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	345305	A. BUILDING _____ B. WING _____	C 12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKY RIDGE HEALTH AND REHABILITATION	310 PENSACOLA ROAD BURNSVILLE, NC 28714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 11/27/23 through 12/01/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #J7DU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted 11/27/23 through 12/01/23. Event ID #J7DU11. The following intakes were investigated: NC00207672, NC00208589, NC00206809, and NC00207342. 4 of the 14 allegations resulted in deficiency.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		12/29/23

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

Electronically Signed | 12/24/2023

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F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to protect private resident health information by leaving confidential medical information unattended in an area accessible to the public on 1 of 4 medication carts (400 hall medication cart). Findings include: An observation on the 400-hall medication cart on 11/29/23 at 9:45AM revealed a report sheet on top of the cart with resident's names, room numbers, and care information. The sheet was turned right side up so anyone walking by could see the private resident information. Nurse#1 was observed in a room giving medications in a nearby room and then returned to medication cart at 9:52 AM. Interview with Nurse #1 on 11/29/23 at 4:00 PM revealed that she was aware that any resident identifying information should be secured by ensuring nothing was on top of the medication cart and the electronic health record screen was placed in privacy mode before leaving it	F 583	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. On 11/30/23, immediate retraining was conducted with Nurse #1 regarding the protection of private health information by keeping medication cart clear of personal identification and any private health information when left unattended in an area accessible to the public. Topics discussed during education review includes, but not limited to: hallway assignment report sheets, meal consumption intake sheets, vital sign flowsheets, and also the screens displaying electronic health information visible on computer/tablet screens. No residents on the assigned 400 hall were adversely affected by the alleged deficient	

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F 583	Continued From page 2 unattended. Nurse #1 stated she should have turned the report sheet over so that the information on it could not be viewed by anyone walking by. Interview with Nurse #2 on 11/30/23 at 10:05 AM she made sure nothing was on top of the cart and the electronic health record screen was placed in privacy mode so no information could be viewed by anyone that walked by the medication carts. Interview with the Director of Nursing on 12/1/23 at 2:30 PM revealed staff were expected to clear the top of medication carts before leaving the cart to help ensure privacy for the residents. Interview with the Administrator on 12/1/23 at 2:40 PM revealed that expectations were that HIPPA compliance should be maintained at all times, screens closed, and report sheets turned over to protect resident's information.	F 583	practice. All residents have the potential to be affected by this alleged deficient practice. 100% audits were completed for 5 out of 7 days since 11/30/23 by Director of Nursing (DON)/Assistant Director of Nursing (ADON)/designee of all medication carts and all publicly viewable computers/tablets to ensure that all electronic medical records were closed/hidden, and all paper documents were covered or turned over when unattended to ensure compliance with not exposing residents personal and medical information in an area accessible to the public. No identified areas of concern were identified during this audit. No additional residents were identified to have been affected by the alleged deficient practice. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) educated all licensed and unlicensed personnel on the policy regarding protecting private health information by closing electronic medical records and concealing paper documents containing resident information when left unattended in an area accessible to the public. This education will be completed by Friday 12/29/23. Any personnel out on leave, vacation, or PRN status will be educated prior to returning to their assignment by Director of Nursing, Assistant Director of Nursing, or assigned designee. All newly hired personnel will be educated on this policy during orientation by the SDC or	

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F 583	Continued From page 3	F 583	designee. 100% of medication carts will be monitored using an audit tool to ensure all documents containing private health information are closed/hidden to protect private health information when left unattended in an area accessible to the public. To ensure continued compliance, audits will be conducted by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), or their designee for all medication carts 5x a week x 2 weeks, then twice weekly x3 weeks, then weekly x4 weeks . The results of these audits will determine the need for further monitoring. All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON/designee, for review and to ensure continued compliance with the plan of correction. Completion date of 12/29/2023	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		12/29/23

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F 584	Continued From page 4 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with staff, the facility failed to ensure the doors to resident rooms (rooms 407, 409, 412, 414, and 503), the closet doors (room 414), and the main dining room doors were kept in good repair; failed to ensure door guards were in good repair and secured to the door to prevent sharp edges (rooms 407, 409, and 414); failed to ensure the floors and walls in resident rooms and bathrooms	F 584	With identified pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy affected the identified residents. Packaged Terminal Air Conditioner (PTAC)S in rooms 311, 312, 316, and 401 were replaced on 12/20/23. New environmental services director was hired on 12/12/23. This director is being cross trained for	

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F 584	Continued From page 5 were kept clean and in good repair (rooms 301, 306, 310, 311, 312, 313, 314, 315, 316, 317, 318, 401, 402, 403, 408, 412, 413, 414, 503, and hall 400); failed to address lingering odors resembling urine (rooms 413, 414, and 503); failed to maintain clean bathroom ceiling vents (bathrooms 310, 311, 312, 313, 314, 315, 316, and 317); failed to maintain packaged terminal air conditioner (PTAC) units in good repair (rooms 311, 312, 316, and 401); failed to ensure resident personal care items were labeled and stored correctly (bathrooms 310, 311, 312, 401, 402, 413, and 414); failed to maintain clean overbed tables in good repair (rooms 314-A, 314-B, 316, 317); failed to maintain clean geriatric chairs (rooms 312-B and 403-B); failed to replace a missing top drawer to a nightstand (room 503); and failed to maintain flooring in good repair (400 Hall) for 3 of 4 halls reviewed for environment (Halls 300, 400, and 500). Findings included: 1. a. Observations of room 414 on 11/27/23 at 3:43 PM, 11/28/23 at 1:38 PM, and 11/29/23 at 4:41 PM revealed the wood door to enter the room had several damaged areas along the edges of the door, mostly located below the doorknob. There were chunks of wood missing causing it to splinter and the door guard placed below the doorknob covering the bottom portion of the door was damaged with areas of jagged plastic and had begun to separate from the door creating a sharp edge. The metal framing around the door had several areas where the paint was missing and appeared it had chipped or was scraped off the frame. b. Observations of the bathroom in room 414	F 584	orientation at our sister facility. A deep cleaning schedule, to be completed by environmental services director, will be implemented of all resident rooms, bathrooms, and common areas mentioned, with particular attention to eliminating odors, cleaning bathroom ceiling vents, and maintaining flooring by 12/29/23. Personal care items in rooms 310, 311, 312, 401, 402, 413, and 414 were labeled on 11/30/23 and stored appropriately. All resident personal care items are labeled with the resident's name and stored correctly according to facility policy. A comprehensive inspection of all doors, door guards, Packaged terminal air conditioner (PTAC) units, overbed tables, geriatric chairs, and nightstands in the specified rooms and halls were completed by 12/20/23. Immediate furniture repair began 11/30/23. Furniture found to be in disrepair will be replaced by 12/29/23 (or when shipping allows). Nightstand dresser in room 503 was discarded and replaced with a new nightstand. Door guards were removed on doors to rooms 407, 409, 412, 414, and 503 and will be sanded and stained to prevent sharp edges by 12/29/23. Floors and walls in the following rooms are identified as being a priority repair and will be completed with precedence during the completion of facility wide renovations: 301, 306, 310, 311, 312, 313, 314, 315, 316, 317, 318, 401, 402, 403, 408, 412, 413, 414, and 503. These identified rooms	

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were made on 11/27/23 at 3:43 PM, 11/28/23 at 1:38 PM, and 11/29/23 at 4:41 PM revealed the bathroom had a strong odor resembling urine that lingered outside to the room and onto hall 400. The flooring surrounding the base of the toilet was stained a black color and the floor appeared dirty and sticky. The wall beside the toilet had a brownish colored stain that ran down the wall and appeared as if a liquid splashed on the wall and was left to dry.

An interview with Housekeeper #1 on 12/01/23 10:19 AM revealed daily cleaning of resident rooms included sweeping and mopping the floor and cleaning the bathroom.

c. Observations of room 414 on 11/27/23 at 3:43 PM, 11/28/23 at 1:38 PM, and 11/29/23 at 4:41 PM revealed the wall by the wardrobe closet had a hole approximately 1.5 inch wide and 3 inches long. The wall was stained and scuffed in several areas, mostly affecting the middle and lower areas of the wall. There was an orange-colored stain on the wall, and it appeared a liquid had splashed on the wall and was left to dry. There were several gray and black colored scuff marks on the lower part of the wall.

d. Observations of room 414 on 11/27/23 at 3:43 PM, 11/28/23 at 1:38 PM, and 11/29/23 at 4:41 PM revealed the closet wardrobe doors from the handles to bottom of the doors had large horizontal marks where the paint was missing and peeling off the doors.

e. An observation of room 414 on 11/27/23 at 3:43 PM and 11/28/23 at 1:38 PM revealed six unlabeled wash basins were stacked inside one another. Two of the wash basins were placed

will be clean and in good repair by 1/31/23.

Damaged floor tiles located on 400 hallway has been completed on 12/22/23. Bathroom floor in room 413 has been replaced and full room renovation completed on 12/27/2023. Bathroom floor in 414 is in the process of being replaced with full room renovation and that room is currently unoccupied due to this. Bathroom floor in 503 is in the process of being replaced by outside contractors and is currently unoccupied. Vents in bathrooms 310, 311, 312, 313, 314, 315, 316, and 317 were cleaned on 11/30/23. Resident rooms and common area vents have been placed on a monthly cleaning schedule via bulidng management platform and services management system, which will be completed by maintenance director/environmental services director/maintenance assistant or assigned designee.

Many residents have the potential to be affected by alleged deficient practice.

All employees will be trained on proper labeling and storage procedures by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or designee by 12/29/23 and ongoing for all new hires during orientation.
Overbed tables for rooms 314A, 314B, 316, and 317 were replaced with new overbed tables on 12/1/23.
Geri chairs in rooms 312B and 403B were pressure washed on 12/1/23. A monthly

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F 584	Continued From page 7 directly on the floor in the bathroom. During an observation and interview on 11/28/23 at 1:38 PM Nurse Aide (NA) #3 observed the wash basins stacked inside one another and the two placed directly on the floor. She stated those should not be stacked inside one another and placed directly on the floor. She revealed it was the NA staff's responsibility to label and properly store residents' personal care items. 2. a. Observations of room 413 on 11/27/23 at 10:11 AM and 11/29/23 04:23 PM revealed the lower portion of the wall by the bathroom had several scrape marks and areas of damaged sheetrock. The bathroom door frame had several scrape marks and areas where the framing was chipped and missing paint. b. Observations of room 413 on 11/27/23 at 10:11 AM, 11/29/23 04:23 PM, and 11/30/23 at 11:37 AM revealed a strong urine-like odor lingered in the room and bathroom and out onto hall 400. The flooring surrounding the base of the toilet was stained black and gray. The bathroom wall had multiple gray colored scuff marks along the lower part of the wall. The floor appeared dirty and sticky and the baseboard behind the toilet had dried brown stains. An interview with Housekeeper #1 on 12/01/23 10:19 AM revealed daily cleaning of resident rooms included sweeping and mopping the floor and cleaning the bathroom. c. Observations of room 413 on 11/27/23 at 10:11 AM, 11/29/23 at 4:23 PM, and 11/30/23 at 11:37 AM revealed 2 unlabeled wash basins stacked together with the one placed directly on the floor.	F 584	cleaning schedule for all geriatric chairs has been to the Environmental Services Director. All employees will be trained on facility maintenance standards, cleanliness protocols, and environmental standards by Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or designee by 12/29/23 and ongoing for all new hires during orientation. A preventative maintenance schedule for regular inspection and maintenance of all facility equipment and resident room furnishings to be completed monthly by maintenance director/designee has been initiated via TELS management system. Staff report maintenance issues promptly via building management platform and services work order system and is ongoing. Staff to report any environmental cleanliness issues identified to Environmental Services Director. Maintenance Director/designee will conduct monthly audits to ensure the environment is maintained in good repair and is clean. Maintenance Director/designee will present these monthly findings to QAPI committee to monitor the effectiveness of the corrective actions from work orders and the preventative maintenance program. Director of Environmental Services and the Director of Nursing/designee will oversee the POC implementation and	

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F 584	Continued From page 8 A toothbrush placed directly on sink. During an interview on 11/28/23 at 1:38 PM NA #3 revealed it was the responsibility of NA staff to label and properly store residents' personal care items. 3. a. Observations of room 503 on 11/29/23 at 1:29 PM and 11/30/23 at 2:01 PM revealed the wood door entering the room had several areas along the edges below the doorknob where chunks of wood were missing and splintered. b. Observations of the bathroom in room 503 on 11/29/23 at 1:29 PM and 11/30/23 at 2:01 PM revealed the flooring surrounding the toilet was heavily stained and buckled and not secured to the subflooring. A wall covering at the lower part of the wall was buckled and peeling away from the wall. The bathroom flooring appeared dirty and sticky. The baseboard along the bottom of the wall and bathroom floor had a black/brown buildup of debris mostly behind the toilet and appeared dirty. An interview with Housekeeper #1 on 12/01/23 10:19 AM revealed daily cleaning of resident rooms included sweeping and mopping the floor and cleaning the bathroom. c. Observations of room 503 on 11/29/23 at 1:29 PM and 11/30/23 at 2:01 PM revealed the top drawer of the nightstand was missing. Walkthrough observations were completed to share environmental concerns for rooms 413, 414 and 503 on 11/30/23 from 12:39 PM through 2:01 PM with the Maintenance Director and Administrator and included interviews. The	F 584	ensure all staff adhere to the new standards and protocols. Facility Angel Room Rounds to be completed by interdisciplinary team member five days a week for two weeks then three times a week for three weeks then twice weekly thereafter, to identify any environmental issues, address resident concerns, label personal items and store correctly. results of this audit will be presented at monthly QAPI meeting until the IDT concludes this goal has been achieved. The facility commits to rectifying the identified issues, ensuring the safety and comfort of residents, and maintaining compliance with CMS regulations. The facility has since enhanced established systems to prevent recurrence of these issues and improve the overall quality of the environment for residents and staff. Compliance date: 12/29/2023	

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environmental issues were unchanged for rooms 413, 414, and 503. The Maintenance Director explained painting and patching walls and doors was a continual process due to residents' wheelchairs bumping into walls, door frames, and closet doors causing damage to the sheetrock and scuff marks, and he was aware those repairs needed to be done. The Maintenance Director and Administrator observed the splintered wood and damaged door guards with sharp edges. The Maintenance Director revealed the doors need to be sanded and smoothed and guards replaced to prevent a resident from a possible skin tear. He revealed the Maintenance Department consisted of 2 staff and there were several things to do, and repairs were prioritized based on emergency problems and special needs of residents were done first. The Maintenance Director stated the urine like odors in rooms 413, 414, and 503 were caused by the male residents missing the toilet. He stated approximately 6 months ago the lower portion of the wall in bathroom 503 was replaced and the use of odor eliminating products including bleach were tried to eliminate the urine-like odor. The Administrator stated attempts to rid the urine-like odors were unsuccessful and at this point it was time to replace the flooring in the bathrooms of rooms 413, 414, and 503. The Maintenance Director revealed he was not aware of the missing nightstand drawer in room 503 and it was an easy fix, and he would replace it. The Maintenance Director and Administrator revealed resident room rounds were assigned to the managers and each person checked 4 rooms. The Administrator revealed it was the responsibility of NA staff and rounding managers to ensure residents personal care items were labeled and properly stored. She revealed Housekeeping staff clean each resident room

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daily and confirmed the observed bathrooms had urine like odors and the floors were sticky. The Maintenance Director revealed he received phone notifications from the computer work order system used by staff to report environmental issues or they verbally report concerns. The Administrator revealed management not doing their assigned resident room rounds contributed to the breakdown in communication related to environmental issues observed during the walkthrough and she expected the facility to be clean and in good repair.

