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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/8/23 through 5/11/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FBYF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/8/23 through 5/11/23. Event ID# FBYF11. The following intakes were investigated NC00192040, NC00200757, NC00201300, NC00200991, NC00198842, NC00198947, NC00192844, NC00200501, NC00196264, NC00198682, NC00202086, and NC00202016. 2 of the 19 complaint allegations resulted in deficiencies.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		5/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/06/2023

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 561	Continued From page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and resident interviews the facility failed to establish a frequency of smoking times to meet the residents' choices for 4 of 10 residents (Resident # 38, Resident #10, Resident #34, and Resident # 5) who were identified as smokers. The findings included: During the Group Resident Council meeting held on 5/9/23 at 1:32 PM, the resident group stated they used to have six smoke breaks a day and now they were down to four times a day. The group indicated that if they missed a smoke break due to an appointment, staff would take them out. The group indicated it was a long time to wait overnight for their next cigarette at 10:00 AM and with the weather getting warmer it would be nice to go back to the six smoking times a day. On 5/8/23 the facility provided a list of the active smokers. The form listed Residents #38, #10, #34, and #5 as smokers. The facility also provided the designated smoking times list as 10:00 AM, 2:00 PM, 4:00 PM and 7:30 PM.	F 561	1. ON Wednesday May 17, 2023 a meeting was held with the residents who smoke to determine an additional smoking time between 7:30PM and 10:00AM to meet residents' choice. The residents chose to add an additional smoke time of 9:00PM. 2. Residents who smoke have been identified as having the potential to be affected. 3. A smoking committee meeting will be held quarterly to assure the resident choices are met related to smoking times. 4. The Quality Assurance and Performance Improvement Committee will review the smoking committee minutes quarterly for four quarters to assure compliance is sustained ongoing.	

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1. Resident #38 was admitted to the facility on 9/29/21.

The most recent quarterly Minimum Data Set dated 4/2/23 revealed Resident #38 as cognitively intact. Resident #38 was coded as independent with his activities of daily living and was coded for smoking.

The care plan updated on 4/3/23 for Resident #38 indicated that he required supervision while smoking. The interventions included instruct the resident about smoking risks and hazards and about smoking cessation aids that are available. Instruct resident about the facility policy on smoking: locations, times, safety concerns., Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Observe clothing and skin for signs of cigarette burns. The resident requires SUPERVISION while smoking.

Review of the most recent smoking assessment dated 4/23/23 revealed Resident #38 was assessed as a supervised smoker, due to noncompliance with the smoking policy.

On 5/9/23 at 2:10 PM the smoking attendant stated residents used to have 6 smoke breaks a day and when the new company took over the breaks were decreased.

During an interview with Resident #38 on 5/11/23 at 9:21 AM he stated there used to be 6 smoking times a day, but new management decreased the number to 4 times a day. He said it was a long stretch from 7:30 PM until 10:00 AM and he missed the late-night smoke break.

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In an interview on 5/11/23 at 9:58 AM the Administrator stated that they used to have six smoking times a day with the last smoke break at 9:30 PM. He revealed when the new company took over, he did a resident survey and from those results they combined the smoke breaks down and discontinued the 9:30 PM smoke break. The Administrator stated there were four smoke breaks a day, with the last break at 7:30 PM. He revealed if a resident was out to an appointment and missed their smoking break, staff were available to take the resident out to smoke.

2. Resident #10 was readmitted to the facility on 9/30/21.

The most recent quarterly Minimum Data Set dated 4/11/23 revealed Resident #10 as cognitively intact. Resident # 10 was coded as required limited assistance with bed mobility, transfers, and extensive assistance with dressing. He was coded for smoking.

The care plan dated 4/11/23 for Resident #10 indicated that he required supervision while smoking. The interventions were to Instruct resident about the facility policy on smoking: locations, times, safety concerns. Notify the charge nurse immediately if it is suspected resident has violated facility smoking policy. The resident requires SUPERVISION while smoking. The residents' smoking supplies are stored.

Review of the most recent smoking assessment dated 4/23/23 revealed Resident #10 was assessed as a supervised smoker, due to

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noncompliance with the smoking policy.

On 5/9/23 at 2:10 PM the smoking attendant stated residents used to have 6 smoke breaks a day and when the new company took over the breaks were decreased.

In an interview with Resident #10 on 5/11/23 at 9:34 AM he stated it was a long time from the nighttime to the 10:00 AM smoke break and it would be nice if there were more smoke breaks. Resident #10 indicated there was nothing he could do about the smoking times.

In an interview on 5/11/23 at 9:58 AM the Administrator stated that they used to have six smoking times a day with the last smoke break at 9:30 PM. He revealed when the new company took over, he did a resident survey and from those results they combined the smoke breaks down and discontinued the 9:30 PM smoke break. The Administrator stated there were four smoke breaks a day, with the last break at 7:30 PM. He revealed if a resident was out to an appointment and missed their smoking break, staff were available to take the resident out to smoke.

3.Resident #34 was admitted to the facility on 11/30/21.

The most recent quarterly Minimum Data Set dated 3/16/23 revealed Resident #34 was cognitively intact. Resident #34 required supervision for bed mobility, transfers, limited assistance with dressing and extensive assistance with personal hygiene. He was coded for smoking.

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The care plan updated on 3/16/23 for Resident #34 indicated he needed supervision for smoking. The interventions included instruct the resident about smoking risks and hazards and about smoking cessation aids that are available. Instruct the resident about the facility policy on smoking: locations, times, safety concerns. Notify the charge nurse immediately if it is suspected resident has violated facility smoking policy. Observe clothing and skin for signs of cigarette burns. The resident requires Supervision while smoking.

Review of the smoking assessment dated 11/30/22 and 4/23/23 revealed Resident #34 was assessed as a supervised smoker, due to noncompliance with the smoking policy.

