STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562	A. BUILDING ______ B. WING ______	11/17/2023

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CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

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F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 11/13/23 through 11/17/23. Three (3) of ten allegations resulted in a deficiency. Intakes NC00210177, NC00210023, NC00209989, NC00209960, NC00209952, NC00209951, NC00209853, and NC00209013 were investigated. Event ID #RDLS11.	F 000		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with residents, staff and the Nurse Practitioner, the facility failed to assess the ability of residents to self-administer medications for 4 of 6 residents observed with medications at the bedside (Residents #30, #52, #25 and #237). The findings included: 1. Resident #30 was admitted to the facility on 4/30/22 with diagnoses that included anemia, chronic kidney disease and liver cirrhosis. The quarterly Minimum Data Set (MDS) assessment dated 8/25/23 indicated Resident #30 was cognitively intact, and was independent with most activities of daily living. A review of Resident #30's medical record indicated no documentation that Resident #30	F 554	Clear Creek Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Clear Creek Nursing and Rehabilitations response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Clear Creek Nursing and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute	12/27/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/15/2023

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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was assessed for self-administration of medications. Resident #30 did not have a physician's order for self-administration of medications.

A review of Resident #30's Medication Administration Record for November 2023 indicated an active physician's order for Vitamin D3 125 micrograms (5000 international units) - give one tablet by mouth one time a day for supplementation.

During an initial observation of Resident #30 in his room on 11/13/23 at 10:17 AM, Resident #30 was sitting up by the side of his bed with his head down and asleep. There was a bottle of red liquid labeled as sore throat oral anesthetic spray, a bottle labeled as Vitamin B12 5000 micrograms (mcg) and another green bottle of pills on the windowsill. There was also a bottle of nasal spray, and a bottle of ear drops on top of Resident #30's bedside table.

An interview with Resident #30 on 11/13/23 at 12:41 PM revealed he took one pill from green bottle and one pill from the Vitamin B12 bottle once a day every morning. Resident #30 stated that the green bottle of pills was just vitamins. During the interview, he pulled out a bag of Epsom salts from inside his closet and stated that he used the Epsom salts to soak his feet at night. He further stated that he did all activities of daily living independently and rarely had to request assistance from staff.

Another observation of Resident #30's room on 11/14/23 at 12:24 PM revealed the same medications previously observed on 11/13/23 were still at Resident #30's bedside. The green

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resolution, formal appeal procedure and/or any other administrative or legal proceeding.

F554 Resident Self- Administration of Medications -Clinically Appropriate

1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice:

Resident #30 remains in the facility. On 11-15-23, the Unit Manager completed Medication Self Administration Assessment. The findings of the assessment and physician have been deemed Resident #30 to be clinically inappropriate for self-administration of medications. The medications were removed from Resident #30�s room at the time.

Resident #52 remains in the facility. On 11-15-23, the assigned Staff Nurse completed Medication Self Administration Assessment. The findings of the assessment and physician have been deemed
Resident # 52 to be clinically appropriate for self-administration of medications.

Resident #25 remains in the facility. On 11-23-23, the assigned Staff Nurse completed Medication Self Administration Assessment. The findings of the assessment and physician has been deemed Resident #25 to be clinically appropriate for self-administration of

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F 554	Continued From page 2 bottle of pills was observed to be Vitamin D3. An interview with Nurse #1 on 11/14/23 at 2:38 PM revealed she had not noticed any of the medications that Resident #30 kept at his bedside. Nurse #1 stated that she always administered his medications at the dining table whenever he ate his breakfast, and she did not usually go to his side of the room. During the interview with Nurse #1, another observation and interview with Resident #30 revealed the green bottle of pills was Vitamin D3 125 mcg (5000 IU), and the Vitamin B12 was 5000 mcg. Both bottles were on Resident #30's windowsill along with a bottle of medicated relief lotion and a bottle of throat spray. Resident #30 stated that he seldom used the throat spray anymore, but he often rubbed the medicated relief lotion to his hands and arms whenever they hurt. Resident #30 also showed a saline nasal spray which was on top of his bedside table and stated that he used this to irrigate his ears. He further revealed a bottle of earache drops which he used whenever his ears hurt. Resident #30 stated that he had brought all of these medications from home, and he was used to using them when he was at home. Nurse #1 stated she did not know whether Resident #30 was assessed for medication self-administration and that she would have to look at his medical record. An interview with Nurse #2 on 11/15/23 at 9:48 AM revealed she had taken care of Resident #30, but she had not noticed any of the medications that he kept at the bedside. Nurse #2 stated Resident #30 was usually out in the hallway, and he always came to the nurses' station or to the medication cart whenever he was ready to take his medications. Nurse #2 stated she did not	F 554	medications. Resident #237 remains in the facility. On 12-12-23, the Unit Manager completed the Medication Self Administration Assessment. The findings of the assessment and physician have deemed Resident #22 to be clinically inappropriate for self-administration of medications. The medications were removed from Resident #30□s room at the time. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: " Current residents have the potential to be affected. On 12-12-23, the Unit Manager completed an audit of 100% of resident rooms. This audit is to ensure no medications were in the resident□s room unless the resident had been assessed, deemed clinically appropriate for self-administration of medications, and physician order obtained. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: " On 12-12-23 , the Staff Development Coordinator (SDC) initiated an in-service with current facility and contract nurses and medication aides noting medications should be administered per physician order and no medications should be left	

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usually go into Resident #30's room.

An interview with Medication Aide (MA) #1 on 11/15/23 at 2:23 PM revealed she had not noticed Resident #30's medications at the bedside. MA #1 stated that Resident #30 was always at the dining table whenever she gave his morning medications.

An interview with Nurse #3 on 11/16/23 at 10:11 AM revealed she normally did not look in Resident #30's room and she usually gave his medications while he was eating breakfast. Nurse #3 stated she noticed that Resident #30 had a lot of stuff in his room that he had ordered online and even if she noticed his medications, she knew it would have been an argument trying to keep him from having medications at the bedside. Nurse #3 stated that if Resident #30 wanted to self-administer medications, the doctor would need to write an order that he was capable of administering his own medication and an assessment would need to be completed. Nurse #3 further stated she was not aware whether Resident #30 had a doctor's order, or an assessment was completed regarding medication self-administration.

An interview with Nurse Aide (NA) #1 on 11/16/23 at 10:11 AM revealed Resident #30 often refused assistance from staff and did most of his activities of daily living by himself. NA #1 stated she still went into Resident #30's room just to check if he needed anything but she did not notice any of the medications that Resident #30 kept at his bedside.

An interview with the Unit Manager (UM) on 11/14/23 at 2:58 PM revealed she was not aware

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at the bedside of a resident unless they have been assessed, noted to be clinically appropriate for self- administration of medication, and have an active physician order for self-administration of medications. Education will be completed by 12-27-23. After 12-27-23, any facility/contract nurse and medication aide that has not worked and received the education will complete upon their next scheduled shift. After 12-27-23, the Staff Development Coordinator (SDC) will include this same education to all new facility/contract nurses and medication aides in general facility orientation.
" The Director of Nursing (DON), Unit Managers (UM), Staff Development Coordinator, or designee will complete an audit of 10 rooms per week for four weeks then monthly x 2 months. The audit is to ensure medications were not left at the resident beside unless the resident had been assessed, deemed clinically appropriate for self-administration of medications, and physician order obtained.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

The Administrator is responsible for the plan of correction and monitoring of audits using the Medication Audit Tool. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review the audits to determine trends and/or further problem resolution if needed.

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F 554	Continued From page 4 that Resident #30 had been administering medications which he kept at the bedside and that she had no idea how Resident #30 had obtained his medications. The UM stated she was not sure whether Resident #30 had been assessed for medication self-administration. She also stated that the residents should be assessed first if they could safely administer medications to themselves before they were allowed to keep medications at the bedside. An interview with the Nurse Practitioner (NP) on 11/16/23 at 2:57 PM revealed she was not aware of Resident #30 self-administering his medications at the bedside. The NP stated that if the staff asked her that Resident #30 wanted to self-administer medications, she would let him as long as he was competent and he was assessed to safely administer medications to himself. The NP stated she did not consider Resident #30 receiving two doses of Vitamin D3 significant and taking over-the-counter medications without a physician's order harmful to him. However, Resident #30 should have been assessed first if it was safe for him to self-administer his medications. An interview with the Director of Nursing (DON) on 11/17/23 at 8:46 AM revealed she was not aware that Resident #30 had been taking medications by himself at the bedside. The DON stated when she found out, she asked a nurse to do a self-administration assessment and he failed so they had to remove all his medications at the bedside and give them to his family member. 2. Resident #52 was admitted to the facility on 3/11/23 with diagnoses that included obstructive	F 554	Date of compliance: 12/27/23	

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F 554	Continued From page 5 sleep apnea. The quarterly Minimum Data Set (MDS) assessment dated 9/11/23 indicated Resident #52 was cognitively intact, and was independent with most activities of daily living. A review of Resident #52's medical record indicated no documentation that Resident #52 was assessed for self-administration of medications. Resident #52 did not have a physician's order for self-administration of medications. A review of Resident #52's Medication Administration Record for November 2023 indicated an active physician's order for Fluticasone Propionate nasal suspension - 1 spray in both nostrils in the morning for allergy signs/symptoms and allergic rhinitis. During an initial observation of Resident #52 in his room on 11/13/23 at 12:40 PM, Resident #52 was lying in bed asleep with his head covered up with a blanket. There was a bottle of Fluticasone nasal spray enclosed in an orange container on top of his bedside table. There was another spray bottle with a red cap labeled as Afrin nasal spray on top of his side table. An interview with Resident #52 on 11/13/23 at 3:30 PM revealed he used the Afrin nasal spray at night whenever his nose got stopped up. Resident #52 explained that he used a BiPAP machine at night and it was hard to use it whenever his nose was stopped up. (A BiPAP machine is a machine that supplies pressurized air into the airways and is also called positive pressure ventilation because the device helps to	F 554		

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open the lungs with this air pressure.) Resident #52 stated the Fluticasone nasal spray was for his allergies and he only used it once in a while. He further stated he did not need it as much as he used to when he first got admitted to the facility.

Another observation of Resident #52's room on 11/14/23 at 12:24 PM revealed the Afrin and the Fluticasone nasal sprays were still available at his bedside.

An interview with Nurse #1 on 11/14/23 at 2:38 PM revealed she had seen Resident #52's Fluticasone nasal spray at the bedside. Nurse #1 stated that Resident #52 preferred to administer this medication to himself, and he wanted to keep this nasal spray at his bedside. However, Nurse #1 stated that she had not noticed the Afrin nasal spray and did not know how Resident #52 obtained it. Nurse #1 stated she did not know whether Resident #52 was assessed for medication self-administration and that she would have to look at his medical record.

An interview with Nurse #2 on 11/15/23 at 9:48 AM revealed she had taken care of Resident #52, but she had not noticed any of the nasal sprays that he kept at the bedside. Nurse #2 stated Resident #52 usually sat in his wheelchair by the side of his bed, and he normally asked for his breathing treatments whenever he had complaints of difficulty breathing. Nurse #2 stated she couldn't remember seeing Resident #52's nasal sprays at the bedside.
An interview with Medication Aide (MA) #1 on 11/15/23 at 2:23 PM revealed she had noticed Resident #52's Fluticasone nasal spray which was on his bedside table, but she left it alone

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F 554	Continued From page 7 because he had another Fluticasone nasal spray which they kept inside the medication cart. MA #1 stated she did not remember seeing an Afrin nasal spray on his side table. An interview with Nurse #3 on 11/16/23 at 10:11 AM revealed she had not noticed any of the nasal sprays that Resident #52 kept at his bedside. Nurse #3 stated that Resident #52 had another bottle of Fluticasone spray in the medication cart which she usually gave to him in the mornings. Nurse #3 stated that if Resident #52 wanted to self-administer medications, the doctor would need to write an order that he was capable of administering his own medication and an assessment would need to be completed. Nurse #3 further stated she was not aware whether Resident #52 had a doctor's order, or an assessment was completed regarding medication self-administration. An interview with Nurse Aide (NA) #1 on 11/16/23 at 10:11 AM revealed she often went into Resident #52's room to check on him but she did not notice any of the nasal sprays that Resident #52 kept at his bedside. An interview with the Unit Manager (UM) on 11/14/23 at 2:58 PM revealed she was not aware that Resident #52 had been administering medications which he kept at the bedside and that she had no idea how Resident #52 had obtained his medications. The UM stated she was not sure whether Resident #52 had been assessed for medication self-administration. She also stated that the residents should be assessed first if they could safely administer medications to themselves before they were allowed to keep medications at the bedside.	F 554		

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An interview with the Nurse Practitioner (NP) on 11/16/23 at 2:57 PM revealed she was not aware of Resident #52 self-administering his medications at the bedside. The NP stated that if the staff asked her that Resident #52 wanted to self-administer medications, she would let him as long as he was competent and he was assessed to safely administer medications to himself.

An interview with the Director of Nursing (DON) on 11/17/23 at 8:46 AM revealed she was not aware that Resident #52 had been taking medications by himself at the bedside. The DON stated she was not sure how Resident #52 obtained the nasal sprays he kept at his bedside, but he should have been assessed for medication self-administration.

3. Resident #25 was admitted to the facility on 10/7/23 with diagnoses inclusive of heart failure, stage 2 chronic kidney disease, pulmonary hypertension and peripheral vascular disease.

The quarterly MDS assessment dated 9/26/23 indicated Resident #25 was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, personal hygiene, and toileting. He was independent with eating and was totally dependent on bathing.

A review of Resident #25's medical record indicated there was no assessment or physician's order for self-administration of medications.

A review of Resident #25's Medication Record for November 2023 revealed an active physician's order for ammonium lactate lotion and natural tears eye ointment. The Medication Record did

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F 554	Continued From page 9 not reveal an order for the following over-the-counter medications: nasal spray, peptide collagen, calcium antacids, or joint pain relief rub roll-on. During an initial observation of Resident #25's room on 11/13/23 at 10:48 AM revealed prescribed ammonium lactate lotion and prescribed natural tears eye ointment and a container of collagen peptide powder next to snacks on a built-in shelf. Additionally, nasal spray, calcium antacids container, and joint pain relief rub roll on were observed on nightstand. An interview with Resident #25 on 11/13/23 at 10:55 AM indicated he used the ammonium lactate lotion, natural tears eye ointment, nasal spray, calcium antacids and joint pain relief rub roll on as needed. He further indicated a nursing aide would also use the lotion and joint pain relief on his legs. He no longer used the collagen peptide powder because he did not believe it helped with his knees. During a follow-up observation to Resident #25's room on 11/14/23 at 2:30 PM, the same medications that were observed on 11/13/23 on Resident #25's nightstand and built-in shelf near his snacks. During a follow-up observation to Resident #25's room on 11/15/23 at 10:10 AM, all medications had been removed from the room. During an interview on 11/15/23 at 10:17 AM, Nurse #5 revealed that the Scheduler did a sweep of Resident #25's room and removed all medications. She further revealed she usually removed any over-the-counter medications	F 554		

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brought in by the Resident's daughter. However, she did not notice the medications in his room when she recently administered his medications. She also stated Resident #25 did not have an order to self-administer medications and the medications should not have been in his room.

During an interview on 11/15/23 at 10:06 AM, Nurse #6 indicated she was assigned to Resident #25 on 11/12/23, administered his scheduled medications and did not recall seeing medicated lotion, eye drops, joint pain relief roll on, or nasal spray in his room.

During an interview on 11/15/23 at 2:27 PM, the Scheduler revealed he usually performed a monthly sweep of all resident rooms to inventory supplies that were ordered and distributed to residents. He further revealed he removed medications from Resident #25's room as instructed.

During an interview on 11/16/23 at 11:22 AM, the DON indicated she was recently informed of over-the-counter medications in resident rooms who had no physician orders for self-administration. Her expectation was for basic nursing rules to be followed as it related to residents being screened to self-medicate and have a documented physician's order. She further indicated there has since been a sweep of resident rooms, in search of and removal of medications from resident rooms where residents did not have an assessment or physician's order to self-medicate.

During an interview on 11/16/23 at 3:15 PM, the NP revealed Resident #25 had not been assessed to self-administer medications at

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bedside and she did not feel he was capable of self-administering medications safely.

4. Resident #237 was admitted to the facility on 10/27/23 with diagnoses inclusive of sepsis, osteoarthritis, hypertension, and asthma.

An admission MDS assessment dated 11/3/23 indicated Resident #237 was cognitively intact and required extensive assistance with bed mobility, transfers, and toileting. He also required supervision with eating.

A review of Resident #237's medical record indicated there was no assessment or physician's order for self-administration of medications.

A review of Resident #237's Medication Record for November 2023 revealed an active physician's order for cream-clotrimazole betamethasone.

During an interview on 11/13/23 at 10:30 AM, Resident #237 indicated he did not know how long the medicine cup of white cream had been on his bedside table. He further indicated he believed the cream was used on his buttocks by the nurse.

During an interview and observation on 11/13/23 at 10:35 AM, Nurse #1 revealed she had not left the medicine cup of white cream in Resident #237's room and that it may have been left there by the 3rd shift nurse. She removed the medicine cup from the Resident's room and agreed to find out what type of medication was in the medication cup.