4. a. An observation of room 301 on 11/27/23 at 11:50 AM revealed multiple scrapes with exposed dry wall behind the resident's bed. On wall behind the residents over bed table contained 4 to 5 quarter sized dried red/brown spots on the wall. Subsequent observations made on 11/28/23 at 9:30 AM and 11/30/23 at 2:15 PM revealed the room unchanged.

b. On 11/27/23 at 12:12 PM an observation of the dining room entrance doors revealed the bottom corner of both doors contained a broken door covering that was sticking out from the door. The Door covering was jagged to touch and contained sharp edges and was at foot and ankle level. Subsequent observations made on 11/29/23 at 8:39 AM and 11/30/23 at 2:15 PM revealed the door to be unchanged.

c. An observation of room 306 on 11/27/23 at 2:11 PM revealed 6 continuous floor tiles directly adjacent to the wall behind the door entrance to be broken and indented. Subsequent observations made on 11/30/23 at 2:15 PM revealed the room to be unchanged.

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An interview with the Maintenance Director on 11/30/23 at 12:39 PM revealed each manager was assigned 4 resident rooms to round on daily and report any concerns, including any needed repairs. He stated he knew there were some walls that needed painting or patching but he did not have any outstanding requests for other repairs. The Maintenance Director reported he knew that some floor tiles needed to be repaired but was unable to find matching floor tile for the replacement.

An interview with the Administrator on 11/30/23 at 1:50 PM revealed she knew the building was old and needed some repairs, but she was not aware of how many rooms needed painting and patching of sheet rock. She stated management rounded twice a week on resident rooms to look for any concerns, including needed repairs. The Administrator stated she felt management staff were not completing their room rounds and that contributed to her not being aware of how many resident rooms needed repairs. She stated she expected the walls to be maintained in good repair.

5. a. An observation of the bathroom door in room 407 on 11/27/23 at 11:29 AM revealed the door protector attached to the front, middle to lower half of the door had lifted from the bottom and the inner edge bent outward with a sharp pointed edge. Subsequent observations of the bathroom door in room 407 on 11/28/23 at 8:24 AM and 11/30/23 at 8:53 AM revealed the condition of the door protector remained the same.

b. An observation of the corner wall by the bathroom door in room 408 on 11/27/23 at 10:39

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AM revealed the corner of the wall was busted creating an open hole with splintered and exposed sheetrock from the floor to approximately 6 inches up the corner of the wall. Subsequent observations on 1/28/23 at 12:10 PM and 11/29/23 at 9:00 AM revealed the condition of the wall remained the same.

c. An observation of the bathroom door in room 409 on 11/27/23 at 11:36 AM revealed the door protector attached to the front, middle to lower half of the door had lifted from the bottom and the inner edge bent outward with a sharp pointed edge. Subsequent observations of the bathroom door in room 409 on 11/28/23 at 8:30 AM and 11/30/23 at 8:55 AM revealed the condition of the door protector remained the same.

An interview with the Maintenance Director on 11/30/23 at 12:39 PM revealed each manager was assigned 4 resident rooms to round on daily and report any concerns, including any needed repairs. He stated he knew there were some walls that needed painting or patching but he did not have any outstanding requests for other repairs.

An interview with the Administrator on 11/30/23 at 1:50 PM revealed she knew the building was old and needed some repairs. She stated management rounded twice a week on resident rooms to look for any concerns, including needed repairs. The Administrator stated she felt management staff were not completing their room rounds and that contributed to her not being aware of how many resident rooms needed repairs. She stated she expected the walls and doors to be maintained in good repair.

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6. (a) An observation of the wall behind 311-A on 11/27/23 at 10:24 AM revealed 2 areas of missing paint with exposed sheet rock and the corner of the wall beside the bathroom in room 311 revealed an area of exposed sheet rock. Additional observations of room 311 on 11/28/23 at 8:34 AM, on 11/29/23 at 8:39 AM, and 11/30/23 at 8:35 AM revealed 2 areas of missing paint with exposed sheet rock behind 311-A and the corner of the wall beside the bathroom revealed an area of exposed sheet rock.

(b). An observation of the wall in room 312 across from A and B beds on 11/27/23 at 10:29 AM revealed multiple areas of missing paint across the wall with exposed sheet rock. Additional observations of the wall in room 312 across from A and B beds on 11/28/23 at 8:36 AM, on 11/29/23 at 8:41 AM, and on 11/30/23 at 8:40 AM revealed multiple areas of missing paint across the wall with exposed sheet rock.

(c). An observation of the corners of both walls beside the bathroom in room 314 and the wall behind B-bed on 11/27/23 at 10:35 AM revealed multiple linear areas of missing paint with exposed sheet rock. Additional observations of the corners of both walls beside the bathroom in room 314 and the wall behind B-bed on 11/28/23 at 8:38 AM, on 11/29/23 at 8:50 AM, on 11/30/23 at 8:43 AM revealed multiple linear areas of missing paint with exposed sheet rock.

(d). An observation of the corners of both walls beside the bathroom in room 313 and the wall behind A-bed on 11/27/23 at 10:41 AM revealed multiple linear areas of missing paint with exposed sheet rock. Additional observations of the corners of both walls beside the bathroom in

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room 313 and the wall behind A-bed on 11/28/23 at 8:42 AM, 11/29/23 at 8:47 AM, and 11/30/23 at 8:41 AM revealed linear areas of missing paint with exposed sheet rock.

(e). An observation of the corners of both walls beside the bathroom in room 310 and the wall behind 310-A on 11/27/23 at 10:47 AM revealed linear areas of missing paint with exposed sheet rock. Additional observations of the corners of both walls beside the bathroom in room 310 and the wall behind 310-A on 11/28/23 at 8:48 AM, on 11/29/23 at 8:34 AM, and 11/30/23 at 8:35 AM revealed linear areas of missing paint with exposed sheet rock.

(f). An observation of the wall behind the bed in room 317 on 11/27/23 at 10:57 AM revealed multiple linear areas of missing paint with exposed sheet rock. Additional observations of the wall behind the bed in room 317 on 11/28/23 at 8:53 AM, on 11/29/23 9:03 AM, and on 11/30/23 at 8:45 AM revealed multiple linear areas of missing paint with exposed sheet rock.

(g). An observation of the corners of both walls beside the bathroom and the wall behind the bed in room 318 on 11/27/23 at 11:02 AM revealed multiple linear areas of missing paint with exposed sheet rock. Additional observations of the corners of both walls beside the bathroom and the wall behind the bed in room 318 on 11/28/23 at 8:55 AM, on 11/29/23 at 9:06 AM, and on 11/30/23 at 8:46 AM revealed multiple linear areas of missing paint with exposed sheet rock.

(h). An observation of the corner of the wall beside the bathroom in room 315 on 11/27/23 at 11:05 AM revealed a linear area of missing paint

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with exposed sheet rock. Additional observations of the corner of the wall beside the bathroom in room 315 on 11/28/23 at 8:57 AM, 11/29/23 at 9:01 AM, and on 11/30/23 at 8:42 AM revealed a linear area of missing paint with exposed sheet rock.

(i). An observation of the wall across from A and B beds in room 402 revealed multiple areas of exposed sheet rock and the bathroom wall across from the toilet in room 402 revealed 2 exposed metal brackets on 11/27/23 at 11:15 AM. Additional observations of the wall across from A and B beds in room 402 revealed multiple areas of exposed sheet rock and the bathroom wall across from the toilet in room 402 revealed 2 exposed metal brackets on 11/28/23 at 9:01 AM, 11/29/23 at 9:10 AM, and 11/30/23 at 8:52 AM.

(j). An observation of the corners of both walls beside the bathroom, the wall behind A-bed, and the wall across from A-bed in room 403 on 11/27/23 at 11:21 AM revealed multiple linear areas of missing paint with exposed sheet rock. Additional observations of the corners of both walls beside the bathroom, the wall behind A-bed, and the wall across from A-bed in room 403 on 11/28/23 at 9:06 AM, on 11/29/23 at 9:14 AM, and 11/30/23 at 8:53 AM revealed multiple linear areas of missing paint with exposed sheet rock.

An interview with the Maintenance Director on 11/30/23 at 12:39 PM revealed each manager was assigned 4 resident rooms to round on daily and report any concerns, including any needed repairs. He stated he knew there were some walls that needed painting or patching but he did not have any outstanding repair requests and he did not have a schedule for painting or patching

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walls in resident rooms.

An interview with the Administrator on 11/30/23 at 1:50 PM revealed she knew the building was old and needed some repairs, but she was not aware of how many rooms needed painting and patching of sheet rock. She stated management rounded twice a week on resident rooms to look for any concerns, including needed repairs. The Administrator stated she felt management staff were not completing their room rounds and that contributed to her not being aware of how many resident rooms needed repairs. She stated she expected the walls to be maintained in good repair.

7. (a). An observation of the bathroom wall below the sink in room 311 on 11/27/23 at 10:24 AM revealed multiple areas of dried brown stains. Additional observations of the bathroom wall below the sink in room 311 on 11/29/23 at 8:39 AM and 11/30/23 at 8:35 AM revealed multiple areas of dried brown stains.

(b). An observation of the wall across from A and B bed of room 312 on 11/27/23 at 10:29 AM revealed multiple dried stains. Additional observations of the wall across from A and B bed of room 312 on 11/29/23 at 8:41 AM and 11/30/23 at 8:40 AM revealed multiple dried stains.

(c). An observation of the wall near the entry door of room 314 on 11/27/23 at 10:35 AM revealed multiple dried stains. Additional observations of the wall near the entry door of room 314 on 11/28/23 at 8:38 AM, 11/29/23 at 8:50 AM, and 11/30/23 at 8:43 AM revealed multiple dried stains.

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(d). An observation of the wall near the entry door of room 310 on 11/28/23 at 8:48 AM revealed multiple dried stains. Additional observations of the wall near the entry door of room 310 on 11/29/23 at 8:34 AM and 11/30/23 at 8:35 AM revealed multiple dried stains.

(e). An observation of the wall behind the bed in room 316 on 11/27/23 at 10:53 AM revealed multiple dried stains. Additional observations of the wall behind the bed in room 316 on 11/28/23 at 8:47 AM, 11/29/23 at 8:54 AM, and 11/30/23 at 8:42 AM revealed multiple dried stains.

(f). An observation of the wall across from A and B beds in room 401 on 11/27/23 at 11:10 AM revealed multiple areas of dried stains. Additional observations of the wall across from A and B bed in room 401 on 11/28/23 at 8:59 AM, on 11/29/23 at 9:09 AM, and on 11/30/23 at 8:50 AM revealed multiple areas of dried stains.

(g). An observation of the bathroom wall beside and behind the toilet in room 402 on 11/27/23 at 11:15 AM revealed multiple areas of dried brown stains. Additional observations of the bathroom wall beside and behind the toilet in room 402 on 11/28/23 at 9:01 AM, 11/29/23 at 9:01 AM, and 11/30/23 at 8:52 AM revealed multiple areas of dried brown stains.

An interview with the Maintenance Director on 11/30/23 at 12:39 PM revealed each manager was assigned 4 resident rooms to round on daily and report any concerns, including any issues with cleanliness, to himself or the Director of Nursing (DON). He stated he was not aware of any concerns with room cleanliness.

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An interview with the Director of Nursing (DON) on 11/30/23 at 1:50 PM revealed there was no Environmental Services Director, but she completed the housekeeping schedule and made housekeeping assignments. She stated there was no checklist of items that housekeeping cleaned daily but housekeeping staff were to clean any areas of resident rooms or bathrooms that were visibly soiled. The DON stated she expected resident rooms and bathrooms to be clean.

An interview with Housekeeper #1 on 12/01/23 10:19 AM revealed she was working on the 300 hall and had been employed at the facility for three weeks. She stated daily cleaning of resident rooms included sweeping and mopping the floor, cleaning the bathroom, and dusting if needed. Housekeeper #1 stated she had been instructed to wipe stains off walls in resident rooms if she observed them, but she hadn't seen any walls that needed to be cleaned.

