STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING ______ B. WING ______	C 02/23/2023

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UNIVERSAL HEALTH CARE/RAMSEUR	**7166 JORDON ROAD RAMSEUR, NC 27316**

(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 02/20/23 through 02/23/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# IR1911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/20/23 through 02/23/23. Event ID# IR1911. The following intakes were investigated NC00198031, NC00191590, NC00193753, and NC00189039. 2 of the 8 complaint allegations resulted in deficiencies.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to assess and obtain physician orders for the self-administration of medications for 1 of 6 residents (Resident #185) reviewed for self-administration. The findings included: Resident #185 was admitted to the facility on 02/13/23 with diagnosis that included multiple sclerosis, acute pulmonary edema, and atrial fibrillation.	F 554	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ As of 2/20/2023 Medications were removed from the bedside for Resident #185 by the Director of Nursing (DON).	3/23/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/13/2023

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

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F 554	Continued From page 1 The admission Minimum Data Set (MDS) assessment dated 02/20/23 indicated Resident #185 was cognitively intact. Continuous observation on 02/20/23 from 12:15 PM through 12:42 PM revealed three bottles of medications located on the bed side table in Resident #185 ' s room. The medications observed were the following: 1. DG Health 1 oz bottle, Nasal Spray-Oxymetazoline HCL 0.5%, Nasal Decongestant 2. CVS Health 15ml bottle of Sodium Chloride Hypertonicity 5% solution (Sodium Chloride 5% Ophthalmic Solution is indicated for the treatment of corneal edema (swelling) associated with Corneal Dystrophy or cataract surgery). 3. Artificial tears lubricant eye drops, 1 fluid ounce bottle. Record review on 02/20/23 at 01:06 PM revealed Resident #185 did not have an active order for the two eye drops or the nasal spray located on the bedside table. Observation on 02/20/23 at 03:12 PM revealed the medications had been removed from the bedside table. An interview was conducted on 02/21/23 at 03:10 PM with resident #185. She stated she did have eye drops and nose spray at bedside on 02/20/23. She stated she would self-administer the eye drops three times a day and the nasal spray as needed. She then stated someone came and removed them from her room. She further	F 554	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 alleged deficient practice, as of 2/21/2023 the Unit Manager's completed a facility observation rounds of resident rooms to ensure medications were not left at the bedside for current facility residents. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All licensed nurses and medication aides, including agency staff, will be re-educated on not leaving medications unattended at the bedside of the resident as of 3/13/2023 by DON/Unit managers/ADON. Any medication that is to be given should be given at the appropriate time by the nurse and/or medication aide and that any resident would have to have an order for self-administration of medications and be observed administering any medication(s) left at the bedside as warranted. Indicate how the facility plans to monitor	

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F 554	Continued From page 2 stated staff had them at this time. An interview was conducted on 02/21/23 at 03:15 PM with Med Aide #1. She stated she worked with Resident #185 on 02/20/23 but did not recall seeing the eye drops and nose spray on the bed side table. She stated she did not have an order for them. An interview was conducted on 02/21/23 at 03:31 PM with Nurse #4. She stated she did get an order for artificial tears eye drops and they are located on the medication cart. She further indicated Resident #185 did not have a self-administration order. An interview was conducted on 02/22/23 at 09:50 AM with the Team Leader. She stated she removed the medications that were located on Resident #185 ' s bedside table because she knew she could not have them at bedside, and she did not have an order for them. She also stated Resident #185 did not have an order to self-administer medications. She indicated an order was obtained for polyvinyl alcohol 1.4% eyedrops (artificial tears) and she was working on getting orders for the other eye drop and the nasal spray. An interview was conducted on 02/23/23 at 12:25 PM with the Director of Nursing (DON). She stated she expected all medications to have an order to administer and if a resident wanted to self-administer medications that a self-administration assessment was to be completed. She indicated that staff should make sure there are no medications in rooms unless a self-administer assessment had been completed.	F 554	its performance to make sure that solutions are sustained: The Director of Nursing and/or designee will audit 5 rooms 5 x per week x 12 weeks to ensure that no medications are left at the bedside. Data obtained during the audit process will be analyzed for patterns and reported to Quality Assurance Performance Improvement team by the Director of Nursing, to ensure continued compliance. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Compliance Date: 3/23/2023	

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F 565	Continued From page 3	F 565		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 565		3/23/23

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F 565	Continued From page 4 Based on record review and staff and resident interviews, the facility failed to resolve grievances which were reported in the Resident Council meetings for 4 out of 6 months reviewed (August 2022, September 2022, October 2022, November 2022, December 2022, January 2023). The findings included: Review of the grievance policy provided by the facility and dated October 2017 read as follows: "The objective of the grievance policy is to ensure the facility makes prompt efforts to resolve grievances a resident may have. The intent of the grievance process is to support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution." Observation of a Resident Council meeting was conducted on 02/21/23 at 3:16 PM and revealed an issue with resolution of grievance regarding activities on the weekend. Residents in the meeting had various ranges of cognition including, cognitively intact, moderately impaired, and severely impaired. The residents reported having expressed concerns about the lack of meaningful activities on the weekends The President of the Resident Council stated "all we do is color. We want more activities on the weekends." She indicated "it's frustrating and annoying that there are no activities on the weekends. We get bored." Another resident indicated "we have to come up with our own activities on the weekends." A third resident	F 565	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ As of 3/10/2023 resident council minutes for August 2022 through February 2023 have been reviewed by the administrator for any concerns related to activities and resolution in place. 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 alleged deficient practice. As of 3/13/2023 meeting, the Administrator met with resident council has been completed to review the activities of interest for the residents on the weekends. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Administrator has been re-educated for facility policy and procedure related to grievances and timely resolution to include resident council by the Regional Director of Operations as of 3/10/2023. The administrator will review resident council minutes monthly x 3 months,	

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F 565	Continued From page 5 indicated she would like to have more engaging activities on the weekends rather than coloring. The residents stated they had discussed their concerns of the activities several times during Resident Council meetings but felt like an appropriate resolution had not been made. Review of the Resident Council minutes dated 09/26/22 indicated activity concerns regarding coloring packets were not enough on the weekends and would like a crochet class and bingo on the weekends. The Resident Council Concern and Recommendation form completed by the Activities Director dated 10/25/22 indicated the plan of action from the 09/26/22 meeting was "cards have been ordered. I will try to find someone that knows how to crochet to do a class and teach them how to do it. As far as activities on the weekends, there is lots of stuff they have access to on the weekends. Cabinets are full and are unlocked on weekends. They know they can go in them and do anything they want. Bingo cards are out as well." The form indicated the views, grievances, or recommendations from the group had not been acted upon by the facility to their satisfaction. Review of the Resident Council minutes dated 10/15/22 indicated activity concerns regarding needing an activity assistant on the weekends to assist with activities. Review of the Resident Council minutes dated 11/29/22 indicated activities concerns regarding there had not been communication regarding the Resident Council requesting an activity assistant on the weekends and would like an assistant on	F 565	following resident council meeting to ensure any concerns are addressed and resolved timely for 6 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The administrator will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction, to ensure continued compliance. QAPI committee will make any necessary adjustments as needed to the current plan. Compliance Date: 3/23/2023	

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F 565 Continued From page 6
the weekends to assist with activities.

F 565

Review of the Resident Council minutes dated 12/27/22 indicated "see attached concern" regarding concerns with activities.

The Resident Council Concern and Recommendation Form (the attached concern from the Resident Council Meeting held on 12/27/22) completed by the Administrator dated 01/31/23 indicated the Resident Council Concerns were "Residents voice concerns re: Activities being only independent and claim she is in the kitchen all of the time. Nothing on weekends ... Activities Director is never in activities to coordinate programs." The Plan of Action indicated "encourage residents to keep director or Social Worker informed of any activity they would like to have. Other residents do not always agree with the complaint." The Monitoring Process stated, "as staffing improves and agency use is gone, will start another interview process to fill the assistant position." The form indicated the views, grievances, or recommendations from the group had been acted upon by the facility to their satisfaction.