During an interview on 11/15/23 at 10:00 AM, Nurse #6 indicated she could not recall if she left

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CLEAR CREEK NURSING & REHABILITATION CENTER	**10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227**

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F 554	Continued From page 12 a medication cup of clotrimazole on Resident #237's bedside table. She further indicated she applied it as prescribed, during her 7a-7p shift on 11/12/23 per her initials on the MAR and that the Resident did not have a physician's order to self-administer medications. She also stated that it was not her practice to leave medications at bedside if a resident was not assessed to self-administer medications. During an interview on 11/16/23 at 11:08 AM, the DON revealed the cup of medicated cream should have been caught if staff were doing rounds as expected. She further revealed that she was not sure which shift nurse left the medicine cup in Resident #237's room, since the MAR indicated it was administered at least twice before the Surveyor observed it on the bedside table. Her expectation was for medications not be left in resident rooms whereas the resident was not assessed and/or there was no physician's order in place for self-administration.	F 554		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		12/27/23

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F 565	Continued From page 13 providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents (Residents #23, #27, #36, #38, #47, #50, #58, #74, and #140) and staff and record review, the facility failed to provide privacy for 5 months during Resident Council meetings. The findings included: A review of Resident Council meeting minutes from June 2023 to November 2023 revealed Residents #23, #27, #36, #38, #47, #50, #58, #74, and #140 attended Resident Council meetings routinely. The minutes did not record concerns voiced by residents regarding the location of their meetings.	F 565	F565 Resident/Family Group and Response 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #23, resident #27, resident #36, resident #38, resident #47, resident #50, resident #58, resident #74, and resident #140 are currently attending Resident Council meetings in the community room where privacy is provided and there are no interruptions.	

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An observation of the activity area on the 500/600 hall occurred on 11/13/23 at 12:15 PM. The activity area was observed with a vending machine and refrigerator. The area was an open space that was adjacent to the open dining room and nurse's station. The area was not enclosed for privacy.

An interview with the Activity Director (AD) occurred on 11/13/23 at 1:18 PM. The AD stated that he had arranged for the Resident Council meeting with the Surveyor to be held in the 500/600 hall activity area. He confirmed that this space did not afford privacy and stated, "This is where the Residents always meet for Resident Council." The Surveyor requested a private space. The AD stated that there were two other activity areas that were typically used for activities, but these areas were not large enough to hold large resident activities. When the Surveyor inquired about the Community Room, the AD stated that the Community Room had not been used for Resident Council meetings before, but it was large enough to hold Resident Council meetings. The AD stated that he would discuss it with the Administrator and follow up. The AD returned at 1:30 PM and stated that the Resident Council meeting with the Surveyor would be held in the Community Room to afford privacy.

A Resident Council meeting was held on 11/15/23 at 2:00 PM with nine Residents (Residents #23, #27, #36, #38, #47, #50, #58, #74, and #140) identified by the AD with intact cognition as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 or higher. The AD placed a sign outside the Community Room that recorded "Resident Council Meeting in Progress, Please Do Not Disturb." During the meeting the Social

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2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:

" Current residents have the potential to be affected. Resident #23, resident #27, resident #36, resident #38, resident #47, resident #50, resident #58, resident #74, and resident #140 will be interviewed by Activity Director or designee to confirm Resident Council meetings are being held in a room where privacy is provided and there are no interruptions. The Administrator will address any concerns identified during the interviews. Interviews will be completed by 12/27/2023.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

" The Administrator will provide education to facility leadership team including Activities Director, Activity Director Assistant, Director of Nursing, Assistant Director of Nursing, Unit Manager, Admissions Director, Business Office Manager, Supply Coordinator/ Appointment Scheduler, Dietary Manager, Housekeeping Manager, Maintenance Director, Minimum Data Set Nurse(s), Medical Records, Social Worker and Therapy Manager noting residents are to have resident council meetings in a room where privacy can be provided and there are to be no interruptions. Education will be completed by 12/27/23
" Staff Development Coordinator (SDC)

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Worker (SW) opened the door to the Community Room, entered the room, looked around the room, said "Excuse me, I apologize," and exited the room. When asked if this interruption to their meeting bothered them, Resident #23 stated "Well yes, we would like to have our privacy." All the Residents expressed they agreed. The Residents stated that the Resident Council meetings were arranged by the AD and were held in the 500/600 hall activity area but did not give them privacy. The Residents stated staff frequently interrupted meetings/activities to use the vending machine and refrigerator stored in the activity area and sometimes the nurse was on the hall with a medication cart administering medications to residents. The Residents stated they were told that was the only space large enough to accommodate everyone.

The SW was interviewed on 11/17/23 at 9:15 AM and stated she had been the SW at the facility for the past three years. The SW stated she entered the Community Room on 11/15/23 during the Resident Council meeting to look for another surveyor. The SW stated that she did not see the sign posted which indicated that a Resident Council meeting was in progress, she stated "I was not focused on that, I was looking for the surveyor." The SW stated she was not aware that staff should not interrupt resident meetings. The SW also stated that Resident Council meetings were held in the activity area of the 500/600 hall and there was a vending machine and a refrigerator that staff used. The SW stated that sometimes staff have come in to use the refrigerator or vending machine while the residents were having a meeting. The SW stated that the 500/600 hall activity area did not afford residents privacy during their meetings.

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will provide education to current facility/ agency nursing staff noting resident council meetings will be held where privacy is to be provided and there are to be no interruptions including medication administration. Education will be completed by 12/27/23. After 12/27/23, any contracted agency/facility nursing staff that has not worked and received the education will complete upon their next scheduled shift. Staff Development Coordinator (SDC) will include the education in general orientation for contract agency/facility nursing staff.

" The Activities Director will ensure Resident Council meetings are held in a room which provides privacy and will ensure there are no interruptions by interviewing 25% of Resident Council meeting attendees with BIMS scores of 13 or greater monthly x 3 months

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

The Administrator is responsible for the plan of correction and monitoring of interview responses. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review the interview responses to determine trends and/or further problem resolution if needed.

*Date of compliance: 12/27/23
1.

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F 565	Continued From page 16 The Administrator stated in an interview on 11/17/23 at 12:48 PM that he had been the Administrator at the facility since June 2023 and that during those five months, Resident Council meetings were always held in the 500/600 hall activity area. The Administrator stated that staff should not interrupt Resident Council meetings and that he would move the Resident Council meetings to the Community Room to give the Residents privacy during their meetings.	F 565		
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	F 578		12/27/23

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F 578	Continued From page 17 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 individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to clarify and update the medical records to reflect the desired advance directive for 1 of 7 residents reviewed for code status (Resident #64). The findings included: Resident #64 was admitted to the facility on 9/27/23. The admission Minimum Data Set (MDS) assessment dated 10/4/23 indicated Resident #64 had moderately impaired cognition. A Do Not Resuscitate (DNR) form dated 10/24/23 for Resident #64 and a Medical Orders for Scope of Treatment (MOST) form dated 10/24/23 indicated do not attempt resuscitation if Resident #64 had no pulse and was not breathing. Both forms were located in Resident #64's physical chart at the nurses' station.	F 578	F578 Request/Refuse/Discontinue Treatment; Formulate Adv Directive 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #64 remains in the center. Advanced directive for resident #64 has been clarified and medical record has been updated to reflect the desired advanced directive. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: " Current residents have the potential to be affected. The Medical Records Director will complete an audit of 100% of current	

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Resident #64's care plan last revised on 10/24/23 indicated Resident #64 had an advance directive of DNR.

Further review of Resident #64's electronic medical record revealed a physician's order dated 10/30/23 for full code.

An interview with Nurse #4 on 11/14/23 at 2:50 PM revealed Resident #68 used to be on the other hall, and she was transferred to her current room on 10/31/23. Nurse #4 stated she did not know why MDS Coordinator #1 had entered an order for full code for Resident #68 on 10/30/23 but she was supposed to be a DNR.

An interview with MDS Coordinator #1 on 11/14/23 at 4:33 PM revealed when she entered Resident #64's advance directive of full code in her medical record, she was just following what the Social Worker was telling her at that time. MDS Coordinator #1 stated she was assisting the Social Worker because she did not know how to enter the order in the electronic medical record. She further stated that she did not know that Resident #64 had a DNR form because she was not in charge of advance directives.

An interview with the Social Worker (SW) on 11/14/23 at 5:26 PM revealed she was responsible for the advance directives for all residents at the facility. The SW stated she remembered discussing advance directives with Resident #64 and her family member on 9/29/23 during her welcome meeting. Initially, they opted for Resident #64 to have a full code status but on 10/24/23, they changed her advance directive to DNR, so she went ahead and had them sign a

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residents to ensure desired advanced directives are reflected in the medical records. The Social Worker and/or nurse will address any concerns identified during the audit. Audit will be completed by 12/27/23.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

" The Staff Development Coordinator will provide education to current contract agency/ facility nurse noting each resident should have advance directive clarified and update should be reflected in the medical records. Education will include the process to be followed to ensure medical record reflects desired advanced directive. Education will be completed by 12/27/23. After 12/27/23, any current contract agency/facility staff nurse that has not worked and received the education will complete upon their next scheduled shift. The Staff Development Coordinator will include the education in general orientation for contract agency/facility nursing staff.
" The Medical Records Director/Social Worker, or designee will audit 5 resident□s medical records weekly x 4 weeks, and then monthly x 2 to ensure the medical record reflects the desired advance directive using the Advance Directive Audit Tool.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

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F 578	Continued From page 19 DNR and a MOST form. The SW further shared that on 10/30/23, she asked MDS Coordinator #1 to enter advance directives for a list of residents. The SW stated that she probably forgot to update her list and did not change Resident #64 from full code to DNR after her advance directive was changed on 10/24/23. An interview with the Unit Manager (UM) on 11/17/23 at 8:03 AM revealed the nurses were responsible for entering the code status in the electronic medical record when they admit residents, but the Social Worker needed to make sure they matched the DNR and MOST forms in the physical charts. An interview with the Director of Nursing (DON) on 11/17/23 at 8:46 AM revealed she was not sure why Resident #64 had conflicting advance directive information in her medical record and whether the nurses did not see her DNR form whenever she switched rooms. The DON stated the advance directive should match in all the documents and they needed to conduct audits on all the advance directives.	F 578	The Administrator will forward the results of the Advance Directive Audit Tool to the QAPI Committee. The QAPI Committee will meet monthly x 3 months and review the Advance Directive Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of compliance: 12/27/23	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585		12/27/23

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F 585	Continued From page 20 facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 585		

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F 585	Continued From page 21 conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the	F 585		

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F 585	Continued From page 22 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, grievance review, policy review, resident/family interviews and staff interviews, the facility failed to ensure a grievance investigation was conducted and a written resolution was provided per the facility's grievance policy for 1 of 1 resident (#2) reviewed for grievances. Findings included: The facility Resident Concerns / Grievances Policy dated 8/2019 included the following guidelines: Information on how to file a grievance or complaint will be available through individual resident notification or by posting in prominent areas accessible to the residents within the facility. This information includes the right to file concerns orally, or in writing or anonymously with the facility's grievance official's name, mailing address, email and business phone number; a reasonable expected time frame for completing the review of the grievance, and the right to obtain a written decision regarding his/her grievance and the contact information for appropriate independent state agencies and other entities. When a resident, family member, or resident representative reports a complaint, concern or grievance to a staff member, the staff member will forward the concern to their supervisor, department head or Administrator. For those complaints arising on nights, weekends and holidays, the staff member in charge will contact the Administer or individual on call as appropriate. For concerns or grievances involving	F 585	F585- Grievances 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #2 remains in the facility. The grievance received from resident # 2 on 10/30/23 has been resolved, the grievance form has been completed, and resident #2 was notified of the results of the investigation which were provided to resident #2 by Administrator in the form of written documentation on 12/13/2023. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. On 12/12/2023, the Social Worker initiated an audit of all grievances submitted in the last 30 days to ensure the grievance investigation was conducted, the grievance form was completed, and if requested the resident and/or resident representative will provided the resolution per the grievance policy. The Administrator and Social Worker will address all concerns identified during the audit. Audit will be completed by 12/27/2023.	

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alleged neglect, abuse, injuries of unknown source or misappropriation of resident property, staff will immediately notify the Administrator as required by law. As the facility's grievance official, the Administrator is responsible for overseeing, directing, tracking, and investigating grievances in a prompt manner. After reviewing the results of the grievance, the Administrator will initiate corrective measures in accordance with state laws. Additionally, the Administrator shall ensure appropriate measures are taken to prevent potential infringements of residents' rights during grievance investigations. The Administrator shall assure the resident, or their representative, are notified of the results of the investigation. The resident and/ or their legal representative has the right to obtain a written decision regarding the grievance.

a. Resident #2 was admitted to the facility on 8/22/23 and her Minimum Data Set assessment dated 8/29/23 indicated she was cognitively intact.

A review of the grievance log for the period of 10/1/23 through 11/13/23 revealed there was not a filed grievance for Resident #2 regarding the grievance shared by the resident on 10/30/23.

A review of a facility grievance concern dated 10/30/23 revealed Resident #2 asked NA #4 to assist her to the restroom while they were in the dining room. Resident #2 stated the NA may not have heard her request, therefore the Resident attempted to toilet herself after turning on her call light and slid to the bathroom floor. The investigation indicated the resident and staff were interviewed and the findings included the Resident acknowledged her wait time was not

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3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

" The Consultant will provide education to the Social Worker and Administrator noting each submitted grievance must have a grievance investigation conducted and if requested a resolution will be provided to the resident or resident□s representative per the grievance policy. Education will be completed by 12/27/2023.
" After 12/27/23, Staff Development Coordinator (SDC) will include education on the grievance policy for any newly hired contract agency/facility Administrator or Social Worker in general orientation.
" The Administrator will audit 10% of submitted grievances weekly to ensure each grievance has been resolved per facility policy, the grievance form has been completed, and if requested will be provided with the resolution to resident and/or resident representative. Grievances will be reviewed weekly x4 weeks, then monthly x 2 months.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

The Administrator will forward the results of the Grievances Audit Tool to the QAPI team. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review the audits to determine trends

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F 585	Continued From page 24 very long and she toileted herself. The Resident also indicated she liked NA #4 and didn't want to get her into trouble. NA #4 stated the Resident did not ask for assistance. Actions taken included the Resident being educated on the importance of waiting for assistance. The grievance was signed by the Administrator and dated 10/30/23. The grievance form had no documentation of follow up with Resident #2, no documentation of having been assigned to a staff member, no documentation of feedback received from the Resident when following up, and no date when the grievance was resolved. During an interview on 11/13/23 at 3:43 PM Resident #2 revealed on 10/30/23 while in the dining room, she asked her assigned Nurse Aide (NA) #4 to assist her to the restroom. When NA #4 did not respond, Resident #2 self-propelled her wheelchair back to her room, rang her call bell, attempted to self-toilet, and slid to the bathroom floor. Later that day, NA#4 and the Social Worker came into her room and confronted her about Resident #2's plan to submit a grievance about NA #4 refusing to provide incontinent care when asked. Resident #2 further revealed she was grilled by the Social Worker (SW) and felt intimidated by their presence until she finally decided that she would not file a grievance against NA #4. The Resident stated after the confrontation, she assumed the SW did not complete the grievance because the Resident did not receive further discussion from any staff member about the issue. She stated that she was unaware if the SW completed a grievance on her behalf later, because she did not receive any follow-up resolution or copy of the grievance. During a phone interview on 11/15/23 at 8:39 AM	F 585	and/or further problem resolution if needed. *Date of compliance: 12/27/23 1.	

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the accused (NA#4) stated the SW told the NA on 10/30/23 and 11/13/23 she, the SW, never completed a grievance on behalf of the Resident regarding the 10/30/23 incident.

During an interview on 11/14/23 at 3:57 PM, the Social Worker (SW) indicated that as the grievance official, she receives the grievance, writes it up, assigns it to a department head, receives a response or outcome and updates the resident or family member after the Administer gives the approval. She stated that another staff member (former Admissions Director) informed her that Resident #2 reported that NA #4 told her she didn't have time assist her with incontinent care on 10/30/23. The SW further indicated she brought NA #4 into Resident #2's room to discuss the matter together and that was not her normal practice when attempting to resolve a matter between a resident and staff member. She stated she redirected. NA #4 not to say anything while they were in the Resident's room. Her intention was not to intimidate Resident #2 by bringing NA #4 into the room and did not realize that Resident #4 felt badgered into not filing a grievance. The SW stated that she did file a grievance on the Resident's behalf and gave it to the Director of Nursing (DON) but never received a resolution or outcome nor any further information regarding the grievance from the DON. The SW stated she had not followed up with the DON regarding having not received the grievance back from the DON. The SW further stated she had not followed up with the resident regarding the grievance because she had not received the grievance back from the DON.