8. (a). An observation of the ceiling vent in the bathroom of room 311 on 11/27/23 at 10:24 AM revealed the vent was covered in a thick layer of gray dust. Additional observations of the ceiling vent in the bathroom of room 311 on 11/28/23 at 8:34 AM, 11/29/23 at 8:34 AM, 11/29/23 at 8:39 AM, and 11/30/23 at 8:35 AM revealed the vent was covered in a thick layer of gray dust.

(b). An observation of the ceiling vent in the bathroom of room 312 on 11/27/23 at 10:29 AM revealed the vent was covered in a thick layer of gray dust. Additional observations of the ceiling vent in the bathroom of room 312 on 11/28/23 at 8:36 AM, on 11/29/23 at 8:41 AM, and on 11/30/23 at 8:40 AM revealed the vent was

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covered in a thick layer of gray dust.

(c). An observation of the ceiling vent in the bathroom of room 314 on 11/27/23 at 10:35 AM revealed the vent was covered in a thick layer of gray dust. Additional observations of the ceiling vent in the bathroom of room 314 on 11/28/23 at 8:38 AM, 11/29/23 at 8:50 AM, and 11/30/23 at 8:43 AM revealed the vent was covered in a thick layer of gray dust.

(d). An observation of the ceiling vent in the bathroom of room 313 on 11/27/23 at 10:41 AM revealed the vent was covered in a thick layer of gray dust. Additional observations of the ceiling vent in the bathroom of room 313 on 11/28/23 at 8:42 AM, 11/29/23 at 8:47 AM, and 11/30/23 at 8:41 AM revealed the vent was covered in a thick layer of gray dust.

(d). An observation of the ceiling vent in the bathroom of room 310 on 11/27/23 at 10:47 AM revealed the vent was covered in a thick layer of gray dust. Additional observations of the ceiling vent in the bathroom of room 310 on 11/28/23 at 8:48 AM, 11/29/23 at 8:34 AM, and 11/30/23 at 8:35 AM revealed the vent was covered in a thick layer of gray dust.

(e). An observation of the ceiling vent in the bathroom of room 316 on 11/27/23 at 10:53 AM revealed the vent was covered in a thick layer of gray dust. Additional observations of the ceiling vent in the bathroom of room 316 on 11/28/23 at 8:47 AM, 11/29/23 at 8:54 AM, and 11/30/23 at 8:42 AM revealed the vent was covered in a thick layer of gray dust.

(f). An observation of the ceiling vent in the

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bathroom of room 317 on 11/27/23 at 10:57 AM revealed the vent was covered in a thick layer of gray dust. Additional observations of the ceiling vent in the bathroom of room 317 on 11/28/23 at 8:53 AM, 11/29/23 at 8:53 AM, and 11/30/23 at 8:45 AM revealed the vent was covered in a thick layer of gray dust.

An interview with the Maintenance Director on 11/30/23 at 12:39 PM revealed maintenance was responsible for cleaning ceiling vents.

In a follow-up interview with the Maintenance Director on 11/30/23 at 1:50 PM he stated the bathroom ceiling vents were last cleaned six months ago and he did not have a routine schedule for cleaning the ceiling vents.

An interview with the Administrator on 11/30/23 at 1:50 PM revealed she expected ceiling vents to be clean.

9. (a). An observation of the packaged terminal air conditioner (PTAC) unit of room 311 on 11/28/23 at 8:34 AM revealed a missing slat to the top vent. Additional observations of the PTAC unit in room 311 on 11/29/23 at 8:39 AM and 11/30/23 at 8:35 AM revealed a missing slat to the top vent.

(b). An observation of the PTAC unit of room 312 on 11/27/23 at 10:29 AM revealed the top vent was dislodged and sitting crooked on the unit. Additional observations of the PTAC unit in room 312 on 11/28/23 at 8:36 AM, 11/29/23 at 8:41 AM, and 11/30/23 at 8:40 AM revealed the top vent was dislodged and sitting crooked on the unit.

(c). An observation of the PTAC unit in room 316

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on 11/27/23 at 10:53 AM revealed a missing slat to the top vent. Additional observations of the PTAC unit in room 316 on 11/28/23 at 8:47 AM, 11/29/23 at 8:54 AM, and 11/30/23 at 8:42 AM revealed a missing slat to the top vent.

(d). An observation of the PTAC unit in room 401 on 11/27/23 at 11:10 AM revealed the top of the vent was dislodged and sitting crooked on the unit. Additional observations of the PTAC unit in room 401 on 11/28/23 at 8:59 AM, 11/29/23 at 9:09 AM, and 11/30/23 at 8:50 AM revealed the top of the vent was dislodged and sitting crooked on the unit.

An interview with the Maintenance Director on 11/30/23 at 12:39 PM revealed each manager was assigned 4 resident rooms to round on daily and report any concerns, including any needed repairs. He stated he was not aware of any concerns with PTAC units in resident rooms.

An interview with the Administrator on 11/30/23 at 1:50 PM revealed management rounded twice a week on resident rooms to look for any concerns, including needed repairs. The Administrator stated she felt management staff were not completing their room rounds and that contributed to repair of PTAC units in rooms not being identified and completed. She stated she expected PTAC units in resident rooms to be in good repair.

10. (a). An observation of the shared bathroom in room 311 on 11/27/23 at 10:24 AM revealed an unlabeled and uncovered round pink pan with dried stains sitting under the sink. Additional observations of the shared bathroom in room 311 on 11/28/23 at 8:34 AM, 11/29/23 at 8:39 AM, and

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11/30/23 at 8:35 AM revealed an unlabeled and uncovered round pink pan with dried stains sitting under the sink.

(b). An observation of the shared bathroom in room 312 on 11/28/23 at 08:36 AM revealed an unlabeled and uncovered bath basin was sitting on top of the towel dispenser. Additional observations of the shared bathroom in room 312 on 11/29/23 at 8:41 AM and 11/30/23 at 8:40 AM revealed an unlabeled and uncovered bath basin sitting on top of the towel dispenser.

(c). An observation of the shared bathroom in room 310 on 11/27/23 at 10:47 AM revealed an unlabeled and uncovered bed pan sitting between a grab bar and the wall. Additional observations of the shared bathroom in room 310 on 11/28/23 at 8:48 AM, 11/29/23 at 8:34 AM, and 11/30/23 at 8:35 AM revealed an unlabeled and uncovered bed pan sitting between a grab bar and the wall.

(d). An observation of the shared bathroom in room 401 on 11/27/23 at 11:10 AM revealed 3 unlabeled and uncovered bath basins stacked inside each other sitting on a dresser. Additional observations of the shared bathroom in room 401 on 11/28/23 at 8:59 AM, 11/29/23 at 9:09 AM, and 11/30/23 at 8:50 AM revealed 3 unlabeled and uncovered bath basins stacked inside each other sitting on a dresser.

(e). An observation of the shared bathroom in room 402 on 11/27/23 at 11:15 AM revealed an unlabeled and uncovered bath basin sitting on the floor near the sink. Additional observations of the shared bathroom in room 402 on 11/28/23 at 9:01 AM, 11/29/23 at 9:10 AM, and 11/30/23 at 8:52 AM revealed an unlabeled and uncovered bath

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basin sitting on the floor near the sink.
An interview with the Director of Nursing (DON) on 11/30/23 at 1:50 PM revealed personal items should be labeled and stored appropriately, and it was the responsibility of all staff to ensure items were labeled and stored appropriately.

11. (a). An observation of the overbed table in room 317 on 11/27/23 at 10:57 AM revealed rust to the wheels and frame. Additional observations of the overbed table in room 317 on 11/28/23 at 8:53 AM, 11/29/23 at 9:03 AM, and 11/30/23 at 8:45 AM revealed rust to the wheels and frame.

(b). An observation of the overbed tables in room 314 A and B bed on 11/27/23 at 10:35 AM revealed dried stains to the frames of both tables. Additional observations of the overbed tables of room 314 A and B bed on 11/28/23 at 8:38 AM, 11/29/23 at 8:50 AM, and 11/30/23 at 8:43 AM revealed dried stains to the frames of both tables.

(c). An observation of the overbed table in room 316 on 11/27/23 at 10:53 AM revealed multiple dried stains to the frame of the table. Additional observations of the overbed table in room 316 on 11/28/23 at 8:47 AM, 11/29/23 at 8:54 AM, and 11/30/23 at 8:42 AM revealed multiple dried stains to the frame of the table.

An interview with the Director of Nursing (DON) on 11/30/23 at 1:50 PM revealed there was no Environmental Services Director, but she completed the housekeeping schedule and made housekeeping assignments. She stated there was no checklist of items that housekeeping cleaned daily but housekeeping staff were to clean any areas of resident rooms that were visibly soiled. The DON stated she expected

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overbed tables to be clean and in good repair.

An interview with Housekeeper #1 on 12/01/23 10:19 AM revealed she was working on the 300 hall and had been employed at the facility for three weeks. She stated daily cleaning of resident rooms included sweeping and mopping the floor, cleaning the bathroom, and dusting if needed. Housekeeper #1 stated she had been instructed to wipe stains off overbed tables in resident rooms if she observed them, but she hadn't seen any tables that needed to be cleaned.

12. (a). An observation of the geriatric chair in room 403 B bed on 11/27/23 at 11:21 AM revealed multiple dried stains on both arm rests and the seat of the chair. Additional observations of the geriatric chair in room 403 B bed on 11/28/23 at 9:06 AM, 11/29/23 at 9:14 AM, and 11/30/23 at 8:53 AM revealed multiple dried stains on both arm rests and the seat of the chair.

(b). An observation of the geriatric chair for the resident in room 312 B bed on 11/27/23 at 2:32 PM revealed multiple dried stains on the arm rests and frame of the chair. Additional observations of the geriatric chair for the resident in room 312 B bed on 11/28/23 at 9:08 AM, 11/29/23 at 9:16 AM, and 11/30/23 at 8:57 AM revealed multiple dried stains on the arm rests and frame of the chair.

An interview with the Director of Nursing (DON) on 11/30/23 at 1:50 PM revealed there was no formal schedule for cleaning geriatric chairs and any staff member could clean them when visibly soiled. She stated she expected wheelchairs to be clean.

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F 584	Continued From page 25 13. An observation of the floor on the upper part of 400 hall on 11/27/23 at 2:32 PM revealed an approximately 2-inch round area of missing tile in the middle of the floor. Additional observations of the floor on 400 hall on 11/28/23 at 9:08 AM, 11/29/23 at 9:12 AM, and 11/30/23 at 8:54 AM revealed an approximately 2-inch round area of missing tile in the middle of the floor. An interview with the Maintenance Director on 11/30/23 at 1:50 PM revealed the tile on 400 hall had been missing for approximately two months and he was holding off repairing the tile as long as possible due to not having replacement tile of the exact color and thickness. He stated he could repair the tile with a different color and use the buffing machine to smooth out the replacement tile being a little thicker. An interview with the Administrator on 11/30/23 at 1:50 PM revealed she expected the floors to be in good repair.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set Assessments (MDS) in the areas of smoking and discharge location for 3 of 7 residents reviewed for accidents and hospitalization (Residents #43, #8 and #88). Findings included:	F 641	MDS assessment ARD 5/02/2023 did not identify Resident #43 as a Smoker in J1300. MDS assessment ARD 1/24/2023 did not identify Resident #8 as a smoker in J1300. MDS assessment ARD 9/01/2023 did not identify Resident #88 as discharged to the	12/29/23

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F 641	Continued From page 26 1. Resident #43 was admitted to the facility on 04/26/23 with diagnosis that included diabetes. Review of the Smoking Safety Screen dated 04/27/23 revealed Resident #43 was assessed as safe to smoke with supervision. The admission MDS assessment dated 05/02/23 revealed Resident #43 did not currently use tobacco. During an interview on 11/30/23 at 9:11 AM, the MDS Coordinator revealed Resident #43 had smoked since her admission to the facility. She stated it was an oversight that Resident #43's MDS assessment dated 05/02/23 was not marked 'yes' to reflect she used tobacco during the MDS assessment period and a modification would be submitted. During an interview on 12/01/23 at 12:34 PM, the Administrator stated it was her expectation for MDS assessments to be completed accurately. 2. Resident #8 was admitted to the facility on 01/13/23 with diagnoses including hypertension. Review of the Smoking Safety Screen dated 01/24/23 for Resident #8 revealed he was able to verbalize he understood the smoking policy and indicated Resident #8 required supervision with smoking. The admission MDS assessment dated 01/24/23 indicated Resident #8 did not use tobacco. During an interview on 12/01/23 at 11:33 AM the MDS Coordinator stated Resident #8 used	F 641	community in A2105. MDS assessment ARD 5/02/2023 for Resident #43 was corrected on 12/01/2023. MDS assessment ARD 1/24/2023 for Resident #8 was corrected on 12/01/2023. MDS assessment ARD 9/01/2023 for Resident #88 was corrected on 12/01/2023. All current residents were assessed to identify current residents were assessed to identify current tobacco use on 12/19/2023 by the MDS Coordinator. MDS assessments were reviewed for accuracy of J1300 x 60 days on 12/18/2023. Audit reviewed by Regional MDS Consultant. All MDS discharge assessments for 60 days were reviewed for accurate coding of discharge status for A2105 and corrected if a discrepancy in discharge status was determined on 12/19/2023. Results from audit will be reviewed by Regional MDS Consultant. MDS Nurse Coordinator was educated on accurate coding of the MDS assessment for J1300 and A2105 on 12/19/2023 by Regional MDS Consultant. To ensure accurate coding of smoking status, all residents scheduled for an Admission, Annual or Significant Change MDS assessments will be reviewed weekly to identify current tobacco use and code J1300 appropriately by the MDS	

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F 641	Continued From page 27 tobacco during the lookback period of the admission MDS assessment dated 01/24/23. The MDS Coordinator confirmed the assessment was incorrectly coded no for tobacco use and she would make a modification to indicate Resident #8 used tobacco. An interview was conducted on 12/01/23 at 12:41 PM with the Administrator and DON. The Administrator stated the MDS should be correctly coded and reflect Resident #8 used tobacco. 3. Resident #88 was admitted to the facility on 08/30/23 with diagnoses including pulmonary fibrosis. The discharge MDS assessment dated 09/01/23 indicated Resident #88 discharged from the facility to the hospital and return to the facility was not anticipated. Review of a nurse progress note written on 09/01/23 indicated Resident #88 discharged from the facility and left with his daughter against medical advice. Review of the document, "Leaving Against Medical Advice", revealed Resident #88 signed the document on 09/01/23 that he understood the consequences and acknowledged he was leaving the facility against the advice of the attending physician and facility administration. During an interview on 11/30/23 at 9:40 AM the MDS Coordinator confirmed she completed the discharge MDS assessment for Resident #88 dated 09/01/23. She recalled Resident #88 left the facility against medical advice and the discharge MDS assessment would be coded to	F 641	Coordinator and Interdisciplinary Team (IDT). The MDS Coordinator will then code section J1300 correctly. To ensure accurate coding of discharge status, residents with a discharge status will be reviewed daily in the morning meeting with IDT. The MDS Coordinator will then code section A2105 correctly. The MDS Nurse Coordinator will audit Resident Admission, Annual and Significant Change assessments for accurate coding of J1300 (Current Tobacco Use) weekly for four weeks, then every other week for two weeks, then each month thereafter. Audit will then be reviewed by the Regional MDS Consultant. Results will be presented at the monthly QAPI meeting. The monthly audit will continue with review at monthly QAPI until the IDT concludes this goal has been achieved. The MDS Nurse Coordinator will audit Resident Discharge MDS assessments for accurate coding of A2105 (Discharge status) weekly for four weeks, then every other week for two weeks, then monthly with results will be presented at the monthly QAPI meeting. The monthly audit will continue with review at monthly QAPI until the IDT concludes the goal has been achieved. Compliance date: 12/29/2023.	

