STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345181	A. BUILDING _____ B. WING _____	C 03/13/2023

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UNIVERSAL HEALTH CARE / GREENVILLE	2578 WEST FIFTH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/06/23 through 03/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #L1TR11.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 3/6/23 to conduct a recertification and complaint survey and exited on 3/9/23. Event ID#L1TR11. Additional information was obtained on 3/13/23. Therefore, the exit date was changed to 3/13/23. The following intakes were investigated NC00188930 , NC00190649, NC00191496, NC00193792, NC00194313, NC00194917, and NC00199234. 6 of the 23 complaint allegations resulted in deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		4/6/23

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

Electronically Signed | 04/02/2023

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to maintain a resident's dignity when incontinent care for a bowel movement was not provided when requested prior to the meal causing the resident to feel "nasty" while trying to eat (Resident #71), and when a staff member spoke in a loud stern harsh voice causing the residents to feel bad and upset (Residents #48 & #18) for 3 of 5 residents reviewed for dignity. The findings included;	F 550	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility Director of Nursing (DON) ensured Resident #71 received incontinence care on 3/6/2023. Resident #71 is no longer a resident at the facility. Residents # 48 and #18 were reinterviewed by the clinical nurse consultant on 3/6/23. An allegation of	

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F 550	Continued From page 2 1. Resident #71 was admitted to the facility on 10/28/22 with diagnoses which included chronic obstructive pulmonary disease, hypertension, and chronic pancreatitis. The quarterly Minimum Data Set assessment dated 1/31/23 documented Resident #71 had no behaviors, required extensive assistance with toileting, was frequently incontinent of urine, and always incontinent of bowel. The care plan with a review date of 3/6/23 revealed Resident #71 had urinary and bowel incontinence so was at risk for infection or skin condition. The interventions included "assist with perineal cleaning as needed." On 3/6/23 at 1:19 PM Resident #71 stated he had an incontinent bowel movement and was still waiting to be changed. Resident #71 added he told the Nursing Assistant (NA) when his meal tray was passed. On 3/6/23 at 1:21 PM NA #8 reported she passed the lunch meal tray to resident #71 and he told her he was soiled. NA #8 said she informed Resident #71 it was facility protocol not to provide incontinent care while passing meal trays. She added she was not sure the last time he had received incontinent care because he was not on her room assignment. On 3/6/23 at 1:22 PM NA #9 reported she was assigned to provide care for Resident #71 during the 7:00 AM to 3:00 PM shift and she last provided incontinent care to him at around 9:30 AM.	F 550	verbal was filed with DHHS related to resident #48's response. Resident #18 stated thought employee #8 was being militant but not abusive. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: DON and administrative nurses completed observation rounds and interviews on 3/6/23, to ensure that current residents have received timely incontinence care. No other concerns related to this alleged deficient practice were reported. No other residents reported any concern of being spoken to in a harsh tone. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: An all-staff in-service was initiated on 3/6/2023 by the Staff Development Coordinator regarding maintaining resident dignity by providing bowel/bladder incontinence care timely prior to or during meals when requested or identified. Additional all staff in-service was initiated on 3/6/2023 by the Staff development Coordinator related to resident rights, including speaking to residents in a caring manner to preserve their dignity and ensure good customer service. All new hires will receive education covering Dignity and Resident Rights during orientation by the SDC or DON, ADON or Unit Managers. The Director of Nursing or designee to	

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F 550	Continued From page 3 On 3/6/23 at 1:29 PM the Director of Nursing said if meal trays were being passed and a resident needed incontinent care the NA should remove the meal tray from the room then provide the incontinent care. After the incontinent care was provided and the NA performed hand hygiene the meal tray could then be provided to the resident. On 3/6/23 at 1:45 PM NA #9 stated she provided incontinent care for Resident #71, and he had a loose bowel movement. During an additional interview with Resident #71 on 3/7/23 at 11:35 AM he said it made him feel nasty to try to eat while being soiled and not getting changed prior to eating. 2. Resident #48 was admitted to the facility on 03/26/2015 with diagnoses to include rheumatoid arthritis and paraplegia. The quarterly Minimum Data Set (MDS) assessment dated 02/03/2023 revealed Resident #48 was cognitively intact and was dependent on staff assistance with activities of daily living (ADL). Review of the plan of care for activity preference dated 10/2/2019 listed Resident #48 preferred independent and self-directed leisure activities with an intervention for: staff will encourage active conversation with me while they are in my room. An observation and interview with Resident #48 occurred on 03/07/2023 at 02:35 P.M. Resident was observed to be laying on an air mattress and the lights were off on the control unit at the foot of the bed. Resident #48 stated that his call bell device was not working and the facility gave him	F 550	include the Assistant Director of Nursing, Staff Development Coordinator or Unit Managers will conduct monitoring over Incontinence Care and resident Dignity to ensure residents are receiving timely incontinent bowel and bladder care and are treated with dignity by staff. The Monitoring will be done by observation and resident interviews and documented for 10 residents, 5 times per week for two weeks, then will be done 3 times per week for two weeks and then will be done weekly for 8 weeks. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON and/or Administrative Nurse will complete a summary of the monitoring results and present them at the facility monthly Quality Assurance Performance Improvement (QAPI) meeting, to ensure continued compliance. The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s)	

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F 550	Continued From page 4 a tap bell to ring. He further stated that his air mattress must have come unplugged when they weighed him in bed this morning. Resident #48 tapped his bell for assistance with the mattress. Resident #48 stated that Nurse #8 was the dayshift nurse. He further stated that Nurse #8 treated him like he was in the army and doesn't know how to talk to residents. Resident #48 indicated that Nurse #8 yelled and argued with him when he asked Nurse #8 questions. He stated that Nurse #8 would say, "I am the nurse and I know what I am doing." Resident #48 stated that, "Nurse #8 gets me upset and makes me feel bad." Resident #48 further stated that they don't speak to each other. He indicated that if he needed something or had an issue he would wait until he saw another nurse ask them to help him. Resident #48 stated that he was not happy with the way Nurse # changed his catheter so he had asked Nurse #5 to change it. Resident #48 stated that the facility had offered to move him to another hall and that he had refused. He further stated that this was his home, and he didn't see why he was the one who should have to move. Resident #48 indicated that Nurse #8 should have to move off the unit not him. He further stated that Nurse #8 always "won" and was still the nurse on the unit. Nurse #8 was asked to come to Resident #48's room by this surveyor on 03/07/2023 at 02:50 P.M. Nurse #8 stated that he had not heard the tap bell. He further stated that the mattress was not plugged in and he plugged it into the unit and left the room. Nurse #8 did not speak or look at Resident #48 when he was in the room. An interview with Nurse #5 was completed on 03/08/2023 at 07:20 A.M. Nurse #5 stated that	F 550	identified. The corrective measures implemented for F 550 with repeat non-compliance identified will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	

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F 550	Continued From page 5	F 550		

Resident #48 and Nurse #8 do not get along. She further stated that she had changed Resident #48's catheter change time to night shift so she could do it for him, because he did not want Nurse #8 to change it. Nurse #5 indicated that Resident #48 had not told her Nurse #8 yelled at him. She further stated that she had not told anyone in administration.

An interview with the Director of Life Enhancement occurred on 03/08/2023 at 07:54 A.M. She stated that Resident #48 told her that he didn't like Nurse #8 because of his attitude and that he doesn't listen to him. The Director of Life Enhancement indicated that Resident #48 and Nurse #5 don't get along.

An interview with Unit Manager #2 was completed on 03/08/2023 at 4:09 P.M. Unit Manager #2 stated that was a time period when Resident #48 refused to accept medications from Nurse #8. She further stated that she had given Resident #48 his medications during that time. Unit Manager #2 indicated that the prior administration had been aware of the issues between Resident #48 and Nurse #8.

An interview with the Central Supply Coordinator occurred on 03/08/2023 at 04:18 P.M. The Central Supply Coordinator stated that Nurse #8 was very militant in his interactions with others. She further stated that Nurse #8 treats everyone like they are in the military.

An interview with the Staff Development Coordinator was completed on 03/08/2023 at 4:24 P.M. She stated that when she interviewed Resident #48 today, he told her Nurse #8 made him feel bad when he talked loudly and argued

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F 550	Continued From page 6	F 550		

with him.

An interview with the Administrator and the Director of Nursing (DON) occurred on 03/09/2023 at 11:36 A.M. The Administrator stated that she had been unaware of any issues between Nurse #8 and Resident #48. She further stated that Nurse #8 was suspended pending further investigation and that the facility had filed a 24-hour report with the State. The DON stated that now that the facility was aware of the allegations, they were taking care of the issue.

A telephone interview with Nurse #8 was completed on 03/13/2023 at 2:49 P.M. Nurse #8 stated that he and Resident #48 had a very respectful relationship. He further stated that he was respectful to Resident #48 and in return Resident #48 was respectful to him. Nurse #8 stated that to his knowledge we don't have a communication problem.

3. Resident #18 was admitted to the facility on 01/08/2021 with diagnosis to include unspecified asthma and anxiety.

The annual Minimum Data Set (MDS) assessment dated 01/06/2023 revealed Resident #18 was cognitively intact and was not hard of hearing.

An interview with Resident #18 was completed on 03/06/2023 at 11:58 A.M. Resident #18 stated that Nurse #8 yelled at him sometimes and made him "feel bad". He stated that he was not a "child" and should not be treated like one.

An interview with Nurse #5 was completed on 03/08/2023 at 07:20 A.M. Nurse #5 stated that

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F 550	Continued From page 7 Resident #18 told her he was upset because Nurse #8 had talked to him like a child when he asked about his inhaler. She further stated that she told Resident #18 he had a breathing treatment and an inhaler that were ordered as needed. An interview with the Central Supply Coordinator occurred on 03/08/2023 at 04:18 P.M. The Central Supply Coordinator stated that Nurse #8 was very militant in his interactions with others. She further stated that Nurse #8 treats everyone like they are in the military. An interview with the Staff Development Coordinator was completed on 03/08/2023 at 4:24 P.M. She stated that when she interviewed Resident #18 today, he told her Nurse #8 made him feel bad when he spoke loudly to him. An interview with the Administrator and the Director of Nursing (DON) occurred on 03/09/2023 at 11:36 A.M. The Administrator stated that Nurse #8 was suspended pending further investigation. She further stated that Resident #18 had not complained about Nurse #8 making him feel like a child or speaking to him in a loud voice. A telephone interview with Nurse #8 was conducted on 03/13/2023 at 2:49 P.M. Nurse #8 stated that to his knowledge he did not have a communication issue with Resident #18. He further stated that he always talked respectful to Resident #18.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		4/6/23

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F 558	Continued From page 8 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to accommodate a resident's need for bed size as evidenced by a bedframe and mattress that was approximately 4 inches shorter than the resident's height for 1 of 1 resident reviewed for accommodation of needs (Resident #48). Findings included: Resident #48 was admitted to the facility on 03/06/2015 with diagnoses to include paraplegia and rheumatoid arthritis. The quarterly Minimum Data Set (MDS) assessment dated 02/03/2023 revealed Resident #48 was cognitively intact and 78 inches tall. An interview and observation were conducted with Resident #48 on 03/06/2023 at 11:25 P.M. Resident #48 was laying in bed on an air mattress. The head of the bed was raised at approximately a 90 degree angle, his feet were up against a pillow at the foot of the bed, and his head was approximately 4 inches above the top of the mattress at the head of the bed. Resident #48 stated that he was 6 feet 6 inches tall and that his bed was too short for him. He further stated that the facility had replaced his old bed in December 2022 with this new bed, but it was still too short. Resident #48 stated that the bed was	F 558	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #48□s bed with extensions and mattress were replaced to accommodate his height on 3/8/2023. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A 100% audit of all residents over six feet in height were assessed for appropriate bed length on 3/7/2023 by the Staff Development Coordinator. No further residents were identified to be affected by this deficient practice requiring a new bed or extensions. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All new admissions to the facility will be screened upon admission for appropriate bed size/length by the unit managers/admissions nurse. The Administrator and Regional Nurse Consultant provided education to the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator	