During an interview on 11/16/23 at 11:52 AM, the DON revealed she was unaware Resident #2 was

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confronted in her room by the SW and NA #4 which had made the resident feel intimidated into not filing a grievance on NA #4. She further revealed she did not receive a grievance from the SW regarding the incident that took place on 10/30/23 and she expected the facility's grievance policy to be followed.

b. During an interview on 11/13/23 at 3:55 PM, Resident #2 revealed on 10/31/23 or 11/1/23 while she was in the dining room, she asked NA #4, who was assigned to her, for assistance with going to the rest room and the NA ignored her request. She then asked NA #4 a second time and NA #4 grabbed her wheelchair and hurriedly pushed her down the hall to her room and told her she could "poop in her diaper like everyone else does". Resident #2 told her "I don't poop in my pants, and I don't wear diapers and that I needed to go to the rest room." NA #4 then stated, "It won't be me," then left out of the room and slammed the door. Resident #2 was able to self-propel her wheelchair out of her door and approach the hall nurse who had another NA provide incontinent care. Resident #2 stated she did not submit a formal grievance but called and spoke to her son on 11/2/23, who in turn contacted the Administrator about the incident. Her son called her back and stated that the Administrator would take care of it. Resident #2 stated that after her son contacted the Administrator about the incident, no one came to talk to her about it and she did not know if a grievance was filed.
During an interview on 11/15/23 at 10:51 AM, Nurse #5 revealed that at the beginning of November 2023, when she returned from days off, Resident #2 reported to her that NA #4 told her to go to the bathroom in her brief like others

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do. Nurse #5 stated she believed the Resident's report to be credible and informed the SW that Resident #2 needed to talk to her about possibly filing a grievance. She further revealed she did not know if the SW filed a grievance or not.

During a phone interview on 11/15/23 at 8:45 AM the accused (NA #4) stated she never told Resident #2 that she should poop in her diaper like everyone else does. NA #4 further revealed during that same week, she told Resident #2 that she would no longer talk to her or be her NA, because she felt the Resident lied about the 10/30/23 incident. The NA stated she was not aware of a grievance regarding what she had allegedly told the resident.

During a follow-up interview on 11/15/23 at 1:59 PM, the SW indicated she was not made aware that Resident #2 had an additional conflict with NA #4 regarding being told to "Poop in her pants." She further stated that neither staff nor Resident #2 made her aware of it. Therefore, she did not file a grievance on the Resident's behalf. The SW added she was the grievance official, and all concerns come to her, she writes up the grievances, distributes them to department heads for investigation and awaits the return outcomes.

During a phone call on 11/15/23 at 4:48 PM, Director of Admissions #2, who no longer works at the facility, revealed while conducting room rounds in early November 2023, Resident #2 seemed very upset as she reported to her that she had an issue with NA #4 and wanted to file a grievance. The former Director of Admissions further revealed she went to the SW and told the SW right away the resident wanted to file a grievance.

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During an interview on 11/15/23 at 6:01 PM, the Administrator indicated that he was not aware of the incidents that occurred on 10/31/23 or 11/1/23, involving NA #4's refusal to provide incontinent care by telling Resident #2 that she could "poop in her pants." He further indicated that he was not aware if a grievance was submitted.

During an interview on 11/16/23 at 11:52 AM, the DON revealed she had no knowledge of the incident Resident #2 described as being taken back to her room and being told to "poop in her pants." She further revealed she did not receive a grievance regarding the incident. Her expectation for the facility's grievance policy to be followed.

During a follow-up interview on 11/16/23 at 4:17 PM the Administrator stated he signed grievances off as resolved when they're completed. The Administrator then revealed that he did not speak to Resident #2's family member about the incident that occurred on 10/31/23 or 11/1/23 and that they only addressed the incident that occurred on 10/30/23. He was not aware of any grievances submitted regarding the incident from 10/31/23 or 11/1/23 and if it was reported, he expected the grievance policy to be followed.

During an interview on 11/17/23 at 12:25 PM, the Speech Therapist indicated she did overhear NA #4 tell Resident #2 while she was in the hallway near dining room that Resident #2 could "poop in her pants." The Speech Therapist further indicated that she submitted a report for the next shift but could not recall if she submitted it on 10/30/23 or 10/31/23. A copy of the report was not provided about the incident.

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F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident/ family and staff interviews, the facility failed to protect a resident's right to be free from verbal and mental abuse when Nurse Aide #4 and Social Worker confronted Resident #2 in her room and intimidated her into not submitting a grievance. Nurse Aide #4 refused to provide incontinent care for Resident #2 by taking her to her room and yelling at her by stating she could "poop in her diaper like everyone else does" then slammed the door as she left. Nurse Aide #4 yelled at Resident #2 who requested incontinent care, by stating "I am not your CNA and will never be your CNA no more in life." These actions caused Resident #2 to feel intimidated, devalued, deprived of care, ignored, depressed, without control of her life, trapped, upset, and as if she did something wrong. This occurred for 1 of 1 resident reviewed for abuse.	F 600	F600 Free from Abuse and Neglect 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident # 2 remains in the center. The allegation was reported, and a thorough investigation was completed. The rights of resident #2 have been protected and resident is free from verbal and mental abuse. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected by the alleged deficient practice. Current residents with BIMS score of 13	12/27/23

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Findings included:

Resident #2 was admitted to the facility on 8/22/23 with diagnoses inclusive of Parkinson's disease, depression, and neurogenic bladder.

An admission Minimum Data Set (MDS) dated 8/29/23 indicated Resident #2 was cognitively intact and dependent on staff assistance with toileting, showering, lower body dressing and putting footwear on / off. She was independent with eating and required set up with oral hygiene. Resident had a suprapubic catheter and was incontinent of bowel habits.

a. During an interview on 11/13/23 at 3:43 PM Resident #2 revealed on 10/30/23 (incident #1) Nurse Aide (NA) #4 and the Social Worker came into her room and confronted her about Resident #2's plan to submit a grievance about NA #4 refusing to provide incontinent care when asked. Resident #2 further revealed she was grilled by the Social Worker and felt intimidated by their presence until she finally decided that she would not file a grievance against NA #4 and did not receive further discussion from any staff member about the issue. Resident #2 stated that NA #4 accused her of lying on her and trying to get her fired, then stated she never heard her (Resident #2) ask for assistance to the bathroom. Resident #2 responded to the SW and NA #4 that perhaps NA #4 did not hear her request for assistance in using the bathroom.

During an interview on 11/14/23 at 3:57 PM, the Social Worker (SW) indicated that a few weeks prior (early November 2023) that another staff member (former Admissions Director) informed her that Resident #2 reported that NA #4 told her

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and greater will be interviewed to identify any residents that may have experienced abuse including but not limited to verbal and mental abuse. Residents with BIMS of 12 or less will have a staff to resident interactions observation to ensure residents are not experiencing verbal and mental abuse, the observations will be conducted across all three shifts.
The interviews and interactions will be completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Social Worker (SW), Minimal Data Set (MDS) Nurses, Wound Nurse, and/or the Activities Director. The Director of Nursing and Administrator will address any identified concerns noted during the audit and interviews. Audit will be completed by 12/27/23.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:
" The Staff Development Coordinator and/or designee will provide education to current staff noting our residents have the right to be free from abuse including but not limited to verbal and mental abuse. Examples of verbal abuse include harassing a resident, humiliation, threatening residents, intimidation, and/or disrespect. Staff is expected to refrain from confronting a resident. Education will be completed by 12/27/23. After 12/27/223, all contracted agency and/or facility staff that has not worked and received the education will complete prior to their next scheduled shift. The Staff

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she didn't have time assist her with incontinent care. Therefore, she took herself to the restroom, attempted to toilet herself and fell on the floor. The SW further indicated she brought NA #4 into Resident #2's room to discuss the matter together and that was not her normal practice when attempting to resolve a matter between a resident and staff member. She stated she redirected NA #4 not to say anything while they were in the Resident's room. Her intention was not to intimidate Resident #2 by bringing NA #4 into the room and did not realize that Resident #4 felt badgered into not filing a grievance.

During an interview on 11/15/23 at 8:39 AM, NA #4 revealed, during the same week of the incident that took place on 10/30/23, she told Resident #2 that she would no longer work with her or speak to her after the incident that took place on 10/30. NA #4 stated she believed Resident #2 lied on her by stating she asked her to take her to the bathroom and NA #4 refused by ignoring the Resident. NA #4 then stated, because of that she did not work with her since 10/30/23, although she was assigned to that hall and Resident #2 as a permanent assignment. NA #4 did indicate that she and the SW went to Resident #2's room to discuss the incident that took place on 10/30 and did not intend to intimidate her into not filing a grievance. NA #4 further stated that the SW did not submit a grievance because Resident #2 agreed that her request to be taken to the bathroom may not have been heard by NA #4.

During an interview on 11/16/23 at 11:52 AM, the DON revealed she was unaware Resident #2 was confronted in her room by the SW and NA #4 and that Resident #2 felt intimidated and badgered into not filing a grievance on NA #4. Her

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Development Coordinator (SDC) will include this education to all new facility/contract staff in general facility orientation.

" The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Social Worker (SW), Minimal Data Set (MDS) Nurses, Wound Nurse, the Activities Director, and/or designee will conduct interviews with 10 residents with BIMS score of 13 or greater 1 time weekly x 4 weeks then 1 monthly x 2 months to ensure residents are not experiencing verbal and mental abuse. All areas of concerns will be addressed immediately.

" 10 Staff-to-resident interactions with aides will be completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Social Worker (SW), Minimal Data Set (MDS) Nurses, Wound Nurse, the Activities Director, and/or designee weekly to include all shifts x 4 weeks, then monthly x 2 months. This audit ensures that staff interact with residents appropriately during care and that there are no signs and symptoms of abuse, including verbal abuse. Concerns identified during the observations, will be addressed immediately.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

The Administrator will forward the results of the audits, Staff to Resident Interactions Audit Tool and interviews to the Quality Assurance Performance Improvement (QAPI) committee monthly x

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expectation was for Resident's rights to be respected and free from abuse according to the facility's abuse policy.

During a follow-up interview on 11/17/23 at 9:30 AM, Resident #2 indicated that she felt trapped, devalued, and as if she did something wrong, when the SW and NA #4 came into her room and confronted her about the incident that took place on 10/30/23. She further indicated she was very depressed that night and wondered if the SW ever filed the grievance.

b. During an interview on 11/13/23 at 3:55 PM, Resident #2 revealed (incident #2) on 10/31 or 11/1/23 while she was in the dining room, she asked her assigned NA#4 for assistance with going to the rest room and was ignored. She then asked NA #4 a second time and NA #4 grabbed her wheelchair and hurriedly pushed her down the hall to her room and told her she could "poop in her diaper like everyone else does". Resident #2 told her "I don't poop in my pants, and I don't wear diapers and that I needed to go to the rest room." NA #4 then stated "it won't be me" then left out the room and slammed the door. Resident #2 was able to self-propel her wheelchair out of her door and approach the hall nurse who had another NA provide incontinent care. Resident #2 further revealed she felt degraded and without control of her life because she needed to use the restroom and could not get help from her assigned aide. Resident #2 stated later that day NA #4 told her that she would no longer speak to her or work with her and that was NA #4's choice. Resident #2 stated she was very upset and reported the incident to her son via telephone on 11/2/23. She stated her son was also upset and contacted the Administrator to discuss the matter

3 months, the audits and interview responses will be reviewed to determine trends and/or further problem resolution if needed.

Date of compliance: 12/27/23

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 33	F 600		

and was promised the incident would be addressed. She also stated she reported the incident to Nurse #5 when she returned from days off and was encouraged to report the incident to the SW. However, she did not feel comfortable reporting another issue to the SW.

During an interview on 11/14/23 at 3:40 PM, NA #7 indicated she may have heard Resident #2 was told she had to wait and go to the bathroom on herself but could not recall who the NA was.

During a telephone interview on 11/15/23 at 8:45 AM, NA #4 revealed that although she was assigned to Resident #2 the week of 10/30, she did not recall taking her to her room on 10/31 or 11/1 and did not refuse to give her incontinent care or tell her that she could "go in her diaper like everyone else." NA #4 stated she worked 10/30- 11/1 and was off 11/2 & 11/3, then worked the weekend of 11/11 & 11/12 and was permanently assigned to Res #2 on the 300 hall.

During a phone interview on 11/15/23 at 6:17 PM, Resident #2's family member revealed the Resident left him a voice mail message on 11/1, that she had something to tell him and to call her back. When he called her back, she told him that NA #4 took her into her room, told her she could poop in her pants and left her there. The family member stated he was very upset and contacted the Administrator who told him that he would take care of it.

During an interview on 11/15/23 at 10:51 AM, Nurse #5 revealed that at the beginning of November 2023, when she returned from days off, Resident #2 reported to her that NA #4 told her to go to the bathroom in her brief like others

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	345562	A. BUILDING ______ B. WING ______	11/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 34 do. Nurse #5 stated she believed the Resident's report to be credible and informed the SW that Resident #2 needed to talk to her about possibly filing a grievance. Nurse #5 further revealed that Resident #2 does not normally have a bowel movement in her brief and normally uses the toilet with staff assistance. Nurse #5 also stated that one day when Resident #2 accidentally had a bowel movement in her brief, she was tearful and mortified. During a follow-up interview on 11/15/23 at 1:59 PM, the SW indicated she was not made aware that Resident #2 had an additional conflict with NA #4 regarding being told to "poop in her pants." She further stated that neither staff nor Resident #2 made her aware of it. Therefore, she did not file a grievance on the Resident's behalf. During an interview on 11/17/23 at 12:25 PM, the Speech Therapist indicated she did hear NA #4 tell Resident #2 while she was in the hallway near dining room that Resident #2 could "poop in her pants." The Speech Therapist further indicated that she submitted a 24-hour internal report about the incident but could not recall if she submitted it on 10/30 or 10/31/23. During an interview on 11/16/23 at 11:52 AM, the DON revealed NA #4 was permanently assigned to 300 hall residents that included Resident #2 and NA #4 worked 10/30, 10/31, 11/1 and was on days off 11/2 & 11/3. She had no knowledge of the incident #2, where Resident #2 described as being taken back to her room and being told to "poop in her pants." Her expectation was for the treatment of all residents to be free from all forms of abuse.	F 600		

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During an interview on 11/15/23 at 6:01 PM, the Administrator indicated that he was not aware of the incident that occurred on 10/31 or 11/1, involving NA #4's refusal to provide incontinent care by telling Resident #2 that she could "poop in her pants." He further indicated that he was not aware if a grievance was submitted.

During a follow-up interview on 11/16/23 at 4:17 PM the Administrator revealed that he did not speak to Resident #2's family member about the incident that occurred on 10/31 or 11/1and that they only addressed the incident that occurred on 10/30/23.

c. During an interview on 11/13/23 at 4:25 PM Resident #2 revealed (incident #3) that on 11/12/23 she needed incontinent care because her catheter was leaking. She asked NA #6 if she was her assigned nurse aide and was told that NA #4 was assigned to her. Resident #2 asked the hall nurse (Nurse #6) if she knew who her assigned nurse aide was. Nurse #6 agreed to find out and have an aide provide care. A short time later, NA #4 came into her room and stated that she would assist her with incontinent care. The following morning, Resident #2 complained to the Administrator and spoke with the DON about not knowing who her assigned nurse aide was for the past two days.