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F 641	Continued From page 28 the community. After review of the MDS assessment and section for discharge status to the hospital the MDS Coordinator stated it was coded incorrectly Resident #88 discharged to the community and she would do a correction to reflect he discharged to the community. An interview was conducted on 12/01/23 at 12:41 PM with the Administrator and Director of Nursing (DON). The DON stated Resident #88 left the facility against medical advice and the discharge MDS indicated he was discharged to the hospital was coded incorrect. The Administrator stated the MDS should be coded correctly and reflect the discharged status of Resident #88 to the community.	F 641		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or	F 645		12/29/23

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(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental

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F 645	Continued From page 30 disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to refer residents who were admitted with mental health disorders for a Level II Preadmission Screening and Resident Review (PASRR) evaluation and determination of specialized services for 3 of 3 residents reviewed for PASRR (Residents #14, #43 and #1). The findings included: 1. Resident #14 was admitted to the facility on 06/19/23 with diagnoses that included anxiety, major depressive disorder, and personality disorder. The admissions Minimum Data Set (MDS) assessment dated 06/30/23 revealed Resident #14 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Review Resident #14's medical record revealed an undated North Carolina Medicaid Uniform Screening Tool (NC MUST) which indicated Resident #14 had a Level I PASRR effective 02/10/10. There were no requests for a Level II PASRR evaluation submitted or completed since 02/10/10. During an interview on 11/28/23 at 4:17 PM, the	F 645	The facility failed to refer Residents #14, #43 and #1 admitted with mental health disorders for a level II Preadmission Screening and Resident Review (PASRR) evaluation and determination of specialized services. Residents #14, #43 and #1 were referred for a level II Preadmission Screening and Resident Review (PASRR) evaluation and determination of specialized services on 12/01/2023 by the Admission Director. All residents with a mental disorder diagnosis have the potential to be affected by the alleged deficient practice. All current residents were reviewed for Level II Preadmission Screening and Resident Review (PASRR) evaluation and determination of specialized services by the Admissions Director and MDS Coordinator with referrals completed on 12/21/2023. To ensure all residents are protected, Preadmission Screening and Resident Review (PASRR) reviews will be completed on all new Resident admissions by the MDS Coordinator/Designee. The Admissions	

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F 645	Continued From page 31 Admissions Director revealed she submitted requests for PASRR evaluations through NC MUST when notified. She explained the MDS Coordinator was the one who was aware of a resident's diagnoses and would notify her. The Admissions Director stated she had not received any notifications to submit requests for Level II PASRR evaluations. During interviews on 11/29/23 at 9:24 AM and 11/30/23 at 2:40 PM, the Social Worker (SW) revealed the Admissions Director handled residents' PASRR. The SW explained the previous SW did not tell her anything about PASRR during training and she did not know to request a Level II PASRR evaluation for a resident with a mental health disorder or the process for doing so. During an interview on 12/01/23 at 12:34 PM, the Administrator revealed the Admissions Director was responsible for requesting Level II PASRR evaluations for residents admitted with mental health disorders and Resident #14's just got missed. 2. Resident #43 was admitted to the facility on 04/26/23 with diagnoses that included bipolar disorder, major depressive disorder, agoraphobia (abnormal fear of places or situations that could cause feelings of panic or embarrassment) with panic disorder, and post-traumatic stress disorder. The admission Minimum Data Set (MDS) assessment dated 05/02/23 revealed Resident #43 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability.	F 645	Director/Designee will complete referrals in NC Must for Level II Preadmission Screening and Resident Review (PASRR). The Admissions Director and MDS Coordinator were educated on the level II Preadmission Screening and Resident Review (PASRR) referral process by the Regional MDS Consultant on 12/20/2023. The Admissions Director will audit resident admissions for Preadmission Screening and Resident Review (PASRR) eligibility weekly x four, then every other week x two weeks, then each month x one month. Results will be presented to monthly QAPI meeting and reviewed until the IDT concludes the goal has been achieved. Compliance date: 12/29/2023.	

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Review Resident #43's medical record revealed an undated North Carolina Medicaid Uniform Screening Tool (NC MUST) which indicated Resident #43 had a Level I PASRR effective 04/26/23. There were no requests for a PASRR Level II evaluation submitted or completed since 04/26/23.

During an interview on 11/28/23 at 4:17 PM, the Admissions Director revealed she submitted requests for PASRR evaluations through NC MUST when notified. She explained the MDS Coordinator was the one who was aware of a resident's diagnoses and would notify her. The Admissions Director stated she had not received any notifications to submit requests for Level II PASRR evaluations.

During interviews on 11/29/23 at 9:24 AM and 11/30/23 at 2:40 PM, the Social Worker (SW) revealed the Admissions Director handled residents' PASRR. The SW explained the previous SW did not tell her anything about PASRR during training and she did not know to request a Level II PASRR evaluation for a resident with a mental health disorder or the process for doing so.

During an interview on 12/01/23 at 12:34 PM, the Administrator revealed the Admissions Director was responsible for requesting Level II PASRR evaluations for residents admitted with mental health disorders and Resident #43's just got missed.

3. Resident #1 was admitted to the facility 03/09/23 with diagnoses including severe intellectual disabilities and paranoid

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schizophrenia.

The admissions Minimum Data Set (MDS) assessment dated 03/18/23 revealed Resident #1 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability.

Review of Resident #1's medical record revealed an undated North Carolina Medicaid Uniform Screening Tool (NC MUST) indicated Resident #1 had a Level I PASRR effective 03/07/23. There were no requests for a Level II PASRR evaluation submitted or completed since 03/07/23.

An interview with the Admissions Director on 11/28/23 at 4:17 PM revealed she submitted requests for PASRR evaluations through NC MUST when notified. She stated the MDS Coordinator was the staff member who was aware of a resident's diagnoses and would notify her. The Admissions Director stated she had not received any notifications to submit requests for Level II PASRR evaluations.

Interviews on 11/29/23 at 9:24 AM and 11/30/23 at 2:40 PM with the Social Worker (SW) revealed the Admissions Director handled residents' PASRR. The SW explained the previous SW did not tell her anything about PASRR during her training and she did not know to request a Level II PASRR evaluation for a resident with a mental health disorder or the process for doing so.

An interview with the Administrator on 12/01/23 at 12:34 PM revealed the Admissions Director was responsible for requesting Level II PASRR evaluations for residents admitted with mental health disorders and Resident #1's just got

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F 645	Continued From page 34 missed.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the 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	F 656		12/29/23

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F 656	Continued From page 35 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a person-centered comprehensive care plan for 2 of 21 (Resident #241 and Resident #62) residents reviewed for comprehensive care plans. Findings included: 1. Resident #241 was admitted to the facility 06/08/23 with diagnoses including pulmonary embolism (a blood clot in the lung) and heart failure. Resident #241 was discharged to the community 08/29/23. Review of Resident #241's medical record revealed a physician's order dated 06/08/23 for Apixaban (anticoagulant) 5 milligrams (mg) twice a day for pulmonary embolism. Review of Resident #241's Medication Administration Record (MAR) for June 2023 revealed he received Apixaban as ordered. Resident #241's comprehensive care plan last updated 06/12/23 was reviewed and did not reveal any care plan focus or interventions related to receiving anticoagulation medication.	F 656	Resident #241 did not have a comprehensive care plan for the use of anticoagulant medication. Resident #62 did not have a comprehensive care plan for Activities of Daily Living (ADL) and incontinence. Anticoagulant medication care plan for Resident #241 could not be added due to resident discharge prior to survey. Activities of Daily Living (ADL) and incontinence care plans were added to Resident #62's Comprehensive Care Plan on 11/30/2023. All residents have the potentail to be affected by alleged deficient practice. To ensure anticoagulant care plans are addressed for residents receiving anticoagulant medication regimen, all current residents were reviewed for use of anticoagulant medication use on 12/19/2023. Comprehensive care plans for residents receiving anticoagulant	

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F 656	Continued From page 36 The admission Minimum Data Set (MDS) assessment dated 06/15/23 revealed Resident #241 was cognitively intact and received anticoagulant (blood thinner) medication 7 out of 7 days during the look back period. An interview with the MDS Coordinator on 11/28/23 at 2:03 PM and 11/30/23 at 9:36 AM revealed she was responsible for developing Resident #241's comprehensive care plan and it should be a reflection of all the care and medications Resident #241 required. She stated it was an oversight that Resident #241 did not have a comprehensive care plan for the use of anticoagulant medication. In an interview with the Director of Nursing (DON) on 11/30/23 at 11:14 AM she confirmed Resident #241's care plan updated in June 2023 was not complete and should reflect all the care he required. 2. Resident #62 was admitted to the facility on 10/19/23 with diagnoses including: Hip Fracture, cerebrovascular Accident, Atrial fibrillation, coronary artery disease, heart failure, hypertension, orthostatic hypotension, Renal insufficiency renal failure. The admission Minimum Data Set (MDS) dated 10/26/23 indicated that Resident # 62 under activities of daily living needed maximum assistance with bed mobility, transfers, personal hygiene, bathing, and locomotion on and off the unit. and always incontinent of bowel and bladder during the MDS assessment period. Review of #62 active care plans, initiated on	F 656	medication were reviewed and updated to include care plan for anticoagulant use on 12/19/2023. Audit reviewed by Regional MDS Consultant. To ensure Activities of Daily Living (ADL) care plans are addressed for all residents, all current residents were reviewed to identify presence of Activities of Daily Living (ADL) care plans on 12/19/2023 by the MDS Coordinator. Care plans for Activities of Daily Living (ADL) were added if needed on 12/19/2023. Audit reviewed by Regional MDS Consultant. The MDS Coordinator is responsible for the development and completion of resident care plans. The MDS Coordinator was educated on 12/19/2023 on care planning for anticoagulant medication regimens by the Regional MDS Consultant. The MDS Coordinator was educated on 12/19/2023 on care planning for Activities of Daily Living (ADL) by the Regional MDS Consultant. The MDS Coordinator was educated on 12/19/2023 on care planning for incontinence by the Regional MDS Coordinator. Education completed with the MDS Coordinator for the care planning process to include anticoagulant medication regimens, Activities of Daily Living (ADL), and incontinence on 12/19/2023 by the Regional MDS Consultant.	

