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BLUMENTHAL NURSING & REHABILITATION CENTER	**3724 WIRELESS DRIVE GREENSBORO, NC 27455**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/21/2023 through 5/25/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #8WL511.	E 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		6/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 06/19/2023

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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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, staff and resident interviews, the facility failed to promote dignity when, 1) a staff member transported a resident (Resident #84) into a public area with the back of their gown open, exposing the backside of the resident and 2) by not shaving a female resident's face (Resident #49) that was dependent on staff for activities of daily living (ADL) care needs. This occurred for 2 of 17 residents reviewed for Dignity and respect.

The findings included:

1) Resident #84 was admitted to the facility on 10/31/2022 with diagnoses that included congestive heart failure, atrial fibrillation, and a lack of coordination.

A review of the quarterly Minimum Data Set assessment dated 5/4/2023 revealed the Resident had no cognitive impairment and required extensive assistance of one staff member with dressing, personal hygiene, and dressing.

A review of Resident #84's care plan for 5/4/2023 had a focused area for activities of daily living

F 550

F550 Resident Rights/Exercise Rights

1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

A) Administrator conducted an interview with Resident #84 to ensure she developed no psychosocial issues due to the event of 5/22/23. She stated that " it was not an issue at the time and believes that it was an unintentional mistake. "

B)NA # 6 was educated on the importance of maintaining dignity at all times for residents when transporting them to and from the designated shower rooms. Education was completed on 5/22/23.

Resident #49 was provided ADL care by her assisted certified Nursing assistant (CNA), this included removal of facial hair on 5/26/23

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F 550	Continued From page 2 care needs that included assisting the Resident with dressing. An observation was conducted on 5/22/2023 at 10:54 a.m. as NA #6 was pushing a shower wheelchair in a hall at the facility. Resident #84 was seated in the wheelchair with a facility gown open in the back and no bath blanket or covering provided. The Resident's backside was open to the air and exposed. Staff and visitors were present in the hallways. An interview was conducted with NA #6 on 5/22/2023 at 10:54 a.m. and she revealed it was standard procedure at the facility to provide a covering to a resident. An interview was conducted with Resident #84 on 5/22/2023 at 1:42 p.m. and she stated if she had been provided an option to cover her backside with a blanket, she would have requested a blanket. She added, when she goes to the rehabilitation room for exercise, she wears a second gown backwards, like a bath robe, to cover up. An interview was conducted with the Director of Nursing (DON) on 5/22/2023 at 3:25 p.m. and she revealed NA #6 retrieved a blanket when it was brought to her attention, by the Surveyor, that the Resident was exposed on the backside. The DON added she provided education to the NA to ensure a resident was provided privacy. 2) Resident #49 was admitted on 5/10/21 with diagnoses that included atrial fibrillation, chronic kidney disease, bradycardia, and cognitive communication deficit.	F 550	2. How the facility will identify other residents having the potential to be affected by the same deficient practice. An observation round was completed on 6/13/23 by the administrative team (includes medical records, social worker, MDS nurses, business office manager, assistant business office manager, admissions, central supply person and activities director) to ensure that all residents were properly groomed, and no other resident had any excessive or unwanted facial hair. Any residents found to have any excess or unwanted facial hair were provided immediate ADL care including the removal of excessive or unwanted facial hair, by their assigned certified nursing assistant (CNA). 3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Ambassador round sheets (rounds conducted by a member of the administrative team) were modified by the administrator on 5/26/23 to identify any residents who need to be shaved and whether any residents were observed openly exposed during their observations. Staff development Coordinator educated all certified nursing assistants on F550 and its content with emphasis on ensuring that dignity is maintained for all residents when providing activities of daily living (adl) care. This includes ensuring that	

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Review of Resident #49's annual Minimum Data Set dated 07/29/2022 showed that she was cognitively impaired and required one-person physical assistance with personal hygiene.

Review of Resident #49's care plan dated 5/19/23 revealed she required assistance with grooming with interventions that included assisting Resident #49 with activities of daily living as needed.

An observation on 05/21/23 at 11:00 AM revealed Resident #49 had facial hair on her chin.

On 05/22/23 at 11:04 AM an interview was conducted with Resident #49. Facial hair was observed on her chin. She stated she did not know "whiskers" were there and hoped no one had been laughing at her. She revealed she would be embarrassed if people laughed at her. She explained she would try to do it herself but had cut her chin in the past. She stated she would like the facial hair to be shaved.

An interview was conducted with NA #4 on 05/25/23 at 10:26 AM. She stated she had assisted Resident #49 with set up for bathing and grooming. She further stated it was her responsibility to shave female residents' facial hair. She added she had not offered to shave Resident #49 in the past. NA #4 said during her NA training she was educated to shave facial hair during care for female residents.

During an interview on 05/25/23 at 10:31 AM the Director of Nursing (DON) revealed that the North Carolina Nurse Aide Curriculum was taught at the facility. She further revealed that the class is a fast track and believed that some skills did not

F 550

residents are properly covered during and after showers, and adequately shaving residents who have undesired facial hair. Education was conducted on 6/13/23 and completed on 6/14/23. Newly Hired staff will be educated during orientation. Any current certified nursing assistant not educated on or before 6/14/23 will be educated prior to the start of their next shift.

4. How the facility will monitor its performance to ensure the deficient practice does not recur.

The facility administrative team will complete observation rounds weekly on 5 random residents as they are being transferred to shower rooms to ensure that they are properly covered. These rounds will be conducted weekly X4, monthly X3 and quarterly thereafter to ensure continued compliance.

These residents will also be observed to ensure that they have no excessive undesired facial hair that needs to be shaved. Findings will be documented on ADL Care audit tool.

The Director of Nursing (DON) and/or designee will complete a summary of the audit results and present them at the facility monthly QAPI meeting to ensure continued compliance.

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F 550	Continued From page 4 get the attention they needed as the curriculum focused on other skills. She stated new staff needed to be reminded that facial hair was part of grooming and activities of daily living (ADL). The DON explained that the majority of the facility's NAs were newly certified within the past two to three months. She added that she will provide in-services and do more education regarding facial hair. She stated that facial hair should be a part of daily grooming for all residents. An interview was conducted with the Administrator on 05/25/23 at 12:07 PM. The Administrator stated he expected staff to provide complete ADL care that included removal of facial hair. He further stated that care should be provided so that residents are comfortable with their appearance and to maintain the residents' dignity.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care.	F 553		6/22/23

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F 553	Continued From page 5 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and medical record reviews, the facility failed to invite a cognitively intact resident to participate in the planning of the resident's care for 2 of 4 residents (Resident #27 and Resident #55) reviewed for participation in care plans. The findings included: 1. Resident #27 was admitted to the facility on 4/19/21. Diagnoses included, in part, hypertension and diabetes. The quarterly Minimum Data Set (MDS) assessment dated 5/5/23 revealed Resident #27 had intact cognition. During an interview with Resident #27 on 5/22/23 at 11:02 AM, she stated she had not been invited to participate in care plan meetings but would participate in the care plan process if the facility	F 553	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. A) On 5/30/23, the facility MDS nurse scheduled a care plan conference with Resident #27 and Resident #55. B) The care plan conference for resident #27 has been scheduled for Wednesday, 6/21/23. C) The care plan conference for resident #55 has been scheduled for Tuesday 6/20/23. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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invited her. She added staff had not updated her or involved her on any changes with her medications or treatments.

MDS Nurse #3 was interviewed on 5/24/23 at 10:14 AM. She stated that typically, during the month of a resident's MDS assessment, she sent a care plan meeting invitation to the alert and oriented residents and to the primary family member. She said she would have sent a care plan invitation to Resident #27's family member at the beginning of April 2023. She added if the interdisciplinary team met as a group for care plan review, they went to the resident's room and reviewed the care plan. If the team had not met as a group, then MDS Nurse #3 went by herself to the resident's room and reviewed care plan information with the resident. She was unable to recall if she personally met with Resident #27 sometime after the 5/5/23 MDS assessment to review the care plan with the resident.

On 5/24/23 at 10:21 AM, a telephone interview was conducted with the Former Social Worker (SW). She explained the MDS nurses invited residents to care plan meetings, but the primary focus was on meetings with new residents which occurred 72 hours after admission. The Former SW said she worked at the facility for 1 ½ years and had recently left her employment at the facility. She said the residents who were at the facility for long term care (including Resident #27) had not been invited to care plan meetings during the time she worked at the facility. She had not invited residents to care plan meetings since she "didn't know the dates of the MDS assessments."

On 5/24/23 at 10:55 AM, a review of the Care Conference Summary section of the electronic

F 553

All residents have the potential to be affected by this alleged deficient practice. An audit was completed of current resident electronic medical records by the facility administrator and MDS Nurse on 5/26/23 to identify any other residents who did not have documented care plan meetings in place for the first quarter of 2023. A letter will be sent to any self-responsible resident and to the responsible party of all residents who are not self-responsible. The facility Administrator will ensure that all residents in need of a care plan meeting will be scheduled by 6/21/23.

3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

The Social Worker will establish contact with the Resident and/or Resident Representative to set the Care Plan Meeting schedule weekly. Attendance of care plan meetings will be documented in the electronic Medical Record by the Social Worker.

The Social Worker and Minimum Data Set Coordinator received education 6/13/23, by the Administrator on tracking and scheduling resident care plan meetings. Education included that the MDS Coordinator will provide the MDS calendar for the SW to create the care plan meeting schedule.

4.How the facility will monitor its

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F 553	Continued From page 7 health record for Resident #27 revealed no documented evidence that the resident was invited to attend or participated in care plan conferences during the time period of 8/5/22-5/24/23. An interview was conducted with the Administrator on 5/24/23 at 1:46 PM. He shared that typically, either the MDS Nurse or SW invited residents to attend care plan meetings. He was unaware that some residents were not being invited to participate in the care planning process or meetings. 2. Resident #55 was admitted to the facility on 8/20/20. Diagnoses included, in part, hypertension and coronary artery disease. The annual MDS assessment dated 5/7/23 revealed Resident #55 had intact cognition. During an interview with Resident #55 on 5/21/23 at 11:45 AM, he stated he hadn't gone to a care plan meeting "for a while" but wanted to be invited to participate in planning his care at the facility. He had not recalled being invited to a care plan meeting but thought his family member was invited by the facility. MDS Nurse #3 was interviewed on 5/24/23 at 10:14 AM. She stated that typically, during the month of a resident's MDS assessment, she sent a care plan meeting invitation to the alert and oriented residents and to the primary family member. She added if the interdisciplinary team met as a group for care plan review, they went to the resident's room and reviewed the care plan. If the team had not met as a group, then MDS Nurse #3 went by herself to the resident's room	F 553	performance to ensure the deficient practice does not recur. The Administrator and Social Worker will monitor the MDS Care Plan calendar and the care plan meeting schedule weekly x 4 weeks, then monthly x 3 months, than quarterly to ensure that current residents are invited to attend and participate in their scheduled care plan meeting. The facility Administrator will complete a summary of monitoring results and present at the facility monthly QAPI to ensure continued compliance	

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and reviewed care plan information with the resident. She reviewed Resident #55's medical record and reported the last documented care plan meeting was 11/28/22, during which Resident #55's family member attended. She was unable to state if a care plan meeting had been held since then.

The Care Conference Summary section of Resident #55's electronic health record was reviewed and revealed a care conference was held on 11/28/22. The names of the participants of the conference included Resident #55's family member; there was no documentation that Resident #55 was invited to or attended the care conference. Further review of the Care Conference Summary demonstrated the next scheduled care conference was to be held on 2/28/23. There was no documented evidence that a care conference was held that date.

On 5/24/23 at 10:21 AM, a telephone interview was conducted with the Former Social Worker (SW). She explained the MDS nurses invited residents to care plan meetings, but the primary focus was on meetings with new residents which occurred 72 hours after admission. The Former SW said she worked at the facility for 1 ½ years and had recently left her employment at the facility. She said the residents who were at the facility for long term care (including Resident #55) had not been invited to care plan meetings during the time she worked at the facility. She had not invited residents to care plan meetings since she "didn't know the dates of the MDS assessments."

An interview was conducted with the Administrator on 5/24/23 at 1:46 PM. He shared that typically, either the MDS Nurse or SW invited

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F 553	Continued From page 9 residents to attend care plan meetings. He was unaware that some residents were not being invited to participate in the care planning process or meetings.	F 553		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		6/22/23

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individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, resident and staff interviews, the facility failed to accurately transcribe the Advance Directive of 1 of the 2 sampled residents reviewed (Resident #13).

Findings included:

Resident #13 was originally admitted to the facility on 1/21/22 and re-admitted on 11/11/22 with diagnoses which included: congestive heart failure, schizoaffective disorder, and bipolar disorder.

The quarterly minimum data set dated 4/28/23 indicated Resident #13 was cognitively intact.

The electronic medical records documented Resident #13's advance directive status as Full Code/CPR (cardiopulmonary resuscitation) on the clinical profile and basic information records. Also, included in the resident's electronic record was the Full Code Agreement signed by the resident's responsible representative on 1/20/22.