An interview was conducted with Resident #34 on 5/8/23 at 10:47 AM. Resident #34 stated he was a grown man and could not do what he wanted. He stated he could not go out to smoke unless it was the smoking times.

On 5/9/23 at 2:10 PM the smoking attendant stated residents used to have 6 smoke breaks a day and when the new company took over the breaks were decreased.

In an interview on 5/11/23 at 9:58 AM the Administrator stated that they used to have six smoking times a day with the last smoke break at 9:30 PM. He revealed when the new company took over, he did a resident survey and from those results they combined the smoke breaks down and discontinued the 9:30 PM smoke break. The Administrator stated there were four smoke breaks a day, with the last break at 7:30 PM. He revealed if a resident was out to an

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appointment and missed their smoking break, staff were available to take the resident out to smoke.

4. Resident #5 was admitted to the facility on 4/12/19.

The most recent quarterly Minimum Data Set dated 2/16/23 revealed Resident #5 as cognitively intact. Resident #5 was coded as required supervision with bed mobility, transfers, and extensive assistance with dressing. He was coded for smoking.

The care plan dated 2/16/23 for Resident #5 indicated that he required supervision while smoking. The interventions included instruct the resident about smoking risks and hazards and about smoking cessation aids that are available. Instruct the resident about the facility policy on smoking: locations, times, safety concerns. Notify the charge nurse immediately if it is suspected resident has violated facility smoking policy. Observe clothing and skin for signs of cigarette burns.

Review of the smoking assessment dated 2/6/23 revealed Resident #5 was assessed as a supervised smoker, due to noncompliance with the smoking policy.

On 5/9/23 at 2:10 PM the smoking attendant stated residents used to have 6 smoke breaks a day and when the new company took over the breaks were decreased.

On 5/11/23 at 1:08 PM Resident #5 stated he enjoyed smoking and when they decreased the number of smoking times, it left him with nothing

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F 561	Continued From page 7 else to do. He stated fewer smoke breaks made him more agitated. In an interview on 5/11/23 at 9:58 AM the Administrator stated that they used to have six smoking times a day with the last smoke break at 9:30 PM. He revealed when the new company took over, he did a resident survey and from those results they combined the smoke breaks down and discontinued the 9:30 PM smoke break. The Administrator stated there were four smoke breaks a day, with the last break at 7:30 PM. He revealed if a resident was out to an appointment and missed their smoking break, staff were available to take the resident out to smoke.	F 561		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid	F 622		5/19/23

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under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident

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F 622	Continued From page 9 needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interviews, the facility failed to allow two residents that were non-compliant with the facility smoking policy to remain in the facility for 2 of 2 residents reviewed for facility-initiated discharge (Resident #32 and Resident #23). The findings included: 1. Resident #32 was admitted to the facility on 8/05/20 with diagnoses which included anxiety disorder, opioid abuse, and chronic pain.	F 622	1. Resident #32 currently resides in the facility. Resident #23 currently resides in a facility closer to his family. 2. Residents with a facility-initiated discharge have been identified as having the potential to be affected. 3. The Regional Vice President of Clinical Services educated the Nursing Home Administrator and Social Worker on May 15, 2023, on facility-initiated discharges and transfer and discharge requirements for non-compliant residents.	

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A care plan was initiated on 8/10/22 and last revised on 5/02/23 for non-compliance with following the smoking policy. Resident #32 was re-educated on the smoking policy. The interventions included smoking materials will remain in designated areas and not in resident room, resident would be supervised in designated smoking area., and will continue to be monitored for non-compliance.

The Minimum Data Set (MDS) quarterly assessment dated 2/16/23 revealed Resident #32 was cognitively intact and used tobacco. Resident #32 was coded for behaviors directed towards others and other behavioral behavior symptoms.

A behavior note dated 2/18/23 at 2:20 pm revealed Resident #32 was verbally aggressive and used inappropriate language towards staff because he was upset about smoking location. Staff were unable to calm or redirect Resident #32 and he continued to speak loudly and call staff names.

The Nursing Home Notice of Transfer/Discharge dated 3/15/23 revealed Resident #32 was issued a 30-day discharge notice which stated the reasons for transfer/discharge was his needs could not be met in the facility and the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident. The notice was signed by Resident #32 with a date of transfer listed as 4/14/23 to another skilled nursing facility that provided the same services.

A discharge progress note dated 3/31/23 at 3:40

F 622

The Nursing Home Administrator educated the Quality Assurance and Performance Improvement Committee on May 19, 2023, on facility-initiated discharges and transfer and discharge requirements for non-compliant residents. Beginning May 19, 2023, the Nursing Home Administrator added facility-initiated discharges to the Monday – Friday Morning Meeting Agenda with the Interdisciplinary Care Team. The Interdisciplinary Care Team will review and discuss upcoming discharge to validate the discharge is safe and orderly and meets the transfer and discharge requirements, per the federal regulations outlined in F622. Beginning May 15, 2023, then weekly for twelve weeks, the Nursing Home Administrator will discuss and review any facility-initiated discharges with the Regional Vice President of Operations to validate the facility-initiated discharge to ensure the discharge is compliant with the transfer and discharge requirements per the federal regulations outlined in F622.

4. The Quality Assurance and Performance Improvement Committee will review any facility-initiated discharges in the monthly meeting for three months to assure compliance is sustained ongoing.

5. Date: 5/19/2023

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pm by the Social Worker revealed Resident #32 was discharged from the facility at approximately 10:00 am and was transported by facility staff in the facility van.

During an interview on 5/08/23 at 12:40 pm Resident #32 revealed he was non-compliant with the smoking policy at the facility but did not see it to be a problem. He stated he does go out when it is not time to smoke because he wants to smoke, and he stated he had been provided the smoking policy on several occasions.

