STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345124	A. BUILDING _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-ELKIN	560 JOHNSON RIDGE ROAD ELKIN, NC 28621

(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 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, §485.542, §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 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	E 001		2/8/23

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

Electronically Signed | 02/04/2023

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E 001	Continued From page 1 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 record review and staff interviews, the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to review and update the plan annually, failed to update emergency policies and procedures annually, failed to review and update the training and testing program annually, failed to provide EP training annually and maintain documentation of the training, and failed to complete a full scale exercise and another full scale or tabletop exercise annually. The findings included: A review of the facility's EP plan, updated 3/2021 revealed: a. The EP plan had not been updated since 3/2021. b. The EP plan did not include updated emergency policies and procedures since 3/2021. c. The EP plan did not include training/testing of the plan since 3/2021. d. The EP plan did not include documentation of employee training since 2021. e. The EP plan did not include evidence of a training and testing program that included a full scale exercise and an additional full scale or table top exercise since 2021. An interview was conducted with the Administrator on 1/11/23 at 6:30 PM. She stated	E 001	No residents were identified in the 2567. The Administrator and Maintenance Director along with the Lead Team Member reviewed and updated the Emergency Management Annual Plan, updated and reviewed all new policies and procedures related to emergency management; updated and reviewed the annual plan; reviewed and updated the training and testing program. The Administrator will ensure that this will be done annually or with any significant policy update. All residents are affected by this deficient practice. Administrator and/or Maintenance Director will in-service all staff on Emergency Management Program by February 8th 2023 or employees will not be able to complete work until attend in-service. Full scale exercises have been completed and documented per requirements and placed in the Emergency Management Manual. Many of our staff members were also involved in the exercise program since we actually had emergency events to occur. The Administrator and/or maintenance	

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E 001	Continued From page 2 the EP plan should be updated annually, but that it was last updated in August 2021. She explained staff were trained "often," but did not have the documentation for the training. The Administrator said the facility talked about disaster training with staff, but "I don't have the documentation to show it." She revealed the former Maintenance Director was responsible for updating the EP plan, but it was her primarily responsibility at this time. She reported the last tabletop exercises included a tornado and weather event but it had not been documented in the EP plan.	E 001	Director will take the findings to the Quality Assurance Performance Improvement Committee meeting monthly times three then quarterly for three quarters. Compliance date 2/8/2023	
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on 1/08/2023 through 1/11/2023. Event ID #42NN11.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		2/8/23

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F 657	Continued From page 3 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to review and revise the care plan in the areas of range of motion for 1 of 2 residents (Resident #33) reviewed for range of motion. The findings included: Resident #33 was admitted to the facility on 4/18/2014. His cumulative diagnoses included nontraumatic intracerebral hemorrhage, Parkinson's disease, hemiplegia, and contractures of the bilateral hips, bilateral ankles, right knee, and left hand. A review of Resident #33 ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 12/05/2022. The MDS indicated the Resident had severe cognitive impairment, was dependent on one staff member for all activities of daily living (ADL) care needs and had limited range of motion in bilateral upper and lower extremities. A review of Resident #33's care plan dated 9/5/2022 identified the following problem areas:	F 657	Resident #33 Care plan was reviewed and revised on January 10th 2023 for removal of splint removed from care plan and on January 12th care plan was reviewed and revised for referral of therapy Audit all care plans for last review and revised dates by Case mix Director and Case Mix Coordinator began on January 25th began review and or revision of Range of Motion care plans and will be completed by February 8th. The Clinical Reimbursement Coordinator will educate the Case Mix Director and Case mix Coordinator as well as the interdisciplinary team thru teams. Education will be complete by February 8th 2023 Interdisciplinary Team will review and revise the care plans with each quarterly, annual, and significant changes. The administrator will review 5 care plans to ensure the review and revision of range	

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F 657	Continued From page 4 1) The Resident had impaired ADL functioning related to a history of a cerebral vascular accident (CVA) with left side hemiparesis, Parkinson's disease, and contractures to the bilateral hips, knees, and ankles. He cannot speak and requires total care with ADL's. 2) The Resident had the potential for alteration in comfort related to impaired mobility from a CVA with left side hemiparesis. He has contractures to the bilateral hips, knees, and ankles. He receives splinting to the hand for contracture prevention. Staff must anticipate and observe the resident for pain. There was not an intervention for the placement of the splint to the hand. A review of the physician notes dated 12/26/2022 documented there were no deformities to the extremities. A review of the physician orders did not include an order for splint placement to the upper or lower extremities. A review of Resident #33 's electronic medical record revealed a contracture risk assessment dated 1/3/2023 at 12:38 p.m. and documented the Resident's general state of health was poor and declining, orientation was alert, with nonfunctional abilities in ADL care, immobile, severe limitation that was greater than 40% in present joint condition and had contributing factors that included Parkinson's disease. A score was calculated based on the assessment and each category was the most severe possible except for the orientation of the Resident. The orientation lowered the contracture risk to a moderate level instead of a severe level. The assessment question for referral needs, was	F 657	of motions care plans weekly times four then monthly for three consecutive months of compliance is sustained, then quarterly thereafter The Administrator will take the findings of care plan compliance to the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is sustained then quarterly thereafter Findings will be taken to Quality assurance committee meeting monthly times three then quarterly for three months. Date of compliance February 8th 2023.	

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F 657	Continued From page 5	F 657		

checked, "no referrals needed and continue current plan of care."

An observation of Resident #33 was conducted on 1/9/2023 at 12:22 p.m. The Resident was observed lying in bed with a blanket covering his body. His left hand was bent at a 90-degree angle at the wrist and his fingers were curled and bent, from the back of his hand, at a 45-degree angle. There was not a splint in place to the left or right hand.

An interview was conducted with a family member on 1/9/2023 at 12:30 p.m. of Resident #33 and revealed the Resident previously wore a splint to his left hand but they had not seen one placed in a long time.