The former Activities Assistant was interviewed on 02/22/23 at 11:00 AM. She stated she was the Activities Assistant 6 months ago, but the facility had not found a replacement since she had become a Medication Assistant. She indicated she did not work on the weekends and there were no activities personnel on the weekends. She stated she was aware Resident Council expressed grievances regarding the lack of activities on the weekends; therefore, they would leave out activity packets which included 30 pages of coloring sheets and word searchers as

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F 565	Continued From page 7 well as left out board games. She stated a preacher came every Sunday, but they did not offer activities for non-religious residents on Sundays. An interview with the Social Worker on 02/23/23 at 9:25 AM revealed she met monthly with the Resident Council to discuss concerns, review old and new business, and encouraged residents to come up with recommendation for expressed concerns. She stated for every grievance expressed in Resident Council meetings, she identified the type of grievance and then provided it to the relevant department head. The Activities Director was made aware of Resident Council's concerns regarding the lack of activities on the weekend. The Activity Director was not available for interview. The Administrator was interviewed on 02/23/23 at 12:45 PM. She stated she was aware of Resident Council's grievances regarding wanting an activity assistant on the weekends and lack of activities on the weekends. She stated she has spoken with Resident Council several times regarding this concern and informed them an activities assistant cannot be hired due to staffing shortage. She stated she felt like she had responded to the Resident Council's grievances appropriately.	F 565		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637		3/23/23

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F 637	Continued From page 8 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment for a resident with two or more areas of decline in Activities of Daily Living (ADLs) for 1 of 1 resident reviewed for significant change (Resident # 38). The findings included: Resident #38 was admitted to the facility on 4/6/22 with diagnoses that included pain in right knee, muscle weakness and diabetes type 2. A quarterly MDS assessment dated 10/11/22 indicated Resident #38 had moderately impaired cognition and was able to complete all mobility and ADL tasks with setup and supervision only. There was no limited range of motion coded. Review of the nursing progress notes revealed Resident #38 had a fall on 12/8/22 with pain and inability to extend her right leg. She was transported to the Emergency Room for further evaluation. She returned to the facility on the same day with a diagnosis of a peri-prosthetic (an area close to an artificial joint) fracture of the	F 637	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ Minimum Data Set (MDS) Nurse completed a review of the medical record for resident #38 and opened a significant change in status assessment with assessment reference date (ARD) of 2/28/23, to reflect that fall with fracture resulted in decline in areas of Activities of Daily Living (ADLs), and significant change completed and transmitted on 3/7/2023. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ Regional MDS and facility Director of Nursing reviewed current residents with fall with fracture in the last 90 days,	

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F 637 Continued From page 9
distal femur (leg joint at the knee).

An orthopedic progress note dated 12/27/22 revealed Resident #38 was sent to the hospital for repair of the right distal femur fracture.

Review of the hospital records dated 12/28/22 through 12/30/22 revealed Resident #38 had repair of the supracondylar (top part of the knee) fracture of the right femur.

A quarterly MDS assessment dated 1/6/23 indicated Resident #38 had moderately impaired cognition. She required setup and supervision for eating tasks; extensive assistance of one staff member for bed mobility, dressing, toileting, personal hygiene, bathing, and extensive assistance of two staff members for transfers. Resident #38 was coded with limited range of motion to one lower extremity.

On 2/20/23 at 12:25 PM, an interview occurred with Resident #38 while she was lying in bed. She explained that she had a fall recently that resulted in a fracture to her right knee. She explained she required very little assistance with ADL care and mobility prior to the fall in December 2022, but after her fall she required assistance from staff for all ADL's except eating and for mobility.

An interview was held with Nurse Aide #3 (NA) on 2/21/23 at 3:21 PM, who stated Resident #38 was very independent with ADL tasks and mobility prior to her fall in December 2022. When she returned from the hospital she required extensive assistance with ADLs, except for eating, and mobility tasks.

The MDS Nurse was interviewed on 2/22/23 at

F 637

resulting in significant change in ADL status per RAI guidelines, to ensure significant change in status assessment was completed appropriately. This was completed on 3/7/2023. The audit results did not reflect any other discrepancies in need for significant change assessment.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Regional MDS Nurse educated facility MDS traveler nurse on proper coding of MDS, per RAI Manual, Chapter 2, related to guidelines for evaluating need for and completing a significant change in status assessment on a resident. This was completed 3/7/23. This education will be included in the orientation of any new MDS nurse for this facility, to be completed by Regional MDS Nurse.

DON and/or administrative nurse will review 5 random residents weekly for 4 weeks, then 5 residents bi-weekly for 3 months, to ensure residents with falls with fractures and ADL changes have significant change assessments opened and completed per the RAI manual.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

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F 637	Continued From page 10 1:26 PM and stated it was an oversight not to have completed a significant change in status assessment due to the increased need for assistance with bed mobility, transfers, dressing, personal hygiene, toileting and bathing and new limited range of motion to one lower extremity, when the quarterly MDS was completed on 1/6/23. On 2/23/23 at 10:53 AM, the Regional MDS Nurse Consultant was interviewed and stated a significant change in status MDS assessment should have been completed as required in the regulation, 14 days after two or more changes in MDS areas were determined.	F 637	DON and/or administrative nurse will complete a summary of audit results and present report findings to the monthly Quality Assurance Performance Improvement (QAPI) committee, to ensure continued compliance. Compliance Date: 3/23/2023	
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	F 640		3/23/23

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F 640	Continued From page 11 standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an 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 transmit a discharge Minimum Data Set (MDS) assessment (Resident #56) and failed to transmit a discharge MDS assessment (Resident #67). This was for 2 of 2 residents selected to be reviewed for submission of Resident Assessments within the required timeframe. The findings included:	F 640	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ Regional MDS Nurse completed a review of the medical record for resident #56 and completed a death in facility tracker on 3/6/23 to reflect current resident status. This was transmitted on 3/6/23.	

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F 640	Continued From page 12 1. Resident #56 was admitted to the facility on 9/3/21 with diagnoses that included a history of a stroke with left sided paralysis/weakness, chronic obstructive pulmonary disease (COPD) and dementia. A review of Resident #56's most recent completed MDS was dated 10/17/22 and coded as a significant change in status MDS assessment. Review of Resident #56's medical record revealed he expired at the facility on 12/8/22. There was no death in facility MDS discharge tracker found in Resident #56's medical record. On 2/22/23 at 1:26 PM, an interview occurred with the Regional MDS Nurse Consultant and the MDS Nurse. The MDS nurse reviewed the most recent MDS completed and verified it was a significant change in status assessment. She confirmed the resident expired on 12/8/22, a discharge MDS for death was not completed and that it was overlooked. 2. Resident #67 was admitted to the facility on 9/16/22 with diagnoses that included muscle weakness, gout, and diabetes type 2. A review of Resident #67's most recent completed MDS was dated 9/30/22 and was coded a discharge to the community. During an interview with the Regional MDS Nurse Consultant and MDS Nurse on 2/22/23 at 1:26 PM, the MDS Nurse indicated the discharge assessment was completed on 9/30/22 but was	F 640	Minimum Data Set (MDS) Nurse completed a review of the medical record for resident #67 on 2/20/23, and completed a discharge return not anticipated on 2/20/23 to reflect current resident status. This was transmitted on 2/20/23. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ Regional MDS Nurse completed a review of residents discharged in the last 60 days, to ensure that they had a MDS tracker to reflect the discharge appropriately. This was completed on 3/6/23. The audit results did not reflect any other discrepancies in MDS trackers being completed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Regional MDS Nurse educated facility MDS traveler nurse on proper coding of MDS, per RAI Manual, Chapter 2, related to opening, completing, and transmitting discharge trackers. This was completed on 3/7/23. This education will be included in the orientation of any new MDS nurse for this facility, to be completed by Regional MDS Nurse. Regional MDS Nurse will review 5 random residents weekly for 4 weeks, then 5	

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F 640	Continued From page 13 not transmitted. She stated that a file was made for submission of the assessment on 2/20/23 because it had been overlooked.	F 640	residents bi-weekly for 3 months, to ensure MDS discharge tracking forms are opened, completed, and transmitted appropriately and timely. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: MDS Nurse will report their findings to the Quality Assurance Performance Improvement (QAPI) committee for any needed improvement. QAPI committee will review monthly and make any necessary recommendations immediately for six months. Compliance Date: 3/23/2023	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of medications for 2 of 21 residents whose MDS were reviewed (Residents # 77 & # 43). Findings included:	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ Regional MDS Nurse completed a review of the medical record for resident #77 and completed a modification of the 2/6/23	3/23/23

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Continued From page 14

1. Resident # 77 was admitted to the facility on 1/19/23 with multiple diagnoses including dementia without behavioral disturbances.

Resident #77 had a physician's order dated 2/3/23 for Risperidone (an antipsychotic drug) 0.5 milligrams (mgs) by mouth twice a day for behaviors.

Review of the February 2023 Medication Administration Records (MARs) revealed that Resident #77 had received Risperidone on February 3, 4, 5 and 6, 2023.