During a phone interview on 11/15/23 at 8:50 AM, NA #4 revealed in reference to incident #3 that took place on 11/12/23, she never spoke to or provided care to Resident #2 on 11/12/23 because she switched assignments with other aides on that weekend, when she was assigned to the Resident #2. She also did not discuss changing her assignment with the hall nurse or

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F 600	Continued From page 36 DON and that it was not uncommon for nurse aides to switch assignments. She stated that she did tell Resident #2 that she did not have to speak to her or be her nurse aide and that was her (NA #4's) choice. Therefore, she switched assignments with other aides. During an interview on 11/16/23 at 10:43 AM, Nurse #6 indicated she did not know that Resident #2's assigned NA #4 had switched with NA #6 because she did not want to care for the Resident. She further indicated she reassured Resident #2, that she would find out and send her in to provide care. Nurse #6 stated that NA#4 told her about Resident #2's leaking catheter and that she switched assignments with NA #6. She did not hear NA #4 refuse to care for Resident #2. However, Nurse #6 stated she did assure that the Resident received care from another aide. During an interview on 11/15/23 at 6:06 PM, the DON revealed that on the morning of 11/13/23 Resident #2 reported to her that she did not receive care from her assigned NA #4 over the past weekend and that she needed incontinent care. The DON further revealed she started an investigation and interviewed both nurse aides (#4 & #6). NA #4 was suspended after NA #6 provided a written statement that she witnessed (on 11/12/23) NA #4 yell out "I will never be your CNA no more in life!" The DON stated that a 24-hour report was completed and sent to the State. The DON stated that Resident #2 did receive care from another aide (NA #6). The DON further stated that she expected residents to be free from all forms of abuse to include verbal and mental abuse. She also stated that nursing staff have had recent in-services on the abuse policy.	F 600		

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F 607	Continued From page 37	F 607		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and review of the facility's policy entitled "Abuse and Neglect ....", and resident and staff interviews, the facility failed on 2 occasions to implement its own policy to immediately report an incident of abuse or	F 607	F607 Develop/Implement Abuse and Neglect Policies 1. What corrective action will be accomplished for each resident found to	12/27/23

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F 607	Continued From page 38 neglect to the Administrator. This affected 1 of 1 resident reviewed for abuse (Resident #2). Findings included: A policy entitled Abuse, Neglect or Misappropriation of Resident Property Policy, dated 5/2013, read in part, "Any employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Failure to report any concern related to neglect, abuse, or misappropriation of property will result in disciplinary action and possible termination of employment. The Administrator is responsible for ensuring that complaints of abuse or neglect are investigated. Measures will be initiated to prevent any further potential abuse while the investigation and report the alleged incident to the appropriate agencies in accordance with state and federal regulations." Resident #2 was admitted to the facility on 8/22/23. The admission Minimum Data Set assessment dated 8/29/23 indicated Resident #2 was cognitively intact. a. During an interview on 11/13/23 at 4:38 PM Resident #2 indicated she told the Speech Therapist about the incident that occurred when she asked NA #4 to take her to the bathroom between 10/31/23 and 11/1/23 and the NA acted like she didn't hear her request when they were in the dining room. Resident #2 asked NA #4 again to take her to the restroom and the NA grabbed the back of Resident #2's wheelchair and wheeled her at a fast pace to the Resident's room	F 607	have been affected by the deficient practice: Resident # 2 remains in the center. Resident #2 has not had any reported abuse allegations that have not been immediately reported to the Administrator. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected by the alleged deficient practice. Facility Nurse Consultant (FNC) will complete audit of previous 6 months of reportable investigation documents to ensure abuse policies was followed by evidence of immediate report of the incident of abuse or neglect to the Administrator. Audit will be completed by 12/27/23. The Administrator and/or Director of Nursing will address any concerns noted during the audit. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: " The Staff Development Coordinator (SDC) will provide education to all current staff noting all incidents of abuse or neglect must be reported to the Administrator immediately. Education will be completed by 12/27/2023. After 12/27/2023, any contract and/or facility staff nurse that has not worked and received the education will complete prior	

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F 607 Continued From page 39

and told her she could "poop in her pants just like the others do." Resident #2 stated that the Speech Therapist encouraged her to file a grievance and told her that she needed to talk to the Social Worker (SW).

During an interview on 11/15/23 at 10:51 AM, Nurse #5 revealed that at the beginning of November 2023, when she returned from days off, Resident #2 reported to her that NA #4 told her to go to the bathroom in her brief like others do. Nurse #5 stated she believed the Resident's report to be credible and only informed the SW that Resident #2 needed to talk to her about possibly filing a grievance.

During an interview on 11/17/23 at 12:25 PM the Speech Therapist revealed she overheard NA #4 tell Resident #2 that she could poop in her diaper. She could not remember if the incident occurred on 10/31/23 or 11/1/23. The Speech Therapist further revealed she did not report the alleged abuse to the Administrator, but she did add it to an internal 24-hour report. The Speech Therapist could not provide documentation that she submitted a report of what Resident #2 reported to her.

During an interview on 11/15/23 at 1:59 PM the SW indicated that she was never made aware of the incident involving Resident #2 being brought back to her room by NA #4 and being told she could 'poop in her diaper like everyone else.' Therefore, no grievance report was submitted, and the Administrator was not informed of the alleged abuse.

During a group interview that included the DON, Administrator and SW on 11/15/23 at 6:01 PM the

F 607

to their next scheduled shift.

" Staff Development Coordinator (SDC) will include this same education in general orientation for contract agency/facility nursing staff.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

" Administrator will audit the investigation details of each reportable event involving allegations of abuse to ensure Administrator was immediately and appropriately notified 1 time a week x 4 weeks, then monthly x2. The Administrator is responsible for the plan of correction. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review the audits and interview responses to determine trends and/or further problem resolution if needed.

Date of compliance: 12/27/23.

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F 607	Continued From page 40 DON and Administrator stated they were not made aware of the incident involving Resident #2 and NA #4 that occurred on between 10/31/23 and 11/1/23 and not made aware of the incident that occurred on 11/12/23 until the next morning of 11/13/23, whereas possible abuse was alleged. They expected any staff member to report any forms of alleged abuse to the Administrator, according to the Abuse policy. b. During an interview on 11/15/23 at 6:06 PM the DON revealed on 11/13/23, she was made aware of the incident involving NA #4, who was witnessed yelling the following statement at Resident #2, 'I will never take care of you ever in life'. The DON further revealed the incident took place on 11/12/23 and after further investigation, it was revealed that NA #6 witnessed the incident and did not report it until she was interviewed the next day 11/13/23. The DON stated she interviewed NA #6 who also provided a written statement of the incident. NA #4 was sent home pending the outcome of the investigation. The DON stated NA #6 did not report the incident to the hall nurse or DON on 11/12/23 and she should have. The DON expected any employee who witnessed abuse, neglect, or misappropriation of property to immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator, according to the facility's Abuse policy. During an interview on 11/15/23 at 6:09 PM the Administrator revealed he was not made aware of the allegation of abuse until 11/13/23, the day after it occurred. The DON further revealed once he was notified of the incident, an investigation began, NA #4 was immediately sent home	F 607		

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F 607	Continued From page 41 pending the outcome of the investigation. The Administrator expected any employee who witnessed abuse, neglect, or misappropriation of property to immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator, according to the facility's Abuse policy. The NA (#6), who witnessed the incident, was not available for an interview and was out of the country.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		12/27/23

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F 656	Continued From page 42 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews, and record review the facility failed to develop an individualized person-centered comprehensive care plan in the area of visual impairment (Resident #14). This deficient practice was for 1 of 1 resident whose comprehensive care plans were reviewed. Findings included: Resident #14 was admitted to the facility on 11/09/2022. A review of Resident #14's quarterly Minimum Data Set (MDS) dated 10/19/2023 revealed Resident #14 was cognitively intact with no documented behaviors. The MDS also revealed	F 656	F656 Develop/Implement Comprehensive Care Plan 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #14 is no longer a resident at the facility. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be	

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Resident #14 had visual impairment. The Care Area Assessment (CAA) was triggered to proceed to care plan for visual impairment.

Review of the care plan dated 10/30/2023 revealed Resident #14 was not care planned for visual impairment.

An interview was conducted with Resident #14 on 11/13/2023 at 2:19 PM. Resident #14 stated she had poor vision and had worn eyeglasses since she was four years old. She also revealed she could not read small print and she thought her vision was getting worse.

An interview was conducted with the MDS Nurse #1 on 11/15/2023 at 11:05 AM. MDS Nurse #1 stated Resident #14's MDS dated 10/19/2023 did reveal she had visual impairment. She also stated the CAA was triggered to proceed to care plan. She further stated Resident #14 should have been care planned for visual impairment.

An interview was conducted with the Director of Nursing (DON) on 11/15/2023 at 11:32 AM. She stated she expected any resident with visual impairment to be care planned appropriately.

An interview was conducted with the Administrator on 11/15/2023 at 11:45 AM. The administrator stated he expected the care plan to be reflective of the resident's clinical condition including visual impairment.

F 656

affected. On 12/13/23, the Regional Minimal Data Set (MDS) Consultant completed an audit of all residents to ensure each resident with visual impairment has an individualized person-centered comprehensive care plan in the area of visual impairment.
The Minimum Data Set (MDS) Consultant addressed all concerns identified during the audit.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

" On 12/15/23, the Staff Development Coordinator (SDC) initiated an in-service with all facility and contract/agency nurses noting resident with visual impairment should have individualized person-centered comprehensive care plan to address visual impairment. Education will be completed by 12/27/23. After 12/27/23, all facility and contract/agency nurses that have not worked and received the education will complete upon their next scheduled shift. After 12/27/23, the Staff Development Coordinator (SDC) will include this education to facility and contract/agency nurses during general facility orientation.
" The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), or designee will review 10 resident care plans weekly x 4 weeks then monthly x 2 months to ensure residents with documented visual impairments have individualized person-centered comprehensive care

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F 656	Continued From page 44	F 656	plans in the area of visual impairment. The Director of Nursing (DON), Unit Managers (UM), or designee will address all concerns identified during the audit to include updating care plan when indicated and re-education of staff. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring of Care Plan Review Audit Tool audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review the audits to determine trends and/or further problem resolution if needed. Date of compliance: 12/27/23	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with the resident, staff and the Hospice Nurse, the facility failed to provide a dependent resident with nail care and facial hair trim to 1 of 4 residents (Resident #68) reviewed for assistance with activities of daily living. The findings included:	F 677	F677 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #68 remains in the facility. On	12/27/23

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Resident #68 was admitted to the facility on 11/4/22 with diagnoses that included congestive heart failure and brain degeneration.

The significant change in status Minimum Data Set (MDS) assessment dated 8/6/23 indicated Resident #68 was cognitively intact, had no rejection of care behaviors, and was totally dependent on staff assistance with personal hygiene and bathing. The MDS further indicated that Resident #68 received hospice care.

Resident #68's activities of daily living (ADL) care plan revised on 8/17/23 indicated Resident #68 required one person to provide extensive assistance with bathing and he preferred to receive bed baths instead of showers. The care plan further indicated that Resident #68 was resistive to care, and treatment related to confusion. Interventions included to allow for flexibility in ADL routine to accommodate the resident's mood, document care being resisted and if the resident refused care, re-attempt at another time.

A review of the nurses' progress notes from 10/1/23 through 11/13/23 in Resident #68's medical record indicated no notes regarding Resident #68 refusing baths, nail care, and facial hair trim.

An observation and interview with Resident #68 on 11/13/23 at 10:10 AM revealed he had long, thick fingernails on both hands which extended approximately one centimeter past the tips of his fingers. Thick brown matter was observed underneath all of his fingernails. Resident #68 had crumbs on his white beard which was

F 677

12/14/23, resident #68 was provided assistance with nail care and facial hair trimming.

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:

" Current residents have the potential to be affected. The Director of Nursing, Assistant Director of Nursing, Unit Manager, and or designee will complete an audit of 100% of current residents to ensure assistance has been provided for nail care and facial hair trimming. The Director or Nursing, Assistant Director of Nursing, and/or Unit Manager will address any concerns identified during the audit. Audit will be completed by 12/27/23.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

" The Staff Development Coordinator will provide education to current contract agency/ facility nursing staff noting dependent residents should be provided assistance with nail care and facial hair trimming as needed and upon request by 12/27/23. After 12/27/2023, all contracted agency/facility staff that has not worked and received the education will complete upon their next scheduled shift. The Staff Development Coordinator (SDC) will include education to contract agency/facility nursing staff in general orientation for contract agency/facility

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approximately three inches long. He had a towel on top of his chest with crumbs and a yellow stain. Resident #68 stated he wanted to get his nails and beard trimmed and wanted to know if the surveyor could do this for him.

An observation of Resident #68 on 11/14/23 at 8:41 AM revealed Resident #68 was sitting up in bed with his breakfast tray in front of him on top of his bedside table. Resident #68 was asleep and Nurse Aide (NA) #2 woke him up and asked him if he was done eating. Resident #68 said to NA #2 that he wasn't done eating. Resident #68 continued to have a long beard and long nails with brown matter underneath.

An interview with Medication Aide (MA) #1 on 11/15/23 at 2:23 PM revealed she had noticed Resident #68's long nails and his long beard. MA #1 stated the Activities Director, and his assistant usually did nail care, but she was not aware of their schedule. MA #1 stated she was not always assigned to take care of Resident #68, but ADL care could be done based on how she approached Resident #68. MA #1 explained that Resident #68 sometimes could be a little aggressive and his care depended on his mood for the day. MA #1 further stated that the nursing staff was responsible for providing nail care and facial hair care to Resident #68, but she had not offered to trim his nails or his beard before.

A phone interview with Nurse Aide (NA) #2 on 11/16/23 at 3:39 PM revealed he had noticed that Resident #68's fingernails were long and dirty, and he tried to clean them, but he was resisting. NA #2 stated he could not remember if he reported this to the nurse. He also stated that he did not offer to trim his beard because he thought

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nursing staff.

" The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), or designee will audit of 10 residents to ensure assistance has been provided for nail care and facial hair trimming as needed and requested 1 time a week x 4 weeks, and then monthly x 2.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

The Administrator is responsible for the plan of correction and monitoring audits, Resident Nail Care and Facial Hair Care Audit Tool and interview responses. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review the audits and interview responses to determine trends and/or further problem resolution if needed.

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Resident #68 wanted it to stay long.

An interview with NA #1 on 11/16/23 at 3:24 PM revealed she usually provided Resident #68 with a bed bath whenever she was assigned to care for him, but she did not attempt to trim his nails because she did not want to cut them too short. NA #1 stated that there was hairdresser at the facility who could trim Resident #68's beard but she was not aware of their schedule. She further stated that Resident #68 had never requested her to trim his fingernails or beard.

An interview with the Hospice Nurse on 11/16/23 at 9:55 AM revealed she had been coming to the facility once a week to see Resident #68 for a little over a month, but they did not send hospice nurse aides to provide care to Resident #68. The Hospice Nurse stated the reason for this was when Resident #68 started with hospice care, he got aggressive and angry with the hospice nurse aides, and he did not allow them to provide personal care. The Hospice Nurse further stated when she started working with Resident #68, the Hospice Doctor placed him on an anti-anxiety medication, and it worked well for him in that he was more cooperative with care and was calmer. The Hospice Nurse stated that she had noticed Resident #68's long nails and long beard and had spoken with the nursing staff about getting them trimmed but nothing had been done about it. The Hospice Nurse further shared that Resident #68 was supposed to receive full bed baths which included washing his hair, shaving his facial hair and trimming his nails.

An interview with Nurse #3 on 11/16/23 at 10:11 AM revealed she had noticed Resident #68's long nails and beard and she remembered mentioning

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this to a nurse aide. Nurse #3 stated the nurse aides could cut Resident #68's fingernails and trim his beard while giving him his bath. Nurse #3 further stated she couldn't remember the Hospice Nurse bringing this to her attention and if she did, it had been a while. Nurse #3 shared that Resident #68 sometimes refused care, but his ADL care could be done depending on the type of mood he was in and what he was feeling that day.

An interview with the Activities Director (AD) on 11/16/23 at 12:13 PM revealed he normally scheduled nail care once a week and residents who were interested would come to the activities area during leisure time. The AD stated that they only provided nail polish and could sometimes file nails if they required filing. However, they were not allowed to trim and cut nails.

A follow-up interview with MA #1 and observation of Resident #68 on 11/16/23 at 10:42 AM revealed she was able to cut Resident #68's fingernails and he also let her trim his beard. MA #1 stated Resident #68 was not resistive to care and did not fight during the procedure. MA #1 further stated that nail and facial hair care was everyone's responsibility and not just whenever he received a bed bath.

An interview with the Unit Manager (UM) on 11/17/23 at 8:03 AM revealed nail care should have been provided by a nurse to Resident #68, but she was not sure if a barber was needed to trim Resident #68's beard.

An interview with the Director of Nursing (DON) on 11/17/23 at 8:46 AM revealed she was aware that Resident #68's nails were brittle, but she did not know that he did not have hospice nurse

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F 677	Continued From page 49 aides who came to the facility to provide care of Resident #68. The DON stated that the nurse aides could trim nails unless the resident was diabetic in which case the nurses would have to do them. She also stated that the nurse aides were also responsible for trimming his beard and both should have been taken care of during routine care to Resident #68. The DON stated she knew that Resident #68 had refused care at times, but this should have been reported to the nurse and documented in his medical record.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and family and staff interviews, the facility failed to provide supervision for meals for 1 of 1 resident reviewed for quality of care (Resident #29). Findings included: Resident #29 was admitted to the facility on 9/29/23 with diagnoses inclusive of stroke, dysphagia/ aphasia, and acid reflux. A review of the Admission Speech Assessment dated 10/3/23 indicated precautions as falls, right hemiparesis, and aphasia/ dysphagia. It further	F 689	F689 Free of Accident Hazards/Supervision/ Devices 1. On 11/8/2023 Resident #29 was ordered a Regular Diet with mechanical texture and honey thick liquids. Resident requires extensive to total assistance with meals. Resident #29 care plan was updated on 12/11/23, to reflect the assistance needed with all meals and liquids. 2. On 12/12/2023 and 12/13/23 Director	12/27/23

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indicated Resident #29's swallowing status for thin liquids and solids (pureed diet) was severe (only swallowing at 10%), and mild pocketing of food was noted.

An admission Minimum Data Set assessment dated 10/6/23 indicated Resident #29 had a severely impaired cognition and required extensive assistance with eating.

The current care plan indicated Resident #29 was at risk for stroke and aphasia. Interventions included: staff assistance with activities of daily living (ADL) to maintain or achieve practical level of functioning, to include partial to moderate assistance with eating and oral hygiene and personal hygiene.

A review of physician's order dated 11/2/23 indicated Resident #29 was on a regular diet with mechanical soft texture with honey consistency and modified barium swallow study due to diagnosis of oropharyngeal dysphagia, and cough.