An observation of Resident #33 was conducted on 1/10/2023 at 10:48 a.m. and he was observed to be positioned on his left side with a pillow used to support his left arm. He did not have a splint in place to the left or right hand.

An interview was conducted on 1/10/2023 at 3:21 p.m. with the Rehabilitation Manager and she revealed Resident #31 was last seen by Occupational Therapy (OT) on 4/15/2015. She stated the OT discharge summary identified the Resident demonstrated impaired range of motion of the left hand and all digits with neutral to hyperextension, without any flexion due to tightness in the joint. A recommendation was made for a left-hand orthotic device to be utilized to aid with achieving optimal skin and joint integrity without negative effect to the Resident in order to achieve neutral position for contracture management. She reviewed the electronic medical record for Resident #33 and did not see

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F 657	Continued From page 6 an order to discontinue the recommendation for the splinting device. The Rehabilitation Manager stated the Resident had not been evaluated for treatment by the OT since 2015. An interview was conducted with the Administrator on 1/10/2023 at 4:10 p.m. and she reviewed the chart for Resident #33. She stated she was not aware the Resident had not been referred to the Occupational therapy department in so long. She stated she was unsure of the reason the splint was no longer being placed on the left hand. She would review the chart and provide documentation if the splint had been discontinued. She revealed it was her expectation that communication occurs between the nursing department, that included the Director of Nursing (DON) and the MDS nurse, and the therapy department. Then orders should be implemented and/or referrals provided as a resident declines. The care plan interventions should match the current orders. She added a referral to the OT department would be made. An interview was conducted with Nurse #2 on 1/11/2023 at 11:34 a.m. and she revealed Resident #31 had a splint for his left hand a long time ago and she thinks this had been stopped. She was unsure of the reason the splint was stopped.	F 657		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 679		2/8/23

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F 679	Continued From page 7 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interview with the Resident Council, resident and staff interviews and record reviews, the facility failed to provide activities as scheduled when the Activities Director (AD) was placed in the Nurse Aide (NA) role. Additionally, the facility failed to provide any scheduled activities on the weekends. This was for 4 of 4 residents (Residents #52, #38, #20 and #26) reviewed for facility activities. Findings included: 1. Resident #52 was admitted to the facility 12/19/2022 with a diagnosis that included, in part, diabetes. The admission Minimum Data Set (MDS) assessment dated 12/23/2022 revealed Resident #52 was cognitively intact. The assessment indicated the resident stated it was very important to her to do things with groups of people, to have books, magazines and newspapers to read, to participate in religious services and to do her favorite activities. The care plan, updated 12/23/22, included a focus area of activities/recreation. A care plan intervention revealed Resident #52 was provided with a monthly calendar of facility activities. An activity/recreation note, dated 12/23/22 and	F 679	Resident #52 has been discharged home and no longer resides in the facility. Resident # 38 frequently leaves facility with friends, attends church services at outside church on Sunday and Wednesday□s, holds prayer meeting on Thursday□s in back dining room, plays wii whenever he desires, spends time on cellphone with friends and family. Resident #20 attends group activities if he desires but will leave before activity is finished often. He goes to bed around 6PM and is up around 5am daily. Naps frequently thru-out the day. Family visits weekly and he socializes with other residents and their families on daily basis. Resident #26 ambulates around facility daily. Socializes with staff, other resident families and residents. He also has alexa, IPAD with voice control, telephone that is voice controlled. Activity and Administrator purchases personal items for him as he needs them. Will attend activities of choice and activity director has even planned outside activities and day of the outing he refused to go. Activity Director has interviewed alert, oriented residents on ideas for different	

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F 679	Continued From page 8 authored by the Activities Director (AD) read, in part, " ...She is very pleasant to be around and stated she enjoys coming to every activity ..." During an interview with the Administrator on 1/9/23 at 9:40 AM, she shared the AD had been "pulled to the floor today" and worked as a NA since two of the scheduled NAs had called off work. The AD was interviewed on 1/9/23 at 9:48 AM and confirmed she was moved to work as a NA for the first shift (7:00 AM-3:00 PM). She stated when she worked as a NA, the facility group activities were canceled because she didn't have another staff member who helped her. An activities calendar for January 2023 was provided by the AD on 1/9/23 at 9:55 AM. A review of the scheduled activities for 1/9/23 included: -9:00 In room visits -10:30 Talk-n-toss ball -2:30 Corn hole -4:00 Mail Further review of the activities calendar specified every Saturday and Sunday's schedule included: "Family Visitation and 4:00 Mail." Resident #52 was interviewed on 1/9/23 at 11:26 AM. She explained she had been at the facility for three weeks. She said the facility had activities during the week and she attended every activity that was held. She shared she was very active at home and wanted to participate in activities at the facility on the weekends, but no activities were scheduled. She stated she didn't think the AD worked on weekends. Resident #52	F 679	activities they would like to see added to calendar. She has added evening and weekend activities that will be carried out by her and/or department managers on after hours. The Administrator educated the Activities Director on _January 30th on the importance of regarding off hours and weekend activity requirement. This education regarding off hours and weekend activity requirement has been added to the general orientation to any newly hired activity staff. Activity staff that has not been educated by 2/8/2023 will be removed from the schedule until education is complete. In the event Activity Director is pulled to the floor due to staffing concerns the daily activities will be assigned in morning meeting to dept managers by the administrator and/or Director of Health Services. The Activities Director will monitor the scheduled activity calendar with the actual activities that occurred weekly for four weeks then monthly thereafter until three months of continued compliance then quarterly. The Activity Director will take the analysis of the activity monitoring to Quality Assurance and Performance Committee meeting monthly until three consecutive months of substantial compliance is maintained, then quarterly thereafter.	

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F 679	Continued From page 9	F 679	Date of compliance February 8th 2023.	

added the facility had some activities over the Christmas weekend, but none since then.