The significant change in status MDS assessment dated 2/6/23 indicated that Resident #77 had received an antipsychotic medication for 4 days during the look back period. However, under the antipsychotic medication review section, the assessment indicated that Resident #77 did not receive an antipsychotic medication since admission/entry, reentry or prior assessment.

The Regional MDS Nurse Consultant was interviewed on 2/22/23 at 2:30 PM. She reviewed Resident #77's MARs and verified that the resident had received an antipsychotic medication during the look back period. She stated that the MDS dated 2/6/23 was not accurate.

The Director of Nursing (DON) was interviewed on 2/23/23 at 12:20 PM. The DON stated that she expected the MDS assessments to be accurate.

2. Resident #43 was admitted to the facility on

F 641

MDS to reflect correct coding of section N, under the antipsychotic medication review section. This was transmitted on 3/8/23.

Regional MDS Nurse completed a review of the medical record for resident #43 and completed a modification of the 1/26/23 MDS to reflect correct coding of section N for antibiotics received during the lookback period. This was transmitted on 3/8/23.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿

Regional MDS Nurse completed a review of active residents on an antipsychotic, to ensure current MDS reflects coding of antipsychotic medication review in section N appropriately. This was completed on 3/10/23. The audit results did not reflect any other discrepancies in MDS coding of antipsychotic medication review.

Regional MDS Nurse completed a review of current residents that were on an antibiotic in the last 60 days, to ensure current MDS reflects coding of antibiotic in section N appropriately. This was completed on 3/10/23. The audit results did not reflect any other discrepancies in the coding of antibiotics.

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F 641	Continued From page 15 1/19/23 with multiple diagnoses including dementia. Resident #43 had a physician's order dated 1/19/23 for Vibramycin (an antibiotic medication) 100 milligrams (mgs.) by mouth twice a day for pneumonia. Review of the January 2023 Medication Administration records (MARs) revealed that Resident #43 had received Vibramycin on January 20 through January 24, 2023. The admission Minimum Data Set (MDS) assessment dated 1/26/23 did not indicate that Resident #43 had received an antibiotic medication during the look back period. The Regional MDS Nurse Consultant was interviewed on 2/22/23 at 2:20 PM. She reviewed the January 2023 MARs and verified that Resident #43 had received an antibiotic medication during the look back period. She stated that she missed to note the use of the antibiotic on the admission MDS dated 1/26/23. The Director of Nursing (DON) was interviewed on 2/23/23 at 12:20 PM. The DON stated that she expected the MDS assessments to be accurate.	F 641	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Regional MDS Nurse educated facility MDS traveler nurse on proper coding of MDS, per RAI Manual, Chapter 3, section N, regarding coding medications, including antipsychotic medication review coding of antibiotics. This was completed on 3/7/23. DON/designee will review 5 random residents weekly for 4 weeks, then 5 residents bi-weekly for 3 months, to ensure MDS assessments are coded accurately for antipsychotic medication review and coding of antibiotic Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: DON/designee will report findings to the Quality Assurance Performance Improvement (QAPI) committee for any needed improvement. QAPI committee will review monthly and make any necessary recommendations immediately for six months.	

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F 641	Continued From page 16	F 641	Compliance Date: 3/23/2023	
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). 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 interviews, the facility failed to review and revise the care plan in the areas of falls (Residents #2, #38 and #58),	F 657	Address how corrective action will be accomplished for those residents found to have been affected by the deficient	3/23/23

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F 657	Continued From page 17 pressure ulcers (Resident #14), and medications (Residents #43 and #77). This was for 6 of 18 resident records reviewed. The findings included: 1. Resident #2 was admitted to the facility on 10/25/22 with diagnoses that included Alzheimer's disease, muscle weakness and anxiety disorder. A review of Resident #2's medical record revealed she sustained an actual fall on 10/26/22 and another one on 1/22/23. Review of Resident #2's active care plan included a care plan for the risk for falls initiated on 1/26/23. A quarterly Minimum Data Set (MDS) assessment dated 1/31/23 indicated Resident #2 had moderately impaired cognition and was coded with one fall with minor injury. On 2/23/23 at 10:53 AM, an interview was conducted with the Regional MDS Nurse Consultant. She reviewed Resident #2's active care plan and stated the care plan should have been revised to reflect the actual falls that occurred on 10/26/22 and 1/22/23. She felt it was an oversight. 2. Resident #38 was admitted to the facility on 4/6/22 with diagnoses that included history of falling, muscle weakness and pain to right knee. Review of Resident #38's medical record revealed she sustained an actual fall on 12/8/22 with injury.	F 657	practice:¿¿ Regional MDS Nurse completed a review of the care plan for resident #2 and noted that care plan referenced in the POC was from a different stay. Care plan for correct stay was initiated 10/27/22 and has been printed and included to reflect the correct and timely updates for falls on 10/26/22 and 1/26/23. Regional MDS Nurse completed a review of the care plan for resident #38 and noted that care plan referenced in the POC was from a different stay. Care plan for correct stay was initiated 4/14/22 but was not updated timely with 12/8/22 fall. Regional MDS Nurse updated 4/14/22 care plan with 12/8/22 fall intervention. Regional MDS Nurse completed a review of the care plan for resident #58 and noted that care plan initiated on 3/2/22 included interventions did include interventions for falls for 8/15/22, 11/19/22, 11/20/22, 11/23/22, 12/18/22, and 1/13/23. A care plan was printed and included to reflect the correct and timely updates for these falls. Regional MDS Nurse completed a review of the care plan for resident #14 and updated it to remove the intervention of	

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A quarterly Minimum Data Set (MDS) assessment dated 1/6/23 indicated Resident #38 had moderately impaired cognition and had sustained a fall with injury.

Review of Resident #38's active care plan, last reviewed 1/10/23, included a care plan for the risk for falls, initiated on 12/31/22.

On 2/23/23 at 10:53 AM, an interview occurred with the Regional MDS Nurse Consultant. She reviewed Resident #38's active care plan and stated the care plan should have been revised to reflect the actual fall that happened on 12/8/22. She felt it was an oversight.

3. Resident #58 was admitted to the facility on 3/1/22 with diagnoses that included history of a stroke, history of falling and muscle weakness.

A quarterly Minimum Data Set (MDS) assessment dated 11/21/22 indicated Resident #58 had severely impaired cognition and was coded with one fall with injury and one fall with major injury.

Review of Resident #58's active care plan, last reviewed 11/30/22, included a care plan for the risk for falls, initiated on 3/2/22. The care plan included the fall that occurred on 11/20/22 only.

Review of Resident #58's medical record revealed he sustained falls on 8/15/22 with no injury, 11/19/22 with minor injury, 11/20/22 with injury, 11/23/22 with no injury, 12/18/22 with no injury and 1/13/23 with no injury.

F 657

"remove C collar to monitor skin for rash/breakdown, as resident no longer wears a C collar". This was completed 2/23/23.

Regional MDS Nurse completed a review of the care plan for resident #77 and updated it to remove the intervention of "diet: clear liquids as ordered and tolerated". This was completed 2/23/23.

Regional MDS Nurse completed a review of the care plan for resident #43 and updated it to remove the intervention of "diet: clear liquids as tolerated". This was completed 2/23/23.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿

Regional MDS Nurse completed a review of current residents that had a fall in the last 60 days, to ensure that the CarePlan reflects the fall intervention appropriately. This was completed on 3/10/23. The audit results did not reflect any other discrepancies in MDS trackers being completed.

Regional MDS Nurse completed a review of residents with a C collar in the last 60 days, to ensure the CarePlan reflects the use of and/or discontinuation of the C collar appropriately.