A review of recent results of a modified barium swallow dated 11/8/23 indicated Resident had severe oropharyngeal dysphagia as evidenced by poor oral control, mistimed pharyngeal initiation when ingesting thin, nectar and honey thickened liquids and cued cough did not remove material. The barium swallow further determined Resident #29 would eventually aspirate due to decreased airway protection during the swallow. Recommendations were inclusive of one-to-one assistance with feeding and check for pocketing of food (holding food in mouth). The assessment results and recommendations were discussed with Resident #29, her family and primary Speech

F 689

of Nursing (DON)/Assistant Director of Nursing (ADON) and Minimum Data Set Nurse (MDS) completed a review of current residents meal assistance interventions to ensure the interventions are current and effective.

3. On 12/15/23 Staff Development Coordinator (SDC) initiated education with nursing staff to include agency and contract nursing staff regarding following meal assistance interventions and where to find them. Education will be completed by 12/27/23. Employees who have not received this education after 12/27/23 will be educated prior to working their next shift. Education related to Assistance with meals will be included in the orientation process for new hires, agency and contract nursing staff.

4. The DON/ADON/Unit Managers will randomly audit six residents per week for 4 weeks then monthly x 2 months to ensure that appropriate meal assistance interventions are in place. Results of Meal Assistance Audit Tool will be shared with the Quality Assurance Performance Improvement (QAPI) members monthly x 3 months or until a time determined by the QAPI members for sustained compliance.

5. Alleged date of compliance is 12/27/23

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F 689	Continued From page 51 Therapist (via phone). A follow-up observation on 11/13/23 at 12:35 PM revealed Resident #29 was sitting in dining area with family member and Speech Therapist observing and cueing the Resident as she fed herself. The family member stated he had some concerns but did not elaborate. During a phone interview on 11/14/23 at 1:07 PM, Resident #29's family member revealed Resident #29 was an aspiration risk due to a recent stroke, had difficulty expressing her thoughts and was supposed to receive assistance with feeding. Although her diet was in the process of being updated, she was still an aspiration risk and was supposed to be supervised and assisted during meal consumption. The family member further revealed there were many occasions when family members arrived to visit Resident #29 and she found her in her room alone feeding herself or nurse aides (NA) would bring the meal tray into the room and leave it on the over bed table, then leave the room. The family member stated Resident #29 does receive assistance and supervision from the Speech Therapist during lunch time when the Resident is in the dining room. The family member further stated she brought these concerns to the attention of Nurse #5, Speech Therapist, and the Director of Nursing (DON). A review of a speech therapy progress note dated 11/14/23 revealed Resident #29 would continue honey thick liquids and upgrade to mechanical soft diet and initiate water trials. The progress note further revealed the Speech Therapist educated nursing on diet recommendations, strategies/ precautions and would continue to	F 689		

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educate nurse aides on safe swallow strategies and precautions.
During an interview on 11/14/23 at 2:00 PM, the Speech Therapist indicated Resident #29 was at risk for aspiration and required supervision during meals although she could feed herself with cueing. The Speech Therapist further indicated Resident #29 continued honey thickened liquids and upgraded to mechanical soft diet as recommended by a recent barium swallow test on 11/8/23. Further, Resident #29 was participating well in lip, tongue, and neck exercises and the Speech Therapist normally supervises the Resident during the lunch meal in the dining room. The Speech Therapist stated she regularly informed the nurse and nurse aides that the Resident should not eat in her room alone without staff supervision. Her expectation was for the Resident to receive supervision during all meals.

During an interview on 11/14/23 at 3:34 PM, Nurse Aide (NA) #7 revealed she was usually assigned to Resident #29, who fed herself, and ate breakfast in her room, ate lunch in the dining room and ate dinner in her room. NA #7 could not recall if Resident #29's meal ticket indicated one-on-one assistance with meals.

During a phone interview on 11/15/23 at 9:11 AM, NA #4 revealed when she was assigned to Resident #29, she only delivered the tray and assisted with tray set up since the Resident fed herself. NA #4 further revealed she would not supervise the Resident's meal and she could only recall that the Resident's tray ticket indicated adaptive equipment (sippy cup, divided plate, and spoon). NA #4 stated she was never informed that the Resident required one-to-one supervision during meals.

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F 689	Continued From page 53 During an interview on 11/15/23 at 10:35 AM Nurse #5 reviewed the care plan and indicated Resident #29 required partial/ moderate assistance with eating. Nurse #5 indicated she had observed Resident #29 alone in her room at times during dinner meals. NA #5 further indicated she expected the Resident to be supervised during meals since she was an aspiration risk. During an interview on 11/16/23 at 11:37 AM the DON reviewed Resident #29's care plan and understood partial/ moderate assistance with eating to mean the Resident was to receive supervision during meals. She expected staff to check the Kardex (communication tool the facility used to communicate resident's needs) and meal tray tickets when caring for residents. She further expected Resident #29 to be transferred to the dining room/ common area where she could be supervised if she could not receive one-on-one supervision in her room when eating.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents	F 695	F695- Respiratory/Tracheostomy Care	12/27/23

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F 695	Continued From page 54 and staff and record review, the facility failed to provide supplemental oxygen (O2) per physician (MD) order for 2 of 2 sampled residents reviewed for respiratory care (Residents #69 and #14). The findings included: 1. Resident #69 re-admitted to the facility on 9/9/23. Diagnoses included dementia, pneumonia, and anxiety disorder. A Nurse Practitioner (NP) progress note dated 9/11/23 documented the NP assessed Resident #69 on re-admission. The Resident denied cough, and shortness of breath. Her lungs were clear, bilaterally, without wheezes, rales, rhonchi, and her breathing was non-labored. A NP progress note dated 9/15/23 recorded nursing reported to the NP that Resident #69 experienced decreased 02 saturations (a measure used to determine oxygen levels in the blood). The NP assessed Resident #69 as alert, in no acute distress, vital signs (VS) within normal limits and her lungs with diffuse wheezes noted. The NP ordered a STAT (immediately) chest Xray. Review of a chest Xray dated 9/15/23 revealed pneumonia to bilateral lungs. The NP was notified. Levaquin and Rocephin (antibiotics) and to monitor O2 saturations were prescribed. A significant change Minium Data Set assessment dated 9/19/23 assessed Resident #69 with adequate hearing, impaired vision, use of corrective lenses, ability to be understood, ability to understand, and intact cognition.	F 695	and Suctioning 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #14 is no longer a resident in the center. Resident #69 is no longer a resident in the center. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: " Current residents have the potential to be affected. On 12/13/23, The Unit Manager completed an audit of current residents to ensure residents are receiving oxygen (O2) therapy per physician (MD) order. The Director of Nursing, Assistant Director of Nursing, and/or Unit Manager will address any concerns identified during the audit. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: " The Staff Development Coordinator initiated education on 12/15/23 to current contract agency and facility nurses noting residents should be provided supplemental oxygen per physician order. After 12/27/23, all contracted agency and facility nurses that have not worked and	

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A September 2023 care plan identified Resident #69 at risk for side effects of medication prescribed for her diagnosis of anxiety. Interventions included: to monitor VS and provide medications per MD order.

Review of electronic MD orders and Medication Administration Records (MAR) for September 1, 2023 - November 17, 2023, revealed the following:
- A standing MD order for the diagnosis of cyanosis (skin with bluish/greyish color that indicates inadequate oxygen levels in the blood) or dyspnea (shortness of breath) to provide supplemental O2 at 2 liters per minute (LPM), via nasal cannula (NC) and to notify the provider. Review of the September 1, 2023 - November 17, 2023, MARs revealed this order was not an active MD order and was not included on the MARs.
- An active MD order dated 9/10/23 with a stop date of 11/1/23 recorded take VS every shift for readmission. The VS results, which included O2 saturations, were documented on the September, October, and November 2023 MARs.
- An active MD order dated 9/29/2023 recorded to change O2 tubing, humidified water, and nebulizer tubing out every Sunday night, sign, and date tubing, on every night shift every Sunday for infection control. The nurses recorded their initials on the September, October, and November 2023 MARs.

Resident #69's September 2023 - October 2023 MAR recorded O2 saturations with a range of 84-98%. The electronic medical record documented O2 saturations with the use of supplemental O2 via NC on the following days:
- Thirteen days in September 2023 (9/11/23 -

F 695

received the education will complete upon their next scheduled shift. The Staff Development Coordinator (SDC) will include the education in general orientation for contract agency/facility nursing staff.
" The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), or designee will audit 10 residents receiving oxygen therapy one time a week x 4 weeks, and then monthly x 2 to ensure residents are receiving oxygen therapy per physician order, concentrator in place, oxygen tubing is in place and the liter flow is per MD order.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

The Administrator is responsible for the correction and monitoring of Oxygen Audits Tools and interview responses. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review the audits and interview responses to determine trends and/or further problem resolution if needed.

Date of compliance: 12/27/23

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F 695	Continued From page 56 9/15/23, 9/17/23 - 9/28/23, and 9/30/23) - Twenty-seven days in October 2023 (10/1/23 - 10/4/23, 10/8/23 - 10/15/23, and 10/17/23 - 10/31/23) An observation of Resident #69 in her room in bed occurred on 11/14/23 at 9:31 AM. Resident #69 fed herself breakfast and received supplemental 02 from a concentrator via NC at 4 LPM; she denied difficulty breathing. An observation of Resident #69 occurred on 11/14/23 at 10:41 AM; she was in her room in bed with supplemental 02 from a concentrator via NC at 4 LPM. An observation of Resident #69 occurred on 11/15/23 at 10:45 AM with Nurse #2. Resident #69 was lying in bed with 02 via NC at 2 LPM, and a humidifier bottle with a small amount of water. Resident #69 kept moving her O2 tubing in/out of her nose. Nurse #2 asked Resident #69 if she was getting enough O2, she replied "Not really." Nurse #2 checked the flow of O2 and stated that she could feel the O2, but that the tubing might be clogged so she would change the O2 tubing and place a new humidifier bottle. Nurse #2 checked Resident #69's O2 saturations and stated, "It's fluctuating between 91 - 92%." An interview with Nurse #2 occurred on 11/15/23 during the observation at 10:45 AM. Nurse#2 stated that she was familiar with Resident #69 and was her Nurse on the 7A-7P shift. Nurse #2 described Resident #69 with increased anxiety with difficulty breathing shortly after re-admission to the facility. Nurse #2 stated, "So we used the supplemental oxygen at 2 LPM continuous per standing order." Nurse #2 reviewed the	F 695		

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	345562	A. BUILDING ______ B. WING ______	11/17/2023

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CLEAR CREEK NURSING & REHABILITATION CENTER	**10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227**

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F 695	Continued From page 57 November 2023 MAR for Resident #69 and stated she was not sure which nurse transcribed the standing order for supplemental O2 because she did not see the standing order as an active order, but that she was aware that Resident #69 should receive continuous O2 at 2 LPM per standing order. A phone interview with Nurse #8 occurred on 11/16/23 at 10:42 AM. Nurse #8 stated she was the Nurse for Resident #69 on the 7P - 7A shift. Nurse described Resident #69 with "a lot of anxiety that's triggered if she feels like she's not breathing the way she should." Nurse #8 stated Resident #69 received supplemental O2 at 2 LPM shortly after her readmission from the hospital. Nurse #8 stated Resident #69 had not expressed difficulty breathing to her but received O2 at 2 LPM per the standing order. Nurse #8 stated she was unsure which nurse implemented the order for O2. An interview with Nurse #6 occurred on 11/16/23 at 6:05 PM. Nurse #6 stated that she assessed Resident #69 on 10/20/23 with low O2 saturations and notified the NP. Nurse #6 stated O2 was already in place via NC at 2 LPM. Nurse #6 stated she received a verbal MD order from the NP to increase O2 to 3 LPM and monitor. Nurse #6 stated that when a nurse started an MD order, the nurse contacted the MD/NP to obtain the MD order. The MD order was either written or verbal and the nurse transcribed the order by entering/activating the MD order in the computer which added the MD order to the MAR. Nurse #6 stated she could not tell which nurse initiated the MD order for O2 for Resident #69 because the MD order was not on the MAR. Nurse #6 stated she thought she returned the O2 rate to 2 LPM	F 695		

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F 695	Continued From page 58 once the Resident's O2 saturations stabilized, but she was not certain. An interview with the Unit Manager (UM) occurred on 11/15/23 at 11:23 AM. The UM stated that she was the UM in the facility since October 2023. The UM stated that a discussion regarding MD orders for all new admissions or re-admissions occurred during morning department manager meetings. She stated that the nurses had access to two sets of standing orders, one set from the MD and one set from the corporate office. The UM described the MD orders for supplemental 02, as one that recorded 02 at 2 LPM, but did not give an option to titrate the O2 up/down, and the second order from the corporate office gave the option to write in the 02 range which would require the nurse to contact the MD to clarify the order. The UM stated both orders would require the nurse to contact the MD. The UM stated that the nurse should contact the MD to obtain an order if they wanted to have the option to titrate the 02. The UM stated that titrating O2 was not left to the discretion of the nurse and the order had to be activated by the nurse so that the order would populate on the MAR. The UM stated that supplemental 02 was a medication and should be on the MAR as an order. The UM reviewed the September 2023 - November 2023 MAR for Resident #69 and stated that the MAR did not include an order for supplemental O2. An interview with the Director of Nursing (DON) occurred on 11/15/23 at 11:44 AM. The DON stated she was not aware of why a nurse would change the 02 rate if there was a standing MD order to provide O2 at 2 LPM. The DON stated that if the nurse did not obtain a MD order to titrate the 02, the nurse did not have the	F 695		

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F 695	Continued From page 59 discretion to do so. The DON stated that it was difficult to determine which nurse initiated the O2 standing order because the nurse did not activate the order so that it would populate on the MAR, but that the MD order should be on the MAR and followed. The DON stated that it was possible that the nurse may have wanted to assess if Resident #69 responded better to an increase in 02 to discuss this with the MD, but then once the nurse completed the assessment, the 02 rate should have been adjusted back per the MD order until an MD order to titrate the O2 rate up was obtained. An interview with the Administrator occurred on 11/15/2023 at 10:20 AM and he stated that he expected nursing to obtain and follow all physician's orders as written. An interview with the NP occurred on 11/16/23 at 3:47 PM. The NP stated that she did recall getting a phone call from a nurse about Resident #69 having low O2 saturations in the last month or so, but that this had occurred more than once. The NP stated the last call she received the nurse said that she applied O2 at 2 LPM, but that the Resident's O2 saturations were coming up slowly. The NP stated she advised the nurse to increase the O2 to 3 LPM until the Resident became stable which brought her O2 saturations up to 92%. The NP stated she was aware that Resident #69 received O2 at 2 LPM due to her diagnosis of pneumonia and fluctuating O2 saturations. The NP stated she expected Resident #69 would need supplemental O2 continuously, but she would expect the nurse to return the O2 to 2 LPM after the Resident became stable and to notify the MD/NP if an MD order was needed to titrate the O2 up for further clarification of the order.	F 695		

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2. Resident #14 was admitted to the facility on 11/09/2022. Resident #14 had diagnoses which included chronic respiratory failure with hypoxia with dependence on supplemental oxygen. Review of the electronic medical record revealed a physician order for Resident #14 dated 11/09/2022 which read in part: oxygen at 2 liters per minute via nasal cannula (NC) related to chronic respiratory failure with hypoxia.

A review of Resident #14's quarterly Minimum Data Set (MDS) dated 10/19/2023 revealed Resident #14 was cognitively intact with no documented behaviors. Resident #14's MDS indicated she was receiving oxygen therapy.

Review of the care plan dated 10/30/2023 revealed Resident #14 had the potential for actual ineffective breathing pattern related to history of chronic respiratory failure with hypoxia requiring supplementary oxygen. The interventions included administer oxygen as ordered and observed for signs and symptoms of respiratory complications.

Observations were completed of Resident #14 on 11/13/2023 at 11:32 AM, 11/13/2023 at 3:55 PM, 11/14/23 at 9:16 AM, and 11/14/2023 at 5:11 PM. During each of the observations Resident #14 was observed in bed with her nasal cannula in her nostrils. The oxygen concentrator was set at 3 liters per minute, and Resident #14 was observed to not be in distress.

Review of Resident #14's oxygen saturation (a measure of oxygen in the body) levels revealed:

F 695 Continued From page 61 F 695

11/13/2023 - 98% (Normal level = 95%-100%)
11/14/2032 - 95% (Normal level = 95%-100%)
11/15/2023 - 94% (Normal level = 95%-100%)

An interview was completed with Resident #14 on 11/14/2023 at 2:45 PM. Resident #14 stated she has been on oxygen since she had been at the facility. She further stated, "I get short of breath if I don't have it on". She further stated the nursing staff takes care of her oxygen.

An interview was completed on 11/15/2023 at 9:10 AM with Resident #14's nursing assistant (NA #3). NA #3 stated she does not do anything with the oxygen machine or the settings. NA #1 further stated she did make sure the tubing was in place in the nose and would notify the nurse if the resident refused to wear it or if the resident was not breathing good.

An interview was completed on 11/15/2023 at 09:16 AM with Nurse #7. Nurse #7 stated Resident #14 was on 2 liters of oxygen. She further stated she received that information during shift report. She also stated she saw the oxygen concentrator was set on 3 liters on 11/14/2023 but it slipped her mind to verify the setting with the physician's order. Nurse #7 explained Resident #14 could not change her oxygen settings independently due to her immobility.