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F 558	Continued From page 9 uncomfortable, and he wanted a bed the correct size. An interview was completed with the Wound Care Nurse on 03/08/2023 at 3:33 P.M. The Wound Care Nurse stated that Resident #48 did not appear to fit in that bed. She further stated that it was a new bed that the facility got for him in December because he had complained his old bed was too short. An interview was conducted with the Central Supply Coordinator on 03/08/2023 at 4:05 P.M. The Central Supply Coordinator stated that Resident #48's bed was the longest bed that the facility's vendor had available. She further stated that the Maintenance Director had checked the bed and it was extended as far as possible. The Central Supply Coordinator indicated that she was going to order a four-inch extender for the bedframe and a longer mattress so that Resident #48 would be able to fit comfortably in bed. An interview was conducted with the Administrator on 03/08/2023 at 4:26 P.M. The Administrator stated that the facility had been unaware that Resident #48 was still not able to fit comfortably in his bed. She further stated that if the 4-inch extender was not long enough for Resident #48 to fit comfortably in his bed then they would reach out to other vendors for a different bed. An interview was conducted with the Director of Nursing (DON) on 03/08/23 4:30 P.M. The DON stated that she could not say if the bed was the wrong size because she had not seen the bed or measured it with him lying in the bed. She further stated that if the bed was not the correct size the	F 558	and Unit Managers over the systematic process of assessing residents upon admission to ensure residents have appropriately sized beds. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 558 with repeat non-compliance identified will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	

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F 558	Continued From page 10 facility would order him a new bed.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to honor a resident choice to get out of bed for 1 of 1 resident (Resident #52) reviewed for choices.	F 561	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:	4/6/23

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F 561	Continued From page 11 Findings included: Resident #52 was admitted to the facility on 11-6-15. The quarterly Minimum Data Set (MDS) dated 2-20-23 revealed Resident #52 was cognitively intact and required total assistance with two people for transfers. The MDS did not document Resident #52 refusing care. Resident #52's care plan dated 2-28-23 revealed the resident required assistance for mobility, transfers, dressing, grooming, toileting, and bathing related to hemiplegia. The care plan goal was for Resident #52 to be clean, dry, and dressed appropriately for the season. The interventions for the goal were in part for Resident #52 to be out of bed by 10:00am. Resident #52 was interviewed on 3-6-23 at 11:25am. The resident stated she was not able to get out of bed on the weekends because there were not enough staff. She explained on Sunday (3-5-23) she was informed by the nurse that she would have to stay in bed because there was not going to be enough staff to put her back to bed on the 3:00pm to 11:00pm shift due to a staff call off. Resident #52 stated she had to stay in bed all day. During an interview with Nursing Assistant (NA) #1 on 3-7-23 at 9:09am, the NA stated she was assigned to Resident #52 on 3-5-23 and explained the resident wanted to be up out of bed everyday by 10:00am. The NA also explained she had been informed by the nurse on 3-5-23 that Resident #52 would need to stay in bed because	F 561	The resident preferences were reviewed with the resident by the Director of Nursing on 3/7/2023. The Director of Nursing completed an interview with Resident #52 and established the resident choice to be out of bed daily. The resident care guide has been updated to include the resident□s preference to be out of bed daily. The nursing assistant and licensed nurse who care for Resident #52 have received training by the Staff Development Coordinator on 3/7/2023 of the resident□s preferred time to be out of bed daily. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. An audit of resident preferences by interview and review of the resident's plan of care was conducted by the Assistant Director of Nursing, nurse managers and Social Worker on 3/28/29 for all residents to determine each resident's preference for getting out of bed. The Resident Care Plan will be updated as appropriate for each residents' preference by the MDS Coordinator and Nurse Managers. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: At time of admission, the resident and/or their resident representative will be interviewed by Social Service to determine their preference for going to or getting up from bed. Resident	

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there had been a staff call out on the 3:00pm to 11:00pm shift so there would not be enough staff to place the resident back in bed. She said this had happened a "few times" before on weekends she had worked but was unable to specify specific dates. NA #1 stated she did not get the resident out of bed on 3-5-23.

Nurse #1 was interviewed by telephone on 3-7-23 at 10:51am. The nurse confirmed he had been assigned to Resident #52 on 3-5-23. He stated Resident #52 and NA #1 were mistaken and he had not told them the resident could not get out of bed due to decreased staff on the 3:00pm to 11:00pm shift. Nurse #1 stated the resident had made the choice to stay in the bed on 3-5-23 and he had not had a conversation with the resident regarding staffing. Nurse #1 said there had been other weekends when he worked Resident #52 had not gotten out of bed, but he could not remember exact dates and stated he did not think it was due to a staffing issue.

The Administrator and Director of Nursing (DON) were interviewed on 3-9-23 at 12:07pm. The DON discussed the facility being adequately staffed for the facility's acuity and census. She also stated she could not recall if there had been a call out on the 3:00pm to 11:00pm shift on 3-5-23 that would of caused Resident #52 to not be able to get out of bed. The Administrator explained if a resident had requested to get out of bed, then the resident should have been gotten out of bed and she said staffing should never be an issue when residents made request.

preferences will be documented and added to the resident care guide. Nursing Managers will review these preferences to ensure they are part of the residents care plan.
Education regarding honoring resident□s choices was initiated on 3/9 /2023 by the Staff Development Coordinator (SDC) for all staff. All new hires will receive this education prior to assignment. Any employee who has not received education by 4/6/23 will not be allowed to work until they have been educated by the Staff Development Coordinator (SDC).

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Nurse managers will audit 10 residents, 5 days a week x 2 weeks, 3 days a week x 2 weeks and weekly x 8 weeks to determine if residents are getting out of bed as they choose. The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s)

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F 561	Continued From page 13	F 561	identified. The corrective measures implemented for F 561 with repeat non-compliance identified will be reviewed monthly for 12 months and continue past 12 months if necessary due to recommendations made by the QA/QAPI committee.	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		4/6/23

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F 578	Continued From page 14 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the advanced directive information was accurate throughout the medical record for 3 of 7 residents (Resident #25, #31 and #395) reviewed for advanced directives. Findings included: 1). Resident #25 was admitted to the facility on 2/1/23 with diagnoses which included in part multiple sclerosis. Resident #25's electronic medical record indicated a 2/1/23 physician order for Full Code. Review of Resident #25's hard chart revealed a form titled No Code Agreement signed by Resident #25 on 2/1/23. Resident #25's signature indicated that resident's wishes were that at the time of the absence of heartbeat or respirations, no extraordinary or heroic measures would be performed. Physician signed the No Code Agreement form on 2/8/23. The No Code Agreement form indicated a physician's order for no extraordinary	F 578	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #25, #31 and resident # 395□s code status was clarified and corrected by the Unit Manager in the resident's medical record on 3/9/2023. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A 100% review of all code statuses was conducted on 3/30/2023 by the Unit Managers. No other discrepancies were found. On 3/30/23 the Staff Development Coordinator provided education to all licensed personnel on assuring the code agreement and the code status correlate for all current residents. Any licensed nurse who has not received this education by 4/6/23 will not work until they receive the education. Newly hired nurses will receive this education prior to assignment. 3. Address what measures will be put	

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F 578	Continued From page 15 means was required. Resident #25's 2/8/23 admission Minimum Data Set (MDS) assessment indicated resident had mild cognitive impairment and was able to make self understood and understand others. A yellow Do Not Resuscitate (DNR) form was not observed in Resident #25's hard chart. Resident #25's electronic medical record revealed a Cardiopulmonary Resuscitation (CPR)/Full Code Status displayed on the dashboard of the resident's record. Resident #25's 2/23/23 care plan dated indicated resident wished to be a Full Code. Interview with Unit Manager #1 on 3/9/23 at 1:45 PM verified that Resident #25 had signed the No Code Agreement form on 2/1/23 but there was no order for DNR or no yellow Do Not Resuscitate form in the hard chart. Unit Manager #1verified the electronic medical record listed Resident #25 as FULL Code and this was incorrect. Unit Manager #1 stated she did not audit the charts for advanced directives but maybe she should. Interview with the Director of Nursing (DON) on 3/9/23 at 1:57 PM revealed when Resident #25 signed the No Code Agreement on 2/1/23 the Do Not Resuscitate order should have been obtained. DON stated she did not know why but it must not have been communicated to obtain DNR orders and paperwork for Resident #25. DON verified the No Code Agreement was missing from Resident #31's medical record	F 578	into place or systemic changes made to ensure that the deficient practice will not recur: The Social Worker and/or Administrative Nurse will review the Code Status/Advance Directives with resident and/or resident representative at the time of admission, re-admission, quarterly during care plan meetings and when/if a significant change is noted to ensure the facility has accurate/up to date information. The Social Worker will conduct a code status audit monthly for accuracy and submit findings to the QA committee. The Staff Development Coordinator provided education to licensed personnel on assuring the code agreement and the code status match on 3/30/31. Any Nurses not receiving this education by 4/6/2-23 will not be allowed to work until educated by the Staff Development Coordinator (SDC). All newly hired nurses will receive this education prior to assignment. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: DON and/or Administrative Nurses will be reviewing resident medical records weekly for 4 weeks, then monthly for 3 months to ensure resident current Advance Directive information is up to date. The facility Interdisciplinary Team (IDT) will review monitoring results and	

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F 578	Continued From page 16 2). Resident #31 was admitted to the facility on 1/31/21 with diagnosis which included head trauma with history of falls, pulmonary hypertension, atrial fibrillation, major depressive disorder, and congestive heart failure. Medical record indicated yellow do not resuscitate form in advanced directive section of resident's chart with effective date of 2/1/23. A 2/1/23 written physician order for do not resuscitate was observed in Resident #31's hard chart. A signed No Code Agreement form between Resident #31 and the facility dated 2/1/23 was not found in the record. Resident #31's electronic medical record indicated a 2/1/23 Do Not Resuscitate order was entered. Resident #31's 2/22/23 care plan indicated a focus of advanced directives do not resuscitate. Interview with Unit Manager #1 on 3/9/23 at 1:45 PM revealed a signed No Code Agreement between Resident #31 and the facility was not found in the medical record. Unit Manager #1 stated the signed No Code Agreement should have been in place. Interview with the DON on 3/9/23 at 1:57 PM revealed the No Code Agreement form signed by Resident #31 and the facility was not found in the medical record. DON stated she did not know why the No Code Agreement was not in the record. DON further revealed that the default was Full Code and if a No Code Agreement was	F 578	outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 578 with repeat non-compliance identified will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	

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not signed the resident was Full Code status.

3). Resident #395 was admitted to the facility on 3/14/22 with diagnoses which included dementia and chronic obstructive pulmonary disease.

A Full Code Agreement signed between the responsible party and the facility on 3/14/22 was found in Resident #395's medical chart.

Resident #395's 12/5/22 quarterly Minimum Data Set (MDS) assessment indicated resident had severe cognitive impairment and impaired communication.

Resident #395's medical chart contained a yellow Do Not Resuscitate form signed by the physician on 1/18/23.

A No Code Agreement form signed between the responsible party and the facility dated 1/18/23 was not observed in Resident #395's medical record.

Resident #395's 1/19/23 care plan indicated a focus of advanced directives Do Not Resuscitate.

Resident #395's medical chart contained a 1/20/23 written physician order for Do Not Resuscitate.

Resident #395's electronic medical record indicated a 1/20/23 Do Not Resuscitate order was entered.

Interview on 3/9/23 at 1:57 PM with the DON revealed the No Code Agreement was missing from Resident #31's medical record. DON stated the Full Code Agreement should have been

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removed and a signed No Code Agreement form should have been in Resident #395's medical record.

Interview on 3/07/23 at 2:57 PM with NA #7, who also worked as a medication aide, indicated DNR status was listed in the electronic health record and showed up when you looked at the medication administration record. NA#7 indicated there was a yellow sheet in the chart also if the resident was a DNR. NA #7 stated she did not know who obtained the order or filled out the paperwork for full code or DNR status. In the event of an emergency, NA #7 indicated she would go to the hard chart and look for the yellow sheet. NA#7 stated if she saw the yellow sheet in the advanced directives section of the hard chart, she would know they were a DNR.