An interview was conducted on 5/09/23 at 11:30 am with the Social Worker who revealed she was present when the 30-day Discharge Notice was delivered to Resident #32, and he did not have any questions at the time the notice was presented.

During an interview on 5/10/23 at 2:22 pm the previous Director of Nursing (DON) revealed she worked at the facility when Resident #32 was presented the 30-day discharge notice. The previous DON stated Resident #32 was non-compliant with the smoking policy during the time she worked at the facility by going out during non-smoking times and not properly storing smoking materials.

An interview was conducted with the Administrator on 5/10/23 at 2:50 pm who revealed Resident #32 had multiple violations of the facility smoking policy and he had spoken with Resident #32 on multiple occasions to re-educate on the policy and discuss his non-compliance. He stated Resident #32 had put all the residents of the facility at risk due to his non-compliance and he felt the 30-day Discharge Notice was

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appropriate due to those concerns. He stated Resident #32 had the opportunity to ask questions and request an appeal, but he chose to discharge.

2. Resident #23 was admitted to the facility on 2/22/21 with diagnoses which included diabetes, anxiety, and depression. Resident #23 was discharged to another facility on 4/27/23.

A progress note dated 8/31/22 revealed Resident #23 was a smoker and was not compliant with the facility smoking policy at times.

The care conference note dated 12/8/22 revealed Resident #23 was noted to require encouragement to allow personal hygiene. No other concerns were documented during care plan meeting regarding behaviors.

A social service progress note dated 3/3/23 revealed Resident #23 was pleasant in his conversations with both staff and other residents and had behaviors such as refusing personal care, urinating on floor, and the smoking policy.

The quarterly Minimum Data Set (MDS) dated 3/4/23 revealed Resident #23 was cognitively intact, used tobacco, and was not coded for any behaviors during the 7-day look back period.

The Nursing Home Notice of Transfer/Discharge dated 3/22/23 revealed Resident #23 was issued a 30-day discharge notice which stated the reasons for transfer/discharge was his needs could not be met at the facility and the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident. The notice was signed by Resident #23 with a

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date of transfer listed as 4/21/23 to another skilled nursing facility which provided the same services.

The Discharge Progress note dated 3/31/23 at 3:35 pm by the Social Worker revealed Resident #23 was discharged from the facility. The Social Worker reported Resident #23 was appreciative of the care and was excited to be closer to family and friends.

Multiple attempts to interview Resident #23 at his new facility were unsuccessful.

During an interview with the Social Worker on 5/09/23 at 11:30 am she revealed was present when the Administrator delivered the 30-day Discharge Notice to Resident #23. The Social Worker stated Resident #23 had requested to be transferred to be closer to his family and friends since his admission and she had sent multiple referrals to facilities in the area he wished to be transferred to but had not been able secure a location for his transfer due to his payor source, need for bariatric equipment, and his documented behaviors which included non-compliance with smoking and personal hygiene concerns. She stated when a bed became available at the receiving facility Resident #23 was asked if he wanted to transfer there and he stated he would like to transfer to the receiving facility.

An interview was conducted on 5/10/23 at 2:22 pm with the previous Director of Nursing (DON) who revealed she worked at the facility at the time of Resident #23's discharge but was not involved with the 30-day Discharge Notice being issued and was not present when Resident #23 was notified a bed was available at the receiving

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F 622	Continued From page 14 facility. The previous DON stated Resident #23 was non-compliant with the smoking policy and had behaviors which included refusal of care and refusal of personal hygiene. During an interview on 5/10/23 at 2:44 pm the Administrator revealed Resident #23 had continued to violate the facility's smoking policy and endangered the rest of the residents in the facility by his non-compliance. The Administrator stated he felt the 30-Day Discharge Notice was presented in accordance with the regulation when it was presented to Resident #23. The Administrator stated Resident #23 wished to be discharged from the facility to a location closer to his home and agreed with the discharge, so he felt the 30-day discharge notice was no longer valid for Resident #23 because he wanted to discharge.	F 622		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interviews, Physician interview, Wound Physician interview, Ombudsman, and receiving facility's Administrator (Administrator #2) and Admission Director (Admission Director #2) interviews, the facility failed to provide a safe and orderly	F 624	1. Resident #32 currently resides in the facility. Resident #23 currently resides in a facility closer to his family. 2. Residents who plan to discharge from the facility have been identified as having the potential to be affected.	5/19/23

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discharge when the facility staff left Resident #32 and Resident #23 at the receiving facility after being informed the residents were not accepted for admission for 2 of 2 residents reviewed for facility-initiated discharge (Resident #32 and Resident #23).
The findings included:

1. Resident #32 was admitted to the facility on 8/05/20.

The Minimum Data Set (MDS) quarterly assessment dated 1/26/23 revealed Resident #32 was cognitively intact and had a colostomy and indwelling catheter. Resident #32 was coded for tobacco use and had an unstageable sacral pressure ulcer.

Resident #32's care plan last revised on 3/15/23 revealed he had a care plan for attention seeking behaviors, falsely accusing other residents and staff of threatening him, and being verbally and physically aggressive towards staff. An additional care plan was in place for resistance to care which included refusal to wear colostomy bags and refusal of pressure ulcer treatments.

The Nursing Home Notice of Transfer/Discharge dated 3/15/23 revealed Resident #32 was issued a 30-day discharge notice with date of transfer listed as 4/14/23. The notice was signed by Resident #32.

A physician order dated 3/16/23 for oxycodone oral table 30 milligrams (mg). Give 1 tablet by mouth four times a day for pain.