Resident #13's portable medical forms, maintained at the nurse's station in the Emergency Book consisted of Resident #13's face sheet which documented the resident's

F 578

1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The Advance Directive Orders for Resident #13 was updated to ensure that all orders, electronic health record, (EHR) and code status binders match and are reflective of resident’s desired code status. The update was completed on 5/24/23 by the Medical Records Clerk.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

Any resident has the potential to be affected by this alleged deficient practice. The EHR of current residents was audited by the Medical Records Clerk on 5/26/23, to ensure that a CODE status was indicated, matched physician orders and electronic health record were reflective of one another. The medical records clerk also conducted an audit of the CODE status binder(s) at each nursing station to ensure that the code status for each resident had validating paperwork. Any

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advance directive status as "Full Code". The book also included a physician's signed MOST form (medical order for scope of treatment) documenting Resident #13's advance directive as Full Code with the effective date of 1/20/22.

The review of the physician's telephone order dated and signed by the nurse practitioner on 2/1/23 revealed Resident #13's advance directive status was DNR (Do Not Resuscitate).

An interview was conducted on 5/23/23 at 11:02 a.m. with both Staff Nurse #1 and Med Tech #2. They stated if/when a resident was in immediate distress requiring emergent measures, they would immediately review the Emergency Notebook located at the nurse's station that consisted of the Face Sheet and Advance Directive status of each resident residing on the residential unit.

On 5/23/23 at 2:50 p.m., the Medical Records Director revealed that when she received the 2/1/23 order documenting the change in Resident #13's advance directive status to "do not resuscitate", she spoke with the resident to ensure this was his request due to his history of fluctuating between having a DNR status or a Full Code status. She stated the resident informed her he did not want to have a DNR status, at that time.

During an interview on 5/23/23 at 3:38 p.m., the Director of Nursing (DON) revealed the staff nurse obtained the signed order for Resident #13's advance directive status of DNR from the nurse practitioner. The staff nurse also signed the order as received and updated the electronic monthly physician's order which automatically

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discrepancies were made know and clarified by nurse management team (which includes director of nursing and staff development coordinator), social worker, and residents attending physician.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

Current residents code status will be reviewed at admission, readmission, quarterly and at the time of a significant change by the administrative nurses (includes Director of Nursing and Staff Development Coordinator.) During the facility clinical meeting, the administrative nurses and facility Interdisciplinary team (includes social worker, MDS Nurse, Activity's Director, and Social Worker) will discuss any changes to a resident's code status to ensure that there is an update in the resident EHR, current physician order and updated code status book. Any updated information will be communicated to the facility licensed nurses to ensure they have updated information.

The morning Clinical meeting has been modified to include a review of new orders and code status binders to ensure that they are reflective of one another.

The medical records clerk was educated by the staff development coordinator (SDC) on 5/26/23 on the importance of ensuring that any new changes in a resident's code status is made known to a member of nurse management and

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F 578	Continued From page 12 transferred the updated DNR status to the resident's monthly medication administration record. The DON indicated the Medical Record Director was responsible for updating the Emergency Notebook located at the nurse's station. The DON stated the Medical Record Director did not have the authority to change or not change a resident's Advance Directive status.	F 578	medical director to ensure that it is confirmed by a matching advanced directive order, and accurately communicated in the resident's electronic health record, and code status binders at the nursing stations. 4.How the facility will monitor its performance to ensure the deficient practice does not recur. The medical records clerk will audit code status binder and EHR for accurate code status for each resident, weekly X4, monthly X3, and quarterly thereafter to ensure compliance with F578 and its content. This audit will also include observation of orders to confirm desired Code status. Findings will be documented on code status Audit tool. The Medical Records Clerk will complete a summary of the audit results and present them at the facility monthly QAPI meeting to ensure continued compliance.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		6/22/23

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F 584	Continued From page 13 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with residents and staff, the facility failed to ensure cigarettes were disposed of in a non-combustible container (courtyard), failed to properly label and store personal care equipment in shared bathroom (rooms 603 and 609); failed to repair the linoleum around the base of the toilet (room 605); failed to maintain walls and baseboards in	F 584	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Cigarette butts in the facility courtyard were cleaned up by the maintenance director on 5/25/23.	

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F 584 Continued From page 14

good repair (rooms 602, 605, 606, and 611); failed to repair loose fitting sink faucets (rooms 602 and 606); failed to maintain toilet paper holders in good repair (room 602 and 603); failed to maintain properly attached call bell wall sockets (room 603); failed to maintain window blinds in good repair (room 604); maintain night stand in good repair (room 603). This occurred for a courtyard and 7 of 11 rooms reviewed for a clean, safe, and homelike environment.

The findings included:

1. An observation was conducted on 5/24/2023 at 11:32 a.m. of the courtyard and it revealed greater than 50 cigarettes were lying on the ground and in the pine needles of the flower beds.

An interview was conducted with the Administrator and Director of Nursing (DON) on 5/24/2023 at 1:25 p.m. in the courtyard. They both stated they observed numerous cigarette butts scattered around on the cement walkway, in the dry pine needles, and flower beds. They were both asked if they were aware that staff were reported to be smoking in the courtyard. The DON stated she was not aware of the cigarette butts in the courtyard, and she had not been told someone was smoking in the courtyard because this was a smoke free facility. The Administrator revealed he had been told staff were smoking in the courtyard and he was aware of the cigarette butts. He added the day shift do not smoke in the courtyard however, 2nd and 3rd shift might be smoking in the courtyard.

2. a. An observation of the shared bathroom of room 603 on 05/21/23 at 11:00 AM revealed 2

F 584

Personal care items for residents in rooms 603 and 609 were labeled and stored in the resident's room on 5/26/23 by attending certified assistant.

The linoleum around the base of the toilet for room 605 will be replaced by the corporate maintenance director on 6/22/23.

Walls and baseboard for room 602, 605, 606 and 611 were repaired by maintenance director. All repairs were completed on 5/26/23.

Loose fitting sink faucet for room 602 & 606 was repaired by the maintenance director. All repairs were completed on 5/25/23.

Toilet paper holders for room 602 and 603 were repaired by the maintenance director on 5/21/23.

The call bell wall socket for room 603 was repaired by maintenance director on 5/26/23.

Window blinds were replaced for room 604 by maintenance director on 5/23/23.

Night stand for room 603 was replaced on 6/19/23.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

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unlabeled and uncovered bath basins were stacked inside each other and were sitting under the sink on the bathroom floor. Additional observations of the shared bathroom of room 603 on 5/21/23 at 12:00 PM, and then on 05/22/23 at 1:39 PM revealed 2 unlabeled and uncovered bath basins were stacked inside each other and were sitting on the bed side table of bed B.

b. An observation of the shared bathroom of room 609 on 05/21/23 at 11:28 AM revealed 3 unlabeled and uncovered bath basins were stacked inside each other and were sitting on the bathroom floor. Additional observations of the shared bathroom of room 609 on 5/22/23 at 1:40 PM, and then on 05/22/23 at 1:39 PM revealed 3 unlabeled and uncovered bath basins were stacked inside each other and were sitting under the sink on the bathroom floor. On 05/24/23 at 9:54 AM 3 unlabeled and uncovered bath basins were stacked inside each other and were sitting under the sink on the bathroom floor.

An interview was conducted with Nurse Aide (NA) #3 on 05/22/23 at 1:39 PM. Regarding the two basins by bed B, the NA revealed she bathed the resident in bed A from a new basin that morning. She further revealed she disposed of the new basin because it was a new one and didn't belong to the resident. She stated she would use the newest looking basin for bathing the resident in bed B. When asked how she knew which basin belonged to thew resident in bed B, she said she should get new ones and label them before she bathed the resident.

An interview was conducted with Resident #52 on 05/24/23 at 9:54 AM regarding the 3 basins stacked on the bathroom floor in room 609.

F 584

Any resident had the potential to be affected by this alleged deficient practice. Facility Maintenance Director, Maintenance Assistant, and facility Administrator completed observation rounds of the facility resident rooms to ensure rooms, call lights, and furnishings are in good repair, including walls, baseboards, toilet paper holders, window blinds, linoleum around base of toilet, sink faucet fitting, and ensuring residents sharing rooms personal items were labeled and stored in resident nightstand. Rounds were completed on 5/26/23.

Facility Administrator and Director of Nursing (including those that helped) completed observation of facility courtyards to ensure these areas were free of cigarette butts. The observation was completed on 5/26/23.

The Facility Administrator and Director of Nursing have completed re-training with current facility staff to ensure they understand that the facility is a smoke-free facility and smoking in facility courtyards are not permitted, this was completed on 6/20 /23. New employees will receive this training at the time of orientation. Any employee who has not received this training by 6/20/23, will not be allowed to work until the training is completed by the Staff Development Coordinator.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

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Resident # 52 stated the NAs used one of the unmarked basins on the floor in the bathroom to bathe her and her roommate. She did not know which one was used for each of them because they were not labeled. Resident #52 explained she washed her face herself with a washcloth wetted at the sink, not out of a basin, because she was not sure which basin was hers.

An interview on 05/24/23 at 9:59 AM with NA #5 revealed she had worked at the facility since 8/22. She stated she usually worked on the rehab hall and that those residents did not share a bathroom. She observed there were no labels on the basins and stated she was not sure which basin she would use. She explained she would throw these away and get new ones and put their names on them.

An interview and observation were conducted with the Staff Development Coordinator/Infection Preventionist (SDC/IP) on 05/24/23 at 10:05 AM. She revealed resident basins should be labeled. She further revealed in an extreme case the NA would use a disinfectant to clean the basin if it was a shared basin. The SDC/IP explained that NAs were educated to use proper technique and not share basins. If they must share, they should be disinfected with wipes on the medication cart. She said new basins were stored in the Clean Utility/Supply room. An observation of the 2 Clean Utility/Supply rooms revealed there were no resident basins available.

On 05/24/23 at 10:30 AM an interview was conducted with the Central Supply Coordinator. She stated that she stocked basins in the Clean Utility/Supply rooms and the overstock was kept in her office. When made aware of no basins in

F 584

When maintenance director and/or assistant arrives to work, in addition to work orders in maintenance book, they will also inquire verbally with staff about whether any maintenance issues were reported on their assignment. Findings will be reported during morning meeting

The Nursing Home Administrator will review weekly work orders with Maintenance Director to ensure requests are completed timely

Staff who fail to follow facility rules will receive disciplinary action.

The Facility Administrator and Director of Nursing have completed re-training with current facility staff to ensure they understand that the facility is a smoke-free facility and smoking in facility courtyards are not permitted, this was completed on 6/20 /23. New employees will receive this training at the time of orientation. Any employee who has not received this training by 6/20/23, will not be allowed to work until the training is completed by the Staff Development Coordinator.

On 6/20/23, maintenance director and Environmental service Manager were educated on F584 with emphasis on the importance of maintaining a clean, homelike environment with a sanitary orderly, and comfortable interior. Anyone not educated on 6/20/23 will not be allowed to work until training is completed.

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F 584	Continued From page 17 the Clean Utility/Supply rooms, she explained she needed to stock them with overstock from her office. She explained she made new admissions kits that included a basin and personal hygiene items labeled with the residents' name for semi-private residents. An observation on 05/24/23 at 11:27 AM revealed unlabeled basins on the bathroom floor in rooms 603 and 609. An interview with the Director of Nursing (DON) on 05/25/23 at 1:45 PM revealed that each resident was supposed to have their own basin and personal items labeled. She stated that basins should be labeled and placed in each resident's drawer or shelf. She added basins should not be stacked together, uncovered on the floor. In an interview with the Administrator on 05/25/23 at 12:13 PM he stated that basins and personal care items should be labeled to differentiate to which resident an item belongs. Items should not be stored directly on the floor. He added that he expected resident's personal hygiene items to be labeled and stored appropriately. 3. A tour of the resident rooms on the 600 hall was conducted on 05/21/23 at 11:00 AM. The following concerns were observed: linoleum around the base of the toilet was lifted from the floor (room 605), gouged sheetrock (room 605 and 609), baseboards were lifted from the walls (rooms 602, 605, 606, and 611), sink faucets were loose from fittings and the hot water would not shut off (rooms 602 and 606), no toilet paper holders (room 602 and 603), call bell wall socket	F 584	4.How the facility will monitor its performance to ensure the deficient practice does not recur. Observations rounds will be conducted by the maintenance director or designee, of 20 rooms and the 2 inner courtyards weekly X4, monthly X3 and quarterly thereafter to ensure adequate compliance with F584. Findings will be documented on an environmental round sheet. The maintenance director will present a summary of the audits at the monthly Quality Assurance and Performance Improvement (QAPI) meeting to ensure continued compliance with F584.	

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hanging from wall (room 603), broken window blinds (room 604), and night stand with peeling veneer on top and chipped legs (room 603).

During an interview with the Maintenance Director on 05/21/23 at 11:40 AM she revealed was new to the position and she had worked for the facility since May 15, 2023. She checked the hot water temperature in 602 and it was 111degrees.She stated the hot water temperature should not exceed 116 degrees. She stated she had cartridges on order to repair the faucets.

An observation and interview were conducted 5/24/23 at 11:32 AM with the Maintenance Director. She revealed that a company had been contracted to repair and replace baseboards and begin painting. She further stated that repairs had started on the 3200 hall. She explained that repairs were prioritized after a walk through with administration. She said the facility was working on known issues on the 600 hall.

On 05/24/23 at 11:56 AM the Administrator stated the facility was working on identified issues and it was an ongoing project.

