at 6:30 AM. The NA indicated that the former Infection Preventionist would have taken the ice coolers to the kitchen daily to be cleaned and she last worked on the previous Thursday. The DM indicated on 9/87/22 at 9:42 AM that he is unsure of the process for cleaning the ice coolers on the unit. missing interview with DM or whoever on system for cleaning ice chests 8. On 9/28/22 at 12:06 PM a kitchen observation revealed 2 eye hooks attached to the ceiling directly above the tray line with thick build-up of fuzzy debris. An electrical conduit pipe located on the tray line with thick fuzzy debris build up spanning the length of the pipe. The DM indicated that he was unaware of the fuzzy debris build up. 9. On 9/28/22 at 12:15 PM an observation in the dish room revealed an area approximately 4 feet by 1 foot with chipped and loose hanging paint hanging from the ceiling. The area contained 3 punctured areas in the ceiling with exposed sheetrock and contained visible insulation directly above the clean dish area in the dish room. An interview with the Maintenance Director on 09/29/22 at 2:57 PM indicated there were maintenance logs hanging on each unit's wall that staff would write on to indicate what needs repairs. The Maintenance Director stated the kitchen does not have a maintenance log in the kitchen, they are to use a log on a hall. The former DM would verbally have told him of any repairs needed in the kitchen and the logs are checked about every 2 hours daily. The Maintenance Director indicated he was aware that one of the three-compartment sink drains	F 812	freedom of debris and build up. Kitchen maintenance request logs will be audited by administrator twice weekly for four weeks to ensure appropriate follow-up and repairs have been made; then weekly for four weeks to ensure appropriate follow-up and repairs have been made. Administrator will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. Administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	

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F 812	Continued From page 43 was leaking and unaware the other two drains had been leaking. The Maintenance Director did not indicate that he was waiting of parts to arrive to repair one of the leaking sinks. He was not aware of the missing section of seal on the walk-in freezer and that moisture entering the freezer when the door was opened caused the ice buildup. The Maintenance Director said he was aware of the standing water around the kitchen drain and has plans to fix it and the area above the clean dishes area of the dish room was due to a recently removed light was going to be replaced with a new one. The Administrator reported on 9/29/22 at 4:23 PM that the Kitchen should follow sanitary practices and repairs should occur timely.	F 812		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility;	F 840		11/11/22

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F 840	Continued From page 44 and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review, an interview with Transportation Owner, and staff the facility failed to ensure a transportation service agreement specified what a driver was supposed to do in the event a resident became unresponsive. The findings included: Review of the Transportation Service Agreement revealed the facility entered an agreement with an independent contractor on 10/15/19 to provide transportation services for facility residents. The agreement acknowledge it was the transportation company's responsibility to hire and train employees but did not specify what an employee was supposed to do if a resident became unresponsive during transport. A phone interview was conducted on 09/27/22 at 3:30 PM with the Manager/Owner of transportation company contracted by the facility to transport their residents. The Manager/Owner wouldn't provide specifics related to the education provided to drivers if a resident became unresponsive during transport and ended the call. During an interview on 09/29/22 at 4:19 PM the Administrator stated she would expect transportation drivers who transport facility residents would know to pullover and call 911 if a resident was having a medical emergency.	F 840	F840 □ Regarding the alleged deficient practice of failure to obtain services that meet professional standards as evidenced by: a. failing to ensure a transportation service agreement specified what a driver was supposed to do in the event a resident became unresponsive. Transportation service agreement updated on 11/09/2022 to specify what a driver is supposed to do in the event a resident became unresponsive. Contracted provider was educated by administrator on 11/09/2022 to contact 911 with any unusual event regarding a resident change in condition, to include unresponsiveness. All residents who are transported by a contracted provider have the potential to be affected. An audit of all transports which occurred in the last 90 days were reviewed with no findings of deficient practice re: significant events/changes of residents during transport were found. Alert and oriented residents were interviewed on 11/08/2022 by facility administrator to ensure they had not been involved in a significant event in the last 90 days. Zero additional resident incidents were identified to have occurred during outside transport. The administrator, director of nursing (DON), or transportation coordinator will audit 3 transports conducted by an outside resource per week X 4 weeks to	

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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 840	Continued From page 45	F 840	ensure prescribed procedures are followed in the event of a resident change in condition during transport and will audit 3 transports conducted by an outside resource monthly thereafter for 3 months. DON or Administrator will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or Administrator will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		11/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345169	A. BUILDING _____ B. WING _____	C 10/03/2022

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F 842	Continued From page 46	F 842		

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

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

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

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

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F 842	Continued From page 47 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document in the medical record a resident's death for 1 of 1 sampled resident (Resident #85). Findings included: Resident #85 was admitted to the facility on 12/09/20. The Minimum Data Set (MDS) dated 09/21/22 indicated Resident #85 expired in the facility. Review of the nurse progress notes for Resident #85 revealed no entry describing the event such as the time of her death, who pronounced her death, or if the family and physician were notified. During an interview on 09/29/22 at 4:23 PM, the Director of Nursing (DON) reviewed Resident #85's medical record and confirmed there was no nurse progress note detailing the events of Resident #85's death in the facility on 09/21/22. The DON confirmed Nurse #2 was the nurse on duty at the time of Resident #85's death and recalled Nurse #2 stating she had documented the event in the medical record; however, they haven't been able to find where. The DON explained when a resident passed away, she would expect for the nurse to document a progress note in the resident's medical record	F 842	F842 □ Regarding the alleged deficient practice of failure to maintain medical records on each resident that are-(i) Complete;(ii) Accurately documented;(iii) Readily accessible; and(iv) Systematically organized as evidenced by: a. failed to document in the medical record a resident's death for 1 of 1 sampled resident Documentation was completed for death of resident #85 on 10/10/2022 by licensed nurse. All residents who expired in the facility have the potential to be affected by this practice. An audit was conducted on 11/07/2022 of all deaths in the facility in the previous ninety days to ensure note was provided for death in facility with follow-up documentation as required per findings. Education provided to licensed nurses regarding documentation of death in the medical record provided by DON & ADON on 11/08/2022 and continued upon return to work with completion by 11/10/2022. Education will be provided by Director of Nursing / Assistant Director of Nursing for any newly hired or contracted nurses upon hire. Deaths (100%) in the facility will be audited every week for 4 weeks by the	

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F 842	Continued From page 48 describing what had transpired such as the condition when found (no pulse or respirations, etc.), time of death, and notification of the physician, family, and funeral home. An unsuccessful telephone attempt was made on 09/30/22 at 12:30 PM for an interview with Nurse #2 who was assigned to work with Resident #85 on 09/21/22 when she passed away at the facility.	F 842	Director of Nursing (DON) or Assistant Director of Nursing (ADON) to ensure proper documentation is present. DON or ADON will review the audits monthly to identify patterns and trends and will adjust plan to maintain compliance. DON or ADON will review the plan during Quality Assurance committee meetings and continue audits at the discretion of the committee. This plan of correction was completed on 11/11/2022	