Review of the email from the receiving facility dated 3/22/23 revealed Resident #32 was

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3. The Regional Vice President of Clinical Services educated the Nursing Home Administrator and Social Worker on May 15,2023 on planned discharges, safe and orderly discharge, and transfer and discharge requirements for non-compliant residents. The Nursing Home Administrator educated the Interdisciplinary Care Team and the Quality Assurance and Performance Improvement Committee on May 19, 2023, on planned discharges, safe and orderly discharge, and transfer and discharge requirements for non-compliant residents. Beginning May 19, 2023, the Nursing Home Administrator added facility-initiated discharges to the Monday – Friday Morning Meeting Agenda with the Interdisciplinary Care Team. The Interdisciplinary Care Team will review and discuss upcoming discharge to validate the discharge is safe and orderly and meets the transfer and discharge requirements, per the federal regulations outlined in F624. Beginning May 15, 2023, then weekly for twelve weeks, the Nursing Home Administrator will discuss and review any facility-initiated discharges with the regional Vice President of Operations to validate the facility-initiated discharges are safe and orderly to ensure the discharge is compliant with the transfer and discharge requirements per the federal regulations outlined in F624.
4. The Quality Assurance and Performance Improvement Committee will review any facility-initiated discharges, to validate the discharge is safe and orderly, in the monthly meeting for three months to

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F 624	Continued From page 16 accepted for admission. An interview was conducted on 5/09/23 at 11:30 am with the Social Worker who revealed she sent Resident #32's referral packet to the receiving facility and she had received an email on 3/22/23 that Resident #32 was accepted for admission. The Social Worker stated she sent all required information in the referral which included Resident #32's smoking status. She stated Admission Director #2, the receiving facility's Admission Director, stated he would be able to go off campus to smoke. The Social Worker stated Resident #32 was notified on 3/30/23 that he was accepted at the receiving facility, and he agreed to be transferred to the receiving facility on 3/31/23. A discharge progress note dated 3/31/23 at 3:40 pm by the Social Worker revealed Resident #32 was discharged from the facility at approximately 10:00 am and was transported by facility staff in the facility van with his belongings and medications. During a telephone interview on 5/10/23 at 5:47 pm with Nurse #1 who discharged Resident #32 from the facility on 3/31/23 and he had no concerns before leaving. Nurse #1 stated she called the receiving facility and gave the nurse a report and they did not state Resident #32 was not being accepted for admission. During an interview on 5/09/23 at 3:45 pm the Wound Nurse revealed she accompanied Resident #32 during the transfer to the receiving facility on 3/31/23. She stated Resident #32's personal items were taken by Administrator #1 and Admission Director #1, in a private car that	F 624	assure compliance is sustained ongoing. 5. Date: 5/19/2023	

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followed the facility van. She stated when they arrived at the receiving facility Resident #32 was taken into the facility and she completed nurse to nurse report and gave Resident #32's medications to the nurse at the facility. The Wound Nurse stated Administrator #1 and Admission Director #1 left the receiving facility after Resident #32's personal items were taken to his room. The Wound Nurse stated as she prepared to leave after giving report when the receiving facility's Administrator, Administrator #2, stated they needed to take Resident #32 back because she was no longer accepting him. The Wound Nurse stated she called Administrator #1 and was instructed that she was able to leave the receiving facility without Resident #32 because the facility had accepted him as a resident, so they left the facility without Resident #32. The Wound Nurse stated they were about halfway back to their facility when they received the call from Administrator #1 that they needed to return to bring Resident #32 back from the receiving facility. She stated the drive to the receiving facility was about 5 hours and she stated when she received the call they turned around and went back to pick up Resident #32. The Wound Nurse reported Resident #32 laid on the back seat and slept most of the way back from the receiving facility and woke one time to ask how much longer but never reported pain or discomfort during either transfer.

An interview was conducted on 5/09/23 at 3:38 pm with the Transportation Aide who revealed she drove Resident #32 to the receiving facility on 3/31/23. She stated when they arrived at the receiving facility, a wheelchair was brought out for Resident #32, and he went into the facility. She stated his belongings were placed in the room

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F 624	Continued From page 18 that was assigned to him. The Transportation Aide reported that as she was leaving, the receiving facility's Administrator, Administrator #2, told her and the Wound Nurse that the facility had changed their mind and would no longer be able to admit Resident #32 and that they needed to take him back. She stated they did stop one time on the drive to the receiving facility for a bathroom break and to purchase a drink for Resident #32. The Transportation Aide stated when they returned to pick up Resident #32, he had a pizza and a drink that was given to him by the receiving facility. She stated during the ride to and from the receiving facility Resident #32 did not report pain, a need for additional stop, and she stated he slept most of the time back to the facility. Admission Director #1 reported during an interview on 5/09/23 at 4:35 pm that she drove with Administrator #1 to the receiving facility with Resident #32's personal items because they were unable to fit in the facility van. Admission Director #1 stated when she left the receiving facility Resident #32 was inside the facility and his belongings were in his assigned room. She stated Administrator #2, the receiving facility Administrator, did not notify her before she left that Resident #32 was not accepted at the facility, but she did contact her Administrator, Administrator #1, on the phone after they left. An interview was conducted on 5/09/23 at 11:30 am with the Social Worker who stated she was not notified that Resident #32 was no longer accepted at the receiving facility. A nursing progress note dated 3/31/23 at 11:39 pm by Nurse #2 revealed Resident #32 was	F 624		

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received back at the facility via facility transportation and returned to his previous room. Resident #32 reported pain and was administered his pain medication.

Multiple attempts to interview Nurse #2 were unsuccessful.

Record review of the Medication Administration Record dated April 2023 revealed Resident #32 was administered oxycodone 30 mg for pain at midnight on 4/01/23 for reported pain level of 5 out of 10.