On 1/9/23 at 11:45 AM an observation of the main dining room revealed a group activity was held (Talk-n-toss ball) and facilitated by the Administrator.

Observations of the main dining room and other common areas of the facility on 1/9/23 at 2:30 PM, 3:04 PM and 3:15 PM revealed the corn hole activity was not being held as scheduled on the activity calendar.

A Resident Council group interview was completed on 1/10/23 at 2:43 PM. During the group interview, residents stated there was a notation on the monthly activities calendar that said activities were subject to change. Residents reported the scheduled corn hole activity was not completed on 1/9/23 since the AD worked on the hall as a NA and no one was available to help conduct the activity. Resident #52 stated she would have come to the activity if it had been held as scheduled on the calendar. The Resident Council group further explained if the scheduled activity was canceled because the AD worked on the hall, either the AD or another NA notified residents of the cancellation of the activity.

Follow up interviews were completed with the AD on 1/10/23 at 3:40 PM and 1/11/23 at 9:58 AM, during which she explained when a resident was admitted to the facility, she completed an activities assessment within 3-5 days. She shared when she completed the assessment for Resident #52, she learned the resident enjoyed "mostly everything," including Bingo and going outside. She added Resident #52 tried to attend

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F 679	Continued From page 10	F 679		

all the group activities unless she wasn't feeling well, and was willing to help during the activities. The AD recalled the resident had recently spoken with her and inquired about having activities available on the weekends. The AD said there were no group activities scheduled on Saturdays or Sundays since she didn't typically work on weekends. The AD explained if residents wanted to do an independent activity on the weekend, such as puzzles, radio, magazines, books, they made arrangements with her prior to the weekend and she then provided those materials for the resident. She added there was no common area in the facility that had independent leisure materials for residents to obtain when she was not in the building. The AD provided a copy of her timecard for November-December 2022 and January 2023. She reviewed the timecard during the interview and explained there were seven days where she worked as a NA, and therefore, group activities were not held on those days; or, if she worked during third shift (11:00 PM-7:00 AM), had not come to work the following day and worked as the AD. She added since she worked as a NA 1/9/23 on first shift, the corn hole activity was not completed as scheduled that day.

The Administrator was interviewed on 1/11/23 at 5:07 PM. She stated when the AD was sent to the hall and worked as a NA, the facility attempted to find someone who assisted with the scheduled group activity, although it may not be the exact activity the AD had planned on the calendar. The Administrator said she had not kept records if another staff member did the activity while the AD worked as a NA. She shared there were some leisure activity items located at the end of the 600 hall that the nurses utilized, such as music and coloring sheets; nursing staff also

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F 679	Continued From page 11	F 679		

visited with residents. Typically, there was not a staff member in the facility on weekends who conducted group activities. The Administrator added the facility was not as consistent with offering recreation on weekends to residents on the rehabilitation unit because families often visited at that time.

2. Resident #38 was admitted to the facility 11/15/18 with diagnoses that included, in part, diabetes and hypertension.

The annual MDS assessment dated 9/8/2022 revealed Resident #38 was cognitively intact. The assessment indicated the resident stated it was very important to him to do things with groups of people, to have books, magazines and newspapers to read, to participate in religious services and to do his favorite activities.

The care plan, updated 1/9/23, included a focus area of activities/recreation. A care plan intervention revealed Resident #38 was provided with a monthly calendar of facility activities.

During an interview with the Administrator on 1/9/23 at 9:40 AM, she shared the AD had been "pulled to the floor today" and worked as a NA since two of the scheduled NAs had called off work.
The AD was interviewed on 1/9/23 at 9:48 AM and confirmed she was moved to work as a NA for the first shift (7:00 AM-3:00 PM). She stated when she worked as a NA, the facility group activities were canceled because she didn't have another staff member who helped her.

An activities calendar for January 2023 was provided by the AD on 1/9/23 at 9:55 AM. A

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review of the scheduled activities for 1/9/23 included:

-9:00 In room visits
-10:30 Talk-n-toss ball
-2:30 Corn hole
-4:00 Mail

Further review of the activities calendar specified every Saturday and Sunday's schedule included: "Family Visitation and 4:00 Mail."

On 1/9/23 at 11:45 AM an observation of the main dining room revealed a group activity was held (Talk-n-toss ball) and facilitated by the Administrator.

Observations of the main dining room and other common areas of the facility on 1/9/23 at 2:30 PM, 3:04 PM and 3:15 PM revealed the corn hole activity was not being held as scheduled on the activity calendar.

A Resident Council group interview was completed on 1/10/23 at 2:43 PM. During the group interview, residents stated there was a notation on the monthly activities calendar that said activities were subject to change. Residents reported the scheduled corn hole activity was not completed on 1/9/23 since the AD worked on the hall as a NA and no one was available to help conduct the activity. Resident #38 stated he would have come to the activity if it had been held as scheduled on the calendar. The Resident Council group further explained if the scheduled activity was canceled because the AD worked on the hall, either the AD or another NA notified residents of the cancellation of the activity. Resident #38 added he thought it "would be good

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for residents" to have activities on the weekend, "in case they got bored," and said he would participate in weekend activities.

Follow up interviews were completed with the AD on 1/10/23 at 3:40 PM and 1/11/23 at 9:58 AM, during which she explained when a resident was admitted to the facility, she completed an activities assessment within 3-5 days. The AD said there were no group activities scheduled on Saturdays or Sundays since she didn't typically work on weekends. The AD explained if residents wanted to do an independent activity on the weekend, such as puzzles, radio, magazines, books, they made arrangements with her prior to the weekend and she then provided those materials for the resident. She added there was no common area in the facility that had independent leisure materials for residents to obtain when she was not in the building. The AD provided a copy of her timecard for November-December 2022 and January 2023. She reviewed the timecard during the interview and explained there were seven days where she worked as a NA, and therefore, group activities were not held on those days; or, if she worked during third shift (11:00 PM-7:00 AM), had not come to work the following day and worked as the AD. She added since she worked as a NA 1/9/23 on first shift, the corn hole activity was not completed as scheduled that day.