An observation was completed with Nurse #6 on 11/15/2023 at 9:20 AM. Nurse #6 stated Resident #14's oxygen concentrator setting was set at 3 liters per minute.

Review of a nursing note dated 11/15/2023 at 9:45 AM revealed Nurse #6 contacted the

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F 695	Continued From page 62 Medical Provider and obtained an order for oxygen 3 liters per minute per nasal cannula. An interview was completed on 11/15/2023 at 9:50 AM with the Director of Nursing (DON). The DON stated the nurses should review the physician's order, ensure the in-room concentrator was at the correct ordered liter. An interview was conducted with the Administrator on 11/15/2023 at 10:20 AM. The Administrator stated he expected nursing to follow all physician's orders as written. An interview was conducted on 11/16/2023 at 2:25 PM with the Nurse Practitioner (NP). The NP stated she expected the nursing staff to follow physician's orders for oxygen therapy including the correct flow rate.	F 695		
F 761 SS=E	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.	F 761		12/27/23

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F 761	Continued From page 63 §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 record review, observations and staff interviews, the facility failed to discard expired medications and date opened insulin vials and eye drops in 1 of 2 medication rooms (300 hall/400 hall medication room) and 3 of 5 medication carts (300 hall/400 hall medication cart, 600 hall medication cart and 500 hall medication cart). The findings included: 1. An observation of the 300 hall/400 hall medication room with Nurse #5 on 11/15/23 at 11:38 AM revealed an opened vial of Tuberculin marked with an open date of 10/2/23. The vial was stored in the medication room refrigerator and was available for use. During the observation, Nurse #5 stated that the opened Tuberculin vial was only good for 28 days after opening and should have been discarded. She also stated that the Tuberculin vial was normally used by the night shift nurse for newly admitted residents. (Tuberculin, also known as purified protein derivative, is a combination of proteins that are used in the diagnosis of tuberculosis.) An interview with the Unit Manager (UM) on 11/17/23 at 8:03 AM revealed the Director of	F 761	F761 Label/Store Drugs and Biological 1.) The expired medications identified, insulin and tuberculin vials, and eye drops that were not labeled were discarded on 11/17/23 by the Director of Nursing. 2.) On 12/15/23 The DON/Assistant Director of Nursing (ADON) initiated an audit of all medication carts and medication rooms with the nurse and/or medication aid to ensure medication has an expiration date when indicated or label the medication with expiration dates. Expired medications are removed and destroyed per facility protocol and/or returned to the pharmacy timely for destruction, The DON will address all concerns identified during the audit to include medication has an expiration date when indicated, or will label the medication with expiration dates, removing expired medications per facility protocol, returning expired or discontinued medications to the pharmacy for destruction when indicated. The audit will be completed by 12/27/23. 3.) On 12/15/23 the Staff Development Coordinator (SDC) initiated an in-service	

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Nursing was responsible for checking the medication rooms for expired medications. The UM stated that she did not even have a key to the medication rooms, but the nurses were supposed to make sure there were no expired medications in the medication rooms. The UM stated that the opened vial of Tuberculin was only good for 28 days and should have been discarded after that.

An interview with the Director of Nursing (DON) on 11/17/23 at 8:46 AM revealed the nurses were responsible for checking the medication rooms and expired medications should be removed. The DON stated the opened Tuberculin vial only lasted for 28 days and should have been discarded after that.

2. a. An observation of the 300 hall/400 hall medication cart with Nurse #5 on 11/15/23 at 11:42 AM revealed an opened Latanoprost eye drop bottle which was not marked when it was opened. There was a sticker on the bottle that indicated it expired 6 weeks after opening. The eye drop bottle was available for use in the top drawer of the medication cart. (Latanoprost is a medication used to treat glaucoma.) During the observation, Nurse #5 stated the bottle of Latanoprost eye drops should have been dated when it was opened because it was only good for 6 weeks after opening. She further shared that the night shift nurse normally gave it which was why she did not notice it.

b. An observation of the 600 hall medication cart with Medication Aide (MA) #2 on 11/16/23 at 11:06 AM revealed an opened vial of Insulin glargine, an opened vial of Insulin lispro and an opened bottle of Latanoprost eye drop in the top

F 761

with all nurses and medication aides regarding Medication Storage with emphasis on expiration date when indicated or will label the medication with expiration dates per facility protocol, responsibility to check medication cart/medication storage room daily for expired medications and discarding expired medications per pharmacy policy. After 12/27/23 any nurse or medication aide to include agency and contract who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses or medication aides to include agency and contract will be in-serviced during orientation regarding Medication Storage.

4.) The SDC, Assistant Director of Nursing, DON will audit all medication carts and medication rooms weekly x 4 weeks then monthly x 2 months utilizing the Medication Cart and Medication Room Audit Tool. This audit is to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed per facility protocol.

5.) The DON will present the findings of the Medication Cart and Medication Room Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The audit results will be forwarded to QAPI Committee monthly for 3 months for review.

Date of Alleged Compliance 12/27/23.

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drawer of the medication cart and available for use. Both opened vials of Insulin glargine and Insulin lispro had stickers that indicated they expired 28 days after opening. (Insulin glargine and Insulin lispro are different types of insulin used to treat diabetes.) The opened bottle of Latanoprost eye drops had a sticker that indicated it expired 6 weeks after opening. During the observation, MA #2 stated she did not know anything about the insulins because she did not give them and the Latanoprost eye drop was given by the night shift nurse. MA #2 stated she knew all medications should be dated when first used but she was not sure about the expiration dates after the medications were opened.

An interview with Nurse #6 on 11/16/23 at 11:18 AM revealed she oversaw MA #2 and was responsible for the insulins on the 600 hall medication cart. Nurse #6 stated she did not notice the undated vials of insulin and Latanoprost eye drops but the nurses need to put a date whenever those were opened.

c. An observation of the 500 hall medication cart with Nurse #6 on 11/16/23 at 11:19 AM revealed two containers of Hydrocortisone 1%/barrier cream/antifungal cream marked with expiration dates of 3/16/23 and 3/23/23. Both containers were available for use in the fourth drawer of the medication cart. (Hydrocortisone cream is a medicated lotion, ointment or solution that treats eczema and other skin conditions.) There was also a bottle of Antacid tablets marked with an expiration date of 8/23 which was available for use in the third drawer of the medication cart. (An antacid is a substance which neutralizes stomach acidity and is used to relieve heartburn, indigestion or an upset stomach.) During the

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F 761	Continued From page 66 observation, Nurse #6 stated that she did not notice the expired medications in the medication cart because she didn't give any of those to her residents, but they should have been discarded after they expired. An interview with the Unit Manager (UM) on 11/17/23 at 8:03 AM revealed the nurses were supposed to check the medication carts daily whenever they used them. All insulins and Latanoprost eye drops should be dated when first opened and all expired medications should be discarded. The UM stated the pharmacy consultant had just checked the medication carts this week and she was not sure why she did not catch any of these. An interview with the Director of Nursing (DON) on 11/17/23 at 8:46 AM revealed the nurses were responsible for checking the medication carts and they should be doing this daily. The DON stated expired medications should be removed from the medication carts and all insulins and eye drops should be dated when they are opened.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		12/27/23

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F 806	Continued From page 67 by: Based on observations, a resident interview, staff interviews and record review, the facility failed to honor a resident's food preferences for no sandwiches and no fish. This failure occurred for 1 of 4 residents reviewed for food preferences (Resident #37). The findings included: Resident #37 was admitted to the facility on 6/7/22. Diagnoses included diabetes mellitus, type 2 (DM2), chronic kidney disease (CKD), and iron deficiency anemia, among others. A physician (MD) diet order dated 6/13/22 recorded Resident #37 received a regular diet with regular texture. A quarterly Minimum Data Set assessment dated 10/5/23 assessed Resident #37 with adequate hearing, clear speech, ability to be understood, ability to understand, impaired vision without the use of corrective lenses, intact cognition, and required set up assistance with meals. A care plan revised 10/12/23 recorded Resident #37 was at nutritional risk due to her diagnoses of DM2, CKD and use of adaptive equipment with meals. Interventions included staff would obtain likes/dislikes; incorporate as many food preferences as possible compatible with dietary restrictions and assess for/provide food preferences. Resident #37 was observed and interviewed in her room during lunch on 11/13/23 at 12:40 PM. Resident #37 received a crabcake, rice, vegetable blend and hush puppies for lunch. She	F 806	F806- Resident Allergies, Preferences, Substitutes 1. Resident #37 remains in the facility. The resident has not experienced a significant weight loss over the last three months. The resident□s food preferences were reviewed with the resident and updated on 11/15/2023 by the Dietary Manager. 2. The Dietary Manager completed an audit of all residents to ensure food preferences were updated for all residents that take food by mouth. Updates were made in Menu Management as appropriate. This audit was completed by 12/15/2023. 3. An in-service was initiated on 12/15/23 by the Dietary Manager for all Dietary staff regarding Diet Record Policy including obtaining, updating, and following food preferences. The Education will be completed by 12/27/23. Any dietary staff member that has not received the education will be educated upon their next scheduled shift. 4. Ten residents diet preferences will be audited using the Food Preference tool by the Dietary Manager or Director of Nursing weekly x 4 weeks, then monthly x 2 months. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) committee monthly for three months or until a time	

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F 806	Continued From page 68 was observed eating her rice, vegetables, and hush puppies, but she did not eat the crabcake. Resident #37 stated she did not like fish, and she told staff that many times, but that she continued to receive fish at least once per week. She stated when she asked for a substitute, staff responded that either they did not have a substitute, or they only had a sandwich or a cup of soup to offer. Resident #37 stated that she did not like sandwiches and if she did not want the soup, she would just eat a snack. The tray card on her lunch meal tray recorded "Notes: No fish, baked potato, Dislikes: Entrees (FISH)." Resident #37 was observed and interviewed in her room during lunch on 11/14/23 at 12:42 PM. Resident #37 received a cheeseburger, tater tots and green beans for lunch. She was observed eating her tater tots and green beans, but she did not eat the cheeseburger. Resident #37 stated she did not like sandwiches, and she told staff that many times, but that she continued to receive sandwiches at least twice per week. Resident #37 was observed and interviewed with the Dietary Manager (DM) during her lunch meal on 11/14/23 at 12:50 PM. Resident #37 stated that she did not eat her cheeseburger because she did not like sandwiches. The DM reviewed her tray card and stated that he was responsible to update food preferences in the tray card system, but that sandwiches were not noted on her tray card as a food she did not like because he was not aware. The DM stated that the alternate entrée for lunch that day was pimento cheese sandwiches and chips, but that salads, and soups were always available. A review of the Fall/Winter 2023 - 2024, Week 2	F 806	determined by the QAPI members for sustained compliance. Date of Alleged Compliance: 12/27/23	

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F 806	Continued From page 69	F 806		

menu revealed the following entrées:
- Sunday dinner - chicken club sandwich
- Monday lunch - crabcake
- Tuesday lunch - cheeseburger
- Friday lunch - baked fish

An interview with Dietary Aide (DA) #1 on 11/14/23 at 1:17 PM revealed he was responsible for plating the food for residents on the 500/600 unit. He stated he should review the tray card for food preferences and plate the food per the resident's preferences listed on the tray card.

Nurse #2 was interviewed on 11/15/23 at 10:55 AM and stated she was the assigned Nurse for Resident #37 on the 7A - 7P shift. Nurse #2 described Resident #37 as alert, oriented and able to communicate her needs/preferences. Nurse #2 stated that at times Resident #37 requested a substitute when she received sandwiches or fish because she stated that she did not like them. Nurse #2 stated that when this occurred, she went to the refrigerator on the unit to get the Resident something else to eat. Nurse #2 stated that most of the time there was something else to offer like soup, or a snack like yogurt, but sometimes the only other option was another sandwich. Nurse #2 stated staff did not have to go to the kitchen to get a substitute, but rather "We just offer her what we have in the kitchen here, but she does not always want that." Nurse #2 stated that she had not reported to the dietary staff that Resident #37 did not like sandwiches because she thought the dietary staff already knew but offered Resident #37 what was available in the kitchen on the unit.

An interview with Nurse Aide (NA) #8 occurred on 11/15/23 at 11:01 AM. NA #8 stated that she was

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F 806	Continued From page 70 familiar with the care Resident #37 received and set up her meal tray for breakfast and lunch. NA #8 stated Resident #37 did not like sandwiches or fish and stated, "So we offer her something else when she gets it." NA #8 stated that sometimes the only other option was another sandwich and when that happened, Resident #37 got a snack or ate food brought from her family. A phone interview with the consultant Registered Dietitian (RD) on 11/17/23 at 10:14 AM revealed the DM updated food preferences in the tray card system quarterly and as needed. The RD stated that staff should honor food preferences the facility was aware of. The RD stated that the tray card system used by the facility did not categorize crabcakes as "fish", but rather as "seafood" and that was the reason Resident #37 received crabcakes as an entrée, because her tray card noted "fish" as a disklike and not "seafood." The RD stated that going forward, dietary staff would need to clarify with the resident specifically which fish or seafood they did not like to capture food preferences more accurately in the tray card system. An interview with the Director of Nursing (DON) occurred on 11/15/23 at 6:00 PM and revealed dietary staff were responsible for providing residents with meals per diet order and per the resident's food preferences. The DON stated that nursing staff should review the tray card when the meal was set up and make sure all foods were received per the diet order and preferences listed on the tray card.	F 806		
F 807 SS=B	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6)	F 807		12/27/23

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F 807	Continued From page 71 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents and staff, and record review, the facility failed to provide beverages per resident choice to 3 of 3 sampled residents reviewed for receiving their preferred beverages (Residents #37, #22, and #79). The findings included: 1. Resident #37 was admitted to the facility on 6/7/22. Diagnoses included diabetes mellitus, type 2 (DM2), chronic kidney disease (CKD), and iron deficiency anemia, among others. A physician (MD) diet order dated 6/13/22 recorded Resident #37 received a regular diet with regular texture and thin liquids. A quarterly Minimum Data Set assessment dated 10/5/23 assessed Resident #37 with adequate hearing, clear speech, ability to be understood, ability to understand, impaired vision without the use of corrective lenses, intact cognition, and required set up assistance with meals. A care plan revised 10/12/23 recorded Resident #37 was at nutritional risk due to her diagnoses of DM2, CKD and use of adaptive equipment with meals. Interventions included staff would obtain likes/dislikes; incorporate as many food	F 807	F807-Drinks Avail to Meet Needs/Preferences/Hydration 1. Resident #37 resides in the facility. An assessment of the resident on 11/15/2023 revealed no evidence of dehydration. Preferred beverages were provided, and preferences updated on Menu Management by Dietary Manager on 11/15/23. Resident #22 resides in the facility. An assessment of the resident on 11/15/2023 revealed no evidence of dehydration. Preferred beverages were provided, and preferences updated on Menu Management by Dietary Manager on 11/15/23. Resident # 79 resides in the facility. An assessment of the resident on 11/15/2023 revealed no evidence of dehydration. Preferred beverages were provided, and preferences updated on Menu Management by Dietary Manager on 11/15/23. 2. The Dietary Manager did a 100% update on beverage preferences for all residents that take fluids by mouth. Updates were made in Menu Management as appropriate. The audit was completed on 12/15/2023	

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F 807

Continued From page 72

preferences as possible compatible with dietary restrictions and assess for/provide food preferences.

An observation of the lunch meal dining area occurred on 11/13/23 at 12:00 PM. Available beverages for meal service included coffee, water, tea, lemonade, assorted juices, milk, and sodas.

Resident #37 was observed in her room during lunch on 11/13/23 at 12:40 PM. Resident #37 ate and drank independently with adaptive equipment. The tray card on her meal tray recorded "Standing Orders: 8 fl. (fluid) oz (ounce) tea and 8 fl. oz water." Resident #37 did not receive water on her lunch meal tray.

An observation of the breakfast meal dining area occurred on 11/14/23 at 9:10 AM. Available beverages for meal service included coffee, water, assorted juices, milk, and sodas.

Resident #37 was observed and interviewed in her room during breakfast on 11/14/23 at 9:15 AM. Resident #37 ate and drank independently with adaptive equipment. The tray card on her meal tray recorded "Standing Orders: 2 x (times) 8 oz assorted juices, 8 fl. oz Coffee, 8 fl. oz water." Resident #37 did not receive two, 8 fl. oz of assorted juices and 8 fl. oz of water. Resident #37 stated she often did not receive all the beverages she wanted, and she told staff that many times. She stated she often had to ask for more to drink, even though her tray card listed her preferences. Resident #37 stated sometimes she received one cup of juice, but usually not two cups, she rarely received water on her meal tray, and when she asked for more juice, she was

F 807

3. An inservice regarding Diet Record Policy including obtaining, updating, and following drink preferences to the Dietary Cook and Aides was initiated by the Dietary Manager on 12/15/2023. The inservice education will be completed by 12/27/23.

4. Ten residents will be audited by Dietary Manager or Director of Nursing using the Beverage Preference Observation Tool weekly x 4 weeks, then monthly x 2 months. Results of audit will be shared with the Quality Assurance Performance Improvement (QAPI) committee for three months.