Interview with the Social Worker (SW) on 3/07/23 at 3:15 PM revealed the Admissions Coordinator addressed advanced directives during the admissions process and relayed the information to the doctor to write the orders. SW stated the nurses were responsible for follow up regarding the orders for advanced directives. SW stated she was not involved in the advanced directives process.

Interview with Nurse #4 on 3/07/23 at 3:28 PM revealed the computer and the hard paper chart had code status information. In an emergency, Nurse #4 indicated she would check the hard chart to determine the resident's advanced directives. Nurse #4 stated she would look for the yellow do not resuscitate form in the hard chart to determine next steps. If a yellow Do Not Resuscitate form was observed in the chart CPR would not be initiated.

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Interview on 3/9/23 at 10:39 AM with Unit Manager #2 revealed she had been in the position since December 2022. Unit Manager #2 stated nursing discussed advanced directives with the resident and family on admission. Unit Manager #2 indicated residents are considered a Full Code until otherwise noted. Unit Manager #2 stated to be considered a DNR, the facility required a signed consent form, a written order by the physician, a yellow Do Not Resuscitate form and the order in the electronic medical record. Unit Manager #2 stated in the event of an emergency, the nurse looked in the electronic medical record for the physician order.

Interview with Unit Manager #1 on 3/09/23 at 11:30 AM revealed she had been in the position since January 2023. Unit Manager #1 indicated nursing asked the resident and the responsible party on admission about advanced directives. Unit Manager #1 stated a resident was considered Full Code until able to determine code status. Unit Manager #1 stated she thought the Social Worker was supposed to be involved in the advanced directives process. Unit Manager #1 stated the Do Not Resuscitate information requirements were a consent form signed by the resident or responsible party, a written physician order, the yellow Do Not Resuscitate form in the medical chart, and the physician order in the electronic medical record. In the event of an emergency, the staff checked the electronic medical record or the paper chart for a DNR order. Unit Manager #1 stated a lot of times the staff know what the code status is, but it might change. Unit Manager #1 stated she did not audit the charts for advanced directives but maybe she should.

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F 578	Continued From page 20 Interview on 3/9/23 at 1:57 PM with the Director of Nursing (DON) revealed she had been in the position at the facility since December 2022 and the Admissions Coordinator had recently left. DON stated the process for advanced directives consisted of the Admissions Coordinator had the resident or responsible party sign the No Code Agreement or FULL Code status agreement. The Admissions Coordinator informed nursing to obtain orders after advanced directives were established with the resident or responsible party.	F 578		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		4/6/23

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F 640	Continued From page 21 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and/or transmit discharge Minimum Data Set (MDS) assessments (Resident #85, Resident #86, and Resident #87) and an entry tracking MDS assessment (Resident #31) within the required timeframes for 4 of 23 residents reviewed for MDS assessments. Findings included: 1. Resident #85 was readmitted to the facility on 9/30/22 and discharged from the facility on	F 640	F640 Encoding/Transmitting Resident Assessments 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #31□s MDS (Minimum Data Set) assessment for ARD (Assessment Reference Date) 1/31/2023 was transmitted and accepted on 3/06/2023. Resident #85□s MDS assessment for ARD 11/17/2022 was transmitted and accepted on 3/06/2023. Resident #86□s	

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F 640	Continued From page 22 11/17/22. Resident #85's discharge MDS with an assessment reference date (ARD) of 11/17/22 was signed as completed by the corporate MDS Nurse Consultant on 3/7/23. This discharge MDS was not encoded or transmitted within the required timeframe. Interview on 3/07/23 at 1:48 PM with the MDS Coordinator indicated she had been in the position for 6 years and was responsible for signing off on the completion and transmission of resident assessments. The MDS Coordinator stated she reviewed the validation reports after she transmitted assessments to check for any warnings related to discrepancies in data. The MDS Coordinator stated assessments were to be completed and transmitted with the required time frames. The MDS Coordinator stated she did not have a system in place to check that all assessments were completed, transmitted, and accepted within the required time frames. The MDS Coordinator stated she might need to implement as system for that. The MDS Coordinator stated Resident #85's discharge MDS assessment was in a batch of assessments that were transmitted but was not accepted. The MDS Coordinator revealed she did not realize Resident #85's assessment was not accepted. The MDS Coordinator stated the corporate MDS Consultant discovered Resident #85's assessment had not been accepted when it was transmitted so she resigned it as completed on 3/7/23. Interview on 3/07/23 at 2:15 PM with the corporate MDS Nurse Consultant revealed she opened and resigned Resident #85's discharge	F 640	MDS assessment for ARD 11/18/2022 was transmitted and accepted on 3/07/2023. Resident #87□s MDS assessment for ARD 11/12/2022 was transmitted and accepted on 11/10/2022. This was completed by the facility MDS Nurse and completed on 3/7/23. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Transmission summary reports for the past sixty (60) days were audited by the Minimum Data set (MDS) Coordinator and validated by the Regional MDS Consultant with validation reports to ensure assessments were transmitted successfully on 3/30/2023. 3. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Education provided by Regional MDS Consultant for Encoding and Transmitting of MDS assessments to MDS Coordinators on 3/31/2023. MDS (Minimum Data Set) Coordinator will print a Transmission Summary report daily and compare it to the Validation report daily. Any difficulty with transmission will be reported to the Regional MDS Consultant, to assist with timely transmission. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Regional MDS Consultant will review transmission and validation reports weekly for four weeks, then every two weeks for two weeks, then monthly for one month,	

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F 640	Continued From page 23 tracking form on 3/7/23 when she determined the form had not been accepted when it was transmitted. The corporate MDS Nurse Consultant revealed the process was to compare the lists of assessments that were transmitted with the validation report to check that all assessments were completed timely, transmitted, and accepted. The validation report indicated if the assessments that were transmitted were accepted or rejected. If assessments that were transmitted did not appear on the validation report the MDS Coordinator should have followed up to determine why. Interview on 3/9/23 at 2:30 PM with the Director of Nursing (DON) revealed that it was her expectation that MDS assessments were completed and transmitted within the regulatory timeframes. DON stated she was new to the position and was not aware that there had been any problems with completion or transmission of assessments. 2. Resident #31 was admitted to the facility on 1/31/23. Resident #31's entry tracking MDS assessment with an assessment reference date (ARD) of 1/31/23 was signed as completed by the corporate MDS Consultant on 3/6/23. This entry tracking MDS assessment was not encoded or transmitted within the required timeframe. Interview on 3/7/23 at 1:48 PM with the MDS Coordinator indicated she had been in the position for 6 years and was responsible for signing off on the completion and transmission of resident assessments. She revealed Resident #31's entry tracking assessment was signed as	F 640	to ensure timely transmission of MDS. The facility MDS Nurse will complete a summary of these audit results and present them at the facility monthly QAPI meeting, to ensure continued compliance. The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 640 with repeat non-compliance identified will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI Committee.	

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F 640	Continued From page 24	F 640		

completed late due to a discrepancy with the resident's name listing from a prior admission. The MDS Coordinator stated she was not aware of the discrepancy until 3/6/23.

Interview on 3/07/23 at 2:15 PM with the corporate MDS Nurse Consultant revealed she discovered on 3/6/23 that there were duplicate records for Resident #31 in the computer system, so she opened the entry tracking form and resigned it on 3/6/23 to try to correct the problem. The MDS Nurse Consultant stated the MDS Coordinator was responsible for checking for duplicate records in the computer system.

Interview on 3/9/23 at 2:30 PM with the Director of Nursing revealed that it was her expectation that MDS assessments were completed and transmitted within the regulatory timeframes. DON stated she was new to the position and was not aware that there had been any problems with completion or transmission of assessments.

3.Resident #86 was admitted to the facility on 7/22/22 and discharged on 11/18/22.

Resident #86's discharge MDS assessment with an assessment reference date of 11/18/22 was signed as complete by the corporate MDS Consultant on 3/7/23. This discharge tracking MDS assessment was not encoded or transmitted within the required timeframe.

Interview on 3/7/23 at 1:50 PM with the MDS Coordinator indicated she had been in the position for 6 years and was responsible for signing off on the completion and transmission of resident assessments. She revealed she did not realize Resident #86's discharge tracking MDS

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F 640	Continued From page 25	F 640		

assessment had not been accepted on 11/23/22 when it was transmitted. The MDS Coordinator stated the corporate MDS Consultant discovered on 3/7/23 that Resident #86's discharge assessment was not accepted when it was transmitted on 11/23/22 so she opened the assessment, resigned it with the completion date of 3/7/23 and transmitted it again on 3/7/23.

Interview on 3/07/23 at 2:15 PM with the corporate MDS Nurse Consultant revealed she discovered Resident #86's discharge assessment had not been accepted so she resigned the assessment as completed on 3/7/23. The corporate MDS Nurse Consultant stated she did not know why the assessment had not been accepted when it was transmitted. The MDS Nurse Consultant further stated the process was for the MDS Coordinator to compare the lists of assessments that were transmitted with the validation report to check that all assessments were completed timely, transmitted, and accepted. The validation report indicated if the assessments that were transmitted were accepted or rejected. If assessments that were transmitted did not appear on the validation report the MDS Coordinator should have followed up to determine why.

Interview on 3/9/23 at 2:30 PM with the Director of Nursing revealed that it was her expectation that MDS assessments were completed and transmitted within the regulatory timeframes. DON stated she was new to the position and was not aware that there had been any problems with completion or transmission of assessments.

4. Resident #87 was admitted to the facility on 10/25/22 and discharged on 11/12/22.

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F 640	Continued From page 26 Resident #87's discharge MDS assessment with an Assessment Reference Date (ARD) of 11/12/22 was transmitted and accepted on 3/7/23. Interview on 3/7/23 at 1:50 PM with the MDS Coordinator revealed she thought Resident #87's discharge MDS assessment was previously transmitted but it was not accepted. The MDS Coordinator stated she may need to check her lists of assessments that were transmitted with the validation report to be sure that all assessments were accepted. Interview on 3/07/23 at 2:15 PM with the corporate MDS Nurse Consultant revealed the process was to compare the lists of assessments that were transmitted with the validation report to check that all assessments were completed timely, transmitted, and accepted. The validation report indicated if the assessments that were transmitted were accepted or rejected. If assessments that were transmitted did not appear on the validation report the MDS Coordinator should have followed up to determine why. Interview on 3/9/23 at 2:30 PM with the Director of Nursing revealed that it was her expectation that MDS assessments were completed and transmitted within the regulatory timeframes. DON stated she was new to the position and was not aware that there had been any problems with completion or transmission of assessments.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		4/6/23