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F 656	Continued From page 37 11/30/23 revealed that the resident did not have care plans that addressed Activities of Daily living (ADL) and incontinence had not been initiated. During an interview on 12/1/23 at 8:41AM with MDS Coordinator who stated she had not been getting care plans initiated in the required timeline. Stated that all care plans should be completed to have a comprehensive care plan. MDS Coordinator revealed that she did not know residents care plans were missing until the Regional Consultant did an audit on 11/30/23. Regional was present and stated that this all occurred due to an update of the charting system and this is why the MDS Coordinator missed some care plans. During a interview with the Administrator on 12/1/23 he stated that the expectations was for the MDS staff to keep care plans up to date and initiated as soon as possible since this is what drives the resident care.	F 656	All current residents receiving an anticoagulant medication regimen will be reviewed weekly in Risk Meeting to verify an anticoagulant care plan is present as part of the resident's comprehensive care plan. All current Residents with completed MDS assessments from the previous week will have comprehensive care plans reviewed weekly via audit to verify the presence of an Activities of Daily Living (ADL) care plan. All current Residents with completed MDS assessments from the previous week will have comprehensive care plans reviewed weekly via audit to verify the presence of an incontinence care plan. The MDS Coordinator whom is responsible for developing and completing comprehensive care plans will audit comprehensive care plans for current residents receiving anticoagulant medication regimen for the presence of anticoagulant care plan weekly x four weeks, then every other week x two weeks, then each month x one month. The audit will be reviewed by the Regional MDS Consultant. Results will be presented at the monthly QAPI meeting and will be reviewed until the IDT concludes that the goal has been achieved. The MDS Coordinator whom is responsible for developing and completing comprehensive care plans will audit comprehensive care plans for current	

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F 656	Continued From page 38	F 656	residents for the presence of Activities of Daily Living (ADL) care plans weekly x four weeks, then every other week x two weeks, then every month x one month. Audits will be reviewed by the Regional MDS Consultant. Results will be presented at the QAPI meeting monthly and reviewed until the IDT concludes that the goal has been achieved. Compliance date: 12/29/2023.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff and medical director interviews the facility failed to monitor a resident's blood sugar for a resident with insulin-dependent diabetes for 1 of 5 residents reviewed for unnecessary medication (Resident # 69). The findings included Resident # 69 was re-admitted to the facility on 11/20/23 with diagnosis that included Diabetes Mellitus type 1, heart failure, vascular dementia, and respiratory failure.	F 684	All residents receiving insulin have the potential to be affected by alleged deficient practice. Resident #69's order was clarified on 11/29/23, after receiving new order by medical director, to reinstitute blood glucose checks prior to meals, as was previously being performed prior to hospitalization on 11/17/23. A comprehensive review of all current residents receiving blood glucose checks was completed on 11/30/23 by the Nursing Supervisor to ensure all residents	12/29/23

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F 684	Continued From page 39 Resident # 69's admission Minimum Data Set (MDS) was still in progress. A review of Resident # 69's physicians orders on 11/20/23 read in part: Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 20 unit subcutaneously at bedtime for DM (11/20/23). Insulin Lispro Injection Solution 100 UNIT/ML Inject 6 unit subcutaneously with meals for diabetes (11/20/23). A review of Resident # 69's medication administration record (MAR) for November 2023 revealed blood sugar checks had not been checked prior to Resident # 69 receiving insulin before meals from his readmission dated of 11/20/23 - 11/28/23. Further review of the MAR revealed blood sugar level checks were completed prior to administering insulin before meals each day until discharged to hospital on 11/17/23. After discovery of the missing blood sugar checks, Resident # 69's assigned nurse (Nurse # 4) and admitting nurse was interviewed on 11/28/23 at 1:58 PM. Nurse # 4 said she had been assigned to Resident # 69 for a long time and knew him well and Resident # 69 was alert and oriented to himself. Nurse # 4 stated Resident # 69 did receive blood sugar checks before she administered insulin at mealtimes prior to his discharge to the hospital on 11/17/23. Nurse # 4 said when Resident # 69 returned from the hospital he did not have orders for checking	F 684	receiving insulin had blood glucose checks prior to insulin administration. No other residents were identified to be affected. All licensed nursing staff to be in-serviced by Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Designee by 12/29/23 and will be included in new hire orientation thereafter. Education review to include expectation of comparing new hospital depart orders to previous orders prior to hospitalization to ensure no previous orders are excluded, all residents who receive insulin are to have a blood glucose check prior to insulin administration, following physician orders and notification of physician when blood glucose readings are outside of ordered parameters for follow up, and established parameters for reporting to physician for any blood glucose checks that were taken at nurses discretion for residents symptomatic for hypo/hyperglycemia. Initial audit performed by Nursing Supervisor on 11/30/23 to review and ensure all residents receiving insulin have a blood glucose check prior to insulin administration. All new admissions/readmissions thereafter will be reviewed by admitting nurse/Nursing Supervisor/Designee and any identified need for initiation or reinitiation of any blood glucose checks will be discussed with provider for determination of course of action. New	

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F 684	Continued From page 40 blood sugars before his insulin was administered. Nurse # 4 stated she should have clarified the blood sugar checks with the doctor and was unsure why the blood sugar checks were not reinstated. Nurse # 4 said she had given Resident # 69 his insulin without checking his blood sugar level. Nurse # 4 stated she monitored his behaviors(lethargic) compared to his baseline, vital signs, and the amount of meal intake to determine if he had hypoglycemia (low blood sugar). She stated she would then notify the provider. Nurse # 4 stated when a resident admits to the facility, the orders from the hospital are reviewed by the admitting nurse, nurse supervisor and verified by a provider prior to placing them on the resident's MAR. The Director of Nursing (DON) was interviewed on 11/28/23 at 4:14 PM. She stated she was not aware Resident # 69 was not receiving blood sugar checks prior to receiving insulin at meals. She stated the facility did not have a standing order for checking blood sugar levels for diabetic residents. The physician made the decision on whether a resident needed to have blood sugar levels checked. The DON said the nurse supervisor reviews every resident's chart before they are admitted and should have reviewed Resident # 69's. NA #1 was interviewed on 11/29/23 at 9:24 AM. NA # 1 stated Resident # 69 was alert and oriented to himself. The Medical Director (MD) was interviewed on 11/30/23 at 3:32 PM. He stated Resident # 69 was to receive his insulin before each meal regardless of his blood sugar level. The MD said Resident # 69 should've had his blood sugar level	F 684	orders obtained are reviewed five times a week by Nursing Supervisor/Designee to ensure accuracy of order and proper set up in Point Click Care (PCC) Electronic Medical Record (EMAR) system. This process will be on going. Nursing Supervisor/Designee will do a weekly audit review of new admissions and insulin orders for diabetics. Review of orders and admission reviews will be submitted weekly for four weeks to establish substantial compliance while continuing five of seven daily order reviews thereafter. Collected data from the audits performed will be reviewed and reported to the QAPI committee for recommendations and to ensure ongoing compliance is met and adjustments made as needed thereafter. Compliance date 12/29/23	

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F 684	Continued From page 41 checked prior to administering insulin. The Administrator, DON, and Administrator In Training (AIT) were interviewed on 12/1/23 at 12:33 PM. The Administrator stated Resident # 69's blood sugar check order should have been reinstated.	F 684		
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 observations, record review, and staff interviews the facility failed to ensure a resident did not receive a straw for 1 of 7 residents (Resident #54) reviewed for accidents. This failure placed Resident #54 at risk for choking/aspiration (inhaling food or fluids into the lungs). Findings included: Resident #54 was admitted to the facility 04/25/23 with diagnoses including dysphagia (difficulty swallowing) and malnutrition. A Speech Therapy (ST) Discharge Summary dated 07/28/23 revealed Resident #54 received dysphagia therapy from 06/20/23 through 07/28/23. The note read in part "provided skilled	F 689	Upon identifying a deficiency under F689, Rehab Director immediately initiated a thorough investigation into the incident involving Resident #54. The care plan was reviewed to assess if the use of a straw was indicated as a necessary intervention for preventing choking/aspiration. Occupational Therapy (OT) evaluated resident #54 and a recommendation of Kennedy cup was a suggested adaptive equipment piece, to aide in self-dining capabilities. A Kennedy cup can only be used with straws, which conflicts speech recommendation for no straws with drinks due to increased risk of aspiration. Clarification with the therapy staff indicated that resident #54 did require use of a handled cup and no straws with	12/29/23

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F 689	Continued From page 42 ST to address swallow function in order to determine least restrictive/safest diet, maximize overall safety and efficiency during PO (oral) intake, reduce risk of aspiration and associated respiratory compromise, and maintain adequate nutrition and hydration. To facilitate safety and efficiency it is recommended the patient use the following strategies and/or maneuvers during oral intake: no straws and general swallow techniques/precautions upright posture during meals." An Occupational Therapy (OT) Discharge Summary dated 08/02/23 revealed Resident #54 received OT from 07/06/23 through 08/02/23. The note read in part: "self-feeding-patient is independent in all components of task using assistive device." The quarterly Minimum Data Set (MDS) assessment dated 10/31/23 revealed Resident #54 was moderately cognitively impaired. The nutrition care plan last updated 09/19/23 revealed Resident #54 was at risk for malnutrition related in part to medical conditions, age, and a history of dysphagia. Interventions included monitoring Resident #54 for signs or symptoms of dysphagia, providing diet as ordered, and not providing straws with meals. An observation of Resident #54 on 11/27/23 at 12:20 PM revealed she was using a straw to drink milk from a carton without difficulty. Resident #54 was not observed to cough or choke while drinking the milk. An observation of Resident #54's meal ticket at the same date and time revealed she was not to receive straws and was supposed to receive a kennedy cup (a cup with a lid that has an opening for a straw and a handle).	F 689	meals. Discontinuation of the Kennedy cup was completed by Occupational Therapist on 11/30/23. Resident #54's orders and dietary meal card were updated to reflect new recommendations for resident #54 which included adaptive equipment use of handled cup with no straws for meals. Resident #54's risk for choking/aspiration was conducted and clarified by Speech Therapy (ST) and necessary adjustments were promptly made to the care plan to reflect new recommendations. All residents who received adaptive equipment have the potential to be affected by alleged deficient practice. Occupational and Speech Therapy staff were educated by Therapy Director, on 11/30/23. Education specifically targeting collaboration between the two entities of recommended adaptive equipment to ensure what is being implemented for a resident, is compatible and used per manufacturer recommendation appropriately. Immediate education on 11/30/23 by DON/designee was initatiated upon notification by surveyor to ensure diet meal cards are reviewed and carried out by staff providing meals if an indication of adaptive equipment or no straws for meals is ordered. All licensed and unlicensed staff will receive education by 12/29/23 by Director of Nursing/Assistant Director of Nursing/designee. Therapy Director will audit OT and ST orders and visually observe the meal trays of residents with	

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F 689	Continued From page 43 No kennedy cup was observed on Resident #54's meal tray. A joint interview with Nurse Aide (NA) #1 and NA #2 on 11/27/23 at 12:30 PM revealed they could not recall who set up Resident #54's meal tray for the lunch meal. An interview with NA #3 on 11/27/23 at 12:31 PM revealed he could not recall who set up Resident #54's lunch meal tray, but whoever set up the tray was responsible for making sure items on the tray matched the tray card. NA #3 confirmed Resident #54's meal tray ticket stated she was not to receive straws and should have received a kennedy cup. He removed the straw from Resident #54's milk and went to the kitchen to request a kennedy cup. An interview with NA #1 on 11/28/23 at 12:25 PM revealed she set up Resident #54's lunch meal tray and placed the kennedy cup in the lid of the meal tray and sat the lid on the resident's dresser. When NA #1 was asked why she did not pour Resident #54's beverage into the kennedy cup, she stated she was told by therapy when Resident #54 was moved to 300 hall that she could hold a cup from the kitchen or a carton of milk and did not require use of the kennedy cup. NA #1 was unable to recall which staff member from therapy told her Resident #54 did not need to use a kennedy cup. An interview with the Speech Therapist (ST) on 11/28/23 at 12:42 PM revealed Resident #54 was not currently on caseload, but she had previously recommended Resident #54 did not receive straws due to the risk of aspiration (when food or fluid is breathed into the airway). She stated	F 689	identified adaptive equipment to ensure that adaptive equipment provided to residents is accurate, present, and necessary. This audit will be completed weekly for four weeks, then twice monthly for one month, then monthly thereafter. Collected data from the audits performed will be reviewed and reported to the QAPI committee for recommendations and to ensure ongoing compliance is met and adjustments made as needed thereafter. Compliance date of 12/29/23.	

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F 689	Continued From page 44 occupational therapy probably recommended the kennedy cup for Resident #54. An interview with the Occupational Therapist (OT) on 11/28/23 at 1:57 PM revealed Resident #54 was not currently on caseload, but she had previously recommended Resident #54 use a kennedy cup to enable her to be able to drink fluids more independently. She stated she was not aware of the speech therapy recommendation that Resident #54 not use straws due to the risk of aspiration and the aspiration risk outweighed the use of a kennedy cup. An interview with the Director of Nursing (DON) on 11/30/23 at 11:13 AM revealed the staff member setting up a resident's tray was responsible for ensuring the meal tray matched the tray ticket. She stated she expected staff to obtain the needed item if it did not come on the tray, or to remove the item that was not supposed to be on the tray before delivering the tray to the resident.	F 689		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the	F 711		1/1/24

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(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 711	Continued From page 45 exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure physician progress notes were documented and completed as required for each physician visit for 2 of 2 sampled residents (Residents #14 and #84). Findings included: 1. Resident #14 was admitted to the facility on 06/19/23 with diagnoses that included hemiplegia (weakness on one side of the body) and hemiparesis (complete paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, diabetes, chronic respiratory failure, chronic obstructive pulmonary disease (difficulty breathing), and hypertension. Review of Resident #14's medical record revealed a progress note which indicated he was seen by the facility Medical Director in conjunction with the Physician Assistant (PA) on 10/13/23. There were no progress notes of physician visits conducted by the Medical Director every 30 days for the first 90 days following Resident #14's admission to the facility. Review of Resident #14's medical record revealed he was seen by the Nurse Practitioner (NP) on 06/22/23 and 11/21/23 and the Physician Assistant on 07/18/23 and 08/02/23. During a telephone interview on 11/30/23 at 3:42 PM, the Medical Director revealed the	F 711	Resident #14's medical chart was reviewed by the facility's Medical Director, and physician visit reviewed and a progress note placed for visit with date of service dated 12\6\23. Resident #84's medical chart was reviewed by the facility Medical Director, and physician visit reviewed and a progress note placed for visit with date of service dated 12\1\23. All residents have the potential to be affected by the alleged deficient pracitice. An audit was completed by Director of Nursing Services on 12/6/23 of residents admitted within the past 60 days to ensure physician visits were completed per CMS guidelines. Moving forward, Medical Records/designee will be responsible for overseeing completion of physician visits per CMS guidelines effective January 2024 in effort to oversee and maintain timely completion of physician visits for regulatory admission visits every 30, 60, 90 day then every 60 days thereafter. Education to be completed by nursing home administrator/designee to medical records personnel by January 1, 2024 regarding auditing tools implemented to monitor physician visits are completed. This audit will be ongoing and any	

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	345305	A. BUILDING _____ B. WING _____	C 12/01/2023

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F 711	Continued From page 46 Administrator had contacted him to discuss the regulatory requirement regarding frequency of physician visits. The Medical Director explained the NP or PA was at the facility most days and when he was there, he often rounded with them but did not document a progress note of his visit in the residents' medical records. The Medical Director stated all the residents at the facility were usually seen by him 2 to 3 times a month and he realizes his visits should have been documented. During a joint interview with the Administrator on 12/01/23 at 12:34 PM, the Director of Nursing (DON) stated she was under the impression the Medical Director was keeping track of when regulatory visits were due. The DON explained they have now developed a log for nursing staff to track when regulatory visits were due, remind the Medical Director and follow-up to ensure progress notes were documented. During a joint interview with the DON on 12/01/23 at 12:34 PM, the Administrator stated she was under the impression the Medical Director was keeping track of when regulatory visits were due. The Administrator stated Resident #14 should have been seen by the physician per regulatory guidelines and facility policy. 2. Resident #84 was admitted to the facility on 09/29/23 with diagnoses that included dementia without behavioral disturbance, atherosclerotic heart disease (damage or disease in the heart's major blood vessels), and gastroesophageal reflux disease (digestive disease in which stomach acid or bile irritates the food pipe lining). Review of Resident #84's medical record revealed no progress notes of physician visits	F 711	non-compliance visit notations will be brought to the immediate attention of administrator and director of nursing. Medical Records/designee will audit resident charts for presence of Physician examination visit note every 30 days for first 90 days following admission and every 60 days thereafter. Medical Records designee will audit newly admitted resident charts for presence of Physician examination visit note every thirty days for the first 90 days then every 60 days thereafter. An auditing tool will be added to be done monthly continuously to ensure physician visits are completed per CMS regulations. Audits will be reviewed by the Administrator. Results will be presented to monthly QAPI meeting and reviewed until the IDT concludes that the goal has been achieved. Compliance date: 1/1/2024	

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F 711	Continued From page 47	F 711		

conducted by the Medical Director.