Date of Alleged Compliance:12 /27/23

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often told that juice was not available.

Resident #37 was observed and interviewed with the Dietary Manager (DM) during her lunch meal on 11/14/23 at 12:50 PM. The tray card on her meal tray recorded "Standing Orders: 8 fl. oz tea and 8 fl. oz water." Resident #37 stated that she did not receive water with her lunch meal. The DM reviewed her tray card and stated that Resident #37 should have received all the beverages as listed on her tray card as the beverages were listed per resident preference to meet their fluid needs.

An interview with Dietary Aide (DA) #1 on 11/14/23 at 1:17 PM revealed he was responsible for plating the food for residents on the 500/600 unit. He stated nursing staff were responsible for placing beverages on each resident's meal tray per the resident's preferences listed on the tray card.

An interview with Nurse Aide (NA) #8 occurred on 11/15/23 at 11:01 AM. NA #8 stated that she was familiar with the care Resident #37 received and set up her meal tray for breakfast and lunch. NA #8 stated Resident #37 did not receive water on her meal trays, but she drank a lot of coffee. NA #8 stated that she did not know that all beverages listed on the tray card were supposed to be provided to each resident and that she did not always read the tray card to verify all items were provided.

Nurse #2 was interviewed on 11/15/23 at 10:55 AM and stated she was the assigned Nurse for Resident #37 on the 7A - 7P shift. Nurse #2 described Resident #37 as alert, oriented and able to communicate her needs/preferences.

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Nurse #2 stated that at times Resident #37 requested more to drink. Nurse #2 stated that when this occurred, she went to the refrigerator on the unit to get the Resident something else to drink. Nurse #2 stated that most of the time there was something else to offer but sometimes what she wanted was not available. Nurse #2 stated staff did not have to go to the kitchen to get a substitute, but rather "We just offer her what we have in the kitchen here, but she does not always want that."

Nurse #10 stated in an interview on 11/16/23 at 11:50 AM that Resident #37 received meals with coffee and juice at breakfast and sweet tea, and lemonade, at lunch, but that she had not observed Resident #27 receive two cups of juice or water on her meal tray.

The Unit Manager (UM) was interviewed on 11/15/23 at 11:23 AM. The UM stated that beverages should be placed on each resident's meal tray by nursing staff according to the beverages listed on the resident's meal tray card.

The DM stated in an interview on 11/15/23 at 10:40 AM that the beverages listed in the Standing Orders section of the meal tray card were based on resident preference and the ounces of fluids listed were based on the calculation of each resident's fluid needs. The DM stated that all fluids listed on the tray card should be provided to ensure fluid needs were met. The DM stated the resident may not drink all the items listed, but staff should provide them, and all the beverages were available for nursing staff to put on the resident's meal tray.

The Director of Nursing (DON) stated in an

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F 807	Continued From page 75 interview on 11/15/23 at 11:44 AM that nursing staff should make sure all items listed on each resident's tray card was placed on the resident's meal tray. The DON stated that dietary staff brought all the beverages from the kitchen to the dining area for each unit and nursing staff was responsible to place beverages on the resident's meal tray using the tray card as the guide to ensure all beverages listed on the tray card were placed on the meal tray. During a phone interview with the Consultant Registered Dietitian (RD), on 11/17/23 at 9:45 AM, the RD stated that she calculated fluid needs for each resident on admission and as needed and the DM responsible for obtaining beverage preferences for each resident. The DM then completed the Standing Orders section of the tray card based on the fluid needs and preferred beverages for each resident. The RD stated that hydration pass, and fluids provided during medication pass counted towards meeting fluid needs, but beverages with each meal should be provided per resident preferences as listed on the meal tray card. 2. Resident #22 was re-admitted to the facility on 10/19/23. Diagnoses included adult failure to thrive, chronic kidney disease, and anemia, among others. A physician (MD) diet order dated 10/20/23 recorded Resident #22 received a regular diet, mechanical soft texture, and thin liquids. A significant change Minimum Data Set assessment dated 10/29/23 assessed Resident #22 with minimal difficulty hearing, clear speech, ability to be understood, ability to understand,	F 807		

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F 807	Continued From page 76 impaired vision with the use of corrective lenses, intact cognition, and required set up assistance with meals. A care plan revised 11/14/23 recorded Resident #22 was at nutritional risk due to her diagnoses. Interventions included staff would obtain likes/dislikes, provide food preferences and diet as ordered. An observation of the lunch meal dining area occurred on 11/13/23 at 12:00 PM. Available beverages for meal service included coffee, water, tea, lemonade, assorted juices, milk, and sodas. Resident #22 was observed and interviewed in her room during lunch on 11/13/23 at 12:38 PM. Resident #22 ate and drank independently. The tray card on her meal tray recorded "Standing Orders: 2 x (times) 8 fl. (fluid) oz (ounces) sweet tea and 8 fl. oz water." Resident #22 did not receive any beverages on her lunch meal tray. When asked if she wanted anything to drink with her lunch meal, Resident #22 replied, "Yes, but I don't see my call light, so I guess I will drink the water in that Styrofoam cup." Resident #22 was observed and interviewed in her room during lunch on 11/14/23 at 12:41 PM. Resident #22 ate and drank independently. The tray card on her meal tray recorded "Standing Orders: 2 x 8 fl. oz sweet tea and 8 fl. oz water." Resident #22 received lemonade, but she did not receive sweet tea or water on her meal tray. When asked if she wanted sweet tea/water to drink, Resident #22 replied, "Yes, but I did not get it. I usually only get one beverage."	F 807		

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An interview with Dietary Aide (DA) #1 on 11/14/23 at 1:17 PM revealed he was responsible for plating the food for residents on the 500/600 unit. He stated nursing staff were responsible for placing beverages on each resident's meal tray per the resident's preferences listed on the tray card.

An interview with Nurse Aide (NA) #8 occurred on 11/15/23 at 11:06 AM. NA #8 stated that she was familiar with the care Resident #22 received, Resident #22 made her needs known, and fed herself after her meal tray was set up. NA #8 stated that she did not know that all beverages listed on the tray card were supposed to be provided and that she did not always read the tray card to verify all items were provided.

Nurse #2 was interviewed on 11/15/23 at 11:00 AM and stated she was the assigned Nurse for Resident #22 on the 7A - 7P shift. Nurse #2 described Resident #22 as able to feed herself and made her needs known. Nurse #2 stated that Resident #22 often received lemonade at lunch and that she had not observed sweet tea or water provided on her lunch meal tray.

The DM stated in an interview on 11/15/23 at 10:40 AM that the beverages listed in the Standing Orders section of the meal tray card were based on resident preference and the ounces of fluids listed were based on the calculation of each resident's fluid needs. The DM stated that all fluids listed on the tray card should be provided to ensure fluid needs were met. The DM stated the resident may not drink all the items listed, but staff should provide them, and all the beverages were available for nursing staff to put on the resident's meal tray.

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The Unit Manager (UM) was interviewed on 11/15/23 at 11:23 AM. The UM stated that beverages should be placed on each resident's meal tray by nursing staff according to the beverages listed on the resident's meal tray card.

The Director of Nursing (DON) stated in an interview on 11/15/23 at 11:44 AM that nursing staff should make sure all items listed on each resident's tray card was placed on the resident's meal tray. The DON stated that dietary staff brought all the beverages from the kitchen to the dining area for each unit and nursing staff was responsible to place beverages on the resident's meal tray using the tray card as the guide to ensure all beverages listed on the tray card were placed on the meal tray.

3. Resident #79 was admitted to the facility on 8/14/23. Diagnoses included dementia, gastroesophageal reflux disease, chronic kidney disease, and anemia, among others.

A physician (MD) diet order dated 8/14/23 recorded Resident #79 received a regular diet, mechanical soft texture, and thin liquids.

An admission Minimum Data Set assessment dated 8/21/23 assessed Resident #79 with minimal difficulty hearing, clear speech, usually able to be understood, usually able to understand, adequate vision with the use of corrective lenses, impaired cognition, and required set up assistance with meals.

A care plan revised 10/2/23 recorded Resident #79 was at nutritional risk due to receipt of a mechanically altered diet and cognitive

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impairment. Interventions included staff would obtain likes/dislikes, provide food preferences and diet as ordered.

An observation of the lunch meal dining area occurred on 11/13/23 at 12:00 PM. Available beverages for meal service included coffee, water, tea, lemonade, assorted juices, milk, and sodas.

Resident #79 was observed and interviewed in his room during lunch on 11/13/23 at 12:30 PM and 11/14/23 at 12:30 PM. Resident #79 ate and drank independently with the use of adaptive equipment. The tray card on his meal tray for each observation recorded "Standing Orders: 4 fl. (fluid) oz (ounces) milk, 2%, 8 fl. oz sweet tea and 8 fl. oz water." Resident #79 did not receive milk or water on his lunch meal tray on 11/13/23 or 11/14/23. During each observation, a disposable cup of water was observed on his nightstand, out of reach. During the lunch meal observation on 11/14/23, Resident #79 stated "Yes" when asked if he liked/wanted milk or water to drink with his lunch meal.

An interview with Dietary Aide (DA) #1 on 11/14/23 at 1:17 PM revealed he was responsible for plating the food for residents on the 500/600 unit. He stated nursing staff were responsible for placing beverages on each resident's meal tray per the resident's preferences listed on the tray card.

During an interview with Nurse Aide #9 on 11/16/23 at 12:30 PM, she stated that she was familiar with the care Resident #79 received. She stated that he required set up assistance with his meals, fed himself, he received juice and coffee

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with his meals, but that she had not provided him with milk or water on his meal tray, because she did not see it on his meal tray card.

Nurse #6 was interviewed on 11/15/23 at 10:10 AM. She stated that Resident #79 required tray set up assistance with his meals, fed himself, he was able to make some of his needs known and that she did not recall him with milk or water on his meal tray at breakfast or lunch.

Nurse #2 stated in an interview on 11/15/23 at 10:50 AM that she was familiar with the care that Resident #79 received. She often observed him feed himself lunch most days in his recliner chair. She stated that he usually received coffee and tea for lunch, but she did not recall milk or water provided to him on his lunch meal tray.

The DM stated in an interview on 11/15/23 at 10:40 AM that the beverages listed in the Standing Orders section of the meal tray card were based on resident preference and the ounces of fluids listed were based on the calculation of each resident's fluid needs. The DM stated that all fluids listed on the tray card should be provided to ensure fluid needs were met. The DM stated the resident may not drink all the items listed, but staff should provide them, and all the beverages were available for nursing staff to put on the resident's meal tray.

The Unit Manager (UM) was interviewed on 11/15/23 at 11:23 AM. The UM stated that beverages should be placed on each resident's meal tray by nursing staff according to the beverages listed on the resident's meal tray card.

The Director of Nursing (DON) stated in an

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F 807	Continued From page 81 interview on 11/15/23 at 11:44 AM that nursing staff should make sure all items listed on each resident's tray card was placed on the resident's meal tray. The DON stated that dietary staff brought all the beverages from the kitchen to the dining area for each unit and nursing staff was responsible to place beverages on the resident's meal tray using the tray card as the guide to ensure all beverages listed on the tray card were placed on the meal tray.	F 807		
F 810 SS=E	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with residents, family and staff, the facility failed to provide adaptive equipment during meals to 2 of 2 sampled residents reviewed for the use of adaptive equipment (Residents #79 and #37). The findings included: 1. Resident #79 was admitted to the facility on 8/14/23. Diagnoses included dementia, drug-induced tremors, lack of coordination, and generalized muscle weakness, among others. A physician (MD) diet order dated 8/14/23 recorded Resident #79 received a regular diet, mechanical soft texture, and thin liquids.	F 810	F810-Assitive Devices -Eating Equipment/Utensils 1. Residents #79 and #37 reside in the facility, and Adaptive Equipment was provided on 11/15/23 by the Dietary Manager. 2. The Dietary Manager and Director of therapy reviewed all residents with current recommendations for adaptive eating equipment on 11/15/23. Any concerns identified during the audit were addressed by the Dietary Manager and Director of therapy. 3. Re-education of the Adaptive Eating	12/27/23

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F 810	Continued From page 82 Occupational therapy (OT) progress notes, recorded Resident #79 was referred for OT services on 8/15/23 for self-care deficits, lack of coordination, and generalized muscle weakness. At the time of the referral, Resident #79 required staff assistance with feeding. The goal was for Resident #79 to eat independently using a divided dish, 2 handled cup with a lid and a built up tablespoon. An admission Minimum Data Set assessment dated 8/21/23 assessed Resident #79 with minimal difficulty hearing, clear speech, usually able to be understood, usually able to understand, adequate vision with the use of corrective lenses, impaired cognition, and required set up assistance with meals. A care plan revised 10/2/23 recorded Resident #79 was at nutritional risk due to receipt of a mechanically altered diet, use of adaptive equipment and cognitive impairment. Interventions included staff would set up his tray and encourage consumption of meals with adaptive equipment. Review of OT daily treatment notes revealed Resident #79 did not receive adaptive equipment with meals on 10/9/23, 10/10/23, 10/11/23, 10/12/23, 10/17/23, and 10/20/23 requiring caregiver re-education to ensure adaptive equipment was provided for decreased food spillage and increased independence with meals. An observation of the lunch meal tray line on the 500/600 hall occurred on 11/13/23 at 12:00 PM. Available adaptive equipment for meal service included built up utensils and 2 handled cups.	F 810	Equipment policy including specialized cups, plates, and utensils to the Dietary Cooks and Aides by the Dietary Manager was initiated on 11/15/2023. The education will be completed by 12/27/23. Any dietary staff member that has not received the education by 12/27/23 will receive the education upon their next scheduled shift. Staff Development Coordinator (SDC) will provide in-services for the nursing staff to identify the use of adaptive equipment, and to make referral to Occupational Therapy if there is a need for adaptive equipment, this will be completed by 12/27/23. Any nursing staff member that has not received the education by 12/27/23 will receive the education upon their next scheduled shift. 4. Ten residents will be audited by Dietary Manager or Director of Nursing using the Assistive Eating Device Tool weekly for 4 weeks then monthly x 2 months. Results of audit will be forwarded to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. Date of Alleged Compliance: 12/27/23	

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Resident #79 was observed and interviewed in his room during lunch on 11/13/23 at 12:30 PM and 11/14/23 at 12:30 PM. The tray card on his meal tray for each observation recorded "Adap. (adaptive) Equip (equipment): 2 handled cup with lid, built-up tablespoon and divided plate." Resident #79 did not receive a 2 handled cup with a lid or a built-up tablespoon on his lunch meal tray on 11/13/23 or 11/14/23. During each observation, he received his meals served on a divided plate, beverages were served in a plastic cup with a lid, but without handles. On 11/13/23 he fed himself lunch with a plastic fork and on 11/14/23, he fed himself with a regular fork. He was observed with food spillage at each meal.

A phone interview with a family member occurred on 11/16/23 at 11:06 AM. The family member stated he visited Resident #79 at times during meals but that he had not observed a 2 handled cup or a built-up tablespoon on his meal trays. The family member stated that he usually held the cup for Resident #79 during meals, otherwise he would spill most of the beverage on himself. The family member stated that Resident #79 fed himself with regular utensils and often spilled food on himself.

An interview with the Certified Occupational Therapy Assistant (COTA) occurred on 11/15/23 at 9:31 AM. The COTA stated the intent of the adaptive equipment was for Resident #79 to reduce food spillage and increase independence with self-feeding. The COTA stated that therapy staff educated the caregivers who were present at the time that Resident #79 received treatment, as well as new staff, so education was continual. The COTA also stated that any therapy concerns were discussed during department manager

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meetings to ensure all managers were aware of any issues. The COTA stated she observed the 500/600 hall dining area with a basket of adaptive equipment available for nursing staff to access and place them on the resident's meal tray. The COTA stated therapy staff completed a communication slip for dietary if adaptive equipment or feeding instructions were needed during meals. If adaptive equipment was needed, it was recorded on the meal tray card by dietary staff so that nursing staff was aware to provide the required equipment during meals. The COTA stated Resident #79 still required the use of adaptive equipment with meals.

An interview with Nurse #6 occurred on 11/15/23 at 10:10 AM. Nurse #6 stated that Resident #79 required set up assistance with meals. Nurse #6 stated the family often visited Resident #79 at meals. She stated that she did not recall Resident #79 having a 2 handled cup with a lid or a built-up tablespoon with meals, he fed himself with regular utensils. She stated that adaptive equipment should come from the kitchen and staff should provide it to residents for their use.

Nurse #2 was interviewed on 11/15/23 at 10:50 AM and stated that she usually saw Resident #79 feed himself lunch, but that she had not seen a 2 handled cup with a lid or a built-up tablespoon on his meal tray. She stated that his meals were served on a divided plate.

An interview with Nurse Aide (NA) #8 occurred on 11/15/23 at 11:01 AM. NA #8 stated that she did not see the adaptive equipment recorded on the tray card because she did not always read it.

An interview with Nurse #10 occurred on 11/16/23

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at 11:34 AM. Nurse #10 stated that family visited Resident #79 for meals, he fed himself with regular utensils, and at times he spilled food on himself. Nurse #10 stated that she did not see the adaptive equipment recorded on the tray card, because that was handled by the NA and dietary staff.