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F 641	Continued From page 27 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and resident interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of the administration of an antidepressant and history of falls prior to admission for 1of 23 residents (Resident #31) reviewed for MDS assessments. Findings included: Resident #31 was admitted on 1/31/23 with diagnosis which included in part fall with head trauma and major depressive disorder. Review of Resident #31's physician orders revealed a 1/31/23 order for paroxetine (a medication used to treat depression) 20 milligrams (mg) daily. Review of Resident #31's February 2023 Medication Administration Record (MAR) revealed resident received paroxetine 20 milligrams (mg) daily. Nursing progress note on 2/2/23 indicated Resident #31 had a fall from bed with a wound to the forehead and was sent to the emergency room. Progress note indicated Resident #31 returned to the facility from the emergency room later on 2/2/23 with no fracture. An orthopedic consult note on 2/6/23 indicated resident with left hip osteoarthritis and bony contusion to the left hand/wrist and Resident#31 was to wear a left wrist brace at all times for two	F 641	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: MDS Nurse Consultant completed a review of Resident #31□s medical record and MDS admission assessment for ARD 2/07/2023 section N0410C was corrected on 3/29/2023. Resident #31□s MDS admission assessment for ARD 2/07/2023 section J1700A was corrected on 3/29/2023, and section J1800 was corrected on 3/29/2023. Corrections were made by the Minimum Data Set Coordinator (MDS). 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: MDS Assessments for the past sixty (60) days were reviewed on 3/20/2023 by the Minimum Data Set Coordinator for accurate coding for Section N0410C. No other discrepancies were found. MDS assessments completed within the past 60 (sixty) days were reviewed for accuracy of coding for Section J1700 on 3/28/2023 by the MDS Coordinator. Corrections for any inaccurate assessments were completed on 3/31/2023 by the MDS Coordinator. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 641	Continued From page 28 weeks. Resident #31's 2/7/23 admission MDS assessment revealed resident was cognitively intact and required extensive assistance with bed mobility, transfers, and toileting. Resident #31 was assessed as no falls during the month before admission and no falls in 2-6 months before admission. MDS assessment indicated Resident #31 had one fall since admission with no injury and did not receive an antidepressant during the look back period. Progress note on 2/13/23 by the Nurse Practitioner included diagnosis of repeated falls and that Resident #31 had been hospitalized 1/28/23-1/31/21 due to a fall at home. Progress note further indicated Resident #31 was sent to the emergency room on 2/2/23 following a fall and returned the same day. Interview on 3/6/23 at 11:30 AM with Resident #31 revealed resident had fallen prior to admission to the facility and sustained an injury to her wrist and her head. Interview on 3/8/23 at 1:11 PM with the MDS Coordinator revealed Resident #31's 2/7/23 Admission MDS should have listed history of falls and received antidepressant during the look back period. MDS Coordinator stated she did not know what the medication paroxetine listed on Resident #31's medication administration record was so she did not list antidepressant on the assessment. MDS Coordinator stated the assessment should reflect accurate information and be checked for accuracy prior to finalization and transmission.	F 641	MDS Nurses were provided education, by Regional MDS Consultant for accurate coding of Section N and Section J of the MDS assessment on 3/31/2023. MDS Coordinator will review all Medication Administration Records for Antidepressant use and code accurately on MDS admission assessment. MDS Coordinator will review all documentation for fall history documentation and code accurately on MDS admission assessment. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Section N0410C, J1700 and J1800 on all admission assessments will be reviewed weekly for 4 (four) weeks, then bi-weekly for 2 months, then monthly for one month by Regional MDS Nurse Consultant. MDS Coordinator will present to QAPI monthly a summary of these audit results to ensure continued compliance. The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to	

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F 641	Continued From page 29 Interview on 3/9/23 at 2:20 PM with the Director of Nursing (DON) revealed that MDS data should be accurate for all resident assessments.	F 641	maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 651 with repeat non-compliance identified will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		4/6/23

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F 656	Continued From page 30 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interviews, the facility failed to develop a comprehensive person centered care plan in the areas of psychotropic medications and falls for 1 of 7 residents (Residents #31) reviewed for comprehensive care plans. Findings included: Resident #31 was admitted on 1/31/23 with diagnosis which included, in part, fall resulting in head trauma and major depressive disorder. Review of Resident #31's physician orders revealed a 1/31/23 order for paroxetine (a medication used to treat depression) 20 milligrams (mg) daily. Review of Resident #31's February 2023 Medication Administration Record (MAR) revealed resident received:	F 656	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Care plan for Resident #31 updated to include use of antidepressant regimen on 3/27/2023. Care plan for Resident #31 updated to include intervention for fall on 2/22/2022. Corrections were completed by the Minimum Data Set Coordinator. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. Care plans for residents receiving antidepressants will be reviewed by the	

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F 656	Continued From page 31 paroxetine 20 milligrams (mg) daily. Nursing progress note on 2/2/23 indicated Resident #31 had a fall from bed with a wound to the forehead and was sent to the emergency room. Progress note indicated Resident #31 returned to the facility from the emergency room later 2/2/23. Resident #31's 2/7/23 admission Minimum Data Set (MDS) assessment revealed resident was cognitively intact and had no falls during the month before admission and no falls in 2-6 months before admission. MDS assessment indicated Resident #31 had one fall since admission with no injury. Resident #31's assessment further indicated she did not receive an antidepressant during the look back period. The Care Area Assessments (CAAs) indicated falls was to be addressed and the care plan decision indicated to proceed to care plan to address falls. Progress note dated 2/13/23 by the Nurse Practitioner included diagnosis of repeated falls and indicated Resident #31 had been hospitalized 1/28/23-1/31/21 due to a fall at home with head trauma. The progress note further indicated Resident #31 was sent to the emergency room on 2/2/23 following a fall at the facility and returned the same day. An interview and observation were conducted on 3/6/23 at 11:30 AM with Resident #31 that revealed the resident in bed with fall mats on the floor on both sides of the bed. Resident #31 indicated she had a fall prior to going to the hospital and a fall here at the facility.	F 656	Minimum Data Set Coordinator for presence of antidepressant care plan with completion on 3/31/2023. Care plans for Residents who sustained a fall within 60 (sixty) days will be reviewed by the Minimum Data Set Coordinator for interventions with completion on 3/31/2023. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Minimum Data Set Coordinator and Assistant received education on care planning of antidepressant medication regimen on 3/31/2023 by Regional MDS Consultant. The MDS Coordinator will ensure Residents receiving antidepressant medication regimens are care planned for use of antidepressants. The Minimum Data Set Coordinator and Assistant received education on care planning of falls completed on 3/31/2023 by Regional MDS Consultant. The MDS Coordinator will ensure Resident□s care plans are updated to include interventions for falls. A 100% Audit of care plans for residents receiving antidepressants was conducted on 3/31/2023 by the Regional MDS Consultant. The MDS Coordinator will ensure residents' care plans are updated correctly for residents with antidepressant medications.	

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F 656	Continued From page 32 Review of Resident #31's active care plan included a focus area of falls initiated on 2/22/23. The interventions were listed as follows: allow rest breaks, assist as needed, Physical Therapy, encourage to request assist, use wheelchair, incontinence pad, provide verbal cues, monitor for changes in condition and keep call bell within arm's length. This care plan related to falls did not include any mention of the fall mat intervention observed to be in place. Additionally, the care plan had not addressed psychotropic medication for Resident #31. Interview with the MDS Coordinator on 3/8/23 at 1:11 PM revealed that if antidepressant medication had been coded on the MDS a CAA would have been triggered for psychotropic medication. She explained that if a CAA was triggered for psychotropic medications then that would have resulted in care plan development identifying a problem, goal, and interventions. After reviewing Resident #31's care plan with the MDS Coordinator, she confirmed that psychotropic medication should have been included in Resident #31's care plan. The MDS Coordinator further indicated the care plan interventions related to falls should have been person-centered and included the specific intervention of a fall mat that was observed to be in place during the survey. An interview with the Director of Nursing (DON) on 3/9/23 at 2:20 PM revealed that areas pertinent to a resident's care should be addressed in the care plan. The DON further indicated the care plan should be person centered to accurately reflect the resident's current care needs.	F 656	A 100% audit of Care plans was conducted on 3/31/2023 by the Minimum Data Set Coordinator and Unit Manager for residents with falls over the past 30 days to ensure fall interventions were care planned. The MDS Coordinator will ensure Resident□s care plans are updated to include interventions for falls for any other residents identified. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Care plans for Residents receiving antidepressant medication regimens will be reviewed by Regional MDS Consultant on 3/28/2023 to ensure appropriate care plan is in place weekly for 4 (four) weeks, then every 2 (two) weeks times two, then monthly for one month. MDS Coordinator will present the results of the audits to QAPI monthly. Care plans for Residents with falls will be reviewed by the Regional MDS Consultant to ensure appropriate care plan fall interventions is in place weekly for 4 (four) weeks, then every 2 (two) weeks times two, then monthly for one month. MDS Coordinator will present the results of the audits to QAPI monthly. The facility Interdisciplinary Team (IDT) will review monitoring results and	

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F 656	Continued From page 33	F 656	outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are corrected. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 656 with repeat non-compliance identified will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	
F 657 SS=E	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).	F 657		4/6/23

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F 657	Continued From page 34 An explanation must be included in a resident's medical record if the participation of the resident 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 record review, and staff, resident and Resident Representative (RP) interviews the facility failed to ensure the resident and/or the RP was involved in the review and revision of the comprehensive care plan by the interdisciplinary team (IDT) for 3 of 3 residents reviewed for care planning. (Resident #38, Resident #52, and Resident #42) Findings included: 1. Resident #38 was admitted to the facility on 12/21/21 with a diagnosis of stroke. A review of her quarterly Minimum Data Set (MDS) assessment dated 1/26/23 revealed she was severely cognitively impaired. A review of Resident #38's current comprehensive care plan revealed 15 active focus areas last updated on 1/31/23. A review of Resident #38's medical record did not reveal any evidence of a care plan meeting was held for this updating of her care plan on 1/31/23.	F 657	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility Social Workers scheduled a care plan meeting for resident #38, #52, and #42 on 3/31/23, the invitation included the resident representative of the resident and facility IDT Team members. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. A 100% audit was done by the Social Worker and Administrator by 3/31/2023 to identify any other residents who do not have documented care plan meetings in place for the first quarter of 2023. A letter will also be sent to all self-responsible residents and/or resident□s representative to schedule a	

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F 657	Continued From page 35 On 3/8/23 at 11:00 AM a telephone interview with Resident #38's RP indicated he used to regularly receive invitations to participate in Resident #38's care plan meetings from the facility. He stated he had not received an invitation since June of 2022. He went on to say while the facility kept him updated with changes in Resident #38's condition, attending care plan meetings were the only way he was able to keep up with everything. He further indicated he would like to continue to receive invitations and participate in Resident #38's care plan meetings. On 3/8/23 at 2:39 PM an interview with the MDS Nurse #1 indicated she reviewed Resident #38's care plan on 1/31/23 herself in conjunction with Resident #38's quarterly MDS assessment dated 1/26/23. She stated she did not recall Resident #38 having a care plan meeting with the IDT at that time. She went on to say in the past she used resident's MDS assessment dates to create a calendar for care plan meetings, sent out letters inviting RPs to care plan meetings, and arranged the care plan meetings with the IDT team but she was not doing this now. MDS Nurse #1 stated she had become overwhelmed with all the things she was responsible for and had stopped doing this. She further indicated it was her understanding the Social Worker (SW) was now responsible for this. She went on to say it had been almost a year that not all residents were having regular care plan meetings. She further indicated she had she had spoken with the previous administrator and the MDS Corporate Consultant about the issue and been told a new plan was to be put in place but that had not happened. She went on to say she continued speaking with any RPs and families that called	F 657	plan of care meeting. The facility Administrator will ensure that all residents in need of a care plan meeting will be scheduled by 4/5/2023. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Social Worker and Minimum Data Set Coordinator received education 3/28/2023 by the Administrator over tracking and scheduling resident care plan meetings. Education included that the MDS Coordinator will provide the MDS calendar for the SW to create the care plan meeting schedule. The Social Worker will establish contact with the Resident/Responsible Party to set the Care Plan Meeting schedule weekly. Attendance of care plan meetings will be documented in the Medical Record by the Social Worker. The care plan meetings scheduled will be monitored by the Administrator and or Designee weekly to ensure that residents and responsible parties were notified of the scheduled meeting and that the meeting record is documented in the residents' medical record. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator and Social Worker will monitor the MDS Care Plan calendar and	

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her and wanted to talk and had been passing on any changes she made to care plans to the Director of Nursing (DON), the nurse on the floor, or whatever department head would be affected by the changes.

On 9/9/23 at 9:13 AM an interview with the MDS Corporate Consultant indicated the information MDS Nurse #1 shared was correct. She stated there had been a conversation with the previous administrator regarding care plan meetings and the outcome had been that the SW would oversee them. She further indicated the SW had been informed. She went on to say as a courtesy, MDS Nurse #1 continued helping with the care plan scheduling and sending out invitations to RPs. The MDS Corporate Consultant stated there seemed to be great confusion, and care plan meetings were not happening like they should. She stated it was a work in progress. She went on to say resident's care plan meetings should be happening at least quarterly and include members of the IDT team including nursing, dietary, social work, and others as appropriate. She stated residents and RPs should also be given the opportunity to participate. She went on to say the meeting, including who attended, should be documented in the resident's medical record.

On 3/9/23 at 9:43 AM an interview with the SW indicated it had not been communicated to her that she was responsible for scheduling or arranging resident's care plan meetings or sending out invitations to them to RPs. She stated she was not doing it. She went on to say MDS had always been responsible for this. She further indicated she could not find any documentation that Resident #38 had a care plan

the care plan meeting schedule weekly comparing to the resident census X 12 weeks to ensure that all residents are invited to attend a scheduled care plan meeting.