Review of Resident #84's medical record revealed he was seen by the Nurse Practitioner (NP) on 10/02/23, 10/09/23, 10/10/23, and 11/13/23 and the Physician Assistant (PA) on 10/11/23.

During a telephone interview on 11/30/23 at 3:42 PM, the Medical Director revealed the Administrator had contacted him to discuss the regulatory requirement regarding frequency of physician visits. The Medical Director explained the NP or PA was at the facility most days and when he was there, he often rounded with them but did not document a progress note of his visit in the residents' medical records. The Medical Director stated all the residents at the facility were usually seen by him 2 to 3 times a month and he realizes his visits should have been documented.

During a joint interview with the Administrator on 12/01/23 at 12:34 PM, the Director of Nursing (DON) stated she was under the impression the Medical Director was keeping track of when regulatory visits were due. The DON explained they have now developed a log for nursing staff to track when regulatory visits were due, remind the Medical Director and follow-up to ensure progress notes were documented.

During a joint interview with the DON on 12/01/23 at 12:34 PM, the Administrator stated she was under the impression the Medical Director was keeping track of when regulatory visits were due. The Administrator stated Resident #84 should have been seen by the physician per regulatory guidelines and facility policy.

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F 761	Continued From page 48	F 761		
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. §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 observations, record review and staff interviews, the facility failed to store a 30 dose bubble pack of Metformin (an hyperglycemic medication) in the medication cart for 1 of 4 carts observed during medication pass. The facility failed to dispose of an expired medication, an unopened bottle of expired medication, Ferrex (an iron supplement), which was discovered in the 100/200 hall medication room for 1 of 2	F 761	A 30 dose bubble pack was immediately placed back into medication cart drawer and securely locked in proper storage upon identification of packaging being noted on top of medication cart on 11/30/23. All residents have the potential to be affected by alleged deficient practice.	12/29/23

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F 761	Continued From page 49 medication rooms reviewed. The facility also failed to secure medicated creams, powder and sprays that were in clear view at the bedside for 1 of 1 sampled resident (Resident #14). Findings included: 1. An observation conducted during a medication pass on the 400 hall on 11/29/2023 at 9:45AM revealed a full bubble pack of 30 doses of Metformin that Nurse #1 left on top of the medication cart and walked away leaving the card and information unsecured. The nurse was out of the line of sight to observe the medication which was left on the medication cart. There were residents sitting in their doorways around the cart while unattended. An interview with Nurse #1 was conducted on 11/30/23 at 10:05AM and she said medications should have been secured before she walked away from the cart. Nurse #1 reported the medication cart should be locked, and no medications should be left on top of the cart. Nurse#1 stated leaving unattended medications on top of the cart can cause potential hazards for confused residents who could take the card and possibly the medication. During an interview with Director of Nurse on 11/30/23 at 9:25AM, she stated that all medications should be secured before the nurse walked away from the cart. An interview with the Administrator on 11/30/23 at 12:55PM revealed she would not expect a nurse to leave any medication unattended. 2. An observation of the 100/200 hall medication	F 761	Nurse #1 was re-educated on 11/30/23 about securing and maintaining proper storage of medications per facility policy. All licensed nursing staff will be in-serviced by Director of Nursing/designee on proper medication storage and securing medications when away from medication cart by 12/29/23. Education will be provided to all new licensed nursing staff during new hire orientation. 100% of medication carts will be monitored using an audit tool to ensure all medications are stored appropriately in a locked cart when left unattended. To ensure continued compliance, audits will be conducted by the Director of Nursing/designee for all medication carts five time a week for two weeks, then twice weekly for three weeks, then weekly for four weeks. The results of these audits will determine the need for further monitoring. All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON/designee, for review and to ensure continued compliance with the plan of correction. The single, unopened, over-the-counter-expired medication discovered in one of two medication rooms observed by surveyor was removed on 11/30/23 by Director of Nursing and was immediately disposed of per facility protocol. All residents receiving over the counter	

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F 761	Continued From page 50 room, on 11/30/23 at 9:25AM with Director of Nursing revealed an unopened and expired bottle of medication Ferrex-150 150mg tabs which had an expiration date of 9/2023. During an interview with the Director of Nursing on 11/30/23 at 9:25AM, conducted in the medication room in conjunction with the observation, she stated the person responsible for ordering and stocking supplies was responsible for checking dates and over-the -counter medications, which was the Medical Record/Central Supply employee. She stated expectations are to check medications to ensure no expired medications are left in the cabinet. An interview was conducted with the Medical Records/Central Supply employee on 11/30/23 at 11:15AM who stated she checked for outdated mediations twice a month. She stated she would go through medications that were in the medication room and would pull older bottles to the front and place newer bottles in the back of the cabinet. She further stated she just missed one expired medication, but she did check routinely. An interview with the Administrator on 11/30/23 at 12:55PM revealed she expected the Medical Records/Central Supply person to check all stock medications and remove any expired medications before the expiration date. She stated she did not feel like this was an issue and it was just an accident. 3. Resident #14 was admitted to the facility on 06/19/23 with multiple diagnoses that included hemiplegia (weakness on one side of the body) and hemiparesis (complete paralysis on one side	F 761	medications have the potential to be affected by the alleged deficient practice. This single identified, unopened medication bottle never reached a patient as it was not placed on any medication cart available for distribution. All licensed nursing staff will be in-serviced on checking expiration date when removing over the counter medications from medication room prior to placing on medication cart for distribution and a second check from medication cart prior to administration by 12/29/23. Education will be provided to all new licensed nursing staff during new hire orientation. All medication storage areas were audited on 11/30/23 by the Director of Nursing, Assistant Director of Nursing, and Nursing Supervisor. No other areas of concern were identified during audit. All medication storage areas for over-the-counter medications will be checked by Central Supply for expired over the counter medications and any expired items will be discarded per facility protocol on a weekly basis. Staff Development Coordinator/Designee will audit medication storage areas for expired medications/supplies twice a week for four weeks, then weekly for four weeks, then monthly thereafter to ensure continued compliance is met. Collected data from the audits performed will be reviewed and reported to the QAPI committee for recommendations and to ensure ongoing compliance is met and adjustments made	

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F 761	Continued From page 51 of the body) following cerebral infarction (stroke) affecting left non-dominant side. The quarterly Minimum Data Set (MDS) dated 10/25/23 revealed Resident #14 had intact cognition. Review of Resident #14's medical record revealed no documentation he was assessed for self-administering medications. Review of Resident #14's November 2023 Medication Administration Record and Treatment Administration Record revealed the following active physician orders: 06/19/23: May apply barrier cream or equivalent with each incontinent episode and as needed (unlicensed personnel to administer, nurse to monitor) every shift for preventative care. 07/12/23: Hydrocortisone (used to treat redness, itching and discomfort of the skin) topical cream 1% apply to face topically daily for rash as needed. 08/07/23: 12-hour nasal solution 0.05% oxymetazoline hydrochloride (used to relieve nasal discomfort caused by colds, allergies and hay fever) - two sprays in nostril twice a day as needed. 11/16/23: Nystatin Powder (used to treat fungal or yeast infections of the skin) 100,000 units/gram - apply topically to groin twice a day for 7 days. There were no other physician orders for medicated creams, powders or sprays. During observations on 11/27/23 at 10:39 AM, 11/28/23 at 12:10 PM, and 11/29/23 at 12:00 PM, in clear view on top of Resident #14's nightstand were an 8-ounce (oz) bottle of wound cleanser spray containing zinc acetate and alcohol	F 761	as needed thereafter. Medicated creams, powders, and sprays within room of resident #14 were immediately removed by nursing management upon notification to Director of Nursing of these items being at resident's bedside on 11/30/23. All residents have the potential to be affected by alleged deficient practice. All employees will be in-serviced on removing medications, creams, ointments, powders, sprays, etc. from resident rooms if identified by 12/29/23. Education will be provided to all new employees during new hire orientation. It is the responsibility of all employees to remove all such listed items from bedside tables and nightstands within resident rooms. All administrative staff are assigned resident room rounds. Facility Angel Room Rounds are conducted five times a week by assigned administrative staff for their indicated room assignments for two weeks then three times a week for three weeks then twice a week continuously thereafter. Any deviations are to be corrected by administrative staff upon notation of finding and report to resident's assigned nurse. Collected data from the audits performed will be reviewed and reported to the QAPI committee for recommendations and to ensure ongoing compliance is met and adjustments made as needed thereafter. Compliance date for all areas of concern	

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F 761	Continued From page 52	F 761	identified: 12/29/23	

formula, a 2 oz bottle of skin protectant spray containing 25% of zinc oxide and 20% of dimethicone, a 1 oz bottle of nasal decongestant spray containing 0.05% of oxymetazoline hydrochloride, and a 2 oz tube of ointment containing 20% zinc oxide. In addition, there was a bottle of Nystatin powder 60 grams labeled with a pharmacy sticker that had Resident #14's name and an expiration date of 09/24/24.

During an interview on 11/27/23 at 10:39 AM Resident #14 stated staff administered the nasal decongestant spray when his nose got stuffy and the medicated creams, powder, wound cleanser and protectant sprays were to treat the skin breakdown he had in his groin area from yeast. Resident #14 stated staff applied the creams, powder and sprays and left them on top of his nightstand.

An observation and interview was conducted with the Director of Nursing (DON) on 11/30/23 at 11:14 AM. The DON explained that the medicated creams, powder and sprays should not have been left in his room.

A joint interview was conducted with Nurse #1 (Wound Nurse) and Nurse #2 (Hall nurse) on 11/30/23 at 12:19 PM. Nurse #2 stated when she went into Resident #14's room to administer his medications, she had noticed the wound cleanser spray and other bottles on his nightstand but was not sure who left them there or when they were left there. Both Nurse #1 and Nurse #2 stated the wound cleanser spray should be stored on the treatment cart and not at beside. In addition, both Nurse #1 and Nurse #2 stated they were not sure where the decongestant spray came from and didn't think it was a brand they typically ordered.

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F 804 SS=B	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and a test tray, the facility failed to provide warm and palatable food for regular and mechanical soft diets for 1 of 1 resident reviewed for food palatability(Resident #84). The findings included: Resident #84 was admitted on 9/29/23. His admission Minimum Data Set (MDS) dated 9/29/23 coded Resident #84 as moderately cognitively impaired with diagnoses that included dementia, and cognitive communication deficit. Resident #84's physician's diet order was regular consistency. On 11/27/23 at 10:30 AM Resident # 84 stated the food he receives was always cold, and the staff accommodated the best they can. Resident # 84 said he was a vegetarian, and the facility did their best to provide a vegetarian diet, and they would reheat his food when he asked. Interviews with Nurse Aide (NA) #1 and NA #2 occurred at the same time on 11/29/23 at 09:24	F 804	Resident #84 was interviewed on 12/22/2023 to follow-up with concern of cold food. He stated that he has had no complaints with temperature or quality of his food presentation. The contracted Registered Dietician completed monthly food tray tasting audit for palatability and temperature maintenance 12/27/23 and found meal to be within appropriate temperature range, presentation, and palatability. All residents have the potential to be affected by alleged deficient practice. The facility will provide warm and palatable food for regular and mechanical soft diets for residents. Administrator/Designee educated all dietary staff regarding meal delivery of all food served is expected to be palatable, attractive, and at a safe and appetizing temperature. Licensed and unlicensed personnel were educated if any negative findings noted	12/29/23