The Administrator was interviewed on 1/11/23 at 5:07 PM. She stated when the AD was sent to the hall and worked as a NA, the facility attempted to find someone who assisted with the scheduled group activity, although it may not be the exact activity the AD had planned on the calendar. The Administrator said she had not kept

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records if another staff member did the activity while the AD worked as a NA. She shared there were some leisure activity items located at the end of the 600 hall that the nurses utilized, such as music and coloring sheets; nursing staff also visited with residents. Typically, there was not a staff member in the facility on weekends who conducted group activities. The Administrator added the facility was not as consistent with offering recreation on weekends to residents on the rehabilitation unit because families often visited at that time.

3. Resident #20 was admitted to the facility 6/14/21 with a diagnosis that included, in part, hypertension.

The annual MDS assessment dated 8/16/22 revealed Resident #20 was cognitively intact. The assessment indicated the resident stated it was very important to him to do things with groups of people and to do his favorite activities.

The care plan, updated 11/29/22, included a focus area of activities/recreation. A care plan intervention revealed Resident #20 enjoyed certain group activities and needed to be reminded of the scheduled activities.

During an interview with the Administrator on 1/9/23 at 9:40 AM, she shared the AD had been "pulled to the floor today" and worked as a NA since two of the scheduled NAs had called off work.
The AD was interviewed on 1/9/23 at 9:48 AM and confirmed she was moved to work as a NA for the first shift (7:00 AM-3:00 PM). She stated when she worked as a NA, the facility group

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activities were canceled because she didn't have another staff member who helped her.

An activities calendar for January 2023 was provided by the AD on 1/9/23 at 9:55 AM. A review of the scheduled activities for 1/9/23 included:

-9:00 In room visits
-10:30 Talk-n-toss ball
-2:30 Corn hole
-4:00 Mail

Further review of the activities calendar specified every Saturday and Sunday's schedule included: "Family Visitation and 4:00 Mail."

On 1/9/23 at 11:45 AM an observation of the main dining room revealed a group activity was held (Talk-n-toss ball) and facilitated by the Administrator.

Observations of the main dining room and other common areas of the facility on 1/9/23 at 2:30 PM, 3:04 PM and 3:15 PM revealed the corn hole activity was not being held as scheduled on the activity calendar.

A Resident Council group interview was completed on 1/10/23 at 2:43 PM. During the group interview, residents stated there was a notation on the monthly activities calendar that said activities were subject to change. Residents reported the scheduled corn hole activity was not completed on 1/9/23 since the AD worked on the hall as a NA and no one was available to help conduct the activity. Resident #20 stated he would have come to the activity if it had been held as scheduled on the calendar. The Resident

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Council group further explained if the scheduled activity was canceled because the AD worked on the hall, either the AD or another NA notified residents of the cancellation of the activity. Resident #20 added "it would be nice to have something to do on the weekends."

Follow up interviews were completed with the AD on 1/10/23 at 3:40 PM and 1/11/23 at 9:58 AM, during which she explained when a resident was admitted to the facility, she completed an activities assessment within 3-5 days. The AD said there were no group activities scheduled on Saturdays or Sundays since she didn't typically work on weekends. The AD explained if residents wanted to do an independent activity on the weekend, such as puzzles, radio, magazines, books, they made arrangements with her prior to the weekend and she then provided those materials for the resident. She added there was no common area in the facility that had independent leisure materials for residents to obtain when she was not in the building. The AD provided a copy of her timecard for November-December 2022 and January 2023. She reviewed the timecard during the interview and explained there were seven days where she worked as a NA, and therefore, group activities were not held on those days; or, if she worked during third shift (11:00 PM-7:00 AM), had not come to work the following day and worked as the AD. She added since she worked as a NA 1/9/23 on first shift, the corn hole activity was not completed as scheduled that day.

The Administrator was interviewed on 1/11/23 at 5:07 PM. She stated when the AD was sent to the hall and worked as a NA, the facility attempted to find someone who assisted with the

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scheduled group activity, although it may not be the exact activity the AD had planned on the calendar. The Administrator said she had not kept records if another staff member did the activity while the AD worked as a NA. She shared there were some leisure activity items located at the end of the 600 hall that the nurses utilized, such as music and coloring sheets; nursing staff also visited with residents. Typically, there was not a staff member in the facility on weekends who conducted group activities. The Administrator added the facility was not as consistent with offering recreation on weekends to residents on the rehabilitation unit because families often visited at that time.

4. Resident #26 was admitted to the facility 3/21/19 with diagnoses that included, in part, diabetes and hypertension.

The annual MDS assessment dated 12/11/22 revealed Resident #26 was cognitively intact. The assessment indicated the resident stated it was very important to him to do things with groups of people and to do his favorite activities.

The care plan, updated 12/24/22, included a focus area of activities/recreation. A care plan intervention revealed Resident #26 was provided with a monthly calendar of facility activities.

During an interview with the Administrator on 1/9/23 at 9:40 AM, she shared the AD had been "pulled to the floor today" and worked as a NA since two of the scheduled NAs had called off work.
The AD was interviewed on 1/9/23 at 9:48 AM and confirmed she was moved to work as a NA for the first shift (7:00 AM-3:00 PM). She stated

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when she worked as a NA, the facility group activities were canceled because she didn't have another staff member who helped her.

An activities calendar for January 2023 was provided by the AD on 1/9/23 at 9:55 AM. A review of the scheduled activities for 1/9/23 included:

-9:00 In room visits
-10:30 Talk-n-toss ball
-2:30 Corn hole
-4:00 Mail

Further review of the activities calendar specified every Saturday and Sunday's schedule included: "Family Visitation and 4:00 Mail."