The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified.

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meeting related to the updating of her care plan on 1/31/23 in Resident #38's medical record.

On 3/9/23 at 10:49 AM an interview with the DON indicated care plan meetings should include members of the IDT team including nursing, dietary, social work, therapy and others as appropriate. She stated she just recently found out that these meetings had not been getting done.

On 3/9/23 at 3:02 PM an interview with the Administrator indicated she was not certain which residents had not had care plan meetings. She stated she had spoken to some resident's family members herself by telephone, but these conversations were not care plan meetings.
2). Resident #52 was admitted to the facility on 11/6/15.

Resident #52's 2/1/23 annual Minimum Data Set (MDS) assessment revealed resident was cognitively intact and was able to understand others and make self understood.

A review of Resident #52's comprehensive care plan revealed the active focus areas had a date of 2/28/23.

There was no evidence in Resident #52's medical record that an interdisciplinary care plan meeting had been held following the 2/1/23 annual MDS assessment or corresponding to the 2/28/23 updating of the care plan.
There was no evidence that Resident #52 was invited to or attended a care plan meeting following the 2/1/23 annual MDS.

Interview with Resident #52 on 3/9/23 at 11:15

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AM revealed resident had not attended a care plan meeting for a long time, and she estimated it had been about a year. Resident #52 indicated she would be interested in having a care plan meeting again with the interdisciplinary team. Resident #52 stated it would be helpful to have a time to discuss her care with her team.

Interview with the MDS Coordinator on 3/07/23 at 2:08 PM revealed care plan meetings were scheduled by MDS Nurse #1. The MDS Coordinator stated MDS Nurse #1 called the resident's responsible party, arranged a time for the meeting and communicated this to the interdisciplinary team. The MDS Coordinator stated MDS Nurse #1and the interdisciplinary team met with the residents and/or the responsible party and the care plan was reviewed.

Interview on 3/07/23 at 2:24 PM with MDS Nurse #1 revealed in the past she used to schedule the care plan meetings and invited the team, but she had not been doing this for about a year. MDS Nurse #1 stated she had some families that contacted her about scheduling meetings, and she met with them. Currently, MDS Nurse #1 stated the Social Worker was supposed to schedule the care plan meetings with resident and the family and coordinate with the rest of the interdisciplinary team. MDS Nurse #1 stated she had not attended a care plan meeting for about a year. MDS #1 stated she was not aware of a care plan meeting being held for Resident #52 recently and was unable to provide evidence that resident was invited, or a meeting occurred.

Interview on 3/07/23 at 3:02 PM with the Social Worker (SW) revealed MDS Nurse #1 scheduled

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the care plan meetings with the residents and/or responsible parties and coordinated the meetings with the interdisciplinary team. SW was unable to provide evidence that a care plan meeting invitation had been extended to Resident #52.

Interview on 3/09/23 at 10:49 AM with the Director of Nursing revealed she just returned to the position at the facility in December 2022 and was recently made aware that care plan meetings were not being done.

3. Resident #42 was admitted to the facility on 8/25/13 with diagnoses which included stroke and diabetes.

The quarterly Minimum Data Set (MDS) assessment dated 1/24/23 indicated Resident #42 was moderately cognitively impaired. He was able to understand others and make himself understood by others.

Resident #42's current comprehensive care plan had a review date of 1/30/23.

There was no evidence in Resident #42's medical record of an interdisciplinary care plan meeting being held following the 1/24/23 quarterly MDS assessment.

There was no evidence in the medial record that Resident #42 was invited to or attended a care plan meeting following the 1/24/23 quarterly MDS.

On 3/6/23 at 3:20 PM Resident #42 said he had not attended a meeting with facility staff to discuss his plan of care. He stated he had never received an invitation to attend a care plan meeting with the interdisciplinary team. Resident

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#42 said he would be interested in participating in his care plan meeting.

On 3/7/23 at 2:08 PM the MDS Coordinator said care plan meetings were scheduled by MDS Nurse #1. The MDS Coordinator stated MDS Nurse #1 called the resident's responsible party, arranged a time for the meeting and communicated this to the interdisciplinary team. The MDS Coordinator stated MDS Nurse #1and the interdisciplinary team met with the residents and/or the responsible party and the care plan was reviewed.

An interview on 3/07/23 at 2:24 PM with MDS Nurse #1 revealed in the past she scheduled the care plan meetings and invited the team, but she had not been doing this for about a year. MDS Nurse #1 stated she had some families that contacted her about scheduling meetings, so she met with them. MDS Nurse #1 stated now the process was the Social Worker (SW) was supposed to schedule the care plan meetings with resident and the family and coordinate with the rest of the interdisciplinary team. MDS Nurse #1 stated she had not attended a care plan meeting for about a year. MDS #1 stated she was not aware of a care plan meeting being held for Resident #42 recently and was unable to provide evidence that resident was invited, or a meeting occurred.

On 3/07/23 at 3:02 PM with the SW stated MDS Nurse #1 scheduled the care plan meetings with the residents and/or their RP and coordinated the meetings with the interdisciplinary team. The SW was unable to provide evidence of a care plan meeting invitation for Resident #42.

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F 657	Continued From page 41 On 3/9/23 at 10:49 AM an interview with the DON indicated care plan meetings should include members of the IDT team including nursing, dietary, social work, therapy and others as appropriate. She stated she just recently found out that these meetings had not been getting done. On 3/9/23 at 3:02 PM an interview with the Administrator indicated she was not certain which residents had not had care plan meetings. She stated she had spoken to some resident's family members herself by telephone, but these conversations were not care plan meetings.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to ensure mobility	F 688	been affected by the deficient practice:	4/6/23

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F 688	Continued From page 42 aides were provided as ordered for 1 of 1 resident (Resident #47) reviewed for range of motion. Findings included: Resident #47 was admitted to the facility on 10-19-22 with multiple diagnoses that included joint derangements of the right hand, joint derangements of the left elbow, joint derangements of the left hand and non-traumatic intracerebral hemorrhage. Physician order dated 1-8-23 revealed an order to apply elbow splint alternating from left to right for a maximum of 6 hours on each elbow as tolerated. Physician order dated 1-8-23 revealed an order to apply right- and left-hand splints for a maximum of 6 hours daily as tolerated. Physician order dated 1-12-23 revealed an order to apply protective boots to bilateral feet as tolerated. Remove boots for skin checks every shift. The quarterly Minimum Data Set (MDS) dated 1-19-23 revealed Resident #47 was severely cognitively impaired and required total assistance with two people for bed mobility, toileting, and extensive assistance with two people for transfers. Resident #47's care plan dated 1-25-23 revealed Resident #47 required assistants for eating mobility, transfers, dressing, grooming, toileting, and bathing related to non-traumatic intracerebral hemorrhage. The goal for Resident #47 was to be clean, dry, and appropriately dressed for the	F 688	Resident #47 is wearing all splints as ordered as initiated by the Director of Nursing on 3/8/2021. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with splint orders have the potential to be affected by the deficient practice. All residents with splint orders were audited on 3-8-2023 by the Treatment Nurse to ensure there is a current physician order and splint information has been added to the resident care guide, for correct splint wear and was validated on 3/30/2023 by the Regional Clinical Nurse Consultant. On 3/8/2023, observation round was completed by WHO and to ensure all residents were wearing their splints as ordered. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing, Assistant Director of Nursing or nursing Managers will review all new admissions and new physician orders for splinting orders. The Treatment nurse will be responsible for reviewing the resident splint list to ensure splints are in place. All Licensed personnel were educated on 3/30/2023 by the Staff Development Coordinator regarding residents requiring splints and the application of the splint.	

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F 688	Continued From page 43 season. The interventions associated with the goal were to apply right- and left-hand splints for a max of six hours a day as tolerated, apply elbow splint alternating from left to right for a max of 6 hours on each elbow as tolerated, and assist with donning protective boots daily. An observation of Resident #47 occurred on 3-6-23 at 10:10am. The resident was observed laying in his bed moving his arms and legs. The observation revealed Resident #47's hand splints, elbow splint or the protective boots to his bilateral feet were not present. Observation of the resident's room revealed his hand splints, and his protective boots were located on a chair. Resident #47's elbow splints were not visible during the room observation. An observation of Resident #47 occurred on 3-6-23 at 12:23pm. The observation revealed Resident #47 was not wearing his hand splints, elbow splint or the protective boots to his bilateral feet. Observation of the resident's room revealed his hand splints, and his protective boots were located on a chair. Resident #47's elbow splints were not visible during the room observation. An observation of Resident #47 occurred on 3-7-23 at 8:00am. The resident was observed laying in his bed with his eyes closed. The observation revealed Resident #47 was not wearing his hand splints, elbow splint or the protective boots to his bilateral feet. Observation of the resident's room revealed his hand splints, and his protective boots were located on a chair. Resident #47's elbow splints were not visible during the room observation.	F 688	Education was conducted for Nursing Assistants on 3/30/2023 over the splinting requirements and identification of residents with splints. Any nursing employees who have not received education by 4/6/23 will not be allowed to work until they have been educated by the Staff Development Coordinator (SDC). 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing, Assistant Director of Nursing or Unit Managers will audit 5 residents 5x a week, then 5 residents 3x/week x 2 weeks and 5 residents weekly x 8 weeks for splint application. The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 688 with repeat non-compliance identified or	

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F 688	Continued From page 44 An observation of Resident #47 occurred on 3-7-23 at 2:09pm. The observation revealed Resident #47 was not wearing his hand splints, elbow splint or the protective boots to his bilateral feet. Observation of the resident's room revealed his hand splints, and his protective boots were located on a chair. Resident #47's elbow splints were not visible during the room observation. A Nursing Assistant (NA) #6 was interviewed on 3-7-23 at 2:25pm. The NA discussed she was aware a resident required splints or protective boots by looking at a resident for contractures. She stated she was aware Resident #47 was to receive hand splints and the protective boots to his feet because she saw them laying in his chair but was unaware the resident was to receive elbow splints as well. NA #6 explained she would apply the splints and boots "sometimes" and stated night shift (11:00pm to 7:00am) would apply them "sometimes". The NA stated if night shift had applied the splints and protective boots she would know because she would remove them when she started her shift at 7:00am. She said she was unaware the resident had to keep the protective boots on daily. NA #6 discussed removing his protective boots and hand splints when she arrived at work this morning (3-7-23). During an interview with Nurse #6 on 3-7-23 at 2:34pm, the nurse discussed knowing when a resident required splints and/or protective boots by the order appearing in the resident's Medication Administration Record (MAR) where the nurse could document the time the splints were placed and what time the splints were removed. She stated she was aware Resident #47 was to receive hand splints and protective boots because she had seen them in his room	F 688	for potential for repeat non-compliance, will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	

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F 688	Continued From page 45	F 688		

but said the resident did not like his protective boots and only wore them 3-4 times a week. She discussed Resident #47's Physician order for his hand and elbow splints were not on the MAR so there was no documentation when the splints were placed or removed. The nurse stated she would "normally" apply the splints and protective boots during her shift (7:00am to 3:00pm) but said she had not done so today (3-7-23) or yesterday (3-6-23). Nurse #6 also explained night shift would also apply the splints "sometimes" and report during shift report that they had applied the splints. The nurse stated the 11:00pm to 7:00am nurse had not reported that she had applied Resident #47's splints during her shift on 3-6-23.

The Rehabilitation Director was interviewed on 3-8-23 at 9:13am. The Rehabilitation Director discussed Resident #47 being discharged from services in January 2023 with orders for bilateral hand splints and bilateral elbow splints to be worn up to 6 hours a day. She explained if the splints were not worn as instructed there could be a negative effect on the resident with possible worsening of his contractures.