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F 657	Continued From page 19 On 2/23/23 at 10:53 AM, an interview was completed with the Regional MDS Nurse Consultant. She reviewed Resident #58's active care plan and stated the care plan should have been revised to reflect the actual falls that occurred and felt it was an oversight. 4. Resident #14 was admitted to the facility on 11/12/20 with multiple diagnoses including Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 12/21/22 indicated that Resident #14 had severe cognitive impairment and she had no pressure ulcers. Resident #14's care plan with a review date of 12/29/22 was reviewed. One of the care problems was "at risk for pressure ulcers and the goal was "to remain free from additional pressure ulcers". The approaches included "remove C collar to monitor skin for rash/breakdown". Resident #14 was observed on 2/21/23 at 8:55 AM and on 2/22/23 at 2:30 PM. The resident was not observed wearing a C collar. The Treatment Nurse was interviewed on 2/21/23 at 10:05 AM. She stated that she had not seen Resident #14 wearing a C collar. Nurse # 3 was interviewed on 2/21/23 at 10:10 AM. She stated that she had not seen Resident #14 wearing a C collar. She reported that the resident might have been admitted with a C collar way back in 2020. The Regional MDS Nurse Consultant was interviewed on 2/22/23 at 2:30 PM. She reviewed Resident #14's care plan and stated that the C	F 657	This was completed on 3/10/23. The audit results did not reflect any other discrepancies in MDS trackers being completed. Regional MDS Nurse completed a review of current residents, to ensure the CarePlan reflects the appropriate diet. This was completed on 3/10/23. The audit results did not reflect any other discrepancies in MDS trackers being completed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Regional MDS Nurse educated facility MDS traveler nurse on proper care plan updates per RAI Manual, Chapter 4. This was completed on 3/7/23. DON/designee will review 5 random residents weekly for 4 weeks, then 5 residents bi-weekly for 3 months, to ensure care plans are appropriately updated in the areas of falls, pressure ulcers (C collar), and medications (clear liquid diet). Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

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collar should have been removed from the care plan when the C collar was discontinued.

The Director of Nursing (DON) was interviewed on 2/23/23 at 12:20 PM. The DON stated that she expected the care plan to be reviewed and revised when indicated.

5. Resident #77 was admitted to the facility on 1/19/23 with multiple diagnoses including severe protein calorie malnutrition.

Resident #77 had a physician's order dated 1/29/23 for a regular diet.

Resident #77's care plan that was initiated on 1/30/23 was reviewed. One of the care plan problems was "at risk for dehydration due to use of antibiotic medication for urinary tract infection" and the approaches included " diet: clear liquids as ordered and tolerated".

Nurse # 3 was interviewed on 2/22/23 at 10:10 AM. She stated that Resident #77 was on a regular diet.

The Regiona MDS Nurse Consultant was interviewed on 2/22/23 at 2:30 PM. She reviewed Resident #77's diet order and verified that Resident #77 was on a regular diet and not on a clear liquid diet. She indicated that the MDS Nurse might have checked the wrong diet on the selection of the care plan approaches.

The Director of Nursing (DON) was interviewed on 2/23/23 at 12:20 PM. The DON stated that she expected the care plan to be reviewed and

DON/designee will report findings to the Quality Assurance Performance Improvement (QAPI) committee for any needed improvement. QAPI committee will review monthly and make any necessary recommendations immediately for six months.

Compliance Date:

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F 657	Continued From page 21 revised when indicated. 6. Resident #43 was admitted to the facility on 1/19/23 with multiple diagnoses including dementia. Resident #43 had a physician's order dated 1/19/23 for mechanical soft diet with thin liquids. Resident #43's care plan that was initiated on 1/30/23 was reviewed. One of the care plan problems was "at risk for dehydration due to use of antibiotic medication for pneumonia" and the approaches included " diet: clear liquids as tolerated". Nurse # 3 was interviewed on 2/22/23 at 10:10 AM. She stated that Resident #43 was on a mechanical soft diet with thin liquids. The Regional MDS Nurse Consultant was interviewed on 2/22/23 at 2:30 PM. She reviewed Resident #43's diet order and verified that Resident #43 was on a mechanical soft diet and not on a clear liquid diet. She indicated that the MDS Nurse might have checked the wrong diet on the selection of the care plan approaches. The Director of Nursing (DON) was interviewed on 2/23/23 at 12:20 PM. The DON stated that she expected the care plan to be reviewed and revised when indicated.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		3/23/23

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F 658	Continued From page 22 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a physician ' s order for a palm splint was accurate on the Medication Administration Record (MAR) for 1 of 3 residents (Resident #29) reviewed for Range of Motion (ROM). The findings included: Resident #29 was admitted to the facility on 03/22/19 with diagnosis that included contracture of right hand. Review of quarterly Minimum Data Set (MDS) assessment, dated 12/14/22, revealed Resident #29 ' s cognition was severely impaired. Resident #29 required extensive assist of one person for bed mobility, dressing, personal hygiene, and toilet use. Resident #29 was coded for functional limitations in range of motion (ROM) on one side of her upper extremities. Review of Resident #29 ' s active orders as of 02-20-22 revealed a physician order dated 07/22/22 that read: Resident to have palm guard to right hand (carrot). Nurse to monitor hand under device for signs and symptoms of redness/infection and ensure hand is cleaned with soap and water and dried thoroughly each shift. Start Date: 7/22/22. Order was scheduled on the Medication Administration Record (MAR) for 06:30 AM only. (Clean hand only scheduled for one time a day on	F 658	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ Resident #29s order for palm guard to right hand (carrot) to be applied was reviewed by the DON and attending physician on 3/8/23. Due to resident refusal the order was discontinued on 03.08.2023. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ Audit of splints to be completed by 03.08.2023 by DON/designee/Rehab of current residents with splints to ensure they are being applied and/or any refusals from residents. 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 658	Continued From page 23 MAR). (First shift is from 7 AM till 7 PM, second shift 7 PM till 7 AM or 7 PM till 11 PM and 11 PM till 7 AM.) An interview was conducted on 02/22/23 at 03:50 PM with the Director of Nursing (DON). She stated it is her expectation that splints be applied per orders. She viewed the order on the Medication Administration Record (MAR) and verified the splint order for Resident #29 was not transcribed correctly. The administration time on the order was every shift but, on the MAR, it only had 6:30 AM. An interview was conducted on 02/22/23 at 03:50 PM with the Director of Nursing (DON). She stated it is her expectation that splints be applied per orders. She viewed the order on the Medication Administration Record (MAR) and verified the splint order for Resident #29 was not transcribed correctly. The administration time on the order was every shift but, on the MAR, it only had 6:30 AM.	F 658	Director of Nursing in-serviced nursing staff, including contract staff, on applying Splints as ordered and accuracy documenting administration and refusals as of 03.13.2023.All new admissions will be evaluated as necessary upon admission for use of splints. All new nursing staff and agency nurses will be required to complete training prior to starting their first shift. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: DON/designee will monitor 5 residents eMARS and visually verify three times weekly X 4 weeks, twice weekly x 4 weeks and once weekly x 4 weeks to ensure splints have Been applied as ordered. The DON will bring a summary of findings of audits and Monitoring to QAPI monthly to ensure that the process is in place and effective And discuss further updates as warranted for 3 months. Compliance Date: 03.23.2023	

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F 677	Continued From page 24	F 677		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interview ' s the facility failed to provide nail care and incontinence care for 3 of 5 residents reviewed for activities of daily living (ADL ' s) (Resident #29, #1, and #2). The findings include: 1. Resident #29 was admitted to the facility on 03/22/19 with diagnoses that included Dementia, stage 3 pressure ulcer, and contracture of right hand. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/14/22, revealed Resident #29 ' s cognition was severely impaired. Resident #29 required extensive assistance of one person for bed mobility, dressing, toilet use, personal hygiene, and toilet use. She required extensive assistance of two people for transfers. Resident #29 was coded for functional limitations in range of motion (ROM) on one side of her upper extremities. Review of Resident #29 ' s care plan with a revision date of 12/20/22 revealed a focus area for Activities of Daily Living (ADLs): required assistance for all ADLs related to polio syndrome, right hand contracture, and dementia. The following interventions were included: assist	F 677	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ Resident # 29, #1 and #2 nails were cleaned and trimmed on 02.22.2023 by Unit Manager. Unit Manager re-educated the nursing staff, including agency, on providing nail care to resident's not Only on shower days but if nails are noted to be long and/or dirty. If unable to provide nail care to residents notify the licensed nurse so the nurse can provide nail care to residents. This education was completed on 02.22.2023. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ Unit Manager's completed nail care observation rounds on, 02.22.2023, to ensure current residents were receiving	3/23/23