On 05/25/23 at 11:58 AM an interview with the Administrator revealed the facility had many ongoing projects related to needed repairs. He explained that the facility made repairs one room at a time. All room will be painted and brought up to par. He explained that the facility census stayed high, so they tried to try work on the rooms on the weekend. He further explained when the census was lower, residents were transferred to other rooms so repairs could be made. The Administrator stated that repairs were behind due to scheduling conflicts with contractors and

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F 584	Continued From page 19 painters. He revealed the corporate maintenance director had assisted with vendors for quotes on work that was needed. The Administrator added that the facility management team did ambassador rounds 2-3 times a week to identify problem areas. He stated anything that could be repaired internally was prioritized and repaired.	F 584		
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 observation, staff interviews and record reviews, the facility failed to accurately code 1. tobacco user status, 2. dental status, and 3. pressure ulcer on the Minimum Data Set (MDS) assessment for 3 of 34 residents (Residents #18, #55 and #28) reviewed for MDS accuracy. The findings included: 1. Resident #18 was admitted to the facility on 4/6/2021 with diagnoses that included chronic obstructive pulmonary disease, heart failure, and a current smoker. A review of the comprehensive Minimum Data Set (MDS) dated 4/5/2023 revealed Resident #18 had moderately impaired cognition and section J1300 coded the resident was not a current tobacco user. A review of the care plan dated 4/5/2023 did not include a focused area that Resident #18 was a	F 641	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The care plan for Resident #18 was updated on 6/15/23 to indicate that she was a tobacco user. The cigarettes belonging to resident #18 were taken away from her possession and placed on the nursing cart. The facility remains a smoke free facility and was resident was re-educated to go off the premises should she desire to smoke. Resident #18 voiced understanding. The MDS for resident #55 was corrected on 5/24/23 by the MDS nurse to indicate that he had dental issues. The MDS for resident #28 was modified to indicate that he had no pressure ulcers.	6/22/23

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current tobacco user.

An interview was conducted on 5/22/2023 at 12:19 p.m. with Resident #18. She revealed she was a current smoker and had been since her admission to the facility. She added she goes outside and across the street to smoke. She opened the top of the storage basket to her walker and demonstrated where she kept her cigarettes and lighter.

An observation was conducted on 5/22/2023 at 12:20 p.m. and Resident #18 had two packs of cigarettes and a lighter.

An interview was conducted with the MDS coordinator on 5/25/2023 at 3:22 p.m. and she revealed any resident that used any tobacco product should be coded as a current tobacco user on section J1300 of the MDS assessment. She reviewed Resident #18's MDS dated 4/5/2023 and stated it was coded as not a current tobacco user and should be coded as a current tobacco user.

2. Resident #55 was admitted to the facility on 8/20/20. Diagnoses included, in part, gastroesophageal reflux disease and coronary artery disease.

On 9/28/22, the resident was seen at the facility by the dentist. The comprehensive examination note read, in part, "Chief Complaint/Dental Concern: broken and missing teeth."

The annual MDS assessment dated 5/7/23, and completed by MDS Nurse #3, revealed Resident #55 had no dental issues.

F 641

The modification was completed on 5/23/23 by regional MDS consultant.

The MDS nurse was educated by regional clinical nurse on 6/19/23, on 641 and its with emphasis on the importance of ensuring that each resident's assessment reflects resident's status.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

On 5/24/23, all residents who were coded to have stage 2 pressure ulcers had their assessments reviewed for accuracy. This audit was completed by the regional clinical imbursement nurse. No other discrepancies were found.

On 5/27/23, all 100% of resident census were assessed by MDS nurses for dental issues. Any issues have been properly coded in the resident MDS. Audit was ompleted on 6/17/23,

On 6/15/23, MDS nurse reviewed the care plans for all residents who have been identified as tobacco users. All identified residents had their care plans updated accordingly. The audit was completed on 6/17/23.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

The Interdisciplinary Team (IDT) (consists

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F 641	Continued From page 21 An observation of Resident #55's mouth was completed with MDS Nurse #1 on 5/23/23 at 1:24 PM. During the observation, MDS Nurse #1 reported the resident had missing and broken teeth. On 5/24/23 at 10:06 AM, an interview was conducted with MDS Nurse #3. She verified she completed the MDS assessment dated 5/7/23. She explained when she coded the dental section on the MDS, she looked in Resident #55's mouth before she coded dental status. When she looked in Resident #55's mouth she saw some cavities and missing teeth. She documented her observations on a paper copy of the MDS assessment, but when she entered the information into the computer she mistakenly coded "no issues." During an interview with the Administrator on 5/24/23 at 1:33 PM, he was unsure why the dental section was incorrectly coded on the MDS assessment. He stated there were a high volume of MDS assessments completed at the facility and there were some travel MDS nurses who assisted with completing MDS assessments. 3. Resident #28 was admitted to the facility on 8/13/22 with an initial admission date of 2/28/22. Resident #28's medical record showed a skin assessment completed on 2/8/23. Resident #28's skin was noted as intact and there were no open pressure ulcers. Review of Resident #28's medical record showed no active physician orders for the treatment of a pressure ulcer.	F 641	of social workers, Activity□s Director, MDS Nurse, Rehab Director), and Director of Nursing (DON), will review a random current resident MDS daily, M-F (5 weekly), at the facility Clinical Meeting, to ensure accuracy of MDS. MDS staff has been educated by Regional MDS Consultant on F641 and its content, with emphasis on importance of coding assessments accurately to reflect the resident's status. Education was completed on 6/19/23. 4.How the facility will monitor its performance to ensure the deficient practice does not recur. The MDS Nurse, director of nursing and/or designee will review an MDS assessment daily (M-F) X4 weeks, monthly X3 months, and quarterly thereafter to ensure accurate coding. Findings will be documented on MDS audit tool. The MDS Nurse or designee will present a summary of these audits at the facility's monthly Quality Assurance and Improvement (QAPI) meeting to ensure continued compliance with F641	

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F 641	Continued From page 22 Review of the quarterly Minimum Data Set (MDS) dated 3/12/23 showed Resident #28 had one stage 2 pressure ulcer (partial thickness skin loss appearing as a shallow opening in the skin). An interview was conducted on 5/23/23 at 2:06 P.M. with the MDS Nurse. During the interview, the MDS Nurse reviewed Resident #28's medical records. The MDS Nurse indicated Resident #28's MDS was marked incorrectly, and Resident #28 did not have a pressure ulcer. During the interview, the MDS Nurse explained she looked at wound treatment progress notes from the previous year and marked Resident #28 as having a pressure ulcer. An interview was conducted on 5/24/23 at 8:01 A.M. with the Director of Nursing (DON). The DON indicated Resident #28 did not have a pressure ulcer. She further indicated she felt it was an oversite when the MDS Nurse marked Resident #28 as having a pressure ulcer on the quarterly MDS.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		6/22/23

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F 655	Continued From page 23 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to develop a baseline care plan within 48 hours of the resident's admission for 2 of 16 newly admitted residents reviewed (Resident #39, Resident #87, and and Resident #98).	F 655	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/19/23, members of the interdisciplinary team (includes MDS	

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Continued From page 24

The findings included:

1. Resident #39 was initially admitted to the facility on 8/30/22. Her cumulative diagnoses included diabetes and malnutrition.

Resident #39's electronic medical record (EMR) did not include a baseline care plan. On 5/23/23 at 1:25 PM, the facility's Director of Nursing (DON) confirmed Resident #39 did not have a baseline care plan.

Further review of Resident #39's EMR revealed a comprehensive, individualized care plan was initiated on 9/6/22 (greater than 48 hours after admission to the facility). The resident's comprehensive care plan included the following areas of focus, in part:
--The resident has a diagnosis of diabetes (Start Date 9/6/22);
--The resident is at risk for nutritional decline due to a past medical history that included diabetes, diabetic neuropathy, recurrent falls, hepatic encephalopathy, generalized weakness and urinary tract infection. The resident has an elevated body mass index and requires a therapeutic diet (Start Date 9/6/22);
--The resident requires assistance for Activities of Daily Living (ADLs) related to decreased mobility and weakness (Start Date 9/6/22);
--The resident is at risk for falls related to decreased mobility, weakness, and psychotropic medications (Start Date 9/6/22).

An interview was conducted on 5/23/23 at 3:45 PM with the facility's Director of Nursing (DON). During the interview, the DON stated the facility had identified a concern regarding missing baseline care plans during a mock survey.

F 655

nurse, Social Worker, Director of Nursing (DON), Staff Development Coordinator (SDC), and Activity's Director were educated on F655 with emphasis on the importance of developing a Baseline care plan within 48 hours of admission. The education was conducted by the regional clinical imbursement nurse.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

On Saturday 5/27/23, an audit was completed on all new admissions admitted within the past 48 hours. Audit was completed by MDS nurse.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

As of 5/27/23, baseline care plans will be completed electronically for more efficient monitoring for completion.

On 6/19/23, members of the interdisciplinary team (includes MDS nurse, Social Worker, Director of Nursing, Staff Development Coordinator (SDC), and Activity's Director were educated on F655 with emphasis on the importance of developing a baseline care plan within 48 hours of admission. The education was conducted by the regional clinical imbursement nurse.

4.How the facility will monitor its performance to ensure the deficient

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F 655 Continued From page 25

However, she reported the facility did not conduct the necessary audits to monitor the completion of baseline care plans for newly admitted residents.

On 5/24/23 at 8:09 AM, a follow-up interview was conducted with the DON to discuss the facility's process for the development of baseline care plans for newly admitted residents. The DON reported the baseline care plan should be initiated by the admitting nurse utilizing information from his/her hospital record. The care of each newly admitted resident would then be discussed in the facility's next daily Clinical Meeting. Each discipline was expected to review the baseline care plan with the resident or family member at his/her "72-hour" care plan meeting. At that time, either the resident or family member would receive information pertaining to the baseline care plan and subsequently sign it.

2. Resident #87 was initially admitted to the facility on 9/15/22. His cumulative diagnoses included depression, hypertension, and diabetes.

Resident #87's electronic medical record (EMR) did not include a baseline care plan. On 5/23/23 at 1:25 PM, the facility's Director of Nursing (DON) confirmed Resident #87 did not have a baseline care plan.

Further review of Resident #87's EMR revealed a comprehensive, individualized care plan was initiated on 9/15/22 with only one area of focus (related to a pressure ulcer). Additional areas of focus were started on or after 9/20/22 (not within 48 hours of admission). The resident's comprehensive care plan included the following areas of focus, in part:
--The resident had a pressure ulcer to his right

F 655

practice does not recur.

The MDS nurse will review the MDS assessment for 5 new admissions (admitted within the past 2 weeks) weekly X 4, monthly X3 and quarterly thereafter to ensure timely completion of the resident’s baseline care plan. Findings will be documented on the baseline Care plan audit tool.

The MDS Nurse will complete a summary of the audit results and present them at the facility monthly Quality Assurance Performance Improvement(QAPI) meeting to ensure continued compliance.

F 655 Continued From page 26 F 655

heel (State Date 9/15/22);
--The resident is at risk for nutritional decline with his past medical history that includes diabetes, hypertension, hyperlipidemia (high fat levels in the blood), benign prostatic hypertrophy and legally blind. He has an elevated body mass index and requires a therapeutic diet (Start Date 9/20/22);
--The resident has a diagnosis of Type 2 diabetes with uncontrolled blood sugar levels (Start Date 9/21/22);
--The resident requires assistance for Activities of Daily Living (ADLs) for eating, mobility, transfers, dressing, grooming, toileting, and bathing related to vision and muscle weakness (Start Date 9/21/22).

An interview was conducted on 5/23/23 at 3:45 PM with the facility's Director of Nursing (DON). During the interview, the DON stated the facility had identified a concern regarding missing baseline care plans during a mock survey. However, she reported the facility did not conduct the necessary audits to monitor the completion of baseline care plans for newly admitted residents.

On 5/24/23 at 8:09 AM, a follow-up interview was conducted with the DON to discuss the facility's process for the development of baseline care plans for newly admitted residents. The DON reported the baseline care plan should be initiated by the admitting nurse utilizing information from his/her hospital record. The care of each newly admitted resident would then be discussed in the facility's next daily Clinical Meeting. Each discipline was expected to review the baseline care plan with the resident or family member at his/her "72-hour" care plan meeting. At that time, either the resident or family member would

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F 655	Continued From page 27 receive information pertaining to the baseline care plan and subsequently sign it. 3. Resident #98 was admitted to the facility on 2/1/23 with diagnoses that included heart failure and end stage renal disease. Resident #98 electronic medical record (EMR) did not include a baseline care plan. Further review revealed that a comprehensive care plan was initiated more than 48 hours after admission to the facility. An interview was conducted on 5/23/23 at 3:45 PM with the facility's Director of Nursing (DON). During the interview, the DON stated the facility had identified a concern regarding missing baseline care plans during a mock survey. However, she reported the facility did not conduct the necessary audits to monitor the completion of baseline care plans for newly admitted residents.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		6/22/23

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F 657	Continued From page 28 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 observations, record reviews, resident and staff interviews, the facility failed to revise the care plan of 1 of 1 sampled resident (Resident #88) reviewed for range of motion and contractures. Findings included: Resident #88 was admitted to the facility on 7/19/22 with diagnoses which included cerebral infarction and flaccid hemiplegia affecting unspecified side. The annual minimum data set (MDS) dated 5/7/23 indicated Resident #88 had moderately impaired decision-making skills; unclear speech; and limited range of motion of the upper and lower extremities to one side of his body. The care plan dated 4/21/23 revealed Resident #88 was at risk for falls and injury related to weakness, impaired mobility, incontinence, potential side effects from medication, poor safety	F 657	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 6/16/23, the care plan for Resident #88 was revised by the MDS nurse to include his right hand contractures 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/16/23, an audit was conducted by the MDS nurse to ensure that all residents with contractures have a reflective care plan. The audit was completed on 6/17/23. 3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Weekly Risks Meetings conducted on	

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F 657

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awareness and history of falls. Interventions included physical therapist to work with transfers and strengthening.