On 1/9/23 at 11:45 AM an observation of the main dining room revealed a group activity was held (Talk-n-toss ball) and facilitated by the Administrator.

Observations of the main dining room and other common areas of the facility on 1/9/23 at 2:30 PM, 3:04 PM and 3:15 PM revealed the corn hole activity was not being held as scheduled on the activity calendar.

A Resident Council group interview was completed on 1/10/23 at 2:43 PM. During the group interview, residents stated there was a notation on the monthly activities calendar that said activities were subject to change. Residents reported the scheduled corn hole activity was not completed on 1/9/23 since the AD worked on the hall as a NA and no one was available to help conduct the activity. Resident #26 stated he would have come to the activity if it had been held

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as scheduled on the calendar. The Resident Council group further explained if the scheduled activity was canceled because the AD worked on the hall, either the AD or another NA notified residents of the cancellation of the activity. Resident #26 added he would like to have activities offered on the weekends.

Follow up interviews were completed with the AD on 1/10/23 at 3:40 PM and 1/11/23 at 9:58 AM, during which she explained when a resident was admitted to the facility, she completed an activities assessment within 3-5 days. The AD said there were no group activities scheduled on Saturdays or Sundays since she didn't typically work on weekends. The AD explained if residents wanted to do an independent activity on the weekend, such as puzzles, radio, magazines, books, they made arrangements with her prior to the weekend and she then provided those materials for the resident. She added there was no common area in the facility that had independent leisure materials for residents to obtain when she was not in the building. The AD provided a copy of her timecard for November-December 2022 and January 2023. She reviewed the timecard during the interview and explained there were seven days where she worked as a NA, and therefore, group activities were not held on those days; or, if she worked during third shift (11:00 PM-7:00 AM), had not come to work the following day and worked as the AD. She added since she worked as a NA 1/9/23 on first shift, the corn hole activity was not completed as scheduled that day.

The Administrator was interviewed on 1/11/23 at 5:07 PM. She stated when the AD was sent to the hall and worked as a NA, the facility

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F 679	Continued From page 20 attempted to find someone who assisted with the scheduled group activity, although it may not be the exact activity the AD had planned on the calendar. The Administrator said she had not kept records if another staff member did the activity while the AD worked as a NA. She shared there were some leisure activity items located at the end of the 600 hall that the nurses utilized, such as music and coloring sheets; nursing staff also visited with residents. Typically, there was not a staff member in the facility on weekends who conducted group activities. The Administrator added the facility was not as consistent with offering recreation on weekends to residents on the rehabilitation unit because families often visited at that time.	F 679		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		2/8/23

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F 688	Continued From page 21 by: Based on observations, staff interviews, and record review, the facility failed to provide treatment and services to a resident (Resident #33) who demonstrated a reduction in range of motion of the bilateral lower extremities in the hips, ankles, and knee, and in the left upper extremity. This occurred in 1 of 2 residents reviewed for limited range of motion. The findings included: Resident #33 was admitted to the facility on 4/18/2014. His cumulative diagnoses included nontraumatic intracerebral hemorrhage, Parkinson's disease, hemiplegia, and contractures of the bilateral hips, bilateral ankles, right knee and left hand. A review of Resident #33 ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 12/05/2022. The MDS indicated the Resident had severe cognitive impairment, was dependent on one staff member for all activities of daily living (ADL) care needs, and had limited range of motion in bilateral upper and lower extremities. A review of Resident #33 ' s care plan dated 9/5/2022 identified a problem area that read: The Resident has the potential for alteration in comfort related to impaired mobility from a cerebral vascular accident with left side hemiparesis. He has contractures to the bilateral hips, knees, and ankles. He receives splinting to the hand for contracture prevention. Staff must anticipate and observe the resident for pain. There was not an intervention for the placement of the splint to the hand.	F 688	Order received for referral to Occupational Therapy (OT) per Physician for evaluation and treatment of contractures and assessment to evaluate for resident #33 on January 12th 2023. Order received for referral to Physical Therapy (PT) per Physician for bilateral contracture management of lower extremities on January 16th for Resident #33. On February 4th the Director of Nursing and Nurse Managers began education with Licensed Nursing regarding completion of contracture Risk Observations to be completed on admission, quarterly, annually and with a significant change in condition. Nurses not educated by 2/8/2023 will be educated prior to their next scheduled shift or will be removed from the scheduled until education is completed. Licensed Nursing began completion of Contracture Risk observations on January 25th. The Contractor Risk observations will be completed on all residents by February 8th and then quarterly thereafter. For residents identified as a contracture risk, a referral is made to the therapy department for evaluation and treatment as needed. The Director of Nursing will review the contracture observations with high risk for contractures with the therapy referrals to	

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F 688	Continued From page 22 A review of the physician notes dated 12/26/2022 documented there were no deformities to the extremities. A review of the physician orders did not include an order for splint placement to the upper or lower extremities. A review of Resident #33 's electronic medical record revealed a contracture risk assessment dated 1/3/2023 at 12:38 p.m. and documented the Resident's general state of health was poor and declining, orientation was alert, with nonfunctional abilities in ADL care, immobile, severe limitation that was greater than 40% in present joint condition and had contributing factors that included Parkinson's disease. A score was calculated based on the assessment and each category was the most severe possible except for the orientation of the Resident. The orientation lowered the contracture risk to a moderate level instead of a severe level. The assessment question for referral needs, was checked, "no referrals needed and continue current plan of care." An observation of Resident #33 was conducted on 1/9/2023 at 12:22 p.m. The Resident was observed lying in bed with a blanket covering his body. His left hand was bent at a 90-degree angle at the wrist and his fingers were curled and bent, from the back of his hand, at a 45-degree angle. An interview was conducted with a family member on 1/9/2023 at 12:30 p.m. of Resident #33 and revealed the Resident previously wore a splint to his left hand but they had not seen one placed in a long time.	F 688	validate compliance. This will be completed daily for 5 days, weekly for 4 weeks then monthly thereafter until three consecutive months of compliance is sustained, then quarterly thereafter. The Director of Nursing will present the analysis of the contracture / rehabilitation referrals to the Quality Assurance and Performance Improvement Committee meeting monthly until three consecutive months of compliance is sustained, then quarterly thereafter Date of Compliance February 8th 2023.	

