STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 12/16/2022

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UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/12/22 through 12/16/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #L1NJ11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 12/12/22 through 12/16/22. Event ID# L1NJ11. The following intakes were investigated: NC00189507, NC00189070, NC00187825, NC00194816, NC00184451, and NC00195894. 3 of the 16 complaint allegations were substantiated resulting in a deficiency.	F 000		
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 observation, staff interviews, and record review, the facility failed to provide activity of daily living (ADL) care to a dependent resident by not cleaning or trimming her fingernails that were dirty and long for 1 of 5 residents reviewed for ADL care, Resident #39. The findings included: Resident #39 was admitted to the facility on 08/29/17 with diagnoses that included: Adult failure to thrive, Alzheimer's disease, and	F 677	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #39 nails were cleaned and trimmed on 12/13/2022 by the hall charge nurse. Nursing Assistant #4 was provided 1:1 re-education by Director of Nursing (DON) on providing nail care to resident�s not only on shower days but if nails are noted to be long and/or dirty. If unable to provide nail care to resident	1/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 01/20/2023

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

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F 677	Continued From page 1 contractures of the left hand. Review of an annual Minimum Data Set (MDS) assessment revealed Resident #39 had severely impaired cognition. She required extensive to dependent assistance with all ADL's. Review of the care plan for Resident #39 revealed a focus area of: Skin alteration related to moisture associate, incontinent of bowel and bladder, decreased mobility, and history of fragile skin. The goal was for her skin to remain intact through the next review. One intervention was to trim her fingernails weekly on shower days. An observation of Resident #39's fingernails was made on 12/12/22 at 12:30 PM. The fingernails on both hands were long, chipped, and black underneath with dirt. A second observation was made on 12/13/22 at 2:00 PM with the Director of Nursing (DON) present. Her fingernails on both hands remained long, chipped and black underneath with dirt. The DON stated he would have staff clean and trim her fingernails. He commented her nails should be clean and trimmed otherwise she could scratch herself because she did sleep with her hand under her head and had scratched herself in the eye in the past with her fingernails. In an interview with Nurse Aide (NA) #4 on 12/13/22 at 1:32 PM she stated she did not trim fingernails. She concluded this task was completed by the Activities Department or the nurses. She noted she was assigned to care for Resident #39. In an interview with Patient Care Assistant (PCA)	F 677	notify the nurse so nurse can provide nail care to residents. This education was provided on 12/14/2022. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Assistant Director of Nursing completed nail care rounds to ensure all residents on, 12/14/2022, to ensure all residents were receiving nail care to include: trimming, cleaning and/or filing if warranted. Any resident identified was provided nail care to include: trimming, cleaning and /or filing. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All clinical staff, including agency was re-educated by the Director of Nursing (DON)and the Assistant Director of Nursing (ADON) on 12/19/2022, on nail care to include cleaning, clipping nails and filing nails on shower days and as warranted. If resident refuses notify nurse. Any staff that has not been educated by 01/13/2023, will not be allowed to work until the re-education is completed. Daily audits will be completed by DON and/or designee five days a week for 2 weeks, three days a week for 2 weeks and then weekly for 2 months Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Audits will be reviewed and discussed in	

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F 677	Continued From page 2 #1 on 12/15/22 at 12:00 PM she stated she did all the same work as a NA except she was not allowed to insert catheters. She provided personal hygiene, peri care, nail care, and oral care to residents. She stated she had cleaned Resident #39's nails yesterday and trimmed them. She reported Resident #39 had not resisted care. She stated she was able to trim all the nails on the contracted hand because the hand had a wash cloth roll in it and the nails were accessible. She reported before she had provided the nail care for Resident #39 yesterday her nails were long and dirty. She noted all nail care was usually done on shower days. In an interview with the Activities Director on 12/16/22 at 11:40 AM she stated the Activities Department provided manicures to the residents twice a month and the activity was scheduled on the activity calendar. She commented they had a "nail cart" and they took it from room to room offering nail care service. She noted they did not clean under nails but if this was needed a NA would be asked to clean under the nails and they would clean on top. They also asked nursing to trim nails if needed, they only filed nails. They removed and replaced nail polish. She stated she had provided a manicure to Resident #39 a couple of times in the past when she would allow it. She stated usually Resident #39 balled her hands into a fist and refused but every once in a while she would allow activities to file her nails. In an interview with PCA #2 on 12/16/22 at 11:48 AM she stated she had worked at facility for 3 months. She reported she was not allowed to do showers or transfer residents alone but could work as a team to provide that care. She was allowed to to nail care that included cleaning and	F 677	weekly clinical meetings and ADL□s including nail care will be noted on ambassador rounds. Both ambassadors rounds and weekly clinical meeting findings will be reviewed and discussed in the monthly QAPI meeting for 3 months.	