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F 677	Continued From page 25 resident as needed and do not rush resident-allow extra time to participate in ADLS as much as possible and then complete task. a. Review of a grievance/concern initiated by Resident #29 ' s responsible party (RP) dated 11/18/22 revealed that Resident #29 was not assigned a Nursing Assistant (NA) from 7:00 AM through 1:00 PM on 11/18/22. Per grievance/concern form, the resident ' s RP came in to visit with Resident #29 at 2:15 PM and asked staff why resident was not out of bed. She was informed by NA #6 at 2:30 PM that Resident #29 was accidentally left off the assignment sheet from 7:00 AM through 1:00 PM. Assignment was immediately corrected to include Resident #29 when this was noted, and education was provided to staff on making sure all residents are included and are receiving care. Review of the assignment sheet for 11/18/22 revealed the assignment schedule had not been adjusted that morning and Resident #29 ' s room was clearly written and assigned to Nursing Assistant (NA) #6. NA #6 was unavailable for interview. An interview was conducted on 02/22/23 at 01:15 PM with the Team Leader. She indicated that she made the assignment schedule for staff the morning of 11/18/22. She stated on 11/18/22 the Nursing Assistants (NAs) assignments were changed that morning and Resident #29 ' s room was accidently left off the assignment sheet. She stated she fed Resident #29 breakfast that morning. She further stated a family member came in and was very upset that the resident had not been changed all morning/afternoon and that	F 677	nail care to include: trimming, cleaning and/or filing if warranted. Any resident identified was provided nail care to include trimming, cleaning and/or filing. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All clinical staff, including the agency were re-educated by Director of Nursing and Unit Manager's on 03.08.2023, on nail care to include cleaning, clipping and filing nails on shower days and as warranted. If the resident refuses notify the nurse. Any staff member that has not been educated by 03.13.2023, will not be allowed to work until the re-education is completed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Daily audits will be completed by the DON and/or designee 5 days a week Monday-Friday x 2 weeks, 3 days a week x2 weeks and then weekly x 2 months. Audits will be reviewed and discussed in	

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F 677	Continued From page 26 Resident #29 was wet. An interview was conducted on 02/22/23 at 01:35 PM with the Social Worker (SW). She stated on 11/18/22 Resident #29 ' s responsible party (RP) came to her because Resident #29 was accidently left off the Nursing Assistants (NAs) assignment sheet. She stated the RP said the resident was soaked in urine and it was unacceptable. An interview was conducted on 02/22/23 at 04:43 PM with Resident #29 ' s responsible party (RP). She stated she came to facility around 2:15 PM on 11/18/22 and Resident #29 was still in bed. She stated she was to be up by 10:00 AM every day. She further stated she was informed by staff that Resident #29 was overlooked on the assignment sheet. She stated she was very upset that Resident #29 had not been bathed, changed, or gotten up until 1:00 PM. An interview was conducted on 02/23/23 at 10:17 AM with the Director of Nursing (DON). She stated she expected all residents to be included on the daily assignment sheet and that every resident should receive care. She acknowledged that Resident #29 was missed on the assignment sheet on 11/18/22 and that all staff were educated on the importance of making sure all residents are listed and receiving care. b. An observation was conducted on 02/20/23 at 11:32 AM and on 02/22/23 at 10:14 AM revealed Resident #29 ' s fingernails on her left hand extended approximately 1/8th to 1/4th of an inch beyond her fingertips as did the index and thumb nails on the resident's right hand. Her	F 677	morning clinical meeting to include ADL's including nail care will be noted on ambassador rounds. Both ambassadors rounds and weekly clinical meeting findings will be reviewed and discussed in the monthly QAPI meeting, to ensure continued compliance. Compliance Date: 03.23.2023	

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left pointer finger was jagged, and the right ring finger was jagged. The resident's 3rd, 4th, and 5th fingers were observed curled into the right palm.

An interview was conducted on 02/22/23 at 09:50 AM with the Team Leader. She stated the Nursing Assistants (NAs) are responsible for cutting residents nails during showers/baths and/or when they see that it needs to be done. She also stated she does rounds monthly to check to see if nails have been done.

An observation and interview were conducted on 02/22/23 at 10:16 AM with the team leader and NA #2. They both confirmed Resident #29 ' s nails were long, the left pointer finger was jagged, and the right ring finger was jagged. They both confirmed her nails needed to be cut. The Team Leader stated nails are to be cut as needed and during showers/baths.

An interview was conducted on 02/22/23 at 03:50 PM with the Director of Nursing (DON). She expected nails to be cut as needed. She stated she normally cuts Resident #29 ' s fingernails but she was unaware they needed to be cut.

2. Resident #1 was admitted to the facility on 11/18/16 with diagnoses that included stroke, Hemiplegia/hemiparesis (Hemiparesis is a mild or partial weakness on one side of the body. Hemiplegia is paralysis on one side of the body), and diabetes mellites.

Review of quarterly Minimum Data Set (MDS) assessment, dated 01/30/23, revealed Resident #1 ' s cognition was severely impaired. She was totally dependent of one person for personal

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hygiene and bathing. There was no rejection of care or behaviors coded. She was coded for functional limitations in range of motion (ROM) on both sides of her upper extremities and impairment on 1 side of her lower extremities.

Review of Resident #1 ' s care plan with a revision date of 11/01/22 revealed a focus for Activities of Daily Living (ADLs): only read the following: total care for ADLs. No interventions were listed related to ADLs other than splint application and skin checks under splints. A focus that she exhibits aggressive behavior with ADLs. Interventions included: to allow opportunity to make choices and participate in care and provide diversional activities.

Observations on 02/20/23 at 10:14 AM and at 01:10 PM, and on 02/21/23 at 12:57 PM revealed Resident #1 ' s fingernails on her left and right hands extended approximately 1/8th of an inch beyond her fingertips. The middle finger on her left hand was jagged.

An observation and interview were conducted on 02/22/23 at 10:16 AM with the team leader and NA #2. They both confirmed Resident #1 ' s nails were long, the middle finger on her left hand was jagged. They both confirmed her nails needed to be cut. The Team Leader stated nails are to be cut as needed and during showers/baths.

An interview was conducted on 02/22/23 at 09:50 AM with the Team Leader. She stated the Nursing Assistants (NAs) are responsible for cutting residents nails during showers/baths and/or when they see that it needs to be done. She also stated she does rounds monthly to check to see if nails have been done.

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F 677	Continued From page 29 An interview was conducted on 02/22/23 at 03:50 PM with the Director of Nursing (DON). She expected nails to be cut as needed. 3. Resident #2 was admitted to the facility on 10/25/22 with diagnoses that included history of a stroke, Alzheimer's disease, and muscle weakness. Resident #2's active care plan, with a start date of 1/26/23, included an area that read "Resident requires assistance for eating, mobility, transfers, dressing, grooming, toileting and bathing related to impaired mobility, hearing impairment, vision impairment, some cognitive decline, fractured right wrist and incontinence." The interventions included to assist with Activities of Daily Living (ADLs) as needed A quarterly Minimum Data Set (MDS) assessment dated 1/31/23 indicated Resident #2 had moderately impaired cognition and displayed no rejection of care. She required total assistance from staff for personal hygiene. A review of Resident #2's nursing progress notes from 11/1/22 through 2/22/23 revealed no refusals of nail care documented. On 2/20/23 at 12:17 PM, an observation of Resident #2 occurred while she was sitting up in the wheelchair. Fingernails to both hands were medium length, and the left thumb and right fifth nails were jagged. Resident #2 was observed on 2/21/23 at 8:30 AM, while sitting in bed eating breakfast. Her fingernails remained unchanged from the previous observation.	F 677		

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On 2/21/23 at 3:17 PM, Resident #2 was observed while sitting up in the wheelchair. Her left thumb and right fifth fingernails remained jagged.

An interview occurred with Nurse Aide (NA) #3 on 2/21/23 at 3:21 PM and was assigned to care for Resident #2 on the evening shift (3:00 PM to 11:00 PM). She stated nail care was normally rendered during personal care or bathing tasks and was unable to state why Resident #2's nails had not been cared for.

On 2/22/23 at 10:04 AM, an interview and observation occurred of NA #4 who was providing personal care to Resident #2. She stated she saw Resident #2 had jagged nails to both hands and had just finished cutting and filing them. NA #4 could not explain why nail care had not been completed prior to this day. She added nail care should be rendered during personal care and bathing.

On 2/22/23 at 11:40 AM, an interview was conducted with NA #5 who was familiar with Resident #2 but not assigned to care for her. He explained nail care should be done daily to ensure nails were short and clean.

The Director of Nursing was interviewed on 2/23/23 at 11:00 AM and stated she was not aware of any refusals of nail care from Resident #2 or that nail care was needed. She added that she would expect fingernails to be observed on shower days and during personal care with nail care rendered as needed.