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F 804	Continued From page 54 AM. The two NAs stated that on occasion a resident would tell them their food was cold when they received it. Both NAs stated the food would be reheated for the resident. The NAs said there was a resident food committee that would meet once monthly, and they thought the cold food was discussed there. A continuous observation of the main dining room lunch meal service on 11/27/23 at 12:12 PM was conducted. The observation revealed the lunch meal trays arrived in the dining room in an enclosed cart at 12:25 PM. Residents who required feeding assistance with meals were served last, with the last meal tray served from the enclosed cart at 1:09 PM. On 11/29/23 at 1:09 PM the dining room meal cart arrived in the dining room from the kitchen. A test tray was conducted with the Dietary Manager (DM) in the dining room on 11/29/23 at 1:17 PM. The test tray was removed from the meal cart when the last resident was served lunch. The test tray consisted of a mechanical soft consistency diet with seasoned rice, ground meatloaf with gravy, and mashed potatoes. The insulated cover was removed from the plate and steam was not observed. The Surveyor and DM tasted the food together. Upon tasting the food, it was found to be cool with poor palatability due to the temperature. The DM agreed with the assessment and said the food was cool and should have been warmer. The DM stated she was not aware of any resident complaints of cold food, and she attended the resident food committee meetings with no cold food concerns voiced to her. The Registered Dietitian (RD) was interviewed on	F 804	during meal delivery related to non-palatable food and appropriate temperature will be addressed at time of findings, by obtaining another meal tray from dietary or reheating meal at resident request. This education will be completed by 12/29/23. Any personnel out on leave, vacation, or prn status will be educated prior to returning for their assignment. All newly hired employees will be education at time of orientation. Random food tray audits will be completed 5 times a week for two weeks then two times a week for three weeks and then weekly for four weeks at various meal times to include either breakfast, lunch, or dinner by Dietary Manager/designee to ensure residents are served appetizing palatable meals at desired temperatures. Designee to oversee audit completion. In addition Monthly test tray will also be audited by Registered Dietician. Collected data from audits performed will be reviewed and reported to the QAPI committee for recommendations and to ensure ongoing compliance is met and adjustments made as needed thereafter. Compliance of of 12/29/2023	

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F 804	Continued From page 55 12/1/23 at 11:29 AM. The RD stated she had not completed any test trays after each resident had been served their meal. She said the test trays completed were done directly from the tray line once monthly, and there had been no concerns about food quality or temperature. The RD stated she was unaware of any resident concerns with cold food but that it was an area of concern she would investigate. On 12/1/23 at 12:33 PM the Director of Nursing (DON), Administrator in Training (AIT), and Administrator were interviewed. The Administrator stated the residents should not be served cold foods that were intended to be served hot.	F 804		
F 806 SS=E	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 by: Based on observation, record review, resident and staff interviews the facility failed to provide an alternative meal choice when requested for 1 of 3 residents reviewed for accommodating resident allergies, intolerances, and preferences (Resident #14). Additionally, the facility failed to provide a nutrional supplement as ordered by a physcian	F 806	All residents have the potential to be affected by the alleged deficient practice. An alternative meal choice will be provided to residents daily. Alternates will be posted at both nursing stations and on 500 hallway. Alternates will be readily	12/29/23

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for 1 of 3 residents (Resident #37) . This practice had the potential to impact other residents.

The findings included:

1. Resident #14 was admitted on 6/19/23 with diagnosis that included diabetes, hypertension, and dysphagia.

A review of Resident #14's quarterly Minimum Data Set (MDS) dated 10/25/23 revealed he was cognitively intact.

On 11/28/23 at 12:10 PM Resident #14 was observed lying in bed with his overbed table across the bed containing an untouched meal tray. Resident #14 stated he can't eat that meal and when asked if he wanted something else to eat, he stated if he did, they would tell him he waited too late and should have told them before lunch. Resident #14 stated he could not ask before the meal because he did not know what meal he would be served.

On 11/29/23 at 10:39 AM Resident #14 was interviewed and stated when he receives a meal that he does not like and asks for an alternative meal, the kitchen tells him it's too late and he should have let them know before the meal.

On 11/29/23 at 12:15 PM Resident #14's assigned Nursing Aide (NA) #3, stated Resident #14 did not like a lot of the food served for meals and he would ask for alternates. NA #3 said if she asked the kitchen for an alternate meal choice, she was told it's too late. NA #3 said once the tray line had started for a meal, the residents had to wait for the next meal to get an alternative. NA #3 stated she would go to the

available up until after meal is served to ensure resident preferences are met if resident does not want the meal tray that was originally delivered to them. There is no cut off time to receive alternate for meals. All employees will receive education by Director of Nursing/Assistant Director of Nursing/designee by 12/29/23 in regards to providing alternates for meals with no cut off time and to notify kitchen of resident preference to receive a substitution. Residents who reguarly request an alternate were notified by dietary manager/designee on 12/1/23 of no cut off time to get an alternate meal and make requests known via nursing staff to communicate preference to the kitchen staff.

Nutritional supplements will be provided to residents as ordered. House supplement for res #37 was corrected to reflect house supplement on the meal card by dietary manager/designee upon identification on 12/1/23. Administrator now has access to change and alter meal cards when the dietary manager is unavailable. Dietary Manager/designee reviewed residents with orders to receive nutritional supplements on 12/1/23 and all meal tray cards were verified for accuracy. An audit was completed on 12/21/23 by Registered Dietician. Dietary Manager/designee will audit daily for one week, twice weekly for two weeks then weekly thereafter.

Dietary Manager/designee will establish a form to document a line list of residents who are requesting alternate meal choice,

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F 806	Continued From page 57 nourishment room to get alternatives such as soup and fruit cups for the residents. The Dietary Manager (DM) was interviewed and stated on 11/29/23 at 3:32 PM the residents have a choice of the previous day's main meal (lunch, dinner) and grilled cheese or alternated sandwiches. Additionally, the residents always have an alternate vegetable available for meals. The kitchen had told the NAs to report which residents would like the alternated meal choice by 10:30 AM for lunch and 4:00 PM for dinner. After those times (10:30 AM, 4:00 PM) it became difficult for the cooks to make more food after the tray-line had started. The DM stated the daily menu was posted in front of the dining room doors and at the nurses' stations. The NAs let the residents know what was on the menu and the residents can request an alternate for the upcoming meal. Interviews with NA #1 and NA #2 occurred at the same time 11/29/23 at 09:24 AM. The two NAs stated residents received a monthly calendar at the beginning of each month that contained the menu for each day of the month. The NAs had to check with each resident to find out if they wanted the regular menu choice or the alternative. Both NAs agreed that food requests had to be delivered to the kitchen by 4:00 PM, if the request comes in after 4:00 PM the Kitchen tells them it was past the cutoff time and too late to request an alternate. NA #1 said when a resident receives a dinner meal and states they would like the alternative, the NAs had to tell the resident it was too late to receive the alternate meal choice. NA #1 and NA #2 said they relied on the food in the nourishment room to provide an alternative for the residents that normally consists of soup	F 806	for all meals provided. Dietary Manager/designee will directly observe and audit alternate meal choice to ensure that any resident who requests an alternate, is given a choice and opportunity to select alternate if requested. This initial audit will be completed daily for one week, twice weekly for two weeks, then weekly thereafter. All staff will be in-serviced by 12/29/23 to ensure that all residents are offered a meal choice alternative and that all residents are being offered nutritional supplements as ordered by physician on meal tray in comparison with meal tray card. Collected data from audits performed will be reviewed and reported to the QAPI committee by dietary manager/designee for recommendations and to ensure ongoing compliance is met and adjustments made as needed thereafter. Compliance of of 12/29/2023	

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and peanut butter sandwich.

A cook was interviewed on 11/29/23 at 3:51 PM and stated there was a cutoff time for resident request for alternative. For dinner the time was 3:00 PM, and after that there were no more request from NAs accepted, and the NAs are told it was past the cut off time.

On 12/1/23 at 12:33 PM the Director of Nursing (DON), Administrator in Training (AIT), and Administrator were interviewed. The Administrator stated the kitchen should not have a cut-off time for residents to request an alternative food choice.

2. Resident #37 was admitted to the facility on 02/20/18. His active diagnoses included protein-calorie malnutrition, underweight and adult failure to thrive.

An active physician's order dated 05/23/23 for Resident #37 read, health shake with meals for weight support related to protein-calorie malnutrition.

The quarterly Minimum Data Set (MDS) dated 09/23/23 revealed Resident #37 had moderate impairment in cognition. He required supervision with set-up help only for eating, weighed 68 pounds, received a mechanically altered diet, and had no significant weight loss or gain during the MDS assessment period.

Review of Resident #37's care plans, last reviewed/revised on 10/12/23, revealed he was at risk for altered nutritional status related in part to being underweight, adult failure to thrive, and protein-calorie malnutrition. Interventions

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included monitor and document any signs of dysphagia (difficulty swallowing), notify nurse of any refusals to eat and offer alternative if he will accept, serve diet as ordered, provide and serve supplements as ordered: health shake three times a day, and set-up all meals and snacks.

Review of a Registered Dietician (RD) progress note dated 11/08/23 revealed in part, Resident #37's current weight was 66 pounds and he received a health shake with all meals. He appears to be meeting/exceeding all estimated nutritional needs with his current intake and nutritional interventions in place as ordered. His intake of meals appears increased since previous RD review, however his weight continues to decline. The RD's recommendations included to continue current nutritional interventions.

Review of a RD progress note dated 11/24/23 revealed in part, Resident #37's current weight was 66 pounds. The RD noted Resident #37 had significant weight loss times one week, likely due to low body weight for his height, but his weight loss appeared stabilized at this time and fluctuated between 66 to 68 pounds. The RD's recommendations included to obtain weekly weights to track weight trend and noted no changes to his current nutritional interventions.

An observation on 11/28/23 at 8:30 AM, revealed Resident #37 sitting up in bed with his head covered by a bed sheet. His breakfast tray was placed on the overbed table directly in front of him and he was served pureed grits, sausage and eggs of which he ate a few bites. There was no health shake served with his breakfast tray. The meal card on his breakfast tray included no instructions to send a health shake with his meal.

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An observation on 11/28/23 at 11:57 AM revealed Resident #37 sitting up in bed with his lunch tray placed on the overbed table directly in front of him, eating and drinking independently. There was no health shake served with Resident #37's lunch tray. The meal card on his lunch tray included no instructions to send a health shake with his meal.

An observation on 11/29/23 at 12:20 PM revealed Resident #37 sitting up in bed with his lunch tray placed on the overbed table directly in front of him, eating and drinking independently. There was no health shake served with Resident #37's lunch tray. The meal card on his lunch tray included no instructions to send a health shake with his meal.

An observation and interview was conducted with Nurse Aide (NA) #3) on 11/30/23 at 8:50 AM. Resident #37 was lying in bed and sleeping peacefully, his breakfast tray already removed from his room. NA #3 retrieved Resident #37's meal tray from the meal cart and stated he ate 50% of his meal and drank almost all of his coffee but did not drink his orange juice. NA #3 confirmed there was no health shake served with Resident #37's breakfast tray.

An observation and interview was conducted with with NA #3 on 11/30/23 at 12:09 PM. NA #3 was observed retrieving Resident #37's lunch tray and delivering it to his room. There was no health shake served with his lunch tray. NA #3 explained health shakes were provided by the kitchen and sent out with the resident's tray. NA #3 confirmed there was no health shake served on Resident #37's lunch tray. She explained he

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used to get a health shake with his meals but hadn't in some time and she didn't know why. NA #3 further explained the health shake was not listed on his meal card and if it was, they would have known to request one from the kitchen.

During an interview on 11/30/23 at 2:15 PM, Cook #1 revealed he didn't have access to put orders into the dietary computer to print on the residents' meal card. Cook #1 explained if the order for Resident #37's health shake was not put into the dietary computer to print on the meal card, dietary staff would not have known to put it on his meal tray.

During an interview on 11/30/23 at 2:47 PM, the Therapy Director stated he was informed by Cook #1 that Resident #37 had not been getting health shakes with his meals as ordered. The Therapy Director stated he reviewed Resident #37's orders and confirmed he had an active order to receive a health shake with all meals. The Therapy Director stated he was not sure what happened or why the order wasn't put into the dietary computer to print on Resident #37's meal card. He explained he didn't have access to change or input orders in the dietary computer; however, the Dietary Manager (DM) did but she was out for a medical procedure. The Therapy Director stated in the interim, he put notes on Resident #37's meal card to send a health shake with his meals until the DM could correct it in the dietary computer to print on the meal card.