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F 677	Continued From page 3 trimming or filing nails if a resident was not diabetic. She noted nails were cleaned and trimmed every scheduled shower day unless the resident refused care. She was familiar with Resident #39. She reported she had never trimmed her nails because she had refused every time she had attempted to trim her nails. In an interview with PCA #3 on 12/16/22 at 12:13 PM he stated he had worked for the facility since September 2022. He stated he was not allowed to do transfers, bathing or operate a lift machine by himself. He was allowed to do nail care. He commented he only cleaned nails and did not trim them. He noted if trimming was needed, he told the nurse. He did check resident nails every day when he provided care. Although he worked on the 100 hall, he usually let the NA on the hall provide care to Resident #39 because she required a lift for transfers. He had never provided nail care to Resident #39. In an interview with NA #3 on 12/16/22 at 12:28 PM she stated in general she did provide nail care to her residents whenever they got a shower and any time she provided ADL care. She noted she only cleaned and filed nails. If the nails needed to be cut she asked the nurse to do it in case the resident was diabetic or on a blood thinner.	F 677		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		1/13/23

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F 692	Continued From page 4 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Registered Dietician, and Nurse Practitioner interviews the facility failed to obtain physician ordered weekly weights for 2 of 2 residents (Resident #26, #75) and failed to obtain and record accurate weights and to identify and verify the accuracy of weights for 3 of 6 residents (Resident #26, #75, #6) reviewed for significant weight change. Findings included. 1). Resident #26 was admitted to the facility on 04/21/19 with diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, hypertension, and edema. Review of the care plan dated 10/01/20 for Resident #26 revealed a nutritional risk for aspiration related to the diagnosis of diabetes, CHF, and COPD with contributing factors of	F 692	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents # 6, #26 and #75 are now receiving weights per physician orders and re-weighs are being completed as warranted. Nurse #3 and #6 and nursing assistant #5 (NA) received 1:1 re-education by Director of Nursing (DON) on 01/09/2023 on obtaining weekly, monthly and re-weights per physician orders, charting accurate weights, and how to weigh residents appropriately. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Director of Nursing audited current residents weight orders to identify residents that are on weekly and monthly	

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F 692 Continued From page 5

shortness of breath, receiving oxygen via nasal cannula, and weight gain. The goal of care included in part; Resident #26 would not experience significant weight changes through the next review period. Interventions included to refer to the Registered Dietician for evaluation of current nutritional status, provide a mechanical soft diet, and weekly weights as ordered.

A physician's order dated 09/29/21 for Resident #26 revealed to obtain weekly weights.

A review of Resident #26's weights were recorded in the medical record as follows:

12/13/2022 165.2 lbs.
12/07/2022 141.2 lbs.
11/16/2022 139.8 lbs.
11/13/2022 172.4 lbs.
09/28/2022 178.6 lbs.
09/09/2022 181.7 lbs.
09/07/2022 182.4 lbs.
08/17/2022 189.9 lbs.
08/10/2022 190.3 lbs.
07/13/2022 186.0 lbs.
07/06/2022 189.0 lbs.

Review of the Minimum Data Set (MDS) quarterly assessment dated 11/11/22 revealed Resident #26 had moderately impaired cognition with no rejection of care and required extensive assistance with activities of daily living (ADLs).

Review of Resident #26's progress notes from 11/16/22 through 12/13/22 revealed no documentation of weekly weights, or documentation indicating a significant weight change and no documentation that a re-weigh was obtained on 11/16/22.