A telephone interview occurred with Nurse #7 on 3-8-23 at 9:40am. Nurse #7 confirmed she worked the 11:00pm to 7:00am shift on 3-6-23. Nurse #7 explained when a resident was ordered splints and or protective boots, the order would be populated onto the resident's MAR so the nursing staff could document when the splints were placed and when they were removed. She stated she was unaware Resident #47's splint orders were not on his MAR. Nurse #7 explained night shift did not place splints on residents so she would not expect to see the order populate on the MAR for her shift. The nurse clarified she

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F 688	Continued From page 46 had not placed Resident #47's hand splints on the resident during her shift on 3-6-23 and she stated she had not seen the resident wearing his protective boots. The Director of Nursing was interviewed on 3-8-23 at 10:22am. The DON explained when there was an order for a resident to wear splints and/or protective boots the order would populate on the residents MAR and care guide. The DON examined Resident #47's medical record and confirmed the order for his hand and elbow splints were not on the MAR. She examined Resident #47's Physician orders and discovered the order for the resident's hand and elbow splints were entered incorrectly causing the order to not populate onto the resident's MAR. The DON confirmed there was no documentation if or when Resident #47's splints had been applied. The Administrator and DON were interviewed on 3-9-23 at 12:07pm. The Administrator explained Physician orders were reviewed every morning during their Administrative meeting for accuracy. The DON stated Resident #47's order had been entered incorrectly and the Administrative team had not seen that the order was incorrectly entered.	F 688		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		4/6/23

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F 695	Continued From page 47 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, physician and nurse practitioner interviews the facility failed to follow up on a physician's recommendation on the hospital discharge summary. This was for 1 of 4 residents reviewed for hospitalization (Resident #70). Findings included: Resident #70 was admitted to the facility on 4/22/20 and re-admitted on 12/29/22 with a diagnosis of obstructive sleep apnea (OSA is a sleep related breathing disorder). A review of the quarterly Minimum Data Set (MDS) assessment for Resident #70 dated 12/31/22 revealed she was cognitively intact. A review of the hospital discharge summary for Resident #70 dated 12/29/22 revealed a discharge diagnosis of OSA not on continuous positive airway pressure (CPAP) and a recommendation for nocturnal (nighttime) oxygen at 2 liters per minute until Resident #70 could have a sleep study and initiation of CPAP. A review of Resident #70's medical record did not reveal any physician's order for oxygen 2 liters per minute at night nor any follow up for a sleep study or CPAP. On 3/8/23 at 6:26 A an observation of Resident #70 in her room revealed there was no oxygen administration or CPAP equipment. An interview with Resident #70 at that time indicated no one at	F 695	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: An order for oxygen at bedtime was added for resident # 70 on 3/10/2023. Resident # 70 refused to have a sleep study scheduled and refused to wear her CPAP device. Resident confirmed her refusals on 3/30/2023 and refusal is documented in the medical record. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The hospital discharge summaries for residents admitted 3/1/23 through 3/30/23 were reviewed on 3/30/23 by the unit managers to assure all orders and recommendations had been noted and acted upon. No other discrepancies were found. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All hospital discharge summaries will be reviewed by the admitting nurse and unit manager upon admission daily Monday through Friday. Admission orders will be reviewed daily as residents are admitted Monday through Friday in the morning clinical meeting by nurse managers.	

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F 695	Continued From page 48 the facility had ever spoken with her about oxygen at night, a sleep study or a CPAP. She stated when she was in the hospital in December 2022, she used a CPAP, but this had not come with her to the facility. She went on to say she had used a CPAP at home prior to entering the facility in 2020, but when she left her home at that time it was an emergency, and she did not think she would be gone for years. Resident #70 stated she had not brought her CPAP with her. She went on to say she never mentioned it to anyone at the facility because she had seen a recall on CPAP machines and was a little scared of them now. She further indicated she did snore a lot and had sleep apnea but had thought she was doing fine without oxygen or a CPAP. On 3/8/23 at 8:11 AM an interview with the Director of Nursing (DON) indicated she initialed the hospital discharge summary for Resident #70 dated 12/29/22 indicating she reviewed it. She stated she could not find any documentation that oxygen 2 liters per minute at night was ever ordered for Resident #70 or that Resident #70 received any follow up for a sleep study or CPAP. She went on to say she should have entered the order for oxygen 2 liters per minute for Resident #70 and if she had questions about the sleep study referral, she should have contacted Nurse Practitioner #1. She further indicated she could not say for certain why she had not. On 3/8/23 at 12:22 PM an interview with Physician #1 indicated she recalled that Resident #70 had some respiratory issues when she was hospitalized in December 2022 related to a virus. She stated while the hospital discharge recommendations for oxygen 2 liters per minute at night and a sleep study should have been	F 695	On 3/30/2023, the Staff Development Coordinator educated all licensed personnel on reviewing the discharge summary upon admission/readmission for orders and recommendations. All new hires will be educated prior to assignment. Any nurses who do not receive this education by 4/6/23, will not be able to work until they receive the education from the SDC and/or administrative nurse. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing, Assistant Director of Nursing, Assistant Director of Nursing or Unit Managers will review hospital discharge summaries for new admissions and re-admissions for Physician recommendations within 48 hours of admissions to ensure that physician recommendations were identified and followed. The monitoring process will be reviewed in the Managers Morning Meeting 5 X a week for 12 weeks, Findings will be reported by the Director of Nursing to the QA/QAPI committee monthly. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 695 with repeat non-compliance identified or for potential for repeat non-compliance, will be reviewed monthly for 12 months and	

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F 695	Continued From page 49 addressed, she did not think there had been any harm to Resident #70. She went on to say the recommendations had probably been overlooked. On 3/9/23 at 1:14 PM a telephone interview with Nurse Practitioner (NP) #1 indicated she had not been made aware of the hospital discharge recommendations for Resident #70. She stated Physician #1 made her aware of these yesterday. She went on to say she would be addressing these recommendations. She further indicated she previously had problems with the facility not providing her with resident's hospital discharge summaries, but currently had a new system in place where the facility provided her the hospital discharge summaries for residents via e-mail. NP #1 stated hopefully that would take care of the problem.	F 695	ongoing if necessary due to recommendations made by the QA/QAPI committee.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732		4/6/23

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F 732	Continued From page 50 (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to post accurate nurse staffing information for Registered Nurses (RN) for 13 of 76 days reviewed for daily posted staffing. Findings included: Review of the daily posted staffing sheets from December 2022 through February 2023 revealed there was no RN included on the posting sheets for the following days: -December 2022: 12/19/22, 12/22/22, 12/23/22, 12/24/22, 12/26/22, 12/27/22, 12/31/22. -January 2023: 1/1/23, 1/7/23, 1/21/23, 1/22/23. -February 2023: 2/4/23, 2/15/23.	F 732	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was named in this alleged deficient practice. The staff posting for 3/3/2023 was corrected by the DON and Staff Development Coordinator by 3/9/2023. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: This alleged deficient practice has the potential to affect any resident. The staffing coordinator and the unit	

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F 732	Continued From page 51 The facility scheduler was interviewed on 3-6-23 at 3:57pm. The scheduler discussed there was always a RN present in the facility for at least 8 hours a day. The scheduler reviewed the schedules and the posting and stated the posting was correct, there had not been a RN scheduled for the above dates. The scheduler explained when she could not find a RN she would inform the Director of Nursing (DON). During an interview with the DON on 3-6-23 at 4:05pm, the DON stated the facility had not had any issues with RN coverage since she arrived at the facility in December 2022. The DON reviewed the schedules and the daily posting sheets and explained the unit manager was a RN which was observed to be on the schedule and the Staff Development Coordinator (SDC) was also a RN which was not placed on the schedule but had worked on the days in question. She stated the scheduler did not think of the unit manager as a RN and that was why she had not documented a RN on the daily posting sheets. A follow up interview occurred with the facility scheduler on 3-9-23 at 8:30am. The scheduler stated she had not thought about adding the unit manager or the SDC to the daily posting for RN coverage. She said she had now learned she could add the unit manager and/or the SDC to the daily posting for RN coverage. The Administrator and DON were interviewed on 3-9-23 at 12:07pm. The Administrator stated she looked at the daily staff posting everyday but just to see it was posted and not for accuracy. She explained the facility scheduler had not been counting the management staff (unit manager	F 732	managers were educated on 3/9/2023 by the Director of Nursing regarding completion of the staff posting and ensuring all RN (Registered Nurse) hours are documented on the daily posting. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility staff scheduler will review the nursing assignment sheet and complete the daily staff hours posting daily to ensure accuracy. The Staff Development Coordinator educated the Nursing Scheduler regarding accurate posting of the Daily Staffing Hours. Staff posting will be reviewed daily by the Administrator and Director of Nursing in the morning department head meeting and compared to the daily schedule for accuracy by the Administrator and Staff Scheduler. Weekend postings will be reviewed on Fridays by the Administrator and the staff scheduler. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing and Administrator will review the daily staff posting daily 5 days a week for 4 weeks, then 3 X week for 8 weeks, to ensure the daily staff hours posting is accurate.	

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F 732	Continued From page 52 and SDC) as RN coverage.	F 732	The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 732 with repeat non-compliance identified or for potential for repeat non-compliance, will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		4/6/23

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F 757	Continued From page 53 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, physician and nurse practitioner interviews the facility failed to follow physician's orders for a change in medication. This was for 1 of 5 residents reviewed for unnecessary medication (Resident #73). Findings included: Resident #73 was admitted to the facility on 11/23/20 with a diagnosis of anemia (a lack of healthy red blood cells). A review of her quarterly Minimum Data Set (MDS) assessment dated 2/8/23 revealed she was severely cognitively impaired. A review of her ferritin test (a blood test that helps the physician understand how much iron the body stores) dated 12/1/22 revealed the result was 848.70 (the normal reference range is 30 to 400) nanograms (ng) per milliliter (ml). A physician's order for Resident #73 dated 2/20/23 indicated to discontinue the ferrous	F 757	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #73□s order was clarified on 3/7/2023 by the Unit Manager. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A review of the last 30 days of MD orders for accuracy was completed on 3/30/2023 by the Assistant Director of Nursing. All orders written were transcribed correctly. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: New admission orders and physician orders will be reviewed By the Director of Nursing, Assistant Director of Nursing or the Nursing Managers Monday □ Friday in the morning clinical meeting to ensure orders are entered properly.	

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F 757	Continued From page 54 sulfate (an iron supplement) 325 milligrams (mg) daily and start ferrous sulfate 325 mg every other day. It further indicated to discontinue the multivitamin. The order was written by Nurse Practitioner (NP) #1 and signed by Nurse #8 indicating he received the order. An additional physician's order for Resident #73 dated 2/20/23 at 5:30 PM indicated to discontinue the ferrous sulfate and vitamin C. The order was written by Nurse #9 as a telephone order from NP #1. It was signed by Nurse #9 indicating she received the order. A review of Resident #73's February 2023 Medication Administration Record (MAR) revealed ferrous sulfate 325 mg by mouth daily for anemia with a start date of 1/18/22 was discontinued on 2/20/23. It further revealed ferrous sulfate 325 mg by mouth every other day for anemia with a start date 2/21/23, multivitamin by mouth daily with supper with a start date of 11/13/20, and vitamin C 500 mg by mouth daily with a start date of 11/13/20 was discontinued on 2/20/23. Additional documentation indicated Resident #73 was administered ferrous sulfate 325 mg daily on 2/1/23 through 2/20/23, every other day on 2/23/23 through 2/27/23 and a multivitamin daily from 2/1/23 through 2/28/23. A review of Resident #73's March 2023 Medication Administration Record (MAR) revealed ferrous sulfate 325 mg by mouth every other day for anemia with a start date 2/21/23 and multivitamin by mouth daily with supper with a start date of 11/13/20. It further revealed documentation Resident #73 was administered ferrous sulfate 325 mg every other day and a multivitamin daily from 3/1/23 through 3/6/23.	F 757	Should any conflicting orders be identified,, clarification orders will be obtained from the physician by the Director of Nursing/designee and transcribed into the medical record for clarification. The Staff Development Coordinator educated current licensed nurses on 3/30/2023 regarding the procedure for transcribing and following physician□s orders. Any new licensed nurse will receive this education during their orientation. If the licensed nurse does not receive this training by 4/6/23, they will not be able to work until they receive this training by the SDC and/or administrative nurse. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Assistant Director of Nursing or designee will review orders for accuracy 5x/week x 2 weeks, 3x/week x 2 weeks and then weekly x 8 weeks. The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee	