NA #9 stated in an interview on 11/16/23 at 12:30 PM that Resident #79 required set up assistance with meals. She stated his food was served on a divided plate, but that he received regular utensils and a regular cup. NA #9 stated that he often spilled food on himself.

The Rehab Manager was interviewed on 11/14/23 at 3:16 PM. She stated that Resident #79 was evaluated by occupational therapy (OT) staff in August 2023 for the use of adaptive equipment with meals and discharged from OT in October 2023 with the continued use of adaptive equipment. The Rehab Manager stated that she expected the adaptive equipment would continue to be provided.

The Unit Manager (UM) was interviewed on 11/14/23 at 3:36 PM. The UM stated during the interview that she expected adaptive equipment to come from the dietary department and to be placed on the resident's meal tray when the meal was plated.

The Director of Nursing (DON) stated in an interview on 11/15/23 at 11:44 AM, that dietary staff should send adaptive equipment to each unit as needed dietary staff should place the adaptive equipment on the meal tray for resident's use. The DON stated that when nursing staff distribute the meals, they should make sure all items listed

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on the meal tray card are on the resident's tray.

2. Resident #37 was admitted to the facility on 6/7/22. Diagnoses included cerebral infarction, contracture of right shoulder, and other feeding difficulties, among others.

Occupational therapy (OT) progress notes, recorded Resident #37 was referred for OT services on 6/8/22 for contracture of right shoulder and other feeding difficulties. At the time of the referral, Resident #37 was able to feed herself with regular utensils requiring staff assistance. The goal was for Resident #37 to feed herself using a divided dish, 2 handled cup with a lid and a built up spoon for 75% of the meal. Resident #37 met this goal prior to her discharge from OT services. At discharge from OT, the use of a divided dish, 2 handled cup with a lid and a built up spoon was recommended for Resident #37.

A physician (MD) diet order dated 6/13/22 recorded Resident #37 received a regular diet with regular texture and thin liquids.

A quarterly Minimum Data Set assessment dated 10/5/23 assessed Resident #37 with adequate hearing, clear speech, ability to be understood, ability to understand, impaired vision without the use of corrective lenses, intact cognition, and required set up assistance with meals.

A care plan revised 10/12/23 recorded Resident #37 was at nutritional risk due to the use of adaptive equipment with meals. Interventions included staff would set up her meal tray and encourage consumption of the meal with the use of adaptive equipment.

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An observation of the lunch meal tray line on the 500/600 hall occurred on 11/13/23 at 12:00 PM. Available adaptive equipment for meal service included built up utensils and 2 handled cups.

Resident #37 was interviewed and observed in her room while having lunch on 11/13/23 at 12:40 PM. The tray card on her lunch meal tray recorded "Adap. (adaptive) Equip (equipment): 2 handled cup with lid, built up spoon and divided plate." Resident #37 received her lunch meal in a sectioned disposable plate. Her lunch meal was received on a sectioned disposable plate and included crabcake, rice, vegetable blend and hush puppies. She fed herself rice and vegetables with a disposable spoon and ate the hush puppies with her fingers. She did not eat the crabcake. Her iced tea was received in a disposable cup with a lid, but without handles. She did not drink her iced tea. Resident #37 stated she did not usually receive a built-up spoon or a 2 handled cup with her meals, but that her meals were usually served on a divided plate. Resident #37 stated she had learned to manage her meals using her left hand, without the use of adaptive equipment.

Resident #37 was observed with the Dietary Manager (DM) in her room while having lunch on 11/14/23 at 12:50 PM. The tray card on her lunch meal tray recorded "Adap. Equip: 2 handled cup with lid, built up spoon and divided plate." Resident #37 received iced tea in a plastic cup with a lid, cheeseburger, tater tots and green beans, served on a divided plate. She received stainless steel utensils. She did not receive a 2 handled cup with a lid or a built-up spoon. She

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ate her tater tots with her fingers, green beans with a spoon, but she did not eat the cheeseburger. The DM reviewed her tray card and stated, "We have the adaptive equipment available on the unit, it should have been provided by staff."

An interview with Dietary Aide (DA) #1 on 11/14/23 at 1:17 PM revealed he was responsible for plating the food for residents on the 500/600 unit. He stated nursing staff were responsible for placing the adaptive equipment like built-up utensils and 2 handled cups on the resident's meal trays. He stated, "I just plate the food."

An interview with Nurse Aide (NA) #9 occurred on 11/15/23 at 11:01 AM. NA #9 stated Resident #37 required set up assistance with her meals. NA #9 stated that her meals came from dietary department on a divided plate, but that she had not seen Resident #37 receive a 2 handled cup for or a built-up spoon with her meals. NA #9 stated she did not notice her tray card recorded adaptive equipment and she thought the dietary staff would put adaptive equipment on the resident's meal trays who needed it.

During an interview with Nurse #8 on 11/16/23 at 10:53 AM, she stated that sometimes Resident #37 spilled food/beverages on herself during her meals and, she drank from a "regular" cup and ate with a "regular" spoon. Nurse #8 stated she was not aware that Resident #37 had a recommendation from therapy for adaptive equipment.

Nurse #10 was interviewed on 11/16/23 at 11:50 AM and stated Resident #37 fed herself, and

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F 810	Continued From page 89 spilled food on herself at meals, but that she had not observed Resident #37 receive a 2 handled cup or built-up spoon with her meals. The Rehab Manager was interviewed on 11/14/23 at 3:16 PM. She stated that Resident #37 was originally evaluated with occupational therapy (OT) in 2022 for the use of adaptive equipment with her meals. The Rehab Manager stated Resident #37 most recently received OT services in June 2023, and the therapist noted Resident #37 still used adaptive equipment with meals and did not indicate that the use of adaptive equipment was no longer needed. The Rehab Manager stated that since the use of adaptive equipment was not discontinued, she expected the adaptive equipment would continue to be provided. The Unit Manager (UM) was interviewed on 11/14/23 at 3:36 PM. The UM stated during the interview that she expected adaptive equipment to come from the dietary department and to be placed on the resident's meal tray when the meal was plated. The Director of Nursing (DON) stated in an interview on 11/15/23 at 11:44 AM, that dietary staff should send adaptive equipment to each unit as needed dietary staff should place the adaptive equipment on the meal tray for resident's use. The DON stated that when nursing staff distribute the meals, they should make sure all items listed on the meal tray card are on the resident's tray.	F 810		
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	F 867		12/27/23

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monitoring.
A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

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

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

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

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F 867	Continued From page 91 systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; 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.	F 867		

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	345562	A. BUILDING ______ B. WING ______	11/17/2023

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F 867	Continued From page 92 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey completed on 05/26/22, the	F 867	F867 QAPI/QAA Improvement Activities 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Corrective action was provided for	

F 867 Continued From page 93

complaint investigation survey completed on 7/13/23, and the complaint investigation survey completed on 08/11/23. This was for five repeat deficiencies originally cited in the areas of freedom from abuse and neglect, develop/implement abuse policies, activities of daily living provided for dependent residents, development of comprehensive care plans, infection prevention and control that was subsequently recited on the current recertification and complaint investigation survey of 11/17/23. The continued failure of the facility during four federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.

The findings included:

This tag is cross referenced to:

F600: Based on record review, resident/ family and staff interviews, the facility failed to protect a resident's right to be free from verbal and mental abuse when Nurse Aide #4 and Social Worker confronted Resident #2 in her room and intimidated her into not submitting a grievance. Nurse Aide #4 refused to provide incontinent care for Resident #2 by taking her to her room and yelling at her by stating she could "poop in her diaper like everyone else does" then slammed the door as she left. Nurse Aide #4 yelled at Resident #2 who requested incontinent care, by stating "I am not your CNA and will never be your CNA no more in life." These actions caused Resident #2 to feel intimidated, devalued, deprived of care, ignored, depressed, without control of her life, trapped, upset, and as if she did something wrong. This occurred for 1 of 1 resident reviewed for abuse.

F 867

Resident #2, Resident #14 and Resident #68, through the plan of correction as stated In F600, F607, F656, F677, and F880.

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:

A QAPI meeting will be held by 12/27/23 to review current action plans and repeat citations regarding areas of freedom from abuse and neglect, develop/implement abuse policies, activities of daily living provided for dependent residents, development of comprehensive care plans, infection prevention and control to measure ongoing compliance.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

" On 12/15/23, the Facility Nurse Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected

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During the complaint investigation survey of 08/11/23, the facility failed to protect a resident's right to be free from employee verbal abuse.

F607: Based on record review and review of the facility's policy entitled "Abuse and Neglect", and resident and staff interviews, the facility failed on 2 occasions to implement its own policy to immediately report an incident of abuse or neglect to the Administrator. This affected 1 of 1 resident reviewed for abuse (Resident #2).

During the complaint investigation survey of 08/11/23, the facility failed suspend an employee immediately after an allegation of abuse.

F656: Based on observations, resident interviews, staff interviews, and record review the facility failed to develop an individualized person-centered comprehensive care plan in the area of visual impairment (Resident #14). This deficient practice was for 1 of 1 resident whose comprehensive care plans were reviewed.

During a recertification and complaint survey of 05/26/22, the facility failed to develop a comprehensive care plan for a resident related to non-pressure skin issues.

F677: Based on record review, observations, and interviews with the resident, staff and the Hospice Nurse, the facility failed to provide a dependent resident with nail care and facial hair trim to 1 of 4 residents (Resident #68) reviewed for assistance with activities of daily living.

During a complaint investigation survey of 7/13/23, the facility failed to provide incontinence

F 867

outcome is not achieved and sustaining an effective QA process. In-service will be completed by 12/27/2023. Any newly hired Administrator, DON and Assistance Director of Nursing will be educated during orientation regarding the QA Process.

" All data collected for identified areas of concerns to include freedom from abuse and neglect, develop/implement abuse policies, activities of daily living provided for dependent residents, development of comprehensive care plans, infection prevention and control will be taken to the Quality Assurance and Performance Improvement (QAPI) committee for review monthly x 3 months by the Director of Nursing (DON). The Infection Preventionist, the Assistant Director of Nursing (ADON) will be trained through the Centers for Medicare/Medicaid Infection Control Program. The Quality Assurance and Performance Improvement (QAPI) committee will review the data and determine if plan of corrections is effective, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance and Performance Improvement Committee will be documented monthly at each meeting by the Administrator.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

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F 867	Continued From page 95 care to a resident dependent on staff for activities of daily living. F880: Based on staff interviews and record reviews the facility failed to implement an infection surveillance plan for monitoring and tracking infections in the facility. This practice had the potential to affect 84 of 84 residents in the facility. During a recertification and complaint survey of 05/26/22, the facility failed to implement infection control practices when 3 nurses did not disinfect multi-use blood glucose meters after use. The administrator stated in an interview on 11/17/23 at 12:35 PM that the facility's QAA Committee met every month and as needed with all department managers, the Pharmacist and Medical Director. He stated that trends were identified using a corporate template and discussed at each meeting to identify any changes in monitoring that were needed. The Administrator stated that a Performance Improvement Plan was implemented for each deficiency from prior surveys and the status of audits were discussed at each monthly QAA Committee meeting. The Administrator stated that he attributed repeat deficiencies to staff turnover and new management staff. He stated that the facility continued to discuss and monitor concerns with abuse, care plans, nail care, and infection control in QAA Committee meetings, but that new concerns had not been identified. He stated that he could not say for sure why concerns were identified in these areas for this survey, but that these areas were still included in orientation for new staff.	F 867	The Administrator will ensure the facility is maintaining an effective Quality Assurance (QA) program by reviewing Quarterly Assurance meeting minute notes and ensuring implemented procedures and monitoring practices are reviewed and any areas of concern will be addressed during the Monthly QAPI meeting. The areas to monitor include but not limited to resident rights, safe/clean/comfortable homelike environment, accuracy of assessments, care plans, and services to meet professional standards and all current citations and QA plans are followed and maintained monthly x3 month. The Facility Consultant will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance Performance Improvement (QAPI) meeting minutes will be presented by the Director of Nursing (DON) to the Quality Assurance Performance Improvement Committee (QAPI) Quarterly x 3 months for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring. Date of compliance: 12/27/23	

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F 880	Continued From page 96	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		12/27/23

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F 880	Continued From page 97 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to implement an infection surveillance plan for monitoring and tracking infections in the facility. This practice had the potential to affect 84 of 84 residents in the facility. The finding included: The Infection Control Plan dated 09/25/2023 and	F 880	F880 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: No residents were affected.	

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F 880	Continued From page 98 the Facility Assessment dated 09/01/2023 revealed services offered by the facility included infection prevention and control with identification and containment of infections, prevention of infections, and tracking and monitoring infections. The Infection Preventionist conducts surveillance of all infections among residents including tracking and analysis of outbreaks of infections. During the Entrance Conference with the Administrator on 11/13/2023 at 9:30 AM, he revealed that the facility's designated Infection Preventionist was the Wound Care Nurse. An interview with the Wound Care Nurse on 11/16/2023 at 10:01 AM revealed she had not performed any duties related to Infection Prevention and Control since she resigned from the Director of Nursing (DON) position on 07/31/2023. She further revealed the current DON was responsible for the facility's Infection Control Program. During an interview with the DON on 11/16/2023 at 3:40 PM, she stated she had occupied the DON position since 08/29/2023 and did not realize she was the facility's designated Infection Preventionist (IP). The DON also stated she was not performing infection surveillance and did not have any tracking forms. She explained she had not tracked or analyzed any infections in the facility since her arrival in August 2023. She also indicated antibiotics were discussed in the weekly interdisciplinary meetings. The discussion included the indication for use and the start and stop date of each antibiotic ordered for a resident. An interview with the Administrator on 11/16/2023 at 3:55 PM revealed he thought the Wound Nurse	F 880	2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: " Current residents have the potential to be affected. The Assistant Director of Nursing (ADON) will implement an infection surveillance plan for monitoring and tracking infections in the facility. The Assistant Director of Nursing will conduct an audit of all infections among residents in the last 30 days including tracking and analysis of outbreaks of infections if any. The Director of Nursing, Assistant Director of Nursing, Unit Manager, or designee will address any concerns identified during audit. Audit will be completed by 12/27/23. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: " The Assistant Director of Nursing and Unit Manager will complete the Centers for Medicare and Medicaid (CMS) Nursing Home Infection Preventionist Training Course by 12/27/23. " The Director of Nursing will audit the infection control surveillance plan and related documents/audits weekly x4 weeks, and then monthly x2. The purpose of the audit is to ensure infection control surveillance is ongoing with evidence of monitoring and tracking infections in the facility.	

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F 880	Continued From page 99 was still acting as the facility's Infection Preventionist. He was not aware the DON was responsible for the Infection Prevention and Control Program. The Administrator explained the IP nurse was responsible for infection surveillance and he was unaware the wound nurse was not tracking and analyzing the resident's infections. He stated he expected infection surveillance to be completed on all identified resident infections.	F 880	4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring audits and interview responses. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review the audits and interview responses to determine trends and/or further problem resolution if needed. Date of compliance: 12/27/23.	
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by:	F 882		12/27/23

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F 882	Continued From page 100 Based on staff interviews, the facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection and Control Program. This had the potential to affect 84 of the 84 residents at the facility. The findings included: During the Entrance Conference with the Administrator on 11/13/2023 at 9:30 AM, he revealed the facility's designated Infection Preventionist was the facility's wound care nurse. An interview with the wound care nurse on 11/16/2023 at 10:01 AM revealed she had not performed any duties related to Infection Prevention and Control since she resigned from the Director of Nursing (DON) position on 07/31/2023. The wound nurse stated she had attended the Statewide Program for Infection Control and Epidemiology (SPICE) and was SPICE trained. She further revealed the current DON was responsible for the facility's Infection Control Program. She also stated she had provided a hand off of Infection Prevention and Control information to the current DON when she exited the DON position in July 2023. During an interview with the DON on 11/16/2023 at 3:40 PM, she stated she had occupied the DON position since 08/29/2023 and did not realize she was the facility's designated Infection Preventionist. The DON also revealed she had not taken the Statewide Program for Infection Control and Epidemiology (SPICE) training and she was not currently registered to take the class. She also indicated she had not received any	F 882	F882 Infection Preventionist Qualifications/Role 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: No residents were affected. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected. The facility has designated the Assistant Director of Nursing (ADON) to be the Infection Control Preventionist. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: " The Assistant Director of Nursing and Unit Manager will complete the Centers for Medicare and Medicaid (CMS) Nursing Home Infection Preventionist Training Course by 12/27/23. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: " The Director of Nursing will be responsible for maintaining an Infection Preventionist with the appropriate specialized training.	

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F 882	Continued From page 101 specialized training in Infection Control. An interview with the Administrator on 11/16/2023 at 3:55 PM revealed he thought the wound nurse was still acting as the facility's Infection Preventionist. He was not aware the DON was responsible for the Infection Prevention and Control Program.	F 882	The Administrator is responsible for the plan of correction and will ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review for further problem resolution if needed. Date of compliance: 12/27/23	