During an interview on 5/08/23 at 12:47 pm Resident #32 reported he was notified by the Social Worker and Administrator #1 on 3/30/31 that he was accepted at the receiving facility, and he would be discharging on 3/31/23. He stated when he arrived at the facility, he was told by the receiving facility's Administrator, Administrator #2, that he was not accepted for admission, and he would need to return to the facility he came from. He stated the receiving facility did not allow him to enter the building and made him stay outside with his belongings, they did not administer any medications, they did not provide any meals during the time at facility and did not allow him to use the bathroom to empty his colostomy bag or catheter bag. Resident #32 stated he was independent for his care needs and was able to transfer without help so he did not need anyone to do anything for him. Resident #32 stated he was in pain when he returned and was not given medication for his pain until the morning of 4/01/23.

During a follow-up interview on 5/09/23 at 3:05 pm Resident #32 revealed he agreed to go to the

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receiving facility after he spoke to Admission Director #2 (from the receiving facility) and she confirmed he would be able to smoke. He stated he now recalled that at some point during his time at the receiving facility they allowed him to enter the building for about 30 minutes to use the bathroom but did not allow him to stay in the building. Resident #32 reported that he now recalled the receiving facility had given him a pizza and a drink during his time there but did not administer any medications.

During a telephone interview on 5/09/23 at 8:41 am the State Ombudsman revealed Resident #32 reported he was discharged from the facility on 3/31/23 to another facility. He stated when he arrived, he was notified that he was not accepted for admission by the Receiving Facility Administrator. She stated Resident #32 reported he was not given food, drink, did not have the opportunity to use the bathroom while he was enroute to and while at the receiving facility, and had to wait 12 hours to return to the facility.

A telephone interview was conducted on 5/09/23 at 1:20 pm with Admission Director #2 from the receiving facility who revealed she had received the admission referral for Resident #32, and he was accepted to the facility with expected admission date of 3/31/23. She stated Resident #32 had contacted her on the day before expected admission (3/30/23) to confirm he would be able to smoke at the facility and she notified Resident #32 that the facility was non-smoking, but he was able to sign himself out and smoke off the property. Admission Director #2 stated she felt she did not receive all the information about Resident #32 but was unable to state what information she felt was omitted. She

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stated she was not at the facility on the date of transfer (3/31/23) and was unable to state why Administrator #2 denied admission.

An interview was conducted on 5/10/23 at 11:07 am with the Medical Director who revealed Resident #32 sitting in a van seat for transport was not a concern due to his ability to normally spend the day sitting in his wheelchair or laying on his sacrum. He stated Resident #32 was non-complaint with offloading of his pressure ulcer and would not let staff complete his pressure ulcer treatments often. The Medical Director stated Resident #32's missed doses of medication while he was at the receiving facility caused no negative outcome as Resident #32 was able to take his next dose of medication when he returned to the facility. He stated Resident #32's pain reported when he returned to the facility was normal for him because he continuously reported pain. The Medical Director reported Resident #32 was administered his scheduled pain medication when he returned to the facility.

During a telephone interview on 5/10/23 at 11:39 am the Wound Physician stated Resident #32 was able to reposition independently and would be able to offload while sitting. The Wound Physician stated Resident #32 was noncompliant with his sacral pressure ulcer which include not allowing a dressing to be applied and history of picking at his sacral pressure ulcer so she was unable to state if sitting in a vehicle for the drive to and from the facility would have caused damage to the pressure ulcer.

A telephone interview was conducted on 5/11/23 at 9:33 am with Administrator #2, the receiving

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F 624	Continued From page 22 facility's Administrator, revealed she did not feel comfortable accepting Resident #32 because he was a smoker and did not have an intention to stop smoking. She stated her facility was a non-smoking facility and she did not feel it was safe for him to cross the street in his wheelchair to smoke. She reported she notified the Transportation Aide and the Wound Nurse but Resident #32 was left at the facility. Administrator #2 stated she contacted Administrator #1 on the phone, and he stated he would send the Wound Nurse and Transportation Aide back to pick up Resident #32. Administrator #2 stated Resident #32 was allowed to enter the facility and she provided food, drinks, and use of bathroom but the facility did not administer any medication due to Resident #32 not being accepted for admission. She stated Resident #32 remained in the facility until the Wound Nurse and Transportation Aide returned. Administrator #2 stated the Wound Nurse and the Transportation Aide did come back and pick up Resident #32, but she felt they should not have left him when they were notified that he was no longer accepted for admission. An interview was conducted with Administrator #1 on 5/11/23 at 2:50 pm who revealed he drove along with Admission Director #1 to deliver Resident #32's belongings to the receiving facility on 3/31/23. He stated he was in contact with Administrator #2 at the receiving facility throughout the five-hour drive to provide updates on travel time since it was a far distance away. He stated at no time during the drive or while he was at the facility did Administrator #2 tell him she had changed her mind and would no longer accept Resident #32 at her facility. Administrator #1 stated he received a phone call from the	F 624		

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Wound Nurse that drove Resident #32 to the receiving facility, and he did tell them it was okay to leave Resident #32 because they had accepted him, and his belongings were in the facility. He stated he then spoke to Administrator #2 by phone who stated Resident #32 needed to be picked back up because they were not able to care for him and she stated she did not know he was a smoker. She stated she did not feel comfortable accepting Resident #32.
Administrator #1 stated he contacted the Wound Nurse and notified them they needed to return and bring Resident #32 back to the facility.
Administrator #1 stated the facility managed the discharge of Resident #32 properly by sending the required information during the referral process, transporting Resident #32 and his belongings including medications, and giving report to receiving nurse at the facility.
Administrator #1 stated the receiving facility was notified of the smoking background during the referral process and they accepted him with that knowledge, so he was unable to state why the receiving facility changed their mind once Resident #32 arrived for admission.
Administrator #1 stated the facility managed the discharge of Resident #32 properly by sending the required information during the referral process, transporting Resident #32 and his belongings including medications, and giving report to receiving nurse at the facility.
Administrator #1 stated the receiving facility was notified of the smoking background during the referral process and they accepted him with that knowledge, so he was unable to state why the receiving facility changed their mind once Resident #32 arrived for admission.