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An observation of Resident #33 was conducted on 1/10/2023 at 10:48 a.m. and he was observed to be positioned on his left side with a pillow used to support his left arm. He did not have a splint in place to the left hand.

An interview was conducted on 1/10/2023 at 3:21 p.m. with the Rehabilitation Manager and she revealed Resident #31 was last seen by Occupational Therapy (OT) on 4/15/2015. She stated the OT discharge summary identified the Resident demonstrated impaired range of motion of the left hand and all digits with neutral to hyperextension, without an flexion due to tightness in the joint. A recommendation was made for a left-hand orthotic device to be utilized to aid with achieving optimal skin and joint integrity without negative effect to the Resident in order to achieve neutral position for contracture management. She reviewed the electronic medical record for Resident #33 and did not see an order to discontinue the recommendation for the splinting device. The Rehabilitation Manager stated the Resident had not been evaluated for treatment by the OT since 2015. She added, the process for any resident to receive therapy was to receive a referral from a member of the administrative nursing team or a physician, or to be identified by herself or another therapist when reviewing electronically generated reports. She indicated there were two reports that she reviewed on a weekly basis. These reports identified any resident that had triggered for contractures, pain, a decline in ADL's, weight loss, and falls. She added a long term resident like Resident #33 could be missed on these reports due to a slow decline in all areas, including contractures. She revealed

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F 688	Continued From page 24 communication between the direct care staff and the therapy department was important to ensure a resident receives therapy services. She provided a copy of an email she had sent to her corporate manager, dated 1/6/2023, for education topics to be provided during 2023. Referrals to the therapy department was the first area identified. She added she had not provided the education yet. An interview was conducted with the Administrator on 1/10/2023 at 4:10 p.m. and she reviewed the chart for Resident #33. She stated she was not aware the Resident had not been referred to the Occupational therapy department in so long. She stated she was unsure of the reason the splint was no longer being placed on the left hand. She would review the chart and provide documentation if the splint had been discontinued. She revealed it was her expectation that communication occur between the nursing and therapy departments and orders be implemented and/or referrals provided as a resident declines. She added a referral to the OT department would be made. An interview was conducted with Nurse #2 on 1/11/2023 at 11:34 a.m. and she revealed Resident #31 had a splint for his left hand a long time ago and she thinks this had been stopped. She was unsure of the reason the splint was stopped.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		2/8/23

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F 690	Continued From page 25 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection or injury for 1 of 2 residents (Resident #33) reviewed with indwelling urinary catheters.	F 690	Resident #33 urinary drainage bag was placed on the frame of the and bed was raised to position where privacy bag would not touch floor. Residents with Foley catheters was	

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F 690	Continued From page 26 The findings included: Resident #33 was admitted to the facility on 4/18/2014. His cumulative diagnoses included nontraumatic intracerebral hemorrhage, reflux uropathy, Parkinson's disease, and hemiplegia. A review of Resident #33 ' s most recent Minimum Data Set (MDS) was a quarterly assessment dated 12/05/2022. The MDS indicated the Resident had severely impaired cognitive skills and had an indwelling urinary catheter. A review of Resident #33 ' s care plan dated 9/5/2022 identified a problem area that read: The Resident has a urinary catheter related to hydronephrosis and a ureteral stone with stent placement. The interventions included to keep the drainage bag below the level of the bladder with a privacy bag in place, prevent tension on the urinary meatus (the opening of the urethra, situated on male genitalia) from the catheter, and keep the tubing free of kinks. A review of the physician orders included an indwelling urinary catheter size 20 french with a 30 cubic centimeter (cc) bulb (the part of the catheter used to prevent the catheter from sliding out of the urinary bladder) for kidney stones and a stent placement. An observation was conducted of Resident #33 on 1/9/2023 at 12:18 p.m. The Resident was observed with a urinary catheter bag, containing dark amber urine. The catheter bag was on the	F 690	monitored to ensure drainage bag was not touching the floor by administrator on January 12th In-services was started on January 15th for all licensed nurses and certified nursing assistants by Infection Control Preventist and Administrator and will be completed by February 8th or will be removed from the schedule until in-service complete. Weekly audits of all residents with Foley catheters will be done 5 times for 1 week by Administrator and/or licensed nurse , then weekly times three then monthly thereafter until three consecutive months of compliance is sustained then quarterly thereafter. The Administrator will present the findings to the Quality Assurance Performance Committee monthly until three consecutive months of compliance then quarterly thereafter. Date of compliance is February 8th 2023.	

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F 690	Continued From page 27	F 690		

door side of the room and lying directly on the floor. A privacy bag was in place and was opened at the bottom. The tubing used to empty the catheter bag was in direct contact with the floor surface.

An observation was conducted of Resident #33 on 1/9/2023 at 3:55 p.m. The Resident was observed with a urinary catheter bag hanging on the window side of the bed. The bed was in the lowest position and the catheter bag was hanging on the bottom right side of the bed. The catheter bag was touching the floor, with a privacy bag in place that was open on the bottom. The tubing to empty the catheter bag was in direct contact with the floor surface.

An observation was conducted of Resident #33 on 1/11/2023 at 9:47 a.m. The Resident was observed to have a urinary catheter bag on the window side of the room and the bag was lying directly on the floor.