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F 757	Continued From page 55 On 3/7/23 at 2:40 PM an interview with Nurse #9 indicated she was the unit manager. She stated on 2/20/23 she was looking over some of the paperwork for Resident #73 and had some things she needed clarified. She stated she called NP #1 for clarification and received the telephone order at that time to discontinue the ferrous sulfate and vitamin C. She went on to say she wrote this as a telephone order, discontinued the medications in the computer system, and forwarded the physician's order sheet to medical records to be scanned into Resident #73's medical record. Nurse #9 stated in looking at the computer record for Resident #73, it looked like Nurse #8 came back in the computer system on 2/21/23 and entered the order for ferrous sulfate 325 mg every other day. She stated the telephone order to discontinue the ferrous sulfate she received from NP #1 on 2/20/23 at 5:30 PM would have come after the order for the ferrous sulfate every other day and would be the correct order. She stated Resident #73 should not have an active order for ferrous sulfate. On 3/7/23 at 3:07 PM an interview with Nurse #8 indicated he received the order dated 2/20/23 to discontinue ferrous sulfate 325 mg daily, start ferrous sulfate 325 mg every other day, and discontinue the multivitamin daily for Resident #73. He stated in looking at Resident #73's computer record he did not see that he discontinued the multivitamin like he should have. He went on to say he could not say for sure why he entered the order for ferrous sulfate every other day on 2/21/23, but he thought maybe he had not quite finished entering the physician's orders that were on his desk on 2/20/23 so he came back in on 2/21/23 and finished the orders.	F 757	monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 757 with repeat non-compliance identified or for potential for repeat non-compliance, will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	

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F 757	Continued From page 56 Nurse #8 stated he could not see that Nurse #9 had discontinued the ferrous sulfate on 2/20/23 in the computer system when he entered his orders, he had not seen that order in Resident #73's chart, and he was not aware there had been a subsequent order to discontinue the ferrous sulfate altogether. On 3/8/23 at 12:12 PM an interview with Physician #1 indicated while the facility should be following physician's orders, continuing to receive ferrous sulfate 325 mg every other day and the multivitamin daily did not put Resident #73 at risk for any harm. On 3/9/23 at 10:16 AM an interview with the Director of Nursing (DON) indicated Nurse #8 had one physician's order and Nurse #9 had another physician's order. She went on to say physician's orders should be entered into the computer system by the nurse when they were received, and while a copy of physicians orders should go to medical records, the physician's order sheets should always remain in the residents chart so nurses would know when new orders came in. On 3/9/23 at 1:14 PM a telephone interview with NP #1 indicated Resident #73 had some anemia which was probably over corrected. She stated the ferrous sulfate, and the multivitamin should have been discontinued in accordance with her order. She went on to say she had been encountering some issues with the facility not carrying out physician's orders, but the issue was improving.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		4/6/23

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F 761	Continued From page 57 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to: accurately record an opened dated for a tube of eye ointment, a bottle of eye drops, and dispose of an expired inhaler on the 300 hall medication cart. The facility failed to accurately record an opened date for two bottles of eye drops, dispose of an expired inhaler and dispose of an opened Lantus insulin pen with no resident name or opened date on the 200 hall medication cart. This was for 2 of 3 medication carts observed for medication storage. The	F 761	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was named in this alleged deficient practice. All expired or undated medications were discarded appropriately by the unit managers on 3/08/2023. 2. Address how the facility will identify	

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F 761	Continued From page 58 facility failed to dispose of an expired box of bisacodyl suppositories in 1of 2 medication storage rooms observed for medication storage. Findings included: 1). Observation on 3/08/23 at 10:47 AM of the 300 Hall medication cart with Nurse #3 in attendance revealed: Resident #10's tube of Systane nighttime eye ointment with no open date. Resident #62's bottle of olopatadine eye drop with no open date. Manufacturer information indicated discard 28 days after opening. Resident #72's Ipratropium bromide and albuterol sulfate inhaler with expiration date of 2/6/23. Interview on 3/8/23 at 10:50 AM with Nurse #3 revealed someone audits the medication carts but she was not sure who was responsible for this or how often it was done. 2). Observation on 3/08/23 at 11:04 AM of the 200 hall medication cart with Nurse #2 in attendance revealed: Resident #24's bottle of alphagan eye drops with no open date. Manufacturer information indicated discard 28 days after opening the bottle. Resident #28's bottle of combigan eye drops with no open date. Manufacturer information indicated discard 28 days after opening the bottle. Resident #17's Budesonide form 160-4.5 inhaler with open date of 11/23/22 and expiration date	F 761	other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. All medication carts and rooms were audited by the DON and Regional Nurse Consultant on 3/8/2023. No other expired medications were found. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing, Assistant Director of Nursing,Staff Developement Coordinator, Regional Nurse Consultant, and/or Pharmacy Nurse consultant will audit each medication cart and medication room weekly x 12 weeks for expired medications and unlabeled/undated items. Any expired or undated medications will be discarded. Audits will be recorded on the Medipack Pharmacy medication cart and medication room tool. All licensed nurses and nurse managers were educated by the Staff Development Coordinator on 3/30/2023 regarding identifying and discarding expired and unlabeled medications. All licensed new hires will receive this education prior to assignment. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes	

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F 761	Continued From page 59 2/21/23. An opened Lantus insulin pen with no pharmacy label indicating the resident name and dispensed date was observed in a plastic bag containing a glucometer. The Lantus insulin pen had no opened date recorded. The plastic bag had Resident #8 's name handwritten on the outside. Manufacturer information indicated discard a Lantus insulin pen 28 days after first use. Interview on 3/8/23 at 11:10 AM with Nurse #2 revealed that all nurses were supposed to audit the carts including checking that all medications were labelled and dated. Nurse #2 further revealed the pharmacy conducted a monthly audit of the medication carts. Nurse #2 stated the Lantus insulin pen should have been labelled with a printed label from the pharmacy containing the resident name and the dispensed date. Nurse #2 stated that when the Lantus pen was opened it should have been labelled with the date it was first used. 3). Observation on 3/8/23 at 11:22 AM of the 100/200 Hall medication storage room revealed a box of bisacodyl suppositories 10 milligrams with a manufacturer expiration date printed on the box of February 28, 2023. Interview with the Director of Nursing on 3/08/23 at 4:53 PM revealed there was a process for an administrative nurse, including the Unit Managers and Staff Development Coordinator, to audit the medication carts twice weekly and the pharmacy also audited the medication carts and medication storage rooms monthly. DON revealed that medications should be accurately labelled and dated and expired medications were to be	F 761	implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 761 with repeat non-compliance identified or for potential for repeat non-compliance, will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	

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F 761	Continued From page 60 discarded.	F 761		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of	F 791		4/6/23

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F 791	Continued From page 61 dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents, staff and physician the facility failed to obtain dental extractions based on the dental provider's recommendations and failed to provide or obtain from outside sources routine dental services for 2 of 3 residents (Resident #65 & # 26) reviewed for dental. The findings included: 1. Resident #65 was admitted to the facility on 12/8/17. His diagnoses included stroke, congestive heart failure, and diabetes. Resident #65's payor source was listed as Medicaid. The notes from the in-house dental provider documented on 4/6/22 and 5/8/22 indicated Resident #65 was not seen because he was at his scheduled dialysis. On 7/19/22 the note documented he was not seen due to his current medical condition. A review of the grievances revealed a grievance from Resident #65 dated 8/22/22 which read "wants to go to the dentist to get new teeth." The resolution to the grievance read; "Per ADON [Assistant Director of Nursing] conversation resident is requesting to have his remaining teeth	F 791	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #65 was assessed by the in-house dentist on 3/23/2023. Resident #65 will have extractions performed on-site on the next scheduled visit to the facility. Resident # 26 has not received consent from her responsible party as of 3/31/23 for an evaluation by the facility dental provider for routine dental care. Attempts have been made to contact the responsible party and are documented in the medical record. On-going attempts will be conducted by the unit manager until responsible party is contacted. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of 100% of current residents was completed on 3/28/2023 by the Assistant Director of Nursing and Unit Manager to determine if any other residents had recommendations for Dental Services that was not completed or not scheduled. No	

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F 791	Continued From page 62 pulled and get dentures. Resident is scheduled to see an in-house dentist and to follow up with this request." The Nurse Practitioner (NP) note dated 8/25/22 included the past history of previous physician/NP notes. This 8/25/22 note revealed the following information related to Resident #65's dental care needs: - The 3/10/22 routine physician visit indicated, in part, "dental consult" - The 5/11/22 routine physician visit indicated, in part, "dental consult re: extractions (reordered from previously)" The annual Minimum Data Set assessment dated 12/23/22 indicated Resident #65 was cognitively intact. His vision was severely impaired and required extensive assistance with eating. He had no weight loss of 5 percent (%) or more in the last month or 10% or more in the last 6 months. He was coded as having no natural teeth or tooth fragments. On 3/7/23 at 10:14 AM Resident #65 stated he had many missing teeth. He added insurance had approved for him to get dentures years ago, but the facility did not schedule him to have his teeth removed so he could get dentures. On 3/8/23 at 12:45 PM the Social Worker (SW) said the nursing staff told her and the Director of Nursing (DON) which residents needed to be seen by the contracted in-house provider. She said the contracted in-house dental provider would email her and the DON the list of residents they planned to see, and the facility would add to the list of residents any new residents who needed to be seen.	F 791	other residents were identified as having Dental Service Recommendations that were not completed. Our Dental Service provider is currently working with us to set up appointments for residents who would like routine dental services provided. Any resident not seen in the last 3 months or in need of dental services will have an opportunity to be scheduled to be seen at the next dental clinic. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Nursing, Assistant Director of Nursing and Unit Manager will monitor will review new admissions and residents with medical appointments for recommendations for Dental Services to ensure dental appointments are made and recommendations followed. The Social worker will track the dental service list of residents who have received dental services and compare it to the resident roster to ensure that residents are offered routine dental services timely. Residents who miss appointments will be offered follow up options for dental services. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nurses, Assistant Director of Nursing or Unit Manager will monitor 5 X week for two weeks then 3 X week for 4	

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F 791	Continued From page 63 On 3/8/23 at 2:35 PM the current Medical Records Clerk stated she was previously responsible for transportation and was aware of the procedure for outside dental appointments. She said Resident #65 had a referral for the dentist on 10/25/22 but the consultation sheet was not returned. She said someone else set up the next appointment on 2/7/23. She saw the consultation sheet for that appointment but now the sheet couldn't be found so they didn't know what the outcome of the appointment was. On 3/9/23 at 11:32 AM Nurse #3 stated whenever a resident was sent for an appointment including outside dental appointments a packet was sent with them that included a consultation sheet for the provider to complete. Nurse #3 said when any consultation sheets or reports from an outside appointment were received, they were reviewed by the nurse then placed in the inside front pocket of the physician's logbook to be reviewed by the physician or the nurse practitioner. Nurse #3 stated if the completed consult sheet or the report from the outside provider was not with the resident upon return from the appointment the nurse should call the provider and request the information be faxed to the facility. On 3/9/23 at 11:47 AM Unit Manager #1 reported the normal protocol to follow if the consulting physician consult sheet was not returned with the resident, then the nurse was to call the consulting physician's office to see what was done and what the plan was. On 3/8/23 at 2:35 PM the nursing Corporate Consultant reported the facility had changed	F 791	weeks then 1 X weekly for 12 weeks to identify any residents who have dental appointments or require routine dental services, to ensure any recommendations requiring follow up appointments are scheduled and services provided. The facility Interdisciplinary Team (IDT) will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 791 with repeat non-compliance identified or for potential for repeat non-compliance, will be reviewed monthly for 12 months and ongoing if necessary due to recommendations made by the QA/QAPI committee.	

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F 791	Continued From page 64	F 791		

dental providers and Resident #65 was seen by the newest dental provider on 2/7/23 but they were not able to locate the consultation report from that visit, so they were going to have the dental provider fax the information to the facility. She said she was unsure why the consultation sheet was not able to be located.