2. Resident #23 was admitted to the facility on

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2/22/21. Resident #23 was discharged to another facility on 4/27/23.

The quarterly Minimum Data Set (MDS) dated 3/4/23 revealed Resident #23 was cognitively intact and used tobacco.

The Nursing Home Notice of Transfer/Discharge dated 3/22/23 revealed Resident #23 was issued a 30-day discharge notice with date of transfer listed as 4/21/23. The notice was signed by Resident #23.

An interview was conducted on 5/09/23 at 11:30 am with the Social Worker who revealed she sent Resident #23's referral packet to the receiving facility and she had received an email on 3/22/23 that Resident #23 was accepted for admission. The Social Worker stated she sent all required information in the referral which included Resident #23's smoking status. She stated Admission Director #2, the receiving facility's Admission Director, stated they would be able to go off campus to smoke. The Social Worker stated Resident #23 had requested to be transferred to be closer to his family and friends since his admission and she had sent multiple referrals to facilities in the area he wished to be transferred to but had not been able secure a location for his transfer. She stated when a bed became available at the receiving facility Resident #23 was asked if he wanted to transfer there and he stated he would like to transfer to the receiving facility. The Social Worker stated Resident #23 did not have many visitors while at the facility, so he was excited to be closer to his friends and family members.

A discharge planning note dated 3/30/23 at 5:21

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pm by the Social Worker revealed Resident #23 was accepted for admission at the receiving facility on 3/22/23 and transportation would be provided by the facility with a discharge date planned on 3/31/23.

A nursing note dated 3/31/23 at 2:48 pm by Nurse #1 revealed nursing report was called to the receiving facility nurse.

During a telephone interview on 5/10/23 at 5:47 pm with Nurse #1 who discharged Resident #23 from the facility on 3/31/23 stated she called the receiving facility and gave the nurse a report and they did not state Resident #23 was not being accepted for admission.

A discharge progress note dated 3/31/23 at 3:35 pm by the Social Worker revealed Resident #23 was discharged from the facility and was transported by facility van. Resident #23 left the facility with his belongings.

During an interview on 5/09/23 at 3:45 pm the Wound Nurse revealed she accompanied Resident #23 during the transfer to the receiving facility on 3/31/23. She stated Resident #23's personal items were taken by the Administrator, Administrator #1, and Admission Director, Admission Director #1, in a private car that followed the facility van. She stated when they arrived at the receiving facility Resident #23 was taken into the facility and she completed nurse to nurse report and gave Resident #23's medications to the nurse at the facility. The Wound Nurse stated Administrator #1 and Admission Director #1 left the receiving facility after Resident #32's personal items were taken to his room. The Wound Nurse stated as she

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prepared to leave the facility the receiving facility's Administrator, Administrator #2, stated they needed to take Resident #23 back because she was no longer accepting him. The Wound Nurse stated she called Administrator #1 and was instructed that she was able to leave the receiving facility without Resident #23 because the facility had accepted him as a resident, so they left the facility without Resident #23. She stated the ride to the receiving facility was about 5 hours with the stop to use the bathroom and they were about halfway back to their facility when she received the call from her Administrator, Administrator #1, to go back and pick up Resident #23. The Wound Nurse reported Resident #23 did not report pain during the time back to the facility.

An interview was conducted on 5/09/23 at 3:38 pm with the Transportation Aide who revealed she drove Resident #23 to the receiving facility, which took about 5 hours one way, on 3/31/23 with the Wound Nurse. She stated when they arrived at the receiving facility, she took Resident #23 into the facility in his wheelchair and assisted him to use the restroom. She stated his belongings were placed in the room that was assigned to him. The Transportation Aide reported that as she was leaving Administrator #2, the receiving facility's Administrator, told her and the Wound Nurse that the facility had changed their mind and would no longer be able to admit Resident #23 and that they needed to take him back. She stated they did stop one time on the drive to the receiving facility to use the restroom for Resident #23. The Transportation Aide stated when they returned to pick up Resident #23, he had a pizza and a drink that was given to him by the receiving facility. She stated during the ride to and from the receiving

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facility Resident #23 did not report pain or a need for an additional stop.

Admission Director #1 reported during an interview on 5/09/23 at 4:35 pm that she drove with Administrator #1 to the receiving facility with Resident #23's personal items because they were unable to fit in the facility van. Admission Director #1 stated when she left the receiving facility Resident #23 was inside the facility and his belongings were in his assigned room. She stated Administrator #2, the receiving facility Administrator, did not notify her before she left that Resident #23 was not accepted at the facility, but she did contact her Administrator, Administrator #1, on the phone after they left.

An interview was conducted on 5/09/23 at 11:30 am with the Social Worker who revealed she was not notified that Resident #23 was no longer accepted at the receiving facility.

A nursing progress note dated 3/31/23 at 11:21 pm by Nurse #2 revealed Resident #23 returned to the facility via facility transport and was admitted to his previous room. Resident #23 reported pain and was administered medication.

Multiple attempts to interview Resident #23 (no longer a resident at this facility) by phone were unsuccessful.

During a telephone interview on 5/09/23 at 8:41 am the State Ombudsman revealed Resident #23 reported he was discharged from the facility on 3/31/23 to another facility. He stated when he arrived the facility declined to admit him. She stated Resident #23 reported he was not given lunch or dinner and he did not have his blood

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sugar checked or scheduled insulin. Resident #23 did not report any negative outcome.

A telephone interview was conducted on 5/09/23 at 1:20 pm with Admission Director #2 from the receiving facility who revealed she had received the admission referral for Resident #23, and he was accepted to the facility with expected admission date of 3/31/23. She stated she knew Resident #23 was a smoker. Admission Director #2 stated she felt she did not receive all the information about Resident #23 in their referral but was unable to state what information she felt was omitted. She stated she was not at the facility on the date of transfer (3/31/23) and was unable to state why Administrator #2 denied admission to Resident #23.