The care plan was not revised to include Resident #88's right hand contractures.

During an observation and resident interview on 5/21/23 at 10:50 a.m., Resident #88 was awake in bed in his room. The resident was alert and oriented but nonverbal, using left hand gestures and nodding of his head in response to yes/no questions. The fingers of the resident's right hand were observed folded inward towards his palm. The resident indicated he received therapy but did not currently receive range of motion exercises or splinting device application for his right hand.

An interview with the Occupational Therapist (OT) on 5/23/23 at 11:22 a.m. revealed Resident #88 was discharged from occupational therapy to the Functional Maintenance Program for contracture management and splinting application with the therapy aide for 10 days before this care was transitioned to the facility's nursing assistants to continue.

On 5/23/23 at 12:09 p.m., the Therapy Aide revealed she trained NA#3 how to work with the resident on hand exercises and the application and removal of the hand/wrist splinting device. She stated Resident #88 was to wear the splinting device up to 5 hours each day, as tolerated.

During an interview on 5/23/23 at 12:31 p.m., the Regional Rehabilitation Department's Vice President stated after communicating with the

F 657

Thursdays will include review of residents who have contractures and ensure that they are care planned accordingly.

The MDS Nurses were educated on the importance of ensuring that the resident care plan is reflective of the resident’s status. Education was completed on 6/19/23 by the regional clinical reimbursement nurse.

4.How the facility will monitor its performance to ensure the deficient practice does not recur.

The care plan for 5 residents who have been identified as having contractures will be reviewed at random to ensure any updates have been made in a timely manner and is reflective of resident’s status. Audits will occur weekly X4, monthly X3 and quarterly thereafter to ensure adequate compliance. Findings will be documented on the care plan audit tool.

The MDS Nurse will complete a summary of the audit results and present them at the facility monthly Quality Assurance and Performance Improvement (QAPI) meeting to ensure continued compliance with F657.

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F 657	Continued From page 30 Director of Nursing, she was informed the resident's Functional Maintenance Plan had been transferred to the Resident's care plan and updated to the facility's Kardex (communication system documenting residents' records). During an interview on 5/25/23 at 2:26 p.m., MDS #1 stated she was aware of Resident #88's one sided deficits due to his diagnosis of cerebrovascular accident but was not aware of the resident having contractures or aware of the resident needing splinting device application. She stated the resident's right sided weakness should have been specified.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and the Wound Physician interview, the facility failed to follow a physician order for a wound dressing change for 1 of 4 (Resident #569) sample residents reviewed for pressure	F 686	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	6/22/23

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ulcers.

The findings included:

Resident #569 had an initial admission date of 1/16/23 and was re-admitted from the hospital to the facility on 2/3/23. His diagnoses included protein-calorie malnutrition and diabetes.

Resident #569's most recent Minimum Data Set (MDS) was a quarterly assessment dated 5/10/23. The MDS showed the resident was severely cognitively impaired and had one stage 4 pressure ulcer (a stage 4 pressure ulcer is a full tissue loss with exposed bone, tendon, or muscle). The MDS showed Resident #569 received hospice services.

A review of Resident #569's most recent care plan, last reviewed on 5/18/23, included a focus area for pressure ulcer to right heel and a risk for nutritional decline. Interventions included remind to shift weight frequently, refer to wound specialist for evaluation, refer to dietician for evaluation, and provide wound care as ordered.

Physician order dated 4/27/23 read clean right heel with sodium hypochlorite 0.125% solution, apply crushed metronidazole 250 milligrams (mg), apply wet to moist gauze with 0.125% sodium hypochlorite solution, cover with dry primary dressing, and change the dressing twice daily.

An observation was conducted on 5/23/23 at 11:06 A.M. of a wound treatment dressing change for Resident #569. The Wound Treatment Nurse retrieved one 250mg tablet of Resident #569's metronidazole from the medication cart and

F 686 (Plan of Correction)

On 5/23/23, The wound nurse was educated by the director of nursing on the importance of verifying the resident name, verifying the strength and dosage of the medication about to be administered, and that the route of medication is reflective of the Medication Administration Record (MAR).

After education was received the treatment was administered by the wound nurse in the presence of the Director of Nursing on 5/23/23.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

On 6/15/23, the wound physician and the treatment nurse reviewed all current wound physician orders to ensure that they were current and reflective of resident's status. No issues were observed.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

Weekly risk meetings conducted on Thursdays will now include review of any new wound physician orders.

On 6/19/23, all licensed nurses were educated by the Director of Nursing on the importance of verifying the resident name, verifying the strength and dosage of the medication about to be administered, and that the route of

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F 686	Continued From page 32 walked to the wound treatment cart in the hallway outside Resident #569's room. The Wound Treatment Nurse reviewed Resident #569's wound dressing order on her computer. The Wound Treatment Nurse retrieved two 8-ounce plastic cups and marked one cup with "WC". She removed a bottle of over the counter 0.057% sodium hypochlorite solution and poured some of the solution into the cup labeled "WC". The Wound Treatment Nurse then removed a 16-ounce bottle of 0.125% sodium hypochlorite solution with a prescription label and poured this solution into the second cup. The bottle of 0.125% sodium hypochlorite solution was replaced in the bottom drawer of the wound treatment cart. The Wound Treatment Nurse knocked on Resident #569's room, entered the room and explained the procedure to Resident #569. An interview was conducted on 5/23/23 at 11:17 A.M. with the Wound Treatment Nurse. During the interview, the Wound Treatment Nurse indicated she had always used the bottle of 0.057% sodium hypochlorite solution to cleanse Resident #569's wound. The Wound Treatment Nurse reviewed the physician order for Resident #569's wound dressing and indicated she had not followed the physician order which read cleanse the right heel with 0.125% sodium hypochlorite solution. The Wound Treatment Nurse further stated the physician's order for dressing changes should always be followed. An interview was conducted on 5/23/23 at 3:42 P.M. with the Wound Physician. The Wound Physician indicated he evaluated residents with open wounds weekly and he wanted staff to follow his wound dressing change orders for the	F 686	medication is reflective of the Medication Administration Record (MAR). 4.How the facility will monitor its performance to ensure the deficient practice does not recur. The Director of nursing (DON) or designee will monitor dressing changes for 5 residents who have been identified as having pressure ulcers, weekly X4, monthly X3, and quarterly thereafter to ensure adequate compliance. Findings will be documented on the Pressure Ulcer Audit tool The Director of Nursing or Designee will complete a summary of the audit results and present at the facility monthly Quality Assurance and Performance Improvement (QAPI) meeting to ensure continued compliance with F686.	

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F 686	Continued From page 33 recommended dressing change to assist the resident with maintaining or healing their wounds. During the interview, the Wound Physician indicated the 0.057% sodium hypochlorite cleansing solution the Wound Treatment Nurse poured into the plastic cup to cleanse Resident #569's wound was a milder antimicrobial cleanser and there would have been no negative effect on the resident. An interview was conducted on 5/24/23 at 8:01 A.M. with the Director of Nursing (DON). The DON indicated when staff were preparing for a wound dressing change, they should both review and follow the physician order.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		6/22/23

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F 688

Continued From page 34

Based on observations, record reviews, resident and staff interviews, the facility failed to consistently provide the functional management program recommended by the occupational therapist for 1 of 1 sampled resident (Resident #88) reviewed for contractures.

Findings included:

Resident #88 was admitted to the facility on 7/19/22 with the diagnoses which included cerebral infarction and flaccid hemiplegia affecting unspecified side.

The annual minimum data set (MDS) dated 5/7/23 indicated Resident #88 had moderately, impaired decision-making skills; unclear speech; and limited range of motion of the upper and lower extremities to one side of his body.

The care plan dated 4/21/23 revealed Resident #88 was at risk for falls and injury related to weakness, impaired mobility, incontinence, potential side effects from medication, poor safety awareness and history of falls. Interventions included physical therapist to work with transfers and strengthening.

During an observation and resident interview on 5/21/23 at 10:50 a.m., Resident #88 was awake in bed in his room. The resident was alert and oriented but nonverbal, using left hand gestures and nodding of his head in response to yes/no questions. The fingers of the resident's right hand were observed folded inward towards his palm. Resident #88 indicated he was unable to use his right upper extremity and right lower extremity as the result of a CVA (cerebral vascular accident).

F 688

1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The care plan and the KARDEX for resident #88 was updated updated to include resident’s need for splinting device. Update was made by MDS nurse on 6/20/23.

2.How the facility will identify other residents having the potential to be affected by the same deficient practice.

The care plans and Kardexes for residents identified as requiring a splinting device were reviewed by MDS nurse on 6/19/23, to ensure that they are reflective of resident’s status. Audit was completed on 6/21/23.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

Therapy <>Nursing Communication forms will be discussed during daily clinical meetings to ensure that any therapy recommendations for a resident who is being discharged from therapy are implemented accordingly. These recommendations will be immediately added to the resident’s care plan and Kardex to ensure the appropriate intervention is in place.

On 6/19/23, all licensed nurses, certified nursing assistants have therapy personnel

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F 688

Continued From page 35

The resident also indicated he received therapy but did not currently receive range of motion exercises or splinting device application for his right hand.

An interview with the Occupational Therapist (OT) on 5/23/23 at 11:22 a.m. revealed Resident #88 received occupational therapy from 2/7/23 through 4/4/23 to optimize the resident's functional independence with activities of daily living (ADL), wheelchair propulsion, and out of bed sitting tolerance in a wheelchair. The OT stated that during treatment, the goal of right upper extremity management was added to the treatment plan. At the time of the resident's discharge from therapy, goals were met for ADLs; he was able to tolerate sitting upright in a wheelchair for 2 to 3 hours each day; and contracture management and splinting was tolerated at 5.5 hours each day. The OT revealed Resident #88 was discharged from occupational therapy to the Functional Maintenance Program for contracture management with the therapy aide for 10 days before this care was transitioned to the facility's nursing assistants to continue with contracture management.

On 5/23/23 at 12:09 p.m., the Therapy Aide revealed she worked with Resident #88 in April 2023 during day shift, Mondays through Fridays for two weeks for contracture management which included: messaging palm of the right hand, flexing of right hand, individual finger stretching, and application of a hand/wrist splint as tolerated. She stated the hand/wrist splint was stored on the top shelf of the closet in the resident's room. She added that the resident was able to assist with the application and removal of the splint but was compliant with wearing the splint and the hand

F 688

were educated on this process, and the importance of reviewing and following the resident Kardex and Care plan when assisting a resident. Education was provided by regional Rehabilitation Director. Anyone not educated prior to 6/21/23, will receive education prior to the start of their next shift. New hires will be educated during orientation.

4.How the facility will monitor its performance to ensure the deficient practice does not recur.

5 residents who have been identified as requiring splinting devices will be observed at random weekly X4, monthly X3 and quarterly thereafter to ensure that they are wearing the devices as recommended. Findings will be documented on the range of motion audit tool.

The Director of Nursing or Designee will complete a summary of the audit results and present at the facility monthly Quality Assurance and Performance Improvement (QAPI) meeting to ensure continued compliance with F688.

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F 688	Continued From page 36	F 688		

exercises. The Therapy Aide stated she trained NA#3 how to work with the resident on hand exercises and the application and removal of the hand/wrist splinting device. She stated Resident #88 was to wear the splinting device up to 5 hours each day, as tolerated.

During an interview on 5/23/23 at 12:31 p.m., the Regional Rehabilitation Department's Vice President stated the rehabilitation department's procedure included that at the end of therapy services if a functional maintenance plan was recommended, the Therapist would develop it and train the therapy aide who would complete the program for 10 days to 2 weeks while training the facility's nursing assistants working with the resident. The facility documentation of the Rehabilitation's Functional Maintenance Plan. She stated after communicating with the Director of Nursing, she was informed the resident's Functional Maintenance Plan had been transferred to the Resident's care plan and updated to the facility's Kardex (communication system documenting residents' records).

On 5/23/23 at 12:45 p.m., Resident #88 was observed awake, reclining in his bed. The resident was not wearing the hand/wrist splinting device. After searching the resident's room (with the resident's permission) a blue hand/wrist splinting device was in the right bottom drawer of the resident's dresser.

On 5/25/23 at 9:05 a.m., Resident #88 was observed awake, reclining in his bed. The resident was not wearing the hand/wrist splinting device. When asked, the resident indicated the splinting device was not applied that morning or the day prior.

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F 688	Continued From page 37	F 688		

During an interview on 5/25/23 9:06 a.m., Nurse Aide #1 revealed she worked off/on with Resident #88 since January 2023 during first and sometimes second shift. She stated the resident's right hand had some contractures, but she had never observed the resident wearing a splint or ever seen one in his room. Nurse Aide #1 stated that she would sometimes place a rolled washcloth in the resident's right hand for 15 to 20 minutes during the shift.