An interview was conducted on 1/11/2023 at 9:49 a.m. with Nursing Assistant (NA) #1 and she revealed she was one of two NA's that had provided care to Resident #33 on this shift. She stated they placed the urinary catheter at the foot of the bed on the right side and it was off of the floor. When asked why it was placed off of the floor, she replied because that would not be sanitary. She indicated she had received education to keep a catheter bag off of the floor several times in her years of working at the facility. She added when the two NA's left the room, Nurse #1 was still providing care. She stated she observed the urinary catheter to be lying on the floor at that time and stated she thought when Nurse #1 lowered the bed, the bag

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F 690	Continued From page 28	F 690		

must have come loose and hit the floor.

An interview was conducted on 1/11/2023 at 9:52 a.m. with Nurse #1 at the bedside of Resident #33. She revealed she observed the urine catheter bag lying directly on the floor with a privacy bag in place. The privacy bag was open on the bottom and the tubing for emptying the urine was lying directly on the floor. She stated she lowered the bed when she exited the room and this could be how the bag ended up lying on the floor. She added it was concerning to her that a urine catheter bag was on the floor because this placed the resident at risk for urinary tract infections.

An interview was conducted with the Director of Nursing (DON) on 1/11/2023 at 10:33 a.m. and she revealed she had been employed at the facility for a month. She added it was her expectation that a urine catheter bag be kept off of the floor to prevent infection. She stated she was not sure when urine catheter education had last been conducted but she would investigate. A copy of the last urine catheter education was provided on 1/11/2023 at a later time.

A review was conducted of the facility education log, dated 9/26/2022, titled, "Catheter Care." The education was reviewed and did not include how to store a urine catheter bag after finishing with the cleansing a resident.

An interview was conducted with the Administrator on 1/11/2023 at 4:00 p.m. and she revealed it was her expectation that a urine catheter bag be kept below the urine bladder area to help with drainage, be secured to prevent pulling of the tubing, and stored in an appropriate

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F 690	Continued From page 29 location on the bed. She added a catheter bag should never be stored directly on the floor. She stated education was conducted for Nurse #1 to ensure the placement of a catheter bag, after lowering a bed, and prior to exiting a room.	F 690		
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 the tile of the kitchen floor in good condition and failed to dispose of expired nutritional supplements in 1 of 3 residents' nourishment room refrigerators. Findings included:	F 812	The area beneath the tray serving steamtable, the dishwashing machine and beneath the 3-compartment sink have been sealed with the epoxy floor covering by Maintenance Director on February 3rd 2023. The Maintenance Director and/or dietary manager will check the kitchen floor tiles	2/8/23

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F 812	Continued From page 30 1. During the initial tour of the kitchen on 1/8/23 at 10:00 a.m. and during the follow-up visit on 1/10/23 at 12:00 p.m., there were missing floor tiles observed beneath the meal tray serving steamtable, the dishwashing machine, and beneath the 3-compartment wash sink. An interview with the Dietary Manager revealed the kitchen floor had the missing tiles for approximately 8-9 years due to a problem with drainage pipes which were repaired, and the areas were covered with concrete, but the floor tiles were never replaced. During an interview on 1/11/23 at 9:32 a.m., the Administrator stated the kitchen's floor had been in that condition for approximately 8-9 years. She indicated she had been in discussion with corporate office's area vice president for about six months concerning the condition of the kitchen floor which "will be a major undertaking". As of the date of this interview, no quotes had been obtained on the floor's replacement. 2. On 1/11/23 at 9:50 a.m., accompanied by the Administrator, the 300/500 hall nourishment room was observed. The refrigerator contained 6(8-ounce) cartons of therapeutic nutrition supplements for dialysis residents with the expired date of 12/1/22. The Administrator discarded expired six cartons and indicated she would have the dietary manager double check her stock.	F 812	bi-weekly for 2 weeks then monthly to assess for missing tiles which will be addressed immediately with the epoxy floor covering. The Facility Administrator discarded the expired therapeutic nutrition supplements on January 12th and an audit was then performed for all remaining stock in house and if expired immediately discarded by the Certified Dietary Manager and Central Supply Tech. The Facility Administrator started education on January 12th with the Certified Dietary Manager and Central Supply to check dates on nutritional supplements when delivered and placed on units. This will be monitored bi-weekly for 2 weeks, then weekly for 2 weeks then monthly thereafter until three months consecutive sustained compliance then quarterly thereafter. The Maintenance Director will present the analysis of the kitchen floor tiles to the Quality Assurance Performance Improvement Committee monthly times three until three consecutive months of sustained compliance then quarterly thereafter. The Certified Dietary Manager will present the analysis of the nutritional supplement to the Quality Assurance Performance Improvement Committee monthly times three until three consecutive months of sustained compliance then quarterly thereafter.	

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F 812	Continued From page 31	F 812	Compliance date 2/8/2023	
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 observations and staff interviews, the facility failed to ensure the side doors and top lids of 2 of 2 trash dumpsters remained closed when not in use. Findings included: During the initial tour of the facility accompanied by the Dietary Manager on 1/08/23 at 10:50 a.m., two trash dumpsters were observed enclosed within a fenced in area with the side doors of the dumpsters open. Half of the top lid of 1 of 2 of the dumpsters was open with two filled trash bags lying on top of the closed half of the lid. Throughout the observation, it was raining and both dumpsters were filled with trash bags. A second observation with the Dietary Manager on 1/10/23 at 12:25 p.m. revealed the side door of 1 of the 2 trash dumpsters was open. There were plastic bags of trash in the dumpster.	F 814	The Maintenance Director when made aware on January 8th closed the doors on the dumpsters after discarding the trash bags and certified dietary manager closed the side door of the dumpster on January 10th. Maintenance Director began on January 10th 2023 began in-servicing Janitor, Housekeeping, and dietary staff on importance of keeping both the side doors and the top lid closed after garbage is disposed for sanitation reasons and will be completed by February 8th 2023 or employees will be removed from the schedule until in-service completed. Maintenance Director and/or Certified Dietary Manager will check dumpsters twice daily for compliance for two weeks, then three times a week for two weeks, then monthly until three consecutive months of compliance then quarterly thereafter. The Maintenance Director and or the Certified Dietary Manager will take the finding to Quality Assurance Committee for three months of consecutive compliance then quarterly thereafter.	2/8/23