During an interview on 5/10/23 at 11:07 am the Medical Director revealed Resident #23 did not have any negative effect from missing his prescribed medication times and being in the vehicle for an extended period on 3/31/23. The Medical Director stated Resident #23 was able to take his evening medications when he returned to the facility and did not have any negative outcome due to the missed doses while he was at the receiving facility.

A telephone interview was conducted on 5/11/23 at 9:33 am with Administrator #2, the receiving facility Administrator, who revealed she did not feel comfortable accepting Resident #23 because he was a smoker and did not have an intention to stop smoking. She stated her facility was a non-smoking facility and she did not feel it was safe for him to cross the street in his wheelchair to smoke. She reported she notified the Transportation Aide and the Wound Nurse but

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Resident #23 was left at the facility. Administrator #2 stated she contacted Administrator #1 on the phone, and he stated he would send the Wound Nurse and Transportation Aide back to pick up Resident #23. Administrator #2 stated Resident #23 was allowed to enter the facility and she provided food, drinks, and use of bathroom but the facility did not administer any medication or check his blood sugar due to Resident #23 not being accepted for admission. She stated Resident #32 remained in the facility until the Wound Nurse and Transportation Aide returned. Administrator #2 stated the Transportation Aide and Wound Nurse should not have left Resident #23 when they were notified that he was no longer accepted for admission.

An interview was conducted with Administrator #1 on 5/11/23 at 2:50 pm who revealed he drove along with the Admission Director #1 to deliver Resident #23's belongings to the receiving facility on 3/31/23. He stated he was in contact with Administrator #2 at the receiving facility throughout the five-hour drive to provide updates on travel time since it was a far distance away. He stated at no time during the five-hour drive or while he was at the facility did Administrator #2 tell him she had changed her mind and would no longer accept Resident #23 at her facility. Administrator #1 stated he received a phone call from the Wound Nurse who drove Resident #23 to the receiving facility, and he did tell them it was okay to leave Resident #23 because they had accepted him, and his belongings were in the facility. He stated he then spoke to Administrator #2 by phone who stated Resident #23 needed to be picked back up because they were not able to care for him and she stated she did not know he was a smoker. She stated she did not feel

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F 624	Continued From page 30 comfortable accepting him. Administrator #1 stated he contacted the Wound Nurse and the Transportation Aide and notified them they needed to return and bring Resident #23 back to the facility. Administrator #1 stated the facility managed the discharge of Resident #23 properly by sending the required information during the referral process, transporting Resident #23 and his belongings including medications, and giving report to receiving nurse at the facility. Administrator #1 stated the receiving facility was notified of the smoking background during the referral process and they accepted him with that knowledge, so he was unable to state why the receiving facility changed their mind once Resident #23 arrived for admission.	F 624		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		5/19/23

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F 656	Continued From page 31 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to implement an individualized person-centered care plan for a resident with a diagnosis of Alzheimer's Disease and usage of a hypnotic medication for 1 of 2 residents reviewed for Dementia Care (Resident #4). The findings included: Resident #4 was admitted to the facility on 6/15/18. Resident #4 had diagnoses which included Alzheimer's Disease and insomnia.	F 656	1. Resident #4 plan of care was updated related to the diagnosis of Alzheimer's Disease and hypnotic medication prescribed by the attending physician to treat Resident #4 insomnia. 2. Residents with diagnosis of Alzheimer's Disease and residents who are prescribed hypnotic therapy have been identified as having the potential to be affected. 3. The Minimum Data Set Coordinator and Interdisciplinary Care Team were	

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A physician order dated 1/04/23 for Zolpidem Tartrate (Ambien) 5 milligram (mg) tablet at bedtime for insomnia.

The Minimum Data Set (MDS) quarterly assessment dated 1/31/23 revealed Resident #4 was coded for Alzheimer's Disease and use of a hypnotic medication.

The care plan last reviewed on 3/23/23 revealed no care plan for Alzheimer's/Dementia care or diagnosis and no care plan for the use of a hypnotic medication.

During an interview on 5/10/23 at 4:16 pm with the previous Director of Nursing (DON) revealed she would at times update or enter a care plan, but the MDS Nurse was responsible to ensure Resident #4's care plan was accurate. She stated the care plan was reviewed every three months and with a significant change but was unable to state how the care plan for Alzheimer's Disease and the use of a hypnotic medication was missed for Resident #4.

A telephone interview was conducted on 5/11/23 at 9:30 am with the MDS Nurse who revealed she had assisted the facility with MDS assessments remotely and would add care plan updates when she could. The MDS Nurse stated a care plan was required for Resident #4's diagnosis of Alzheimer's Disease and his use of a hypnotic medication. The MDS Nurse stated she did not participate in the clinical meetings at the facility, so she was unable to state how the care plan for Resident #4's Alzheimer's Disease and Ambien was missed during clinical reviews.

F 656

educated by the Nursing Home Administrator on May 18, 2023, on care planning diagnosis and medications. The Director of Nursing will audit two care plans per week for twelve weeks to validate diagnosis and medications are care planned accordingly. If there are any improvement opportunities noted from the audits, the Director of Nursing will provide one-to-one education for the Interdisciplinary Care Team Member and the plan of care will be updated at that time.