On 3/8/23 following dental notes for Resident #65 were received via fax:
- The dental consult note dated 10/25/22 read "Established teeth no viable teeth for lower partial except #20. Patient will need FU/FL [full upper/full lower] denture. Patient agrees with treatment. FU/FL extracting remaining teeth."
- The dental clinical note report dated 2/7/23 read in part, "Patient is present today wanting to get extractions done. Pt was originally in office on 5/18/22 where he was treatment planned for full mouth extraction with full upper and lower denture. The patient was informed we need medical clearance from his primary provider stating the precautions or concerns with his health condition and getting dental work done."

During an interview on 3/08/23 at 05:02 PM Resident #65's physician stated she had not seen the dental consult report dated 2/7/23 and was not aware she needed to provide clearance for the resident to get his teeth extracted. She said she would immediately provide the clearance for Resident #65 to get the extractions.

2. Resident #26 was admitted to the facility on 1/27/21 with diagnoses which included diabetes and hypertension.

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F 791	Continued From page 65	F 791		

Resident #26's payor source was listed as Medicaid.

A nursing progress note dated 12/9/22 documented Resident #26 was alert and oriented for person, place and time with occasional episodes of confusion.

The annual Minimum Data Set assessment dated 12/15/22 revealed Resident #26 was cognitively impaired and required supervision with eating. She had no weight loss of 5 percent (%) or more in the last month or 10% or more in the last 6 months. Resident #26 had no dental concerns.

On 3/6/23 at 12:11 PM Resident #26 stated she had not seen a dentist since being at the facility and she did not know why. She said she had no mouth, teeth or gum pain or bleeding. She said she would like to have the dentist see her.

During the interview on 3/6/23 at 12:11 PM Resident #26 was observed eating her regular consistency diet. She was able to chew her food.

A record review revealed no documentation from any dental provider during her stay at the facility.

On 3/8/23 at 12:45 PM the Social Worker (SW) said the nursing staff told her and the Director of Nursing which residents needed to be seen by the contracted in-house provider. She said the contracted in-house dental provider would email her and the DON the list of residents they planned to see, and the facility would add to the list of residents any new residents who needed to be seen including residents who were newly admitted since the last in-house dental visit.

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F 791	Continued From page 66 During an interview on 03/08/23 at 5:02 PM Resident #26's physician stated she was not aware Resident #26 had not received any dental services. On 3/8/23 at 2:35 PM the nursing Corporate Consultant reported the facility had changed in-house dental providers who provided routine dental services for the facility. She stated there were also changes in management staff.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		4/6/23

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representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.

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F 842	Continued From page 68 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure the medical record contained dental consultation notes resulting in a delay with dental extractions needed to obtain dentures for 1 of 3 residents (Resident #65) reviewed for dental services. The findings included: Resident #65 was admitted to the facility on 12/8/17. The Nurse Practitioner (NP) note dated 8/25/22 included the past history of previous physician/NP notes. This 8/25/22 note revealed the following information related to Resident #65's dental care needs: -The 3/10/22 routine physician visit indicated, in part, "dental consult" -The 5/11/22 routine physician visit indicated, in part, "dental consult re: extractions (reordered from previously)" A review of Resident #65's medical record did not reveal any information about Resident #65s' consultations with an out of the facility dental provider. On 3/8/23 at 2:35 PM the current Medical Records Clerk stated she was previously responsible for transportation and was aware of the procedure for outside dental appointments. She said Resident #65 had a referral for the dentist on 10/25/22 but the consultation sheet was not returned. She said someone else set up the next appointment on 2/7/23. She saw the consultation sheet for that appointment but now	F 842	1 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: A copy of the dental consult for resident #65 was obtained by the Director of Nursing on 3/10/2023. 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A review of all appointments for the past 30 days was conducted on 3/31/2023 by the Assistant Director of Nursing to assure all consultation were in the resident medical record. No other residents were found to be affected by the alleged deficient practice. 3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The unit managers will track appointments and the receipt of the consult through the consult audit tool as appointments are attended. This monitoring process will be done daily, Monday through Friday, x 12 weeks. 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The facility Interdisciplinary Team (IDT)	

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F 842	Continued From page 69 the consultation sheet couldn't be found so they didn't know what the outcome of the appointment was. On 3/9/23 at 11:47 AM Unit Manager #1 reported the normal protocol to follow if the consulting physician consult sheet was not returned with the resident was that the nurse was to call the consulting physician's office to see what was done and what the plan was. On 3/8/23 at 2:35 PM the nursing Corporate Consultant reported the facility had changed dental providers and Resident #65 was seen by the newest dental provider on 2/7/23 but they were not able to locate the consultation report from that visit, so they were going to have the dental provider fax the information to the facility. She said she was unsure why the consultation sheet was not able to be located. On 3/8/23 the following dental notes for Resident #65 were received at the facility via fax: - The dental consult note dated 10/25/22 read "Established teeth no viable teeth for lower partial except #20. Patient will need FU/FL [full upper/full lower] denture. Patient agrees with treatment. FU/FL extracting remaining teeth." - A dental clinical note report dated 2/7/23 read in part, "Patient is present today wanting to get extractions done. Pt was originally in office on 5/18/22 where he was treatment planned for full mouth extraction with full upper and lower denture. The patient was informed we need medical clearance from his primary provider stating the precautions or concerns with his health condition and getting dental work done."	F 842	will review monitoring results and outcomes from systematic changes implemented at least weekly in morning meetings. Findings will be addressed by the Administrator with the IDT in the morning meeting process to ensure compliance is maintained and that any problems identified are correctly resolved. These findings will be taken by the Administrator to the QA/QAPI committee monthly for review. The QA/QAPI committee will make recommendations as needed for any additional actions or systematic changes needed to continue to maintain compliance with the deficient practice(s) identified. The corrective measures implemented for F 842 with repeat non-compliance identified or for potential for repeat non-compliance, will be reviewed monthly for 12 months and continue past 12 months if necessary due to recommendations made by the QA/QAPI committee.	

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F 842	Continued From page 70 During an interview on 03/08/23 at 05:02 PM Resident #65's physician stated she had not seen the dental consult report dated 2/7/23 and was not aware she needed to provide medical clearance for Resident #65 to get his teeth extracted. She said she would immediately provide the clearance for Resident #65 to get his teeth extractions.	F 842		
F 867 SS=E	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		4/6/23

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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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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;

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F 867	Continued From page 73 (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 resident, Resident Representative (RP) and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 3/11/22 focused infection control and complaint investigation survey and the 6/25/21 recertification/complaint survey .This was for 1 deficiency in the area of F761 Medication Storage and Labeling that was cited on the 3/11/22 focused infection control and complaint investigation survey and again cited on the current recertification and complaint investigation survey of 3/9/23 and 7 deficiencies in the areas of F550 Resident Rights, F561 Self Determination, F641 Accuracy of Assessments, F656 Develop/Implement Comprehensive Care Plan, F657 Care Plan Timing and Revision, F688 Range of Motion and Mobility and F761 Medication Storage and Labeling cited on the 6/25/21 recertification and complaint investigation survey that were cited again on the current recertification survey of 3/9/23. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective QAA. Findings included: This tag is cross referenced to: F550: Based on observations, staff and resident	F 867	1 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: There was no resident named in the alleged deficient practice. All department managers (includes; social worker, director of nursing (DON), business office manager, activities director, housekeeping manager, maintenance director, admissions director, staff development coordinator, medical records, Rehab Director, MDS Nurse, and Central Supply Person) and Administrator, received re-education on 3/30/2023 by the Regional Clinical Nurse on F867, its content, including the importance of developing and maintaining appropriate action plans to correct identified quality/regulatory deficiencies. Any new facility department manager will receive this training during their orientation by the facility Administrator. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident had the potential to be affected by alleged deficient practice. On 3/31/2023 the facility department managers conducted a review of the	

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F 867	Continued From page 74 interviews and record review the facility failed to maintain a resident's dignity when incontinent care for a bowel movement was not provided when requested prior to the meal causing the resident to feel "nasty" while trying to eat (Resident #71), and when a staff member spoke in a loud stern harsh voice causing the residents to feel bad and upset (Residents # 18 & # 40) for 3 of 5 residents reviewed for dignity. During the recertification/complaint survey of 6/25/21 the facility was cited for failing to maintain the dignity of dependent residents during dining and failing to keep the collection bag of an indwelling catheter covered. F561: Based on record review, resident and staff interviews the facility failed to honor a resident choice to get out of bed for 1 of 1 resident (Resident #52) reviewed for choices. During the recertification/complaint survey of 6/25/21 the facility was cited for failing to provide an opportunity for residents on the isolation hall to smoke. F641: Based on record review and resident interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of the administration of an antidepressant and history of falls prior to admission for 1of 23 residents (Resident #31) reviewed for MDS assessments. During the recertification/complaint survey of 6/25/21 the facility was cited for failing to accurately code the MDS. F656: Based on record review and staff	F 867	action plans implemented at the completion of the survey completed on 3/13/2023 to determine the root cause of the repeat deficiencies cited at the completion of the survey. 3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Monthly Quality Assurance Performance Improvement (QAPI) minutes will now include the Regional Director of Operations and/or Regional Director of Clinical Services to ensure that all Performance Improvement Plans are effective, attainable, and properly addressing areas of self-identified and cited deficiencies. All department managers (includes; social worker, director of nursing (DON), business office manager, activities director, housekeeping manager, maintenance director, admissions director, staff development coordinator, medical records, Rehab Director, MDS Nurse, and Central Supply Person) and Administrator, received re-education completed by 3/31/2023, by the Regional Clinical Nurse on F867, its content, including the importance of developing and maintaining appropriate action plans to correct identified quality/regulatory deficiencies. Newly hired department managers will receive this training during their orientation by the facility Administrator.	

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F 867	Continued From page 75 interviews the facility failed to develop and update the comprehensive care plan for 1 of 7 residents (Residents #31) reviewed for comprehensive care plans. During the recertification/complaint survey of 6/25/21 the facility was cited for failing to develop the comprehensive care plan and establish discharge goals. F657: Based on record review, and staff, resident and Resident Representative (RP) interviews the facility failed to ensure the resident and/or the RP was involved in the review and revision of the comprehensive care plan by the interdisciplinary team (IDT) for 3 of 3 residents reviewed for care planning. (Resident #38, Resident #52, and Resident #42) During the recertification/complaint survey of 6/25/21 the facility was cited for failing to schedule a care plan meeting for a newly admitted resident and failing to invite the resident to care plan meetings. F688: Based on observation, record review, and staff interviews the facility failed to ensure mobility aides were provided as ordered for 1 of 1 resident (Resident #47) reviewed for range of motion. During the recertification/complaint survey of 6/25/21 the facility was cited for failing to ensure mobility aides were available as ordered. F761: Based on observation and staff interviews, the facility failed to: accurately record an opened dated for a tube of eye ointment, a bottle of eye drops, and dispose of an expired inhaler on the 300 hall medication cart. The facility failed to	F 867	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: QAPI action plans will be reviewed by the Regional Director of Operations (RDO) and/or facility Administrator will review the facility action plans weekly x4 weeks, then monthly X3 months, and quarterly thereafter to ensure continued compliance with F867, The results of the RDO and/or facility Administrator reviews will be presented in a summary and presented at the monthly QAPI meeting to ensure continued regulatory compliance.	

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accurately record an opened date for two bottles of eye drops, dispose of an expired inhaler and dispose of an opened Lantus insulin pen with no resident name or opened date on the 200 hall medication cart. This was for 2 of 3 medication carts observed for medication storage. The facility failed to dispose of an expired box of bisacodyl suppositories in 1of 2 medication storage rooms observed for medication storage.

During the 3/11/22 focused infection control and complaint investigation survey the facility was cited for failing to remove loose unsecured pills, discard expired medications, and ensuring all medications had resident identifier information.

During the recertification/complaint survey of 6/25/21 the facility was cited for failing to secure the medication cart when left unattended.

On 3/9/23 at 3:20 PM during an interview the Administrator stated the facility's entire nursing administration team was new. She stated it had been a challenge for the team to learn the residents and for the residents to learn the new administration team. She went on to say even though meetings were held to let residents and staff know they could come forward with any issues or problems, it took time to build trust. She further indicated there had been a short period where the facility was using agency staff, and when the MDS staff had been out. The Administrator stated she felt all those things compounded together contributed to the facility having repeated issues in certain areas.