On 5/25/23 at 2:46 p.m., Nurse Aide #4 revealed she only worked with Resident #88 twice during the first shift and 5/24/23 was the second time she worked with the resident. She revealed she did not observe the resident wearing a splinting device and did not observe one in the resident's room.

During an interview on 5/25/23 at 2:55 p.m., Nurse Aide #3 stated she often worked with Resident#88 during the first shift. She revealed she would apply the hand/wrist splint to the resident's right hand for 4 hours (approximately 8:00 a.m. to 12:00 p.m.). She stated the resident never attempted to remove the splint when she applied it. Nurse Aide #3 revealed she did not work with Resident #88 on 5/21/23, 5/23/23, and 5/24/23. She stated she worked with the resident on 5/22/23 but did not apply the splint to the resident's hand and did not inform the second shift nurse aide. When asked where she documented the application of the splint, Nurse Aide #3 indicated there was nowhere to document the splinting application in the kiosk (electronic charting system used by nursing assistants).

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F 758	Continued From page 38	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		6/22/23

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F 758	Continued From page 39 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interviews with staff, the consultant pharmacist and Medical Director, and record reviews, the facility failed to limit the use of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) ordered on an as needed (PRN) basis to 14 days and/or indicate the duration for the PRN order to be extended beyond 14 days, when appropriate. This occurred for 1 of 5 residents (Resident #569) reviewed for unnecessary medications. The findings included: Resident #569 was admitted to the facility on 1/16/23 with re-entry from a hospital on 2/3/23. His cumulative diagnoses included senile degeneration of the brain. A review of the resident's electronic medical record (EMR) revealed his medication orders dated 2/3/23 included an order for 1 milligram (mg) lorazepam (an antianxiety medication) to be given as one tablet by mouth every 4 hours as needed (PRN) for anxiety. No stop or discontinue date was included in the resident's PRN order for	F 758	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #569 expired on 6/19/23. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/15/23, the medication administration records (MARS) for any resident prescribed for psychotropic medications was reviewed by the Director of nursing (DON) and Staff Development Coordinator to ensure that a stop or discontinue date was indicated. 3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. All psychotropic medications will now possess a stop date not to exceed 14 days unless indicated by the physician	

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the lorazepam. Lorazepam is a psychotropic medication.

Resident #569 was admitted to Hospice on 2/4/23.

The facility's consultant pharmacist documented in Resident #569's EMR that a new admission review was completed on 2/4/23. A review of the 2/4/23 Medication Regimen Review (MRR) recommendation form read: "This resident is ordered Ativan [lorazepam] 1 mg by mouth every 4 hours PRN anxiety. Per CMS [Centers for Medicare and Medicaid Services] guidelines, an anxiolytic can only be prescribed for a maximum of 4 months at a time after the initial 14 day trial period. This resident requires reassessment for appropriateness of continuing this therapy at this time. Please consider the following: [Option 1 of 2 was checked]: Yes. Continue Ativan 1 mg by mouth every 4 hours PRN anxiety x 4 months - resident was re-evaluated by provider and the medication was determined to have continued need with benefit outweighing the risk of therapy ..." The Physician Response Section of the MRR was completed with the provider indicating his/her agreement with the pharmacist's recommendation.

The resident's February 2023 Physician's Orders documented continuation of the 2/3/23 order for 1 mg lorazepam to be given as one tablet by mouth every 4 hours PRN for anxiety with a discontinue date of 6/3/23. Resident #569's February 2023 MAR indicated he received one dose of (oral tablet) lorazepam on 2/6/23 at 5:36 PM.

The resident's March 2023 Physician's Orders indicated a new order (dated 2/12/23) was written

F 758

with supporting documentation. This includes hospice residents.

The regional clinical nurse educated all administrative nurses (includes Director of Nursing (DON), and Staff Development Coordinator (SDC),) on the importance of ensuring that all psychotropic medications possess a stop or discontinue date not to exceed 14 days or have supporting documentation from the physician a reason to exceed the 14 days. Education was conducted and completed on 6/19/23.

4.How the facility will monitor its performance to ensure the deficient practice does not recur.

A review of all residents who are receiving psychotropic medications will be conducted by Director of Nursing or Designee weekly X4, monthly X3, and quarterly thereafter to ensure any new or existing psychotropic medications possess stop dates. Findings will be implemented on the psychotropic medication audit tool.

The DON and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly Quality Assurance and Performance Improvement (QAPI) meeting to ensure continued compliance

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for 2 mg / milliliter (ml) lorazepam to be injected as 0.5 mg intramuscularly (IM) every 6 hours as needed for severe agitation. No stop or discontinue date was included in the resident's PRN order for the injectable lorazepam. No doses of injectable lorazepam were documented as administered on the February 2023 MAR.

The facility's consultant pharmacist documented an MRR was completed for this resident on 3/4/23. Documentation in the 3/4/23 MRR read, in part: "PRN Ativan tablet to continue through 6/3/23 per provider ...PRN Ativan IM [intramuscularly] started 2/9/23 ..." A review of the 3/4/23 MRR consultation form read, in part: "This resident is ordered Ativan 2 mg/ml vial, give 0.5 mg IM every 6 hours PRN severe agitation. Per CMS guidelines, an anxiolytic can only be prescribed for a maximum of 4 months at a time after the initial 14 day trial period. This resident requires reassessment for appropriateness of continuing this therapy at this time. Please consider the following: [Option 1 of 2 was checked]: Yes. Continue Ativan 2 mg/ml vial, give 0.5 mg IM every 6 hours PRN severe agitation x 4 months -resident was re-evaluated by provider and the medication was determined to have continued need with benefit outweighing the risk of therapy ..." In the Physician Response Section of the consultation report, none of the three boxes were checked to indicate whether the provider agreed, disagreed, or wished to write in another comment related to the pharmacist's recommendation.

The resident's March 2023 Physician's Orders documented continuation of the 2/3/23 order for 1 mg lorazepam to be given as one tablet by mouth every 4 hours PRN for anxiety with a discontinue

F 758 Continued From page 42 F 758

date of 6/3/23. Resident #569's March 2023 MAR reported he received one dose of (oral tablet) lorazepam on 3/25/23 at 2:31 PM and one dose on 3/26/23 at 10:35 PM. No doses of injectable lorazepam were documented as administered on the March 2023 MAR.

The facility's consultant pharmacist documented an MRR was completed for this resident on 4/6/23. Documentation in the 4/6/23 MRR read, in part: " ...continue Ativan IM x 4 months per MD [Medical Doctor] response to March rec [recommendation] ..."

The resident's April 2023 Physician's Orders documented continuation of the 2/3/23 order for 1 mg lorazepam to be given as one tablet by mouth every 4 hours PRN for anxiety with a discontinue date of 6/3/23. The resident's April 2023 MAR documented he received one dose of (oral tablet) lorazepam on 4/15/23 at 4:11 AM. The resident's April 2023 Physician's Orders also continued to include the order dated 2/12/23 for 2 mg / ml lorazepam to be injected as 0.5 mg intramuscularly (IM) every 6 hours as needed for severe agitation. No stop or discontinue date was included in the Physician's Orders for the PRN injectable lorazepam. No doses of injectable lorazepam were documented as administered on the April 2023 MAR.

The facility's consultant pharmacist documented an MRR was completed for Resident #569 on 5/3/23.

The resident's May 2023 Physician's Orders documented continuation of the 2/3/23 order for 1 mg lorazepam to be given as one tablet by mouth every 4 hours PRN for anxiety with a discontinue

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date of 6/3/23. The resident's May 2023 MAR documented he received one dose of (oral tablet) lorazepam on 5/9/23 at 4:42 PM. No doses of injectable lorazepam were documented as administered on the May 2023 MAR.

Resident #569's most recent Minimum Data Set (MDS) was a quarterly assessment dated 5/10/23. At that time, the resident was assessed to have severely impaired cognition. He was reported as having no behaviors nor rejection of care. The MDS assessment indicated the resident received an antianxiety medication on 1 out of 7 days during the look back period. He was reported as receiving Hospice services.

Review of the resident's May 2023 MAR revealed Resident #569 received a second dose of (oral tablet) lorazepam during the month (on 5/16/23 at 2:22 PM).

Resident #569's EMR included physician's orders dated 5/18/23 for the following medications, in part:
--0.5 mg lorazepam to be given as one tablet by mouth every 4 hours PRN for anxiety; and,
--0.5 mg haloperidol (an antipsychotic medication) to be given as one tablet by mouth every 4 hours PRN for restlessness or agitation. Haloperidol is a psychotropic medication.
No stop date or limitation on the duration of the PRN psychotropic medications was included in either the lorazepam or haloperidol orders dated 5/18/23.

A telephone interview was conducted on 5/24/23 at 4:35 PM with the facility's consultant pharmacist. During the interview, the consultant pharmacist was asked about the failure of the

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BLUMENTHAL NURSING & REHABILITATION CENTER	3724 WIRELESS DRIVE GREENSBORO, NC 27455

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F 758	Continued From page 44	F 758		

physician's orders to limit the duration of PRN psychotropic medications. In response, she reported, "Normally what happens.... the nursing staff will go back to the MD orders to put in an end date." During the pharmacist interview, the 5/18/23 orders for PRN lorazepam and PRN haloperidol without a specified end date were discussed. The pharmacist stated on her next visit, she would have needed to call the prescriber's attention to the omission of an end date for these medications.

An interview was conducted on 5/25/23 at 11:33 AM with the facility's Director of Nursing (DON). During the interview, the DON reported the concern related to the failure to limit the timeframe for PRN psychotropic medications was also identified during a recent mock survey conducted at the facility. When asked, the DON reported the facility had started a plan of correction for this issue but had not completed all components of it. The DON reported the facility's process involved having the Hospice MD write orders for PRN psychotropic medications for 14 days, then re-evaluate residents before re-writing these orders. She stated if a PRN psychotropic medication was not being used, it would be discontinued. She also reported that if a resident later had behaviors requiring it, the MD would be contacted to re-instate the medication.

A telephone interview was completed on 5/25/23 at 12:01 PM with the facility's Medical Director. During the interview, the MD was informed of the concerns regarding a failure to limit the timeframe for PRN psychotropic medications. The MD stated he was aware of the need for a PRN psychotropic medication to have an end date. He also reported the Nurse Practitioner who worked

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F 758	Continued From page 45 at the facility was typically good about including an end date if a PRN psychotropic medication was ordered. The MD stated that unfortunately, Hospice protocols may not include an end date for psychotropic medications ordered on an as needed basis.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to	F 761	1.How the corrective action will be accomplished for those residents found to	6/22/23

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Continued From page 46

secure medications for 1 of 1 resident (Resident #88) observed with medications at bedside.

Findings included:

Resident #88was admitted to the facility on 7/19/22. Diagnoses included, in part, aphasia following cerebral infarction and diabetes.

The yearly Minimum Data Set assessment dated 5/7/23 revealed Resident #40 had minimal impaired cognition.

An observation of Resident #88's room was completed on 5/21/23 at 11:31 AM. The resident was alert and lying in bed. A bottle of Nystatin powder with his name on it was observed on the resident's bedside table. During an interview with Resident #88 on 5/21/23 at 11:35 AM, he indicated by nodding his head and using a thumbs up sign that the bottle belonged to him and that he used it occasionally when needed.

During a record review performed on 5/21/23 there was no self-administer medication assessment found for Resident #88.

Med Tech #1 was interviewed on 5/22/23 at 09:35 AM during a medication pass observation. She stated that she was unaware that Resident #88 had Nystatin powder by his bedside. She stated that was supposed to be for only 10 days in April. She indicated that she did not know who would have given it to him to keep and promptly removed it from his room.

During an interview with the Director of Nursing on 5/23/23 at 2:49 PM, she stated that Resident #88 was capable of administering the powder at

F 761

have been affected by the deficient practice.

The Nystatin Powder located at the bedside of Resident #88 was removed by the charge nurse on 5/22/23.

2.How the facility will identify other residents having the potential to be affected by the same deficient practice.

On 5/24/23, the administrative staff (includes social worker, MDS Nurse, Admissions Director, Central Supply Person, Business office manager, Assistant Business office manager, Medical Records, and Activity’s Director) completed a room inspection of all resident rooms to ensure that no other medications were observed at bedside.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

Administrative staff are now required to conduct one set of room rounds in the mornings during breakfast to ensure that no medications were left at bedside during 3rd shift.

On 6/19/23, all nursing staff were educated on F761 with emphasis on the importance of not leaving medications at bedside to minimize the risk of any adverse outcomes such as drug diversion or residents consuming medication unsupervised. Anyone not educated before 6/21/23 will be educated prior to

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F 761	Continued From page 47 his discretion, however, a self-assessment had not been completed for him to do so at that time.	F 761	the start of their next shift. New hires will be educated during orientation. 4.How the facility will monitor its performance to ensure the deficient practice does not recur. 20 resident rooms will monitored at random by a member of the administrative staff to ensure that no medications are observed at bedside. Observations will be conducted weekly X4, monthly X3 and quarterly thereafter to ensure adequate compliance. Findings will be documented on Ambassador round audit tool. The Director of Nursing (DON) and/or Administrative Nurses will complete a summary of the audit results and present at the facility monthly Quality Assurance and Performance Improvement (QAPI) meeting to ensure continued compliance with F761.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:	F 791		6/22/23

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F 791	Continued From page 48 (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, interview with the Dental Practice Administrator, and record review, the facility failed to reschedule a follow up dental care appointment for recommended extractions for 1 of 3 residents (Resident #55) reviewed for dental services.	F 791	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The dental care appointment was rescheduled for 6/6/23. Resident #55 was	

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F 791

Continued From page 49

Findings included:

Resident #55 was admitted to the facility on 8/20/20. Diagnosis included, in part, gastroesophageal reflux disease.