F 692

weights to ensure that weights are being obtained, reviewed for accuracy, and re-weighed as indicated and documented per physician orders .Audit was completed on 01/09/2023

Address what measures or systemic changes will be put in place to ensure that the deficient practice will not recur:
On admission or re-admission, weights will be completed per physician orders. The Director of Nursing (DON) and/or designee will complete retraining with the facility nursing staff, on weighing and re-weighing of residents per facility policy. Designated staff members will be given a list of weights on Monday that needs to be completed and charted on by end of day Thursday. All weights obtained and charted will be audited by DON or designee on Friday for completion and accuracy weekly for 3 months.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Director of Nursing or designee will monitor accuracy of weights and re-weights. Any weight variances will be reviewed in clinical morning meeting 5 times per week. Results of the audited information will be reviewed and discussed in the monthly QAPI meeting for 3 months

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F 692	Continued From page 6 An interview as conducted on 12/14/22 at 11:51 AM with Nurse #6. She stated Resident #26 had CHF, and COPD. She stated the medications aides, or the nurse aides obtained the weights and at one time there was a designated staff member who obtained the weights, but they no longer had a designated person. She stated the typical process included either the nurse or the medication aide would notify the nurse aides each day and let them know which residents needed to be weighed. She stated if there were orders for daily weights it would also be documented in the nurse aide care plan book which was kept in a drawer in the common areas and nurse aides referred to it routinely. She stated the medication aide, or the nurse aide would report the weight back to the nurse and the nurse would document the weight in the resident's electronic medical record. She stated the unit manager printed out a monthly report, that showed weights and would notify the physician and the registered dietician if there were any concerns. She stated if there was a significant increase or decrease in weight a re-weigh should be obtained and the physician notified if needed. She indicated the weight fluctuations recorded for Resident #26 on 11/16/22 and 12/07/22 were most likely not accurate and a re-weigh should have been done. An interview was conducted on 12/14/22 at 12:50 PM with Nurse Aide #5. She stated Resident #26 was compliant with care. She stated at times they would have a designated staff member to obtain weights, and if not, the nurse would notify the nurse aide to get a weight. She stated the wheelchair or the mechanical lift was used for weights and the weight was subtracted from the total weight, then given to the nurse. She stated	F 692		

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F 692	Continued From page 7 the nurse aides did not record weights in the medical record. She indicated she relied on the nurse to inform her of who needed to be weighed each day. An interview was conducted on 12/14/22 at 2:57 PM with the Registered Dietician. She stated each week she evaluated new admissions, and residents with significant weight changes, residents receiving tube feedings, residents with wounds, and any other concerns from the last 30 days. She stated recommendations were sent to the Director of Nursing (DON) at the end of the day. She stated she saw Resident #26 on 11/16/22 and asked for a reweigh due to a significant decrease in weight from 172.4 down to 139.8 over 3 days. She stated the DON at the time who was no longer employed at the facility stated she would get the reweigh and a reweigh was never done. She stated the Nurse Practitioner also noted weight fluctuations for Resident #26. She stated Resident #26's appetite had decreased, and the recommendation was made to start nutritional supplements. She stated she thought the weight recorded on 11/16/22 was inaccurate because of the significant decrease and indicated a re-weigh should have been done and stated weekly weights should be obtained per the physician's order. An interview was conducted on 12/15/22 at 9:23 PM with Nurse #3. She stated the nurse aides get the weights by the 10th of the month. She stated at one time they had consistent staff that obtained the weights then staffing decreased and the nurse aide assigned to the floor would have to do the weights. The nurse aides would then inform the nurse of the weight and the nurse on the floor recorded the weight on the Medication	F 692		

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F 692	Continued From page 8	F 692		

Administration Record (MAR). She indicated the weight fluctuations for Resident #26 on 11/13/22 and 12/07/22 were most likely not accurate and a re-weigh should have been done.

A phone interview was conducted on 12/16/22 at 11:46 AM with Nurse Practitioner #2. She stated Resident #26 was sent out to the hospital a while ago, her appetite had decreased, and some weight loss would be expected. She stated she spoke with the Registered Dietician recently and recommendations were made. She stated residents with significant weight change should be re-weighed for accuracy. She stated weight orders should be followed and weights recorded accurately.