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F 679 SS=E	Activities Meet Interest/Needs Each Resident	F 679		3/23/23

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F 679	Continued From page 31 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to ensure group activities were planned on weekends to meet the needs of residents who expressed that it was important to them to attend group activities (Residents #35, #13, #3) for 3 of 3 residents reviewed for activities. The findings included: A review of the Activities Calendar from August 2022 through January 2023 revealed there was 1 activity planned every Saturday and 1 religious activity on every Sunday. a. Resident #35 was originally admitted to the facility on 09/26/19 with diagnoses that included major depressive disorder and anxiety disorder. The annual Minimum Data Set (MDS) assessment dated 12/02/22 indicated Resident #35's cognition was fully intact. This assessment indicated that it was very important to Resident #35 to do activities with groups of people.	F 679	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ As of 3/23/2023 residents #3, #13, and #35 will be provided activities of interest on weekends by the activity department. Administrator interviewed residents #3, #13, and #35 on activities of interest as of 3/17/2023. 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 alleged deficient practice. As of 3/23/2023 all residents' activities assessment will be reviewed for activities of interest and updated as necessary by the activities department.	

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The Activity Assessment dated 12/01/22 indicated Resident #35 preferred to participate in activities in the morning and afternoon, in the day/activity room, and was motivated to participate in activities. The assessment indicated she preferred to participate in cards, games, crafts/arts/hobbies, exercise/walking/jogging, music, baking/cooking, spiritual/religious, time outdoors, watching TV/radio, watching movies, talking/conversing, helping others/volunteer work, parties/social events, and keeping up with the news.

Resident #35's active care plan dated 12/01/22 included the focus area of Resident #35 to verbalize her preferences and she stated she enjoyed cards, games, crafts, exercise, music, baking/cooking, spiritual/religious, watching TV, movies, talking/conversing, helping others, parties/social events, and keeping up with the news. The goal included Resident #35 will participate in activities she prefers. Interventions included to assist Resident #35 with getting to activities, remind her when activities are scheduled, and post a personal activity calendar in her room.

During a Resident Council meeting held on 02/21/23 at 3:16 PM Resident #35 indicated residents had to come up with their own activities on the weekends. She indicated the weekends can be "boring" due to the lack of activities. She would like more activities rather than coloring and worksheets.

b. Resident #13 was originally admitted to the facility on 11/24/15 with diagnoses that included major depressive disorder and anxiety disorder

F 679

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

As of 3/23/2023 the Administrator will re-educate the activities department on policy for providing activities of interest for residents in group settings as well as individual activities to include weekends. The administrator will review activities calendar weekly for three months to ensure activities are provided for all residents seven days a week to include group activities based on the interest of residents.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The administrator will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction, to ensure continued compliance. QAPI committee will make any necessary adjustments as needed to the current plan.

Compliance Date:

3/23/2023

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The quarterly Minimum Data Set (MDS) assessment dated 01/21/23 indicated Resident #9's cognition was moderately impaired.

The Activities Assessment dated 10/04/22 indicated Resident #13's current interests included cards, games, crafts/arts/hobbies, exercise, music, baking/cooking, spiritual, time outdoors, watching tv and movies, gardening, talking, helping others, parties/social events, and keeping up with the nose.

Resident #13's care plan dated 05/29/22 included a focus area of verbalizing her preferences and had stated she enjoyed cards, crafts, games, exercise, music, baking/cooking, spiritual/religious, spending time outdoors, watching TV and movies, gardening, talking and conversing, helping others, parties/social events, keeping up with the news, and community outings. The goal included for Resident #13 to participate in her preferred activities. Interventions included post a personal activity calendar in her room; encouraged her to attend activities that include music, and invited and encouraged her to participate in activity groups of interest.

During a Resident Council meeting held on 02/21/23 at 3:16 PM Resident #13 indicated there were very few meaningful activities on the weekends and stated "All we do is color." She stated she would like more activities on the weekends. She indicated she gets "bored" on the weekends because of the lack of activities.

c. Resident #3 was admitted to the facility on 12/18/19 with diagnoses that included Alzheimer's

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UNIVERSAL HEALTH CARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 34	F 679		

disease.

The annual Minimum Data Set (MDS) assessment dated 12/14/22 indicated Resident #3 cognition was severely impaired and it was important for her to do favorite activities with groups of people.

The Activities Assessment dated 12/14/22 indicated she was interested in cards, games, crafts/arts, music, baking/cooking, spiritual, time outdoors, watching TV and movies, listening to the radio, talking/conversing, parties/social events, and keeping up with the news. She was assessed as being motivated and interested in attending activities.

Resident #3's active care plan dated 12/24/19 included the focus area of verbalizing her preferences and stated she enjoyed cards, crafts, games, music, reading, spiritual/religious, spending time outdoors, watching TV and movies, talking, conversing, baking/cooking, parties, social events, and keeping up with the news. The goal included for her to participate in her preferred activities. Interventions included to encourage her to attend activities that involve music; staff will take her outside when the weather is nice for fresh air; and invite and encourage her to participate in activities.

During a Resident Council meeting held on 02/21/23 at 3:16 PM Resident #3 indicated she mostly does coloring sheets and word searches on the weekends. She stated she would prefer more activities on the weekends. She stated she does not attend the religious services.

The former Activities Assistant was interviewed

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on 02/22/23 at 11:00 AM. She stated she was the Activities Assistant 6 months ago, but the facility had not found a replacement. While she was an Activities Assistant she assisted with activities such as playing music for residents, assist with snack time, play balloon toss with residents, and facilitate exercise class. She indicated she did not work on the weekends and there were no activities personnel on the weekends. They would leave out activity packets which included 30 pages of coloring sheets and word searchers as well as left out board games. She stated a preacher came every Sunday, but they did not offer activities for non-religious residents on Sundays.

An interview with the Social Worker on 02/23/23 at 9:25 AM revealed she met monthly with the Resident Council to discuss concerns, review old and new business, and encouraged residents to come up with recommendation for expressed concerns. She indicated the lack of weekend activities was an ongoing issue with Resident Council, and was working with Resident Council to resolve the concern. She stated the residents would like more variety of activities on the weekends.

The Activity Director was not available for interview.

The Administrator was interviewed on 02/23/23 at 12:45 PM. She stated she felt she had attempted to accommodate the residents several times, but the residents seem to not find the resolutions acceptable. She had attempted to make changes, but residents did not attend the alternative activities. She stated she had attempted to provide additional activities to celebrate

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F 679	Continued From page 36 Thanksgiving, but very few residents attended. She indicated she was "swamped" with staffing issues and was focused on resident care rather than additional activities on the weekends.	F 679		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions (Resident #2). This was for 1 of 8 residents reviewed for accidents. The findings included: Resident #2 was admitted to the facility on 10/25/22 with diagnoses that included history of a stroke, Alzheimer's disease, and muscle weakness. Record review revealed Resident #2 rolled off the bed on 10/26/22. At that time the bed was moved, and a fall mat was placed next to the bed. Resident #2's active care plan dated 1/26/23, included a focus area for risk for falls and injury related to weakness, impaired mobility, incontinence, wears glasses, potential side	F 689	Director of Nursing and Regional Clinical Nurse completed a review of medical record for Resident #2, to ensure a fall mat was the correct intervention as of 2/23/23. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ As of 3/23/2023 all residents have the potential to be affected by this alleged deficient practice. All residents with order for fall mats have been audited ensure the fall mat is in place as ordered.	3/23/23

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effects from medications, poor safety awareness and history of falls. The interventions included fall mat to the side of the bed.

A review of Resident #2's medical record revealed she was found sitting on the floor in her room on 1/30/23.

A quarterly Minimum Data Set (MDS) assessment dated 1/31/23 indicated Resident #2 had moderately impaired cognition and required limited to extensive assistance with Activities of Daily Living (ADLs). A wheelchair was used for mobility, and she was coded with 1 fall since the last assessment.

An observation occurred of Resident #2 on 2/20/23 at 12:17 PM. She was observed to be sitting up in a wheelchair next to her bed. The bed was in the lowest position, however there was no fall mat located in the room or bathroom.

On 2/21/23 at 8:30 AM, Resident #2 was observed sitting up in her bed eating breakfast. Her bed was in the lowest position, but there was no fall mat located next to the bed, in the room or in the bathroom.

An observation occurred of Resident #2's bed on 2/21/23 at 3:17 PM. There was no fall mat located in the room or bathroom.

On 2/21/23 at 3:21 PM, an interview was conducted with Nurse Aide (NA) #3 who was familiar with Resident #2 and worked the evening shift (3:00 PM to 11:00 PM). She thought Resident #2 had a fall mat next to her bed but was unable to locate it in the room or bathroom and could not explain where it was.