On 9/28/22, the resident was seen at the facility by the dentist. The comprehensive examination note read, in part, "Diagnosis: Unrestorable teeth, needs extractions-multiple root tips and teeth with advanced bone loss. Patient would like dentures ..." The note further recommended that prior authorization for dentures be obtained and that extractions were to be performed on the next regularly scheduled visit.

A dental visit note dated 1/10/23 revealed Resident #55 was scheduled to be seen by the in-house dental provider for extractions; however, the resident had not felt well on the day of the visit and asked to wait until "the next time" for dental services.

The medical record was reviewed and there were no other dental consultations or evidence of appointments scheduled for Resident #55 since 1/10/23.

The annual Minimum Data Set (MDS) assessment dated 5/7/23 revealed Resident #55 was cognitively intact. He was coded as having no dental issues.

The care plan, updated 5/14/23, included an area of focus for dental care. Care plan interventions included the facility would refer the resident for a dental examination and assist with resources to pay for dentures.

F 791

treated on 6/6/23.

2.How the facility will identify other residents having the potential to be affected by the same deficient practice.

On 6/5/23, all residents were assessed by MDS nurses to ensure that anyone in need of dental services would be seen on 6/6/23. The dental clinic was held on 6/6/23. All residents who were identified as needing dental care were seen and treated on 6/6/23.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

In addition to scheduling the dental clinic with the facility social worker, the notification will also be shared with the administrator. Additionally any needed follow up needed from the original appointment, this communication will be shared with the facility social worker to communicate with the Director of Nursing.

The social worker and administrative nurses (Director of Nursing (DON), Staff Director of Nursing,) were educated on the importance of ensuring that residents in need of dental care are seen in a timely manner.

How the facility will monitor its performance to ensure the deficient practice does not recur.

10 residents will be interviewed at random

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F 791	Continued From page 50 On 5/21/23 at 11:46 AM, an interview was conducted with Resident #55, during which he shared he wanted dentures and was scheduled to be seen by the facility dentist in January 2023 for extractions, but he was sick on the day of the visit and the dentist was unable to see him. Resident #55 stated the facility was supposed to reschedule the appointment, but he hadn't heard if the appointment had been rescheduled. The resident said he was able to eat food with no issues, had not lost any weight and was not having any mouth pain. An observation of Resident #55's mouth was completed with MDS Nurse #1 on 5/23/23 at 1:24 PM. During the observation, MDS Nurse #1 reported the resident had missing and broken teeth. Resident #55 denied any pain with his teeth. During a telephone interview with the Former Social Worker (SW) on 5/24/23 at 10:21 AM, she explained a dental practice provided services to residents at the facility. Typically, she emailed them a list of residents who needed to be seen or the dental practice emailed her about upcoming visits. She stated the dental practice was supposed to schedule another visit with the facility to perform extractions for Resident #55 and if she hadn't heard from them, she normally contacted them to schedule the appointment. The Former SW acknowledged she had not followed up with the dental practice and rescheduled the appointment for Resident #55 and stated, "It just got missed. I was the only SW in the building and it was an oversight on my part." The Director of Operations was interviewed on	F 791	by a member of the administrative staff (includes, social worker, medical records. Admissions director, central supply person, MDS Nurse, Business office manager, Assistant Business office Manager, and Activity's Director) weekly X4, monthly X3 and quarterly thereafter to ensure that residents are being treated timely if they need dental services. If a resident is not able to be interviewed, a member of the administrative staff will contact the responsible party of that resident to inquire about any dental needs to ensure that any concerns are being addressed as soon as possible. The Director of Nursing and/or designee will complete a summary of the audit results and present at the facility monthly QAPI meeting to ensure continued compliance with F791.	

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F 791	Continued From page 51	F 791		

5/23/23 at 2:16 PM. She reported Resident #55 had an initial visit with the dentist at the facility on 9/22/22. The resident had some broken teeth and wanted dentures. The dental practice created a treatment plan which included multiple extractions prior to obtaining dentures. The Director of Operations said the dentist's last visit at the facility was in January 2023. She had spoken to a representative at the dental practice 5/23/23 and their next scheduled visit was 6/6/23 and Resident #55 was on the list to be seen.

A telephone interview was conducted with the Dental Practice Administrator on 5/23/23 at 3:31 PM. She explained the dental practice came to the facility about every three months. She stated the dentist saw Resident #55 on 9/22/22 and formulated a treatment plan for extractions and then dentures. The resident needed 13 extractions, then once healed, impressions would be made for dentures. She added the extractions needed to occur over several dental visits. The dentist came to the facility in January 2023 but Resident #55 was not feeling well and the dentist was unable to perform extractions. She shared a follow up had not been scheduled because the dental practice missed scheduling a date with the facility after January 2023. She reported the facility contacted the dental practice 5/23/23 and scheduled a time for the dentist to come to the facility on 6/6/23.

In an interview with the Administrator on 5/24/23 at 1:33 PM, he stated the social work department was responsible for coordinating dental services. He said the Former SW should have reached out to the dental practice and scheduled or confirmed the next dental clinic at the facility.

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F 809	Continued From page 52	F 809		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and the consultant Registered Dietitian (RD), and record review, the facility failed to provide a nourishing evening snack when more than 14 hours elapsed between the provision of a substantial evening meal and breakfast the following day for residents residing on 7 of 7 resident hallways (700 Hall, 200 Hall, 3200 Hall, 300 Hall, 400 Hall, 500 Hall and 600 Hall). The findings included: A review of the facility's "Tray Delivery Schedule" (updated 10/20/21) indicated the meal cart	F 809	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/25/23, the mealtimes were modified by the administrator not to exceed a time frame of 14 hours between breakfast and dinner. On 5/29/23,the administrator and dietary manager reviewed the process on how to obtain snacks between meals. The resident council voiced understanding.	6/22/23

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F 809	Continued From page 53 delivery times were scheduled as follows: --The meal cart for the 700 Hall was scheduled to be delivered at 5:00 PM for Dinner and at 8:00 AM for Breakfast (indicative of a 15-hour time span between the two meals). --The meal cart for the 200 Hall was scheduled to be delivered at 5:25 PM for Dinner and at 8:25 AM for Breakfast (indicative of a 15-hour time span between the two meals). --The meal cart for the 3200 Hall was scheduled to be delivered at 5:35 PM for Dinner and at 8:35 AM for Breakfast (indicative of a 15-hour time span between the two meals). --The meal cart for the 300 Hall was scheduled to be delivered at 5:45 PM for Dinner and at 8:45 AM for Breakfast (indicative of a 15-hour time span between the two meals). --The meal cart for the 400 Hall was scheduled to be delivered at 5:45 PM for Dinner and at 8:45 AM for Breakfast (indicative of a 15-hour time span between the two meals). --The meal cart for the 500 Hall was scheduled to be delivered at 5:55 PM for Dinner and at 8:55 AM for Breakfast (indicative of a 15-hour time span between the two meals). --The meal cart for the 600 Hall was scheduled to be delivered at 6:00 PM for Dinner and at 9:00 AM for Breakfast (indicative of a 15-hour time span between the two meals). An interview was conducted with the Dietary Manager on 5/23/23 at 10:50 AM regarding between-meal snacks provided to residents, including bedtime snacks. The Dietary Manager reported residents who had a physician's order for a specific snack would be provided one. For other residents, a container was placed in the nourishment rooms with a variety of snack items which may include the following: goldfish	F 809	2.How the facility will identify other residents having the potential to be affected by the same deficient practice. On 6/16/23, the administrator and dietary manager went and communicated with all alert and oriented residents and reviewed current mealtimes and how to obtain snacks between meals. The families of all other residents were notified by phone. Notifications were completed by 6/20/23. 3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The mealtimes were modified on 5/25/23 by the administrator not to exceed a time frame of 14 hours. The dietary manager was educated on 5/25/23 on the importance of ensuring that there are no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime. 4.How the facility will monitor its performance to ensure the deficient practice does not recur. Meal times will be monitored 5 days a week X4, monthly X3 and quarterly thereafter to ensure that the facility is in compliance with F 809 and its content. Findings will be documented on the mealtime Audit tool.	

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F 809	Continued From page 54 crackers, saltine crackers, graham crackers, cookies, animal crackers, fig bars, peanut butter crackers, and potato chips. She noted small juice containers were also kept in the nourishment room refrigerators for residents. The Dietary Manager stated it was the Nurse Aides' (NAs') responsibility to offer snacks to residents. An interview was conducted on 5/23/23 at 11:20 AM with the facility's consultant Registered Dietitian (RD). During the interview, the RD reported nourishments were sent out to the nourishment rooms and included such items as crackers, pudding (on occasion), and fruit juice. When asked if all residents were offered an evening snack, the RD stated, "I don't think so." She added that residents with diabetes who needed a sandwich for a bedtime snack may receive a sandwich on his/her tray with the evening meal so it would be available to that resident as a bedtime snack. A Resident Council Meeting was held on 5/24/23 at 11:00 AM. During the meeting, the residents reported they were not offered snacks. The residents stated they could go to the kitchen to get a snack themselves or alternatively, they could ask nursing staff to get a snack for them from the nourishment room (if available). The residents reported snacks typically consisted of cookies, crackers, and potato chips. A follow-up interview was conducted with the consultant RD on 5/24/23 at 1:48 PM to discuss the timing of the meals served and the 15-hour time span scheduled between the provision of the residents' evening meal and breakfast the following day. During this interview, the RD reported she had not specifically looked at the	F 809	The Administrator or designee will present a summary of these audits to present at the monthly Quality Assurance and Performance Improvement (QAPI) meeting to ensure continued compliance with F809.	

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F 809	Continued From page 55 meal schedule and was not aware the time span between dinner and breakfast the next day was greater than 14 hours. Upon review of the current meal schedule, the RD stated she thought the facility would need to consider adjusting the scheduled mealtimes.	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and the consultant Registered Dietitian (RD), and record reviews, the facility failed to: 1) Seal, label/date, and/or discard expired food items in 1 of 1 walk-in cooler; 2) Seal and label/date opened food items in 1 of 1 Dry Storage area; 3) Label/date opened food items stored in the kitchen preparation / cooking area; and 4)	F 812	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The plastic container that contained the link sausages, pureed meats and eggs and were warm to touch were discarded	6/22/23

F 812

Continued From page 56

Label/date opened food items in 1 of 1 Nourishment Room observed (200 Hall). These practices had the potential to affect food served and distributed to all residents.

The findings included:

1. An initial tour of the Dietary Department was conducted on 5/21/23 at 10:10 AM and a follow-up observation done with the Dietary Manager on 5/21/23 at 2:23 PM. Observations made of the walk-in cooler identified the following concerns:
--A 1/2 (4-inch deep) steam table pan contained 3 plastic container bags piled 6-inches high (over the top of the pan). Both the steam table pan itself and contents of the 3 plastic bags were warm to the touch. The contents of the plastic bags included link sausages, pureed meat, and eggs. During the follow-up observation conducted with the Dietary Manager on 5/21/23 at 2:23 PM, the contents of the plastic bags stored in the steam table pan were not yet cooled. The Dietary Manager reported the contents of the plastic bags needed to be discarded.
--An undated plastic bucket containing whole, cooked eggs was stored unsealed in the walk-in refrigerator. The lid of the bucket was loosely placed (not snapped shut) on the container and the inner plastic bag was observed to be completely open to air (not sealed).
--An opened, undated box with an opened and unsealed interior plastic bag was observed to contain approximately 60 pieces of Texas garlic toast. Neither the box nor the plastic bag was closed, leaving the garlic toast exposed to air (not sealed).
--An undated plastic bag labeled "chicken" contained approximately 6 pieces of chicken.

F 812

on 5/21/23 by the dietary manager.

The undated plastic bucket containing whole cooked eggs was discarded on 5/21/23 by the dietary manager.

The undated box with an open seal that contained the 60 pieces of Texas Garlic Toast was discarded by the dietary manager on 5/21/23.

The undated plastic bag labeled chicken that contained approximately 6 pieces of chicken was discarded by the dietary manager on 5/21/23.

The 2 plastic bags containing French Toast sticks were discarded on 5/21/23 by the dietary manager.

The 5 quart plastic container labeled cheesecake was discarded by the dietary manager on 5/21/23.

The 5 quart plastic container labeled tuna salad was discarded on 5/21/23 by the dietary manager.

The 5 quart plastic container of creamy cole slaw was discarded on 5/21/23 by the dietary manager.

The 1 quart carton of whipping cream was discarded by the dietary manager on 5/21/23.

The Seafood Breader was discarded by the dietary manager on 5/21/23.