2). Resident #75 was admitted to the facility on 11/29/21 with diagnoses including kidney failure, dysphagia, and dementia.

Review of the care plan dated 11/29/21 revealed Resident #75 had difficulty swallowing. Interventions included in part; refer to the Dietician for evaluation of current nutritional status and provide pureed diet with thin liquids.

A physician's order dated 09/14/22 for Resident #75 revealed to start weekly weights for four weeks.

A review of Resident #75's weights were recorded in the medical record as follows:

11/24/2022 159.4 lbs.
10/12/2022 161.0 lbs.
09/28/2022 163.0 lbs.
09/07/2022 173.4 lbs.
08/17/2022 173.1 lbs.

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F 692	Continued From page 9 08/14/2022 173.1 lbs. 07/13/2022 174.0 lbs. Review of Resident #75's progress notes from 09/14//22 through 12/13/22 revealed no documentation of weekly weights, or documentation indicating a significant weight change on 09/28/22, and no documentation that a reweigh was obtained. Review of the Minimum Data Set (MDS) quarterly assessment dated 11/25/22 revealed Resident #75 had severely impaired cognition and required extensive assistance with activities of daily living. Weight loss was noted, and the resident received a therapeutic diet. An interview was conducted on 12/14/22 at 11:51 AM with Nurse #6. She stated Resident #75 had an order in place dated 09/14/22 for weekly weights. She stated Resident #75 received a pureed diet and ate all of her meals in the dining room so that supervision was provided. She acknowledged that weekly weights had not been obtained for Resident #75 per the physician's order. She indicated it was the nurse's responsibility to identify which residents needed to be weighed each day and then inform the nurse aide to get the weights. An interview was conducted on 12/14/22 at 2:57 PM with the Registered Dietician. She stated Resident #75 had a weight loss of 6.2% over one month in September 2022 and weekly weights were ordered. She indicated the resident should have been re-weighed for accuracy and weekly weights obtained. She indicated she notified the previous DON of concerns regarding weight discrepancies.	F 692		

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An interview was conducted on 12/16/22 at 12:25 PM with personal care aide #3. He stated he was not aware of which residents had weekly weight orders. He stated the nurse would let him know at the beginning of the shift which residents needed to be weighed and stated he gets the weight and gives it to the nurse.

A phone interview was conducted on 12/16/22 at 11:46 AM with Nurse Practitioner #2. She stated weekly weights should be obtained as ordered and weights checked for accuracy.

3). Resident #6 was admitted to the facility on 05/13/22 with diagnoses including in part; heart failure, respiratory failure, obstructive sleep apnea, and chronic obstructive pulmonary disease (COPD).

A review of Resident #6's weights were recorded in the medical record as follows:

12/14/2022 140.2 lbs.
12/07/2022 140.2 lbs.
11/23/2022 140.6 lbs.
09/28/2022 164.0 lbs.
09/28/2022 164.0 lbs.
09/07/2022 164.3 lbs.
08/17/2022 163.0 lbs.
08/03/2022 166.5 lbs.
07/22/2022 170.4 lbs.

Review of the Minimum Data Set (MDS) quarterly assessment dated 11/28/22 revealed Resident #6 had severely impaired cognition. She had no rejection of care and required extensive assistance with activities of daily living. Weight loss was noted, and the resident received a

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F 692	Continued From page 11 therapeutic diet. Review of Resident #6's progress note dated 11/30/22 revealed a note from the Registered Dietician that read in part; comfort measures ordered. Significant weight loss over 1-2 months, will obtain further weights to verify; however, resident endorsed decreased appetite, intake now 50% meals, and not meeting needs for weight maintenance. Recommendations were made. Review of the care plan dated 12/12/22 for Resident #6 revealed a nutritional risk and to refer to the Dietician for evaluation of current nutritional status. An interview was conducted on 12/14/22 at 2:57 PM with the Registered Dietician. She stated Resident #6 was now on comfort measures and did show weight loss. She stated although comfort measures were in place and weight loss was expected a re-weigh should have occurred for accuracy on 11/23/22 when significant weight loss was noted. A phone interview was conducted on 12/16/22 at 11:46 AM with Nurse Practitioner #2. She stated Resident #6 was also sent out to the hospital and her appetite had decreased, with some weight loss expected. She stated she spoke with the Registered Dietician recently and recommendations were made. She indicated although Resident #6 was on comfort measures weights should be recorded accurately and a re-weigh obtained if significant weight loss or gain. An interview was conducted on 12/16/22 at 12:30	F 692		