F 689

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

As of 3/10/23 the Director of Nursing (DON) has re-educated all nursing staff to include agency nursing staff on the placement of fall mats as ordered for fall safety. all new nursing staff and agency staff will be re-educated prior to starting a shift. DON/designee will monitor 3 resident rooms with fall mat daily Monday-Friday for 4 weeks then 5 residents weekly for 8 weeks to ensure fall mats are in place as ordered.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The Director of Nursing will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly, to ensure continued compliance. QAPI committee will make any necessary adjustments as needed to the current plan.

Compliance Date:

3/23/2023

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F 689	Continued From page 38 A phone interview occurred with Nurse #2 on 2/22/23 at 8:55 AM, who was familiar with Resident #2 on the evening shift from 7:00 PM to 7:00 AM. She stated at one time Resident #2 had a fall mat next to her bed but could not recall if it was still being used. On 2/22/23 at 10:04 AM, an observation was made of Resident #2's room, which revealed a fall mat next to the left side of the bed. An interview was held with the Director of Nursing (DON) on 2/22/23 at 11:20 AM. She was familiar with Resident #2 and stated a fall mat was to be placed next to the bed when Resident #2 was in it. She explained staff would remove it when she was up in the wheelchair for safety. The DON was unable to state why the fall mat was not in place on 2/20/23 and 2/21/23 but stated it was her expectation for fall interventions to be implemented by the staff.	F 689		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an	F 727		3/23/23

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F 727	Continued From page 39 average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours a day for 7 out of 38 days reviewed for staffing. The failure to have RN coverage for the facility had the high likelihood to impact every resident in the facility. The findings included: Review of the Payroll Based Journal (PBJ) facility reporting, Posted Nurse Staffing as compared to the Staff Schedule/Assignment Sheets, and RN timecard reports revealed there was no RN coverage for eight consecutive hours on for 07/31/22, 08/07/22, 08/20/22, 08/21/22, or 08/28/22. This was for 5 of the 8 days reviewed from PBJ triggered days. Review of the Posted Nurse Staffing as compared to the Staff Schedule/Assignment Sheets and RN timecard reports for the period of 01/20/23 through 02/20/23 corroborated there was no RN coverage on 01/21/23 or 01/22/23. This was for 2 of the 30 days reviewed. An interview was conducted on 02/21/23 at 03:47 PM with the Administrator. She stated she did not have an RN on 07/31/22, 08/07/22, 08/20/22, 08/21/22, 08/28/22, 01/21/23 or 01/22/23. She further stated the agency did not have an RN available at that time. She stated she has had a hard time finding an RN to hire. An interview on 02/23/23 at 09:50 AM was conducted with the facility scheduler. She verified that the number of licensed staff and the total	F 727	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. 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. As of 3/16/2023 all Saff posting/schedules have been reviewed by Administrator and or Director of Nursing to ensure 8 hours of RN coverage daily. 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 727	Continued From page 40 hours worked for licensed staff were incorrect for 21 out of 38 days. She stated she was counting the Minimum Data Set (MDS) nurse under 1st shift although she had not provided direct care to residents and that the accurate Posted Nurse Staffing Information Sheets had not been updated daily to reflect the correct hours that licensed staff had worked. She further stated they had hired a RN supervisor in January, who would have counted towards the RN hours, but she did not work out and was terminated. An interview was conducted on 02/23/23 at 10:17 AM with the Director of Nursing (DON). She stated she was aware they did not have RN coverage on some days. She further stated agency did not have an RN available at that time.	F 727	Director of Nursing and scheduler was re-educated on 02.23.2023 on the requirements of proper RN coverage and the recording on the daily staff posting, by the Regional Nurse Consultant. Staff Development Nurse and Unit Manger's were educated on the requirements of proper RN coverage on 02.23.2023 by the Director of Nursing. One RN that works Monday through Friday as Unit Manger and the weekend has coverage with use of agency to ensure that proper RN coverage is maintained. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Staffing schedules will alter to ensure that proper RN coverage is maintained. Administrator and/or Director of Nursing will audit the daily staffing schedule 5 days per week x 12 weeks to ensure proper RN coverage is maintained. Discussion will be done during Morning Stand Up meeting if RN coverage is compliant for the following day. Results from audits will be taken to QAPI by the Director of Nursing monthly x 3 months. QAPI committee will evaluate the effectiveness of the intervention to	

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F 727	Continued From page 41	F 727	determine if to continue the auditing process as necessary to maintain compliance. Compliance Date: 3/23/2023	
F 730 SS=B	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 4 of 5 Certified Nurse Aides (CNAs) had a documented performance review every twelve months to ensure in-service education was designed to address the outcome of the performance reviews (CNA #3, #9, #10 and #11). The findings include: 1. a. Certified Nurse Aide (CNA) #3's employee file revealed the Date of Hire (DOH) was 11/21/17. CNA #3's employee file did not include documentation of a performance review.	F 730	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ As of 3/10/2023 employee performance reviews have been completed for certified nursing aides (CNA's) #3, #9, #10, and #11 to address areas of in-service education training based on performance review. Address how the facility will identify other	3/23/23

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F 730	Continued From page 42 b. Certified Nurse Aide (CNA) #9's employee file revealed the Date of Hire (DOH) was 05/22/14. CNA #9's employee file did not include documentation of a performance review. c. Certified Nurse Aide (CNA) #10's employee file revealed the Date of Hire (DOH) was 11/09/10. CNA #10's employee file did not include documentation of a performance review. d. Certified Nurse Aide (CNA) #11's employee file revealed the Date of Hire (DOH) was 01/25/18. CNA #11's employee file did not include documentation of a performance review. An interview was conducted on 02/21/23 at 03:15 PM with NA #11. She stated the facility uses an online education system for continuing education and skills checklists. She indicated she had not received a performance review. An interview was conducted on 02/23/23 at 11:42 AM with Infection Control Preventionist/Staff Development Coordinator (ICP/SDC) Nurse regarding yearly performance review. She indicated the facility did not currently have a yearly skills performance review, but she was trying to put one in place (a copy was provided). She stated that the facility uses an online education program that consisted of learning modules and that some modules, not all, had a checklist at the end for the CNAs to sign off on. She further stated she does not observe the CNAs performing skills demonstration. She also stated if the module contained a checklist the Director of Nursing (DON) observed the CNA performing the skills demonstration and then signed it off.	F 730	residents having the potential to be affected by the same deficient practice:¿ All CNA's have the potential to be affected by this alleged deficient practice. As of 3/16/2023 an audit of current CNA's has be completed to ensure all CNA's have a performance review by the Director of Nursing (DON). Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: As of 3/13/2023 the Administrator has re-educated the DON on the facility policy to complete a performance review of all CNA's every 12 months to ensure in-service education was designed to address the outcome of review. Director of Nursing will review 5 CNA files weekly, then 3 CNA records weekly for 8 weeks to ensure all CNA's have a performance review at least every 12 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction. QAPI committee will make any necessary	

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F 730	Continued From page 43 A review of a module checklist that was provided by the ICP/SDC Nurse with a heading of, "Fall Prevention in Bed" was conducted. At the top of page under "Description" it read, in part, the following: This checklist identifies the steps needed to fall prevention falls from bed. It also provides rationales to explain why these steps are performed. The use of this content is for educational purposes only and should only be used as a guide in performing this skill. Any federal, state, and local regulations and protocols must be observed. An interview was conducted on 02/23/23 at 12:25 PM with the Director of Nursing (DON). She indicated the facility did not have a yearly skills performance review only the online education program that consisted of learning modules. She then stated she did not typically observe the CNAs demonstrating the task. She further stated she and the Infection Control Preventionist/Staff Development Coordinator (ICP/SDC) Nurse reviewed the online education program to see if any module check off was completed, and if it was completed, she signed off on it.	F 730	adjustments as needed to the current plan. Compliance Date: 3/23/2023	
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	F 732		3/23/23

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by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(g)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to display accurate Posted Nurse Staffing Information as compared to the Staff Schedule/Assignment Sheets for 22 out of 38 days reviewed.