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The label only had "Friday" circled on it (no date). During the follow-up observation conducted with Dietary Manager on 5/21/23 at 2:23 PM, the Dietary Manager acknowledged without the specific date on the bag, it was not possible to know whether the chicken had been stored in the plastic bag for 2 days or 9 days.
--Two plastic bags containing French toast sticks (approximately 20-30 sticks in each) were stored in opened, undated plastic bags.
--A 5-quart plastic container labeled "cheesecake" and dated 5/9/23 (expired) was stored in the walk-in cooler. During the follow-up observation conducted with Dietary Manager on 5/21/23 at 2:23 PM, the Dietary Manager reported the cheesecake should not have been held more than 7 days. She was observed as she pulled the cheesecake filling from the walk-in cooler to be discarded.
--A 5-quart plastic container stored in the walk-in cooler was labeled as "tuna salad" and dated 5/17/23 with a "use by" date of 5/20/23 (expired). During the follow-up observation conducted with Dietary Manager on 5/21/23 at 2:23 PM, the Dietary Manager reported the tuna salad needed to be discarded. She was observed to pull the tuna salad container from the walk-in cooler to be discarded.
--A 5-quart plastic container containing a creamy-appearing coleslaw was observed to be stored in the walk-in cooler. The container was not dated. During the follow-up observation conducted with Dietary Manager on 5/21/23 at 2:23 PM, the Dietary Manager was observed to pull the container from the walk-in cooler to be discarded.
--A 1-quart carton of whipping cream with an expiration date of 5/20/23 (expired) was observed to be stored in the walk-in cooler. During the

F 812

The flour bag on the inside of the bin was discarded on 5/21/23 by the dietary manager.

The contents on the white sugar bin was discarded on 5/21/23 by the dietary manager.

The 16 ounce container of tapioca pudding was discarded by the dietary manager on 5/21/23.

The one half pitcher of tea bags left in the container was discarded by the dietary manager on 5/21/23.

The plastic grocery bag containing ¿ quart container of fresh fruit was discarded by the dietary manager on 5/21/23.

The plastic grocery bag observed to be labeled with masking tape containing the pieces of meat and corn on the cobb was discarded on 5/21/23 by the dietary manager.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

Dietary Manager and Administrator conducted an observation round of the kitchen on 6/12/23, to identify other areas of the kitchen that needed attention to ensure adequate compliance with F812 and its content.

3.What measures will be put in place or systemic changes made to ensure that

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F 812	Continued From page 58 follow-up observation conducted with Dietary Manager on 5/21/23 at 2:23 PM, the Dietary Manager was observed to pull the carton from the walk-in refrigerator to be discarded. 2. An initial tour of the Dietary Department was conducted on 5/21/23 at 10:22 AM and a follow-up observation done with the Dietary Manager on 5/21/23 at 2:23 PM. Observations made of the Dry Storage area of the kitchen identified the following concerns: --A manufacturer bag of "Seafood Breader" dated "9/17" was stored in the dry storage area of the kitchen. The contents of the bag were observed to be open to air (not sealed). --The lid of the flour bin in the dry storage area was not placed tightly onto the bin, leaving the lid open approximately one inch and the contents of the bin open to air. The flour bag inside the bin was open and unsealed. --The white sugar bin in the dry storage area was observed to have a scoop left in the sugar. The label on the outside of the bin read, "Do not leave scoops in product." The shelf life on the label of the bin read use by "3/28/23." An interview was conducted with the CDM during the follow-up observations of the Dry Storage area on 5/21/23 at 2:23 PM. At that time, the Dietary Manager reported all food items in the dry goods storeroom needed to be sealed, labeled, and dated. 3. An initial tour of the Dietary Department was conducted on 5/21/23 at 10:40 AM and a follow-up observation done with the Dietary Manager on 5/21/23 at 2:23 PM. Observations made of the food preparation and cooking areas of the kitchen identified the following concern:	F 812	the deficient practice will not recur. The administrator, dietician, and dietary manager will be completing weekly observations of the kitchen and have implemented weekly meetings with the dietary manager to ensure consistent compliance with F812. All dietary staff (including cooks and dietary aides) were in serviced on F812 and its content with emphasis on the importance of ensuring that food stored in the walk-in cooler is completely sealed and dated to indicate origin of it being opened, the importance of not leaving scoops inside of bins, and proper labeling and dating items stored in the nourishment room. Education was conducted on 5/22/23 and completed on 5/23/23 by dietician. New hires will be educated during orientation. Anyone not educated prior to 5/23/23 will not be scheduled to work until completion of education. 4.How the facility will monitor its performance to ensure the deficient practice does not recur. Random kitchen and nourishment room observation audits will be conducted 5 times weekly X4, monthly X3 and quarterly thereafter to ensure items observed are properly labeled and dated, utensils are properly stored, and items are properly sealed. Audit checklist will be completed by dietary manager or designee or designee. Findings will be	

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--An unlabeled 4-quart container storing a fine, white powder was placed on the kitchen counter near a food processor and prep sink. A scoop was observed stored inside the container and in contact with the white powder. During a follow-up observation conducted with Dietary Manager on 5/21/23 at 2:23 PM, the Dietary Manager reported the white powder was a food thickener. The Dietary Manager also stated the scoop should not have been left in the container.

4. An observation was made of the 200 Hall Nourishment Room on 5/21/23 at 11:50 AM. Observations made of the Nourishment Room identified the following concerns:
--A 16-ounce container of prepared tapioca pudding was stored in the door of the refrigerator. The manufacturer's expiration date on the bottom of the container read, "Best by Jan 18 2023" (expired). The container was labeled with a resident's name and room number.
--An undated, one-half full pitcher was observed to have two tea bags left in the container. The pitcher was only labeled with a resident's room number.
--A plastic grocery bag (not labeled, not dated) contained 1/2 of a quart container of fresh fruit with a plastic fork left in the container. The pineapple in the container was discolored red; the fruit no longer appeared to be fresh.
--A plastic grocery bag was observed to be labeled with masking tape on the outside of the bag and a hand-written note which read, "4/2/23" and a room number. The grocery bag contained a plastic container and two foil-wrapped items (all unlabeled). Upon opening the plastic container, a pasta appearing to contain a meat sauce was observed to have a white fuzzy substance on the pieces of meat. The two foil-wrapped items were

F 812

documented on Kitchen Audit tool

The Dietary Manager or designee will present a summary of these audits at the facility's monthly Quality Assurance and Performance Improvement (QAPI) meeting to ensure continued compliance with F812.

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F 812	Continued From page 60 identified as a cob of corn and a slice of garlic bread. An interview was conducted with the Dietary Manager on 5/21/22 at 2:23 PM. During the interview, the Dietary Manager reported the Nourishment Rooms were typically checked once daily by the Dietary Staff. She reported all items in the refrigerator needed to be dated and labeled with a resident's name and room number. The Dietary Manager reported the unlabeled, undated, and/or expired items found in the Nourishment Room needed to be discarded. An interview was conducted on 5/24/23 at 11:34 AM with the facility's consultant Registered Dietitian (RD). During the interview, concerns identified during the initial tour and follow-up observations of the Dietary Department were discussed. The RD reported that all opened or prepared food items stored in the Dietary Department needed to be labeled and dated. All unlabeled food or expired food items needed to be immediately discarded. Also, she stated food items kept in the Nourishment Room refrigerators needed to be labeled with a resident's name, room number, and date with the stored food kept only for 3 days. The RD added that Dietary personnel were responsible for cleaning out the Nourishment Rooms (including the refrigerator) twice daily.	F 812		
F 867 SS=F	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	F 867		6/22/23

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F 867	Continued From page 61	F 867		

collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, 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

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F 867	Continued From page 62 aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; 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	F 867		

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F 867	Continued From page 63 number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey dated 6/21/2021 and 8/4/2022, and the complaint survey dated 10/11/2022. This was for nine deficiencies that were cited in the areas of resident rights (F550), formulate advanced	F 867	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. As of 6/10/2023 facility Quality Assurance Performance Improvement (QAPI) process has been corrected to effectively correct and monitor deficient areas.	

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directives (F578), safe/clean/homelike environment (F584), accuracy of assessments (F641), care plan timing and revision (F657), treatment and services to prevent/heal pressure ulcers (F686), free from unnecessary psychotropic medications and as needed use (F758), label and store drugs and biologicals (F761), and food procurement (F812). The nine areas were recited on the current recertification and complaint survey of 5/25/2023. The duplicate citations during two federal surveys of record demonstrate a pattern of the facility's inability to sustain an effective QAA program.

The findings included:

This tag is cross referenced to:

1. F550 - Based on observation, record review, staff and resident interviews, the facility failed to promote dignity when, 1) a staff member transported a resident (Resident #84) into a public area with the back of their gown open, exposing the backside of the resident and 2) by not shaving a female resident's face (Resident #49) that was dependent on staff for activities of daily living (ADL) care needs. This occurred for 2 of 17 residents reviewed for Dignity and respect.

During the recertification and complaint survey dated 8/4/2022, the facility failed to provide privacy to a resident receiving a COVID test in the dining room for 1 of 5 residents reviewed for dignity (Resident #2). Additionally, the facility failed to provide a privacy cover over a urinary catheter drainage bag for 1 of 1 resident reviewed for urinary catheter (Resident #24).

An interview was conducted with the

F 867

2.How the facility will identify other residents having the potential to be affected by the same deficient practice.

As of 6/21/2023 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.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

As of 6/21/2023 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. The administrator will review the Plan of Correction during the weekly Ad Hoc Quality Assurance and Performance Improvement (QAPI) meeting to ensure no future repeats of prior tags for 12 weeks.

4.How the facility will monitor its performance to ensure the deficient practice does not recur.

The administrator will report all findings to

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F 867	Continued From page 65 Administrator on 5/25/2023 at 3:58 p.m. and he stated the Quality Assurance committee meets monthly and consist of the Administrator, Director of Nursing, Dietary Manager, Admission Director, Medical Director, Staff Development coordinator, Rehabilitation Director, maintenance Director, Minimum Data Set coordinator, and Social Worker. He added the committee discuss ways to enhance the facility performance and the way they care for the residents and the systems that allow them. He stated the facility had a lot of newly trained and hired staff. The committee will need to ensure the new staff are being properly trained and are adapting to the expectations set by the facility and the residents. 2. F578 - Based on record reviews, resident and staff interviews, the facility failed to accurately transcribe the Advance Directive of 1 of the 2 sampled residents reviewed (Resident #13). During the recertification and complaint survey dated 8/4/2022, the facility failed to accurately document code status in the electronic health record (EHR) and paper record for 2 of 2 residents (Resident #8 and Resident #58) reviewed for advance directives. An interview was conducted with the Administrator on 5/25/2023 at 3:58 p.m. and he stated the Quality Assurance committee meets monthly and consist of the Administrator, Director of Nursing, Dietary Manager, Admission Director, Medical Director, Staff Development coordinator, Rehabilitation Director, maintenance Director, Minimum Data Set coordinator, and Social Worker. He added the committee discuss ways to enhance the facility performance and the way they care for the residents and the systems that	F 867	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.	

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F 867	Continued From page 66 allow them. He stated the facility had a lot of newly trained and hired staff. The committee will need to ensure the new staff are being properly trained and are adapting to the expectations set by the facility and the residents. 3. F584 - Based on observations and interviews with residents and staff, the facility failed to ensure cigarettes were disposed of in a non-combustible container (courtyard), failed to properly label and store personal care equipment in shared bathroom (rooms 603 and 609); failed to repair the linoleum around the base of the toilet (room 605); failed to maintain walls and baseboards in good repair (rooms 602, 605, 606, and 611); failed to repair loose fitting sink faucets (rooms 602 and 606); failed to maintain toilet paper holders in good repair (room 602 and 603); failed to maintain properly attached call bell wall sockets (room 603); failed to maintain window blinds in good repair (room 604); maintain night stand in good repair (room 603). This occurred for a courtyard and 7 of 11 rooms reviewed for a clean, safe, and homelike environment. During the recertification and complaint survey dated 8/4/2022, the facility failed to maintain a clean living environment for 5 of 12 residents (Resident #35, Resident #58, Resident #86, Resident #17 and Resident #93) and 1 of 6 residents' halls (700 hall) reviewed for environment. An interview was conducted with the Administrator on 5/25/2023 at 3:58 p.m. and he stated the Quality Assurance committee meets	F 867		

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F 867	Continued From page 67 monthly and consist of the Administrator, Director of Nursing, Dietary Manager, Admission Director, Medical Director, Staff Development coordinator, Rehabilitation Director, maintenance Director, Minimum Data Set coordinator, and Social Worker. He added the committee discuss ways to enhance the facility performance and the way they care for the residents and the systems that allow them. He stated the facility had a lot of newly trained and hired staff. The committee will need to ensure the new staff are being properly trained and are adapting to the expectations set by the facility and the residents. He added the facility needs to be more intentional about maintaining the homelike environment regulatory requirements and not just in regard to the interior of the facility but should include the exterior. 4. F641 - Based on observation, staff interviews and record reviews, the facility failed to accurately code 1. tobacco user status, 2. dental status, and 3. pressure ulcer on the Minimum Data Set (MDS) assessment for 3 of 34 residents (Residents #18, #55 and #28) reviewed for MDS accuracy. During the recertification and complaint survey dated 8/4/2022, the facility failed to code the Minimum Data Set (MDS) assessment accurately for limitations in range of motion (Resident #43) for 1 of 1 resident record reviewed for positioning. An interview was conducted with the Administrator on 5/25/2023 at 3:58 p.m. and he stated the Quality Assurance committee meets monthly and consist of the Administrator, Director of Nursing, Dietary Manager, Admission Director, Medical Director, Staff Development coordinator,	F 867		

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F 867	Continued From page 68	F 867		

Rehabilitation Director, maintenance Director, Minimum Data Set coordinator, and Social Worker. He added the committee discuss ways to enhance the facility performance and the way they care for the residents and the systems that allow them. He stated the facility had a lot of newly trained and hired staff. The committee will need to ensure the new staff are being properly trained and are adapting to the expectations set by the facility and the residents.