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	345549	A. BUILDING ______ B. WING ______	C 12/16/2022

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F 692	Continued From page 12 PM with the Director of Nursing. He stated he started working in the facility in November 2022. He stated he was not aware that weights were not being obtained per the physician's order and stated he was not aware of the inaccuracies of the recorded weights. He stated his expectation was that weights were checked for accuracy and weights were obtained according to the physician's order.	F 692		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain the area surrounding the dumpsters free of debris and ensure waste was contained for 2 of 2 dumpsters observed. Findings included: During an observation of the dumpster area on 12/12/22 at 11:45 AM revealed: 1. Eleven large gray plastic 55-gallon garbage cans were randomly lying on the ground around the two dumpsters, inside the enclosed area. 2. One large yellow plastic 55-gallon garbage can, standing up-right next to the first dumpster was half full of brownish colored water. On 12/13/22 at 5:15 PM, 12/14/22 at 5:15 PM, and 12/15/22 at 5:45 PM the dumpster area was observed in the same condition. In an interview on 12/16/22 at 9:17 AM the DM and Maintenance Director indicated the dumpster	F 814	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Garbage cans from dumpster area were disposed of week of 1/9/2022 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Not applicable Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Executive Director or designee will audit dumpster area 5 times per week for 2 weeks, 3 times per week for 2 weeks, then monthly for 2 months Indicate how the facility plans to monitor	1/13/23

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F 814	Continued From page 13 area should be kept clean by maintenance staff and dietary staff and was not. In an interview on 12/16/22 at 9:35 AM the Administrator and Corporate Clinical Consultant indicated facility staff should have kept the dumpster area clean and free of clutter and debris and was not.	F 814	it□s performance to make sure that solutions are sustained: Audits will be reviewed and discussed in the monthly QAPI meeting for 3 months	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		1/13/23

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F 867	Continued From page 14	F 867		

including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas;

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F 867	Continued From page 15 consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		

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F 867	Continued From page 16 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey on 10/26/21 and the complaint investigation on 03/08/21. This was for a deficiency that was originally cited on 03/08/21 and on 10/26/21 in the area of nutrition and hydration maintenance and was subsequently recited on the current recertification survey of 12/16/22. The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included. This tag is cross referenced to: F692: Based on record review, staff, Registered Dietician, and Nurse Practitioner interviews the facility failed to obtain physician ordered weekly weights for 2 of 6 residents (Resident #26, #75) and failed to obtain and record accurate weights and to identify and verify the accuracy of weights for 3 of 6 residents (Resident #26, #75, #6) reviewed for significant weight change. During the recertification survey and complaint investigation completed on 10/26/21 the facility failed to obtain a physician ordered weight for a	F 867	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents # 6, #26 and #75 are now receiving weights per physician orders and re-weighs are being completed as warranted. Nurse #3 and #6 and nursing assistant #5 (NA) received 1:1 re-education by Director of Nursing (DON) on 01/09/2023 on obtaining weekly, monthly and re-weights per physician orders, charting accurate weights, and how to weigh residents appropriately. Designated staff members will be given a list of weights on Monday that needs to be completed and charted on by end of day Thursday. All weights obtained and charted will be audited by DON or designee on Friday for completion and accuracy weekly for 3 months. Resident rooms #400, #401, #409 and #411 privacy curtains were obtained and hung on 12/15/2023 by Housekeeping Supervisor. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: As the facility realizes the potential for the alleged deficient process to affect other residents of the facility QAPI committee was reeducated by the Director	