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F 814	Continued From page 32	F 814	Date of Compliance 2/8/2023	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint surveys conducted 4/1/2021 and 1/9/2020, and a complaint survey conducted 5/28/2021. This was for three deficiencies that were cited in the areas of Activities meet the interest and need of each resident (F679), Increase or prevent a decrease in range of motion and mobility (F688), and food procurement, store/prepare/serve-sanitary (F812). The three areas were recited on the current recertification survey of 1/11/2023. The duplicate citations during two federal surveys of record demonstrates a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: 1. F679 - Based on observations, interview with the Resident Council, resident and staff interviews and record reviews, the facility failed to	F 867	No residents were identified in the 2567. The Administrator will review and complete the electronic education in relias training Quality Assurance/Performance Improvement developing and sustaining a quality culture by February 8th 2023. How the facility will identify other residents having the potential to be affected: All residents have the potential to be affected by this practice. Systemic changes made to ensure that deficient practice will not The Administrator and Director of Health Services initiated reeducation on February 3rd 2023 and the QAPI process for all staff on the QAA/QAPI Committee with emphasis on identifying areas that may lead to deficiency practice. Education to be completed by February 8th 2023. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis	2/8/23

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F 867	Continued From page 33 provide activities as scheduled when the Activities Director (AD) was placed in the Nurse Aide (NA) role. Additionally, the facility failed to provide any scheduled activities on the weekends. This was for 4 of 4 residents (Residents #52, #38, #20 and #26) reviewed for facility activities. During the complaint survey of 5/28/2021, the facility failed to provide activities as scheduled when the AD was placed in the NA role for 3 of 5 residents interviewed for facility activities. An interview was conducted with the Administrator on 1/11/2023 at 6:51 p.m. and she revealed the QAA committee meets monthly and consist of the Director of Nursing (DON), financial counselor, nurse navigator, Minimum Data Set (MDS) nurse, the wound care nurse, social worker, housekeeping/maintenance manager, dietary management, and the Medical Director. The team reviewed event monitoring, risk assessments, rounds on the unit, consultant reports, resident interviews, and town hall minutes. The Administrator indicated the facility had experienced administrative nursing turnover which she felt contributed to the repeat citation. She added the team would continue to work on staffing needs and a back up plan put into place to ensure the activities would be conducted as scheduled. 2. F688 - Based on observations, staff interviews, and record review, the facility failed to provide treatment and services to a resident (Resident #33) who demonstrated a reduction in range of motion of the bilateral lower extremities in the hips, ankles, and knee, and in the left upper extremity. This occurred in 1 of 2 residents reviewed for limited range of motion.	F 867	and focus on ensuring that any areas of non-compliance are addressed to prevent further deficient practices related to Activities (F679), prevention and decrease in ROM (F688) and food procurement, storage and preparation (F 812). Monitoring of performance to make sure that solutions are sustained: Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on areas that have led to repeated citations and/or deficiencies. This will ensure that the facility has identified areas of non-compliance and are addressed to prevent further deficient practices related to Activities (F 679), prevention and decrease in ROM (F 688), and Food Procurement, storage and preparation (F 812). At least one member of the regional team that includes Senior Nurse Consultant, Clinical Reimbursement consultant or Area Vice President will attend QAPI meetings monthly times three months and then quarterly for three quarters to ensure that any area leading to deficient practice identified during clinical and compliance rounds are completed upon by the facility according to QAPI process. The administrator will report to the QAPI committee any areas of non-compliance for three months and then quarterly for three quarters for recommendations as needed. This will be completed by February 8th	

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F 867	Continued From page 34	F 867	2023	

During the recertification and complaint survey of 4/1/2021, the facility failed to provide restorative services to one of three residents (Resident #62) reviewed for range of motion and Mobility services.

An interview was conducted with the Administrator on 1/11/2023 at 6:51 p.m. and she revealed the QAA committee meets monthly and consist of the Director of Nursing (DON), financial counselor, nurse navigator, Minimum Data Set (MDS) nurse, the wound care nurse, social worker, housekeeping/maintenance manager, dietary management, and the Medical Director. The team reviewed event monitoring, risk assessments, rounds on the unit, consultant reports, resident interviews, and town hall minutes. The Administrator indicated the facility had experienced administrative nursing turnover and this had prevented effective communication between the rehabilitation department and the administrative nursing team. She added the Rehabilitation and manager and herself would work to establish an effective plan.

3. F812 - Based on observations and staff interviews, the facility failed to maintain the tile of the kitchen floor in good condition and failed to dispose of expired nutritional supplements in 1 of 3 residents' nourishment room refrigerators.

Based on observations, staff interviews and record reviews, the facility failed to label, and date opened refrigerated food items; failed to label and date refrigerated food that was brought in from outside the facility; and failed to discard expired food available for use in 3 of 3 of nourishment

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F 867	Continued From page 35 refrigerators. An interview was conducted with the Administrator on 1/11/2023 at 6:51 p.m. and she revealed the QAA committee meets monthly and consist of the Director of Nursing (DON), financial counselor, nurse navigator, Minimum Data Set (MDS) nurse, the wound care nurse, social worker, housekeeping/maintenance manager, dietary management, and the Medical Director. The team reviewed event monitoring, risk assessments, rounds on the unit, consultant reports, resident interviews, and town hall minutes. She added the companies corporate team would need to be included in the resolution of the kitchen because the replacement of floor tiles was a major task.	F 867		