The findings included:

F 732

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿

There are no resident names in this

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F 732	Continued From page 45 A review of the Staff Schedule/Assignment Sheets and timecard reports compared to the daily Posted Nurse Staffing Information sheets for 07/31/22, 08/07/22, 08/20/22, 08/21/22, 08/28/22 and from 01/20/23 through 02/20/23 revealed discrepancies in the areas of actual hours worked and actual nursing staff who worked including the licensed Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). The number of licensed staff and actual hours worked of licensed staff on 1st shift were incorrect for the following days: 07/31/22, 01/20/23, 01/22/23, 01/23/23, 01/25/23, 01/26/23, 01/27/23, 01/31/23, 02/01/23, 02/02/23, 02/03/23, 02/07/23, 02/08/23, 02/09/23, 02/13/23, and 02/15/23. The number of licensed staff and actual hours worked of licensed staff on 2nd shift were incorrect for the following days: 07/31/22, 08/28/22, 01/20/23, 01/21/23, 01/22/23, 01/23/23, 01/25/23, 01/26/23, 01/27/23, 01/31/23, 02/01/23, 02/02/23, 02/03/23, 02/04/23, 02/06/23, 02/07/23, 02/08/23, 02/09/23, 02/11/23, 02/12/23, 02/13/23, and 02/15/23. The number of licensed staff and actual hours worked of licensed staff on 3rd shift were incorrect for the following days:07/31/22, 08/07/22, 01/22/23, 01/23/23, 01/27/23, 01/31/23, 02/04/23, 02/08/23, 02/11/23, 02/12/23, The number of licensed and unlicensed staff and actual hours worked of licensed and unlicensed staff on 2nd shift were incorrect for the following days: 01/06/23, 01/07/23, 01/08/23, 01/11/23, 01/12/23, 01/13/23, 01/14/23, 01/16/23, 01/17/23, 01/18/23, 01/21/23, 01/22/23, 01/23/23, 01/25/23,	F 732	alleged deficient practice. As of 2/23/2023 all current staff postings have been corrected to reflect current correct hours. 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. As of 3/10/2023 all postings for the month of March 2023 have been reviewed to ensure that hours and census are posted correctly based on census and nursing staff. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: As of 3/10/23 the Administrator has re-educated the Director of Nursing/and or designee on the facility policy for staff posting regarding census and nursing staff in the facility working. Director of Nursing/and or designee will monitor staff posting daily Monday-Friday and weekends to ensure correct nursing hours and census are posted x 3 months. All staff postings will be reviewed during morning meeting to ensure correct posting from prior day by IDT team for correct staffing and posting for 4 weeks.	

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	345523	A. BUILDING ______ B. WING ______	C 02/23/2023

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F 732	Continued From page 46 01/26/23, 01/27/23, 01/30/23, 01/31/23, 02/01/23, 02/02/23, 02/04/23, 02/05/23, and 02/06/23. An interview was conducted on 02/21/23 at 03:47 PM with the Administrator. She stated she was unaware the daily Posted Nurse Staffing Information sheets were inaccurate and did not reflect the correct actual working hours or the correct number of staff for 22 out of 38 days reviewed. An interview on 02/23/23 at 09:50 AM was conducted with the facility scheduler. She verified that the number of licensed staff and the total hours worked for licensed staff were incorrect for 21 out of 38 days. She stated she was counting the Minimum Data Set (MDS) nurse under 1st shift although she had not provided direct care to residents and that the accurate Posted Nurse Staffing Information Sheets had not been updated daily to reflect the correct hours that licensed staff had worked. An interview on 02/23/23 at 10:17 AM was conducted with the Director of Nursing (DON). She reviewed and confirmed the daily Posted Nurse Staffing Information sheets were inaccurate and did not reflect the correct actual working hours or the correct number of staff for 22 out of 38 days reviewed.	F 732	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly, to ensure continued compliance. QAPI committee will make any necessary adjustments as needed to the current plan. Compliance Date: 3/23/2023	
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	F 867		3/23/23

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F 867	Continued From page 47 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, 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	F 867		

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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; 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

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F 867	Continued From page 49 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; (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 record reviews, observations, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification and complaint survey completed on 06/11/21. This was for 6 deficiencies that were cited in the areas of Accuracy of Assessments, Services Provided Meet Professional Standards, Activities of Daily Living Care Provided for	F 867	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:¿¿ As of 3/10/2023 facility Quality Assurance Performance Improvement (QAPI) process has been corrected to effectively correct and monitor deficient areas.	

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Dependent Residents, Free of Accident Hazards/Supervision/Devices, Increase/Prevent Decrease in Range of Motion/Mobility, Registered Nurse 8 hours/7 Days/Week, Full Time Director of Nursing, and Posted Nurse Staffing Information. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.

The findings included:

1. F641 - Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of medications for 2 of 21 residents whose MDS were reviewed (Residents # 77 & # 43).

During the facility's recertification survey of 06/11/21 the facility failed to code the Minimum Data Set (MDS) accurately in the areas of prognosis, range of motion, and Preadmission Screening Resident Review (PASRR) level 2. This was for 3 of the 19 MDS's reviewed for accuracy.

In an interview with the Administrator on 02/23/23 at 12:45 PM, she felt the repeat citation in MDS accuracy was felt to be related to the MDS Nurse feeling overwhelmed with the amount of MDS assessments she had to do.

2. F658 - Based on record review and staff interviews, the facility failed to ensure a physician's order for a palm splint was accurate on the Medication Administration Record (MAR) for 1 of 3 residents (Resident #29) reviewed for Range of Motion (ROM).

F 867

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿

All prior identified deficient citations have the potential to be affected by this deficient practice therefore, the Administrator has reviewed annual and complaint surveys for the prior 3 years to review all areas of repeat deficient practice.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

As of 3/13/2023 Regional Director of Operations has re-educated the Administrator on the facility QAPI procedures for monitoring areas of identified deficient practice and process of removing monitoring of areas. Regional Director of Operations will review QAPI minutes monthly to ensure improvement and monitoring of areas of deficient practice for 3 months. Administrator will review the Plan of Correction during weekly Ad Hoc QAPI meeting to ensure no future repeats of prior tags for 12 weeks.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

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F 867	Continued From page 51 During the facility's recertification survey of 06/11/21 the facility failed to obtain a physician order since admission (5/27/2021) for the required intravenous line flush before and after antibiotic administration for 1 of 1 reviewed. In an interview with the Administrator on 02/23/23 at 12:45 PM, she felt the repeat citation in Services Provided Meet Professional Standards was felt to be related to human error and the MDS Nurse feeling overwhelmed. 3. F677 - Based on observations, record review, resident, and staff interview's the facility failed to provide nail care and incontinence care for 3 of 5 residents reviewed for activities of daily living (ADL's) (Resident #29, #1, and #2). During the facility's recertification survey of 06/11/21 the facility failed to provide scheduled showers, baths, nail care, and facial shaving for 7 of 8 activity of daily living (ADL) dependent residents reviewed. In an interview with the Administrator on 02/23/23 at 12:45 PM, she felt the repeat citation in ADL care was related to staff turnover and agency staff not being invested in the facility or the residents. 4. F689 - Based on record review, observations and staff interviews, the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions (Resident #2). This was for 1 of 8 residents reviewed for accidents. During the facility's recertification survey of 06/11/21 the facility failed to provide supervision	F 867	The administrator will report all findings to the Quality Assurance Performance Improvement (QAPI) committee monthly of findings for any needing correction. QAPI committee will make any necessary adjustments as needed to the current plan. Compliance Date: 3/23/2023	

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to 2 residents with known behavioral symptoms to prevent the physical assault, unwanted physical contact, and/or unwanted advancements into the personal space of cognitively impaired residents. This was for 2 of 3 residents reviewed for resident to resident altercations.

In an interview with the Administrator on 02/23/23 at 12:45 PM, she felt like the repeat citation in Free of Accident Hazards/Supervision/Devices was not warranted because she disagreed with the repeat citation.

5. F727 - Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours a day for 7 out of 38 days reviewed for staffing. The failure to have RN coverage for the facility had the high likelihood to impact every resident in the facility.
During the facility's recertification survey of 06/11/21, the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive hours per day 7 days a week for 15 of 31 days reviewed.
In an interview with the Administrator on 02/23/23 at 12:45 PM, she felt like the repeat citation in Registered Nurse/7 Days/Week, Full Time DON was related to staffing shortage. She indicated she has not be able to hire an in-house registered nurse. She relies on agency registered nurses. If the agency registered nurse calls out, she cannot get coverage.

6. F732 - Based on record review and staff interviews, the facility failed to display accurate Posted Nurse Staffing Information as compared to the Staff Schedule/Assignment Sheets for 22 out of 38 days reviewed.

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F 867	Continued From page 53 During the facility's recertification survey of 06/11/21 facility failed to accurately complete the posting on 31 of 31 days reviewed (5/01/21 through 5/31/21). In an interview with the Administrator on 02/23/23 at 12:45 PM, she felt the repeat citation in Posted Nurse Staffing Information was not warranted because she disagreed with the repeat citation.	F 867		