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F 867	Continued From page 17 resident who was having weight loss for 1 of 3 residents (Resident #63) observed for nutrition. During the complaint investigation survey completed on 03/08/21 the facility failed to implement a dietary recommendation for ice cream to be served with lunch and dinner meals for 1 of 1 resident (Resident #1) observed for nutrition. An interview was conducted with the Administrator on 12/16/22 at 2:00 PM. He stated QAPI meetings were held monthly, and the committee focused on problems related to processes and services that were provided to residents. He stated performance data was reviewed, including adverse events and the potential impacts. He indicated he was not aware of the issues regarding staff failing to obtain weekly weights and documenting accurate weights for residents. He stated education would be provided and improvements would continue in this area and would be reviewed in QAPI until improvements occurred.	F 867	of Operations on the proper QAPI process. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Processes that were put in place to address F677 and F914 will be reviewed and audited in monthly QAPI meeting. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Regional Director of Operations or the designee will monitor the QAPI process monthly for 3 months then quarterly for 2 quarters, to ensure continued compliance.	
F 914 SS=E	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by:	F 914		1/13/23

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F 914	Continued From page 18 Based on observations and staff interviews the facility failed to provide privacy curtains in resident rooms to provide full visual privacy for 4 of 11 rooms on the 400 hall (Room # 400, 401, 409, 411). Findings included. During an observation on 12/13/22 at 1:00 PM there were no privacy curtains that would provide privacy for the residents in bed A and bed B, in rooms 400, 401, 409, and 411 each of which were semiprivate rooms with two residents in each room. During an observation on 12/13/22 at 4:00 PM there continued to be no privacy curtains observed in rooms 400, 401, 409, and 411 that would provide privacy for the residents in bed A and bed B. An interview was conducted on 12/13/22 at 4:30 PM with the Director of Nursing (DON). He stated he was not aware there were no privacy curtains in some of the rooms on the 400 hall but stated he would check with the Housekeeping Supervisor to determine why there were no curtains and would have them hang the curtains immediately. During an observation on 12/14/22 at 10:00 AM there were no privacy curtains observed in rooms 400, 401, 409, and 411 that would provide privacy for the residents in bed A and bed B. During an observation on 12/14/22 at 4:00 PM there continued to be no privacy curtains observed in rooms 400, 401, 409, and 411 each of which were semiprivate rooms that would	F 914	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Privacy curtains were rehung in rooms #400, #401, #409 and #411 on 12/15/2023 by housekeeping Supervisor. 1:1 Education was provided to the housekeeping supervisor regarding privacy curtains by the Executive Director on 12/14/2022. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Executive Director or designee will audit all semi-private rooms in facility was to ensure that all rooms had privacy curtains Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Executive Director or designee will audit for presence of privacy curtains in semi private rooms. Audits will be conducted 5 times per week for 2 weeks, 3 times per week for 2 weeks, then monthly for 2 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Audits will be reviewed and discussed in the monthly QAPI meeting for 3 months	

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F 914	Continued From page 19	F 914		

provide privacy for the residents in bed A and bed B.

An interview was conducted on 12/14/22 at 4:15 PM with the Director of Nursing (DON). He stated he didn't get a chance to talk with the Housekeeping Supervisor but would have him address the issue immediately.

During an observation on 12/15/22 at 12:00 PM privacy curtains were observed in rooms 400, 401, 409, and 411 the curtains provided full visual privacy for the residents in bed A and bed B.

An interview was conducted on 12/16/22 at 10:00 AM with the Housekeeping Supervisor. He stated the privacy curtains were taken down in rooms 400, 401, 409, and 411 on the morning of 12/13/22 to be cleaned. He stated they typically tried to get the curtains hung back up the same day but that didn't occur. He stated he received a new shipment of privacy curtains today that would be used to replace the privacy curtains at the time they were taken down to be cleaned so that residents would not be without a privacy curtain at any time.

An interview was conducted on 12/16/22 at 2:00 PM with the Administrator. He indicated resident privacy should be maintained at all times with privacy curtains in place. He stated Housekeeping should not have removed the privacy curtains for that length of time and the curtains should have been cleaned and replaced the same day.