5. F657 - Based on observations, record reviews, resident and staff interviews, the facility failed to revise the care plan of 1 of 1 sampled resident (Resident #88) reviewed for range of motion and contractures.

During the recertification and complaint survey dated 6/24/2021, the facility failed to review and revise a resident's care plan to accurately reflect the assistance required to safely transfer 1 of 10 residents reviewed for accidents (Resident #48).

An interview was conducted with the Administrator on 5/25/2023 at 3:58 p.m. and he stated the Quality Assurance committee meets monthly and consist of the Administrator, Director of Nursing, Dietary Manager, Admission Director, Medical Director, Staff Development coordinator, Rehabilitation Director, maintenance Director, Minimum Data Set coordinator, and Social Worker. He added the committee discuss ways to enhance the facility performance and the way they care for the residents and the systems that allow them. He stated the facility had a lot of newly trained and hired staff. The committee will need to ensure the new staff are being properly trained and are adapting to the expectations set

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F 867	Continued From page 69	F 867		

by the facility and the residents.

6. F686 - Based on observations, record review, staff interviews, and the Wound Physician interview, the facility failed to follow a physician order for a wound dressing change for 1 of 4 (Resident #569) sample residents reviewed for pressure ulcers.

During the recertification and complaint survey dated 8/4/2022, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 1 of 6 residents reviewed for pressure ulcers (Resident #41).

An interview was conducted with the Administrator on 5/25/2023 at 3:58 p.m. and he stated the Quality Assurance committee meets monthly and consist of the Administrator, Director of Nursing, Dietary Manager, Admission Director, Medical Director, Staff Development coordinator, Rehabilitation Director, maintenance Director, Minimum Data Set coordinator, and Social Worker. He added the committee discuss ways to enhance the facility performance and the way they care for the residents and the systems that allow them. He stated the facility had a lot of newly trained and hired staff. The committee will need to ensure the new staff are being properly trained and are adapting to the expectations set by the facility and the residents.

7. F758 - Based on interviews with staff, the consultant pharmacist and Medical Director, and record reviews, the facility failed to limit the use of

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psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) ordered on an as needed (PRN) basis to 14 days and/or indicate the duration for the PRN order to be extended beyond 14 days, when appropriate. This occurred for 1 of 5 residents (Resident #569) reviewed for unnecessary medications.

During the recertification and complaint survey dated 8/4/2022, the facility failed to identify the need for an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving a daily antipsychotic medication for 2 of 5 residents reviewed for unnecessary medications (Residents #32 and #20).

An interview was conducted with the Administrator on 5/25/2023 at 3:58 p.m. and he stated the Quality Assurance committee meets monthly and consist of the Administrator, Director of Nursing, Dietary Manager, Admission Director, Medical Director, Staff Development coordinator, Rehabilitation Director, maintenance Director, Minimum Data Set coordinator, and Social Worker. He added the committee discuss ways to enhance the facility performance and the way they care for the residents and the systems that allow them. He stated the facility had a lot of newly trained and hired staff. The committee will need to ensure the new staff are being properly trained and are adapting to the expectations set by the facility and the residents.

8. F761 - Based on observation, resident and staff interviews and record review, the facility failed to secure medications for 1 of 1 resident

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(Resident #88) observed with medications at bedside.

During the recertification and complaint survey dated 8/4/2022, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 1 of 6 residents reviewed for pressure ulcers (Resident #41).

An interview was conducted with the Administrator on 5/25/2023 at 3:58 p.m. and he stated the Quality Assurance committee meets monthly and consist of the Administrator, Director of Nursing, Dietary Manager, Admission Director, Medical Director, Staff Development coordinator, Rehabilitation Director, maintenance Director, Minimum Data Set coordinator, and Social Worker. He added the committee discuss ways to enhance the facility performance and the way they care for the residents and the systems that allow them. He stated the facility had a lot of newly trained and hired staff. The committee will need to ensure the new staff are being properly trained and are adapting to the expectations set by the facility and the residents.

9. F812 - Based on observations, interviews with staff and the consultant Registered Dietitian (RD), and record reviews, the facility failed to: 1) Seal, label/date, and/or discard expired food items in 1 of 1 walk-in cooler; 2) Seal and label/date opened food items in 1 of 1 Dry Storage area; 3) Label/date opened food items stored in the kitchen preparation / cooking area; and 4) Label/date opened food items in 1 of 1 Nourishment Room observed (200 Hall). These

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practices had the potential to affect food served and distributed to all residents.

During the recertification and complaint survey dated 8/4/2022, the facility failed to date an open box of vegetables in the walk-in cooler, an open box of wheat rolls in the walk-in freezer, wet-stacked pans, failed to immerse pans in disinfectant/sanitizing solution for an appropriate length of time, and had stained plastic cups and plastic bowls for 2 of 2 kitchen observations. These practices had the potential to affect food served to the residents (109 out of 116 residents).

An interview was conducted with the Administrator on 5/25/2023 at 3:58 p.m. and he stated the Quality Assurance committee meets monthly and consist of the Administrator, Director of Nursing, Dietary Manager, Admission Director, Medical Director, Staff Development coordinator, Rehabilitation Director, maintenance Director, Minimum Data Set coordinator, and Social Worker. He added the committee discuss ways to enhance the facility performance and the way they care for the residents and the systems that allow them. He stated the facility had a lot of newly trained and hired staff. The committee will need to ensure the new staff are being properly trained and are adapting to the expectations set by the facility and the residents.

F 883 SS=E — Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) — F 883 — 6/22/23

§483.80(d) Influenza and pneumococcal immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization,

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F 883	Continued From page 73 each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		

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F 883	Continued From page 74 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to offer the opportunity to be vaccinated with the Prevnar 20 (pneumococcal conjugate vaccine (PCV) 20) in accordance with nationally recognized standards for 4 of 5 residents reviewed for pneumococcal immunizations (Resident #58, #53, #70, and #3). Findings include: The Center for Disease Control and the Advisory Committee on Immunization Practices (ACIP) now recommends "routine vaccination against pneumococcal infection for all adults aged 65 years or older and 19-64 with certain underlying medical conditions. Beginning June 8, 2021, for persons aged 65 years and older who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown, they should receive 1 dose of PCV15 or 1 dose of PCV20." Review of the facility's immunization policy last revised in 2019 stated that all residents would be offered a pneumococcal vaccine upon admission; brand unspecified. A. Record review revealed Resident #58 was	F 883	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. As of 6/19/23 residents #3, #53, #58 and #78 medical records were reviewed by the Physician/ NP and the Director of Nursing to verify if the resident was offered or received the pneumonia vaccine according to the CDC guidelines and national recognized standards. If residents' pneumonia vaccine was not up to, the resident and/or the responsible party were educated by the Infection Preventionist and /or the licensed nurse on the benefits and potential risk of receiving the pneumonia vaccine before providing consent or refusal. Once consent was obtained the vaccine was administered as ordered by the physician/NP by the licensed nurse. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. A 100% audit was conducted by medical	

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F 883

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admitted to the facility on 3/10/20 and was over 65 years of age at the time of admission.

Review of the pneumococcal immunizations, provided by the facility, indicated Resident #58 received a pneumococcal vaccine prior to admission to the facility. There was no other information since the last recertification on 8/4/2022 that the resident had specifically received PCV15 or PCV20.

B. Record review revealed Resident #53 was admitted to the facility on 10/18/22 and was over 65 years of age at the time of admission.

Review of the pneumococcal immunizations, provided by the facility, indicated Resident #53 declined to receive a pneumococcal vaccine. There was no documentation on the declination form that the resident had specifically been offered PCV15 or PCV20 vaccines. There was no documentation that the resident received a pneumococcal vaccine prior to admission or since the last recertification on 8/4/2022.

C. Record review revealed Resident #70 was admitted to the facility on 5/26/22 and under the age of 65 but admitted with underlying medical conditions, heart failure and diabetes mellitus.

Review of the pneumococcal immunizations, provided by the facility, indicated Resident #70 declined to receive a pneumococcal vaccine. There was no documentation on the declination form that the resident had specifically been offered PCV15 or PCV20 vaccines since the last recertification on 8/4/2022. There was no documentation that the resident received a pneumococcal vaccine prior to admission.

F 883

records to verify all residents' status on being offered or receiving the pneumonia vaccine according to CDC guidelines and national recognized Standards. Any residents identified as not being up to date was discussed with the physician regarding the appropriate vaccine to be administered. Audit was completed on 6/19/23. Education was provided by the Infection Preventionist and/or licensed nurse and consent obtained before administering the vaccine.

3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.

The administration of the vaccine will be entered in the resident medical record along with documentation of the education provided to the resident. Resident vaccine status will be reviewed by the clinical team daily during clinical meeting.

On 6/19/23 the Director of Nursing (DON) educated the Infection Preventionist and licensed nurses in the process for obtaining vaccine status on admission and annually to verify residents' pneumonia immunization vaccine status is up to date. The resident will be offered the appropriate vaccine according to immunization guidelines. Before administering the vaccine provide education on the benefits and the risk and obtain consent. Staff will not be permitted

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F 883	Continued From page 76 D. Record review revealed Resident #3 was admitted to the facility on 10/7/21 and was over 65 years of age at the time of admission. Review of the pneumococcal immunizations, provided by the facility, indicated Resident #3 declined to receive a pneumococcal vaccine. There was no documentation on the declination form that the resident had specifically been offered PCV15 or PCV20 vaccines since the last recertification on 8/4/2022. There was no documentation that the resident received a pneumococcal vaccine prior to admission. During an interview with the Staff Development Coordinator/Infection Preventionist on 5/25/23 at 3:04 PM, she stated that the facility offers PPSV23 (Pneumovax 23) to all residents. She stated that she had been working at the facility in her role since February 2022. She stated that, as far as she was aware of, the facility had never offered the Prevnar vaccine. She stated she was not aware of the regulation that stated the facility should follow the ACIP recommendations. During an interview with the Administrator on 5/25/23 at 4:00 PM, he stated that he was unaware that the facility had to offer the Prevnar 20 vaccine.	F 883	to work until education is complete. New hires will be educated during orientation. 4.How the facility will monitor its performance to ensure the deficient practice does not recur. The Director of Nursing and/or the Infection Preventionist will audit new admission upon admission and current residents annually to verify pneumonia immunization status is up to date. Audit will be conducted 5xper week for 4 weeks; 3xper week for 4 weeks; then 1xper week for 4 weeks. A summary of these audits will be presented during the monthly Quality Assurance and Performance Improvement meeting (QAPI) to ensure continued compliance with F883.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff	F 919		6/22/23

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F 919	Continued From page 77 work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to maintain the pull cord of a bathroom call light for 1 of 2 front hall public restrooms. Findings included: On 5/23/23 at 11:30 AM an observation was made of the emergency call light in the women's front hall public restroom was in the activated/down position with the cord wrapped around the safety bar attached to the wall. On 5/25/23 at 1:06 PM an observation was made of an alert and oriented resident using the women's front hall restroom. During an interview on 5/25/23 at 1:32 PM, the resident stated that she used that restroom at times when she went outside the front door to smoke. During an interview and observation with the Maintenance Director on 5/25/23 at 1:58 PM, she stated that she had worked at the facility for 2 weeks. She stated she expected staff to alert her to broken call lights so that maintenance could fix them immediately. She stated she also expected the safety cords to not be wrapped around the safety bars and for the emergency call lights to all be in good working order.	F 919	1.How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The emergency call light in the women's front hall public rest room was fixed on 5/25/23 by the maintenance director. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. The emergency call lights of all resident bathrooms were checked to ensure they were properly functioning on 5/25/23 by the facility maintenance director. No issues were found. 3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The environmental round audit form conducted at least weekly by maintenance director was modified by the administrator on 5/30/23 to include observations of bathroom light system. The maintenance director and maintenance assistant were educated on 6/15/23 on the importance of ensuring the all resident emergency call light systems	

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F 919	Continued From page 78	F 919	are properly functioning at all times. Should there be a need for maintenance and the immediate issue cannot be resolved, other interventions be put in place until the issue is resolved, and the administrator must be notified. 4.How the facility will monitor its performance to ensure the deficient practice does not recur. Maintenance Director or Designee will conduct audits of 10 resident call systems weekly X4, monthly times 3 or quarterly thereafter to ensure adequate compliance. Findings will be documented on the call system audit tool. The Maintenance Director will complete a summary of the audit results and present them at the facility monthly Quality Assurance and Performance Improvement (QAPI) meeting to ensure continued compliance with F919.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/21/2023 through 5/25/2023. Event ID#8WL511. The following intakes were investigated NC00196028, NC00196881, NC00196978, NC00197476, NC00197584, NC00198436, NC00198444, NC00198745, NC00198822, NC00198998, NC00199012, NC00199043, NC00199507, NC00198567, NC00199714, NC00200506, NC00200604, NC00201090, NC00202339, and NC00202510. 17 of the 73 complaint allegations resulted in deficiency.	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345006	A. BUILDING ______ B. WING ______	C 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUMENTHAL NURSING & REHABILITATION CENTER	**3724 WIRELESS DRIVE** **GREENSBORO, NC 27455**

(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