4. The Director of Nursing will report the audits to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits in the monthly meeting for three months to assure compliance is sustained ongoing.
5. Date: 5/19/2023

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F 656	Continued From page 33 An interview was conducted on 5/11/23 at 2:32 pm with the Administrator who revealed the MDS Nurse was required to update Resident #4's care plan as needed. He stated reviews were done in the clinical meetings, but he was unable to determine why the care plans for Resident #4 did not reflect his Alzheimer's Disease and use of a hypnotic medication.	F 656		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain food service equipment clean without a debris build up on 1 of 1 convection ovens observed for cleanliness, and failed to maintain 9 of 9 sheet pans and 2 of 2 sauce pans free of dried food debris. This	F 812	1. The convection oven was cleaned on the afternoon of May 11, 2023, due to observation of grease buildup and cleaned for charred debris on the bottom. All sheet pans that were noted for buildup were discarded and new ones were	5/19/23

F 812

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practice has the potential for cross contamination of food served to residents. This was evident in 2 of 2 kitchen observations.
The Findings included:

During the initial kitchen tour conducted on 5/8/23 at 10:29 AM, the convection oven was observed to have a buildup of grease inside the oven doors, both the right and left sides, and the bottom of the convection oven was observed with a buildup of black charred food debris. Located on the drying rack, 5 of 5 sheet pans were observed stacked ready for use with a buildup of dark dried food debris ¼ inch under the rim. Two sauce pans stored on the drying rack were observed with a buildup of grease that coated the outside of the sauce pans.

A second observation of the kitchen on 5/11/23 at 10:40 AM, revealed 9 of 9 sheet pans were observed stacked ready for use with a buildup of dark dried food debris ¼ inch under the rim. Two sauce pans were observed stored on the drying rack with a buildup of grease that coated the outside of the sauce pans. The convection oven was observed to be in the same condition.

Review of the Daily Cleaning Schedule for May 2023 documented the convection oven was last cleaned on 5/7/23.

An interview was conducted with the Dietary Manager (DM) on 5/11/23 at 10:43 AM, she stated they deep clean the kitchen on Fridays and usually deep cleaned the convection oven every two weeks.

In an interview on 5/11/23 at 11:50 AM the Administrator stated staff should clean the sheet

F 812

ordered by Dietary Manager on May 11, 2023 and arrived to the facility already. Also, the two saucepans that were noted for buildup were discarded on May 11, 2023, and new ones were ordered by Dietary Manager on May 11, 2023 and have already arrived to the facility.
2. Residents who eat food prepared in the kitchen have been identified as having the potential to be affected.
3. The Nursing Home Administrator educated the dietary employees on May 12, 2023, on maintaining clean food service equipment and storing, preparing, and distributing food in accordance with professional standards for food service safety as well as notifying the Nursing Home Administrator when equipment needs to be discarded and replaced. Beginning 5/19/23, weekly for twelve weeks, the Dietary Manager will observe food service equipment for cleanliness. Any concerns noted during the observational audits will be corrected and addressed at that time. The Dietary Manager will provide education to the Dietary Staff ongoing as needed. The Dietary Manager will present the observational audits to the Quality Assurance and Performance Improvement (QAPI) Committee for review.
4. As part of the facility's continuous Quality Assessment and Performance Improvement, the Nursing Home Administrator will perform weekly rounds in the kitchen to validate the dietary department is maintaining clean food service equipment and storing, preparing,

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F 812	Continued From page 35 pans or discard the items if they would not come clean.	F 812	and distributing food in accordance with professional standards for food service safety. The Administrator will be responsible for completing audits during dietary rounds on a weekly basis for twelve weeks, beginning 5/12/23. If there are any new findings this will be corrected and brought to the attention of the Dietary Manager and will be addressed during QAPI as well. The Nursing Home Administrator will validate any identified areas are addressed and corrected during monthly QAPI meetings for a minimum of three months, or longer if recommended by the QAPI Committee.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but	F 867		5/19/23

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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 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

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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 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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING ______ B. WING ______	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AND REHABILITATION	38 CARTERS ROAD GATESVILLE, NC 27938

(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

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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 review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place following the 1/29/21 complaint investigation and the 3/17/22 complaint and recertification survey. This was for a recited deficiency on the current complaint and recertification survey of 5/11/23 in care plan development and implementation (F656). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.

The findings included:

This tag is cross referenced to:

F656 Based on record review and staff interviews the facility failed to implement an individualized person-centered care plan for a resident with a diagnosis of Alzheimer's Disease and usage of a hypnotic medication for 1 of 2 residents reviewed for Dementia Care (Resident #4).

During the complaint investigation survey of

F 867

1. August Healthcare Vice President, Regional Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC).
2. Residents residing in the facility have the potential to be affected.
3. On 5/15/23 the Regional Vice President of Clinical Services provided education and training to the Facility Administrator regarding the Quality Assessment Performance Improvement (QAPI) process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 5/15/23, under the direction and supervision of the Regional Vice President of Clinical Services, the Administrator providing education and training to the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator (MDSC), Maintenance Director, Staff

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1/29/21 the facility was cited for failing to develop a resident centered care plan for a resident with an indwelling urinary catheter.

During the complaint and recertification survey on 3/17/22 the facility was cited for failure to develop a comprehensive care plan for a resident with an indwelling urinary catheter.

An interview was completed on 5/11/23 at 2:48 pm with the Administrator. The Administrator reported the QAA committee meets monthly to discuss the facility's ongoing performance improvement plans. The Administrator revealed there were no ongoing performance improvement plans regarding care plan development and implementation. He stated the facility had multiple staff members trying to assist with care plan development and implementation and that it led to deficient practice. The Administrator stated it was the responsibility of the QAA to identify deficient practice and create performance improvement plans to correct the deficient practice.

Development and Social Service Director on the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put into place after deficient practice has been alleged and cited.
4. The QAPI Committee will meet weekly for four weeks starting 5/19/23, then monthly until substantial compliance is obtained, to monitor the implementation of the plan of correction, including the education component and the ongoing audits, to evaluate the effectiveness of the plan of correction and if necessary, provide additional education and request additional audits/reports. An Ad Hoc QAPI meeting was held on 5/30/23, to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab Services Director, Admissions Director, and Regional Vice President of Clinical Services. The Administrator is responsible for ensuring this plan of correction is implemented.