During a telephone interview on 12/01/23 at 11:41 AM, the RD revealed she had just found out yesterday (11/30/23) that Resident #37 was not receiving health shakes with his meals as ordered. The RD explained when she spoke to

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F 806	Continued From page 62 the DM, the DM stated she was almost certain Resident #37 was getting the health shake with meals at one point and was not sure what happened for it not to print on his meal card. The RD stated she spoke with dietary staff and instructed them to make sure the health shake was marked on any meal cards that had already been printed for Resident #37 so that he would receive it with his meals. The RD explained with Resident #37's low weight, any type of nutrition he could get to promote weight stabilization would be beneficial. She stated Resident #37 could still eat and did so independently and she would want him to receive health shakes as ordered just for him to get some sort of nutrition, as much as he would allow. During an interview on 12/01/23 at 12:34 PM, the Administrator stated Resident #37's order should have been followed and health shakes provided with his meals.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		12/29/23

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F 812	Continued From page 63 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain clean ceiling vents located in the dry storage room and in the kitchen, failed to maintain a clean walk-in refrigerator and remove food with signs of spoilage from the walk-in refrigerator. Additionally, the facility failed to clean and maintain 3 of 3 ice makers, and clean and maintain ice cooler scoops and holders (the kitchen ice maker, North and South nourishment room ice makers). This practice had the potential to affect food and beverages served to residents. The findings included: a. On 11/27/23 at 9:23 AM an observation of a ceiling vent in the dry storage area of the kitchen contained a build up of fluffy debris with spider webs spread across the vent. An approximately 4 foot long by 6-inch strip of ceiling in front of the vent contained a black splotchy/and spotted substance covering the area. b. On 11/27/23 at 9:28 AM the walk-in refrigerator circulatory fan contained a thick build up of crumbly to touch debris that was spread to the ceiling of the walk-in refrigerator. During the same observation, a box of fresh cucumbers contained multiple cucumbers with splotchy white fuzzy substance on them. c. On 11/27/23 at 9:31 AM an observation of the	F 812	The walk-in refrigerator was thoroughly cleaned, and all food showing signs of spoilage was discarded on 12/01/23. The ice machines located in the kitchen and nourishment rooms were cleaned 12/1/23. The ice scoop storage container was addressed and drainage system initiated 12/4/23. All ceiling vents in the dry storage room and kitchen were cleaned immediately 12/1/23 to remove any dust, debris, or other contaminants. Cleaning of vents has been scheduled to be done monthly via maintenance management system (TELS) by Maintenance Director/designee. All residents have the potential to be affected by the alleged deficient practice. In response to the identified deficiencies regarding the maintenance and cleanliness of ceiling vents, walk-in refrigerator, ice makers, and ice cooler scoops and holders that has the potential to affect all residents. Education was provided to dietary staff 12/1/23 by Dietary Manager/Designee to ensure compliance is met with identified alleged deficient practice related to food procurement, storage, and cleanliness. In addition education included retraining on proper cleaning and maintenance procedures for	

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F 812	Continued From page 64 kitchen's ice maker contained black/brown substance on the back inside wall of the ice maker with the ice not touching the substance. The ice maker mechanism (freezes the water into ice) contained multiple small round white spots. d. On 11/27/23 at 9:35 AM a large ceiling vent approximately 3 x 3 foot located above the cook's food preparation table had a thick buildup of crumbly debris spanning the entirety of the vent. The cook's food preparation table had clean serving utensils positioned below the vent. A follow-up observation of the kitchen area with the Dietary Manager (DM) occurred on 11/29/23 at 10: 43 AM. All observed areas on 11/27/23 remained unchanged. The DM wa interviewed during the observation. She Stated the ceiling in the dry storage area had been repaired several months ago due to a leak and had not been aware of the dirty air vent in walk-in refrigerator. She stated the ice maker in the kitchen was cleaned by her a couple months ago and was not aware of the debris on the walls of the ice maker. On 11/29/23 at 3:32 PM the DM stated the ceiling and ceiling vents in the kitchen had been overlooked and would be added to a cleaning schedule. e. An observation of the south nourishment room with the DM on 11/29/23 at 10: 49 AM revealed the ice maker contained multiple pinpoint size black specks on both the right and left inside wall of the ice maker. The same observation revealed an ice scoop in holder attached to the ice cooler contained standing water with hair and other debris visible. f. On 11/29/23 at 11:06 AM the north nourishment	F 812	the ceiling vents, walk-in refrigerator, ice makers, and ice cooler scoops and holders. Training emphasized the importance of regular cleaning schedules and the potential risks associated with poor maintenance practices. The ice makers in dietary and the nourishment rooms were cleaned on 12/01/23 and have been placed on a cleaning schedule via maintenance management platform (TELS). Training for maintenance department was conducted by Director of Facility Services regarding checking filters, sanitizing interior of ice machines, cleaning coils, and de-liming as necessary on 12/1/23. Staff report issues regarding ice machines promptly via building management platform and services work order system. Ice machines are scheduled to be cleaned by maintenance director/designee monthly and as needed. An audit tool will be implemented and monitored by housekeeping supervisor/designee weekly to visually monitor condition of all ice machines to ensure cleanliness and working condition. Maintenance Director/Environmental Services Director/designee will oversee the POC implementation and ensure all staff adhere to the new standards and protocols. The ice cooler scoops and holders in the kitchen and nourishment rooms were cleaned and sanitized on 12/01/23. Drain openings were made in ice scoop holders on both ice scoop cooler holders to	

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F 812	Continued From page 65 room was observed with the DM. The ice maker contained multiple pinpoint size black spots on the left and right inner sides of the ice maker. The ice cooler scoop and holder were observed to contain a cold wet to touch cloth towel in the bottom of the scoop holder with the ice scoop placed on top of the towel. The DM stated on 11/29/23 at 11:01 AM she was unsure of who was responsible for cleaning and maintaining the ice makers in the nourishment rooms. The DM stated she would add the nourishment room ice makers to the cleaning schedule and that she last cleaned the ice maker in the kitchen about 2 months ago. The ice maker in the kitchen was to be deep cleaned every 6 months and as needed. Additionally, the DM stated the nurse aides bring the ice coolers to the kitchen at night to be cleaned but was unaware how often that occurred. The Administrator stated on 12/1/23 at 12:33 PM the kitchen should not contain any expired food, the kitchen including the ceiling vents should be cleaned when needed. The ice makers and ice coolers should be cleaned on a regular schedule or as needed.	F 812	prevent standing water on 12/04/23. The items have been placed on a weekly cleaning schedule to be sanitized in dietary. Dietary Manager/designee is responsible for audits. The results of these audits will determine the need for further monitoring. All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the Dietary manager/designee, for review and to ensure continued compliance with the plan of correction. Follow-up review in QAPI will be done to ensure that the plan of correction has been effectively implemented and that the identified issues have been resolved. If any issues persist, immediate corrective action will be adjusted to the plan as necessary. Compliance date 12/29/2023	
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		12/29/23

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F 867	Continued From page 66 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

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F 867	Continued From page 67 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility	F 867		

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F 867	Continued From page 68 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 interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions previously put in place following a COVID-19 focused survey that occurred 12/04/20. This failure was for one deficiency that was originally cited in the area of Infection Control (F-880) and was subsequently recited on the current recertification and complaint investigation survey of 12/01/23. The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program.	F 867	Quality Assurance Performance Improvement Committee met and reviewed the purpose and function of the QAPI Committee, as well as reviewed the on-going compliance issue regarding F880. On 12/5/23, the Administrator educated the QAPI Committee on the appropriate functioning of the QAPI Committee and its purpose to identify issues and correct repeat deficiencies related to F880. Education included identifying other areas of concern related to the Quality Improvement (QI) process, for example: orientation, review of audit	

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F 867	Continued From page 69 Findings included: This tag is cross referenced to: F880: Based on observations, record review and staff interviews, the facility failed to assess the facility's water system to identify where Legionella and other waterborne pathogens could grow and spread which had the potential to affect 92 of 92 residents. The facility also failed to ensure staff implemented their infection control policies and procedures when Nurse #1 did not place a barrier between the wound care supplies and an overbed table that had crumbs and dried debris on the surface and did not change her gloves after removing a wound dressing and before cleaning the wound for 1 of 1 sampled resident (Resident #54). During the COVID-19 focused survey conducted 12/04/20 the facility failed to follow their Infection Control COVID-19 policy by allowing an employee to complete her shift after she reported to her supervisor that she had a fever and was not feeling well. In an interview with the Administrator on 12/01/23 at 12:34 AM she stated she was not aware a Legionella risk assessment needed to be completed. A follow-up interview with the Administrator on 12/01/23 at 1:26 PM revealed the quality assurance (QA) team met monthly and included the Medical Director, administrative staff, and most department managers. She stated audits were put in place based on concerns identified in the meetings. The Administrator stated she	F 867	tools, and observations during management rounds. Systemic Changes include a new format for monthly QAPI meeting consisting of our Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Nursing Supervisor, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Care Nurse, Activities Director, Director of Rehabilitation, Admissions Coordinator, and Social Worker to review audit findings for compliance and/or revisions. The QAPI committee will continue to meet monthly to develop and implement appropriate corrective actions for identified issues. Administrator will be responsible for ensuring QAPI committee concerns are addressed thoroughly for further training and/or other interventions as needed. Foresighted action has been taken for the identified concern related to the repeat deficiency. All staff will be educated by 12/29/23 on proper infection control policies and procedures. The QAPI committee will established and utilize a systemic approach to performance improvement activities to ensure changes are effective and improvements are sustained. Staff Development Coordinator/designee will observe infection control practices three times a week for two weeks, then twice a week for three weeks, and then weekly for four weeks. Collabortaively with the QAPI committee team members, the infrction Preventionsist will identify root cause	

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F 867	Continued From page 70 attributed the current concern with hand hygiene and no barrier being place between the surface and dressing supplies to staff being nervous.	F 867	analysis for any identified problems and develop an ppropraite plan of action to maintain compliance with F 880. Collected data from the audits performed will be reviewed and reported to the QAPI committee for recommendations and to ensure ongoing compliance is met as it related to F 880 and adjustments made as needed thereafter. Compliance date 12/29/23	
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	F 880		12/29/23

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F 880	Continued From page 71	F 880		

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;
(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

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F 880	Continued From page 72 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to assess the facility's water system to identify where Legionella and other waterborne pathogens could grow and spread which had the potential to affect 92 of 92 residents. The facility also failed to ensure staff implemented their infection control policies and procedures when Nurse #1 did not place a barrier between the wound care supplies and an overbed table that had crumbs and dried debris on the surface and did not change her gloves after removing a wound dressing and before cleaning the wound for 1 of 1 sampled resident (Resident #54). Findings included: 1. Review of the facility's Emergency Preparedness Plan revealed no evidence a facility water safety risk assessment was completed to identify where Legionella or other waterborne pathogens could grow and spread in the facility's water system. During an interview on 11/30/23 at 8:56 AM, the Maintenance Director confirmed he had not completed a water safety risk assessment for the facility. He explained the facility utilized town water and it was his understanding they did not need to complete a water safety risk assessment as the facility did not have a boiler system and there was nowhere for Legionella to grow. He further explained the facility's water pipes were primarily overhead and were constantly pushing water through the pipes leaving little chance of standing water where bacteria could grow.	F 880	The facility failed to conduct an adequate assessment of the building water systems to identify areas where Legionella and other opportunistic waterborne pathogens could grow and spread. The facility performed a comprehensive assessment of the building's water systems completed 11/28/23 by Licensed Nursing Home Administrator. The assessment concluded the facility was not at risk for Legionella and or any other opportunistic waterborne pathogen. All residents have the potential to be affected by the alleged deficient practice. On 12/1/23 the facility implemented a policy to establish primary and secondary strategies for the prevention and control of Legionella disease. Based on the assessment's findings, the facility will implement control measures to prevent the growth of Legionella and other opportunistic waterborne pathogens and complete a reassessment annually or intermittently if there is a change in circumstance that could increase risk. These measures may include regular visible inspection and temperature control strategies. Per the results of the Legionella assessment the facility was identified as having no risk factors. Based on the facility assessment conducted by licensed nursing home administrator the facility will continue to do the following to identify the risk for Legionella and other	

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F 880	Continued From page 73 During a follow-up interview on 11/30/23 at 1:08 PM, the Maintenance Director provided a document titled, Legionella Environmental Assessment Form, which noted the date of assessment as "0/28/22." The Maintenance Director clarified he had completed the assessment today (11/30/23). During an interview on 12/01/23 at 12:34 PM, the Administrator revealed she did not realize they were required to complete a facility water safety risk assessment for Legionella and she would be the person responsible for ensuring one was done. The Administrator reviewed the Legionella Environmental Assessment Form provided by the Maintenance Director and confirmed the date of "0/28/22" was an error. She stated it should have been dated "11/30/23" which was when the assessment was completed. 2. Review of the facility's policy titled "Handwashing/Hand Hygiene" revised in April 2012 read in part as follows: "This facility considers hand hygiene the primary means to prevent the spread of infection. 1. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 2. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropranol for the following situations:	F 880	opportunistic waterborne pathogens could grow and spread. Temperature checks will continue weekly at various locations throughout the facility to ensure compliance with temperature range of cold water entering building less 68 degrees Fahrenheit and hot water will be circulated at a minimum return temperature of 124 degrees Fahrenheit. All maintenance and relevant staff received training on the water management program and the importance of adhering to the control measures on 12/1/23. The facility will establish a routine monitoring plan to ensure the effectiveness of the implemented control measures. The findings of this monthly audit, conducted by maintenance supervisor, to monitor water temperature checks will be brought to QAPI for review to ensure ongoing compliance. The Administrator will be responsible for overseeing the development and implementation of the POC. The Director of Maintenance will be responsible for the daily execution of the water management program. The facility anticipates that all corrective actions will be completed, and compliance will be achieved by 12/29/2023. Immediate education was provided to assigned treatment nurse on 11/29/23 regarding proper hand hygiene and infection control practices during wound care upon notification to Director of	

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F 880	Continued From page 74 (a). Before handling clean or soiled dressings (b). Before moving from a contaminated body site to a clean body site during resident care (c). After handling used dressings (d). After removing gloves." A continuous observation of wound care for Resident #54 on 11/29/23 from 12:02 PM through 12:12 PM revealed dressing change supplies were sitting directly on her overbed table and the table had scattered crumbs and dried debris on the surface. Dressing change supplies included a cup containing gauze moistened with a bleach solution, a cup containing medical grade honey and collagen (an aid for wound healing), a packaged abdominal pad, 2 unpackaged rolls of gauze, and tape. With gloved hands Nurse #1 cut Resident #54's dressings to both heels off with scissors, removed her gloves and applied clean gloves, removed the old dressings to both heels, and cleaned both heels with bleach moistened gauze, and removed her gloves. Nurse #1 did not perform hand hygiene after removing her gloves and before applying clean gloves when she cut the dressings off Resident #54's heels and did not remove her gloves and perform hand hygiene after removing the old dressings and before cleaning both heel wounds. An interview with Nurse #1 on 11/29/23 at 12:13 PM revealed she placed the dressing change supplies directly on Resident #54's overbed table before beginning wound care. She stated she did not notice the crumbs and dried debris on the overbed table and did not usually place a barrier between wound care supplies and the surface where they were placed. Nurse #1 stated she didn't usually perform hand hygiene every time she changed her gloves during wound care and	F 880	Nursing of alleged deficient practice with infection control during wound care observation. All residents with wounds have the potential to be affected by alleged deficient practice. All licensed nursing staff to be in-serviced by Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Designee on proper hand hygiene during wound care and infection control practices during wound care by 12/29/23 and will be included in new hire orientation thereafter. Staff Development Coordinator/designee will observe wound care practices of two separate residents three times a week for two weeks, then twice a week for three weeks, and then weekly for four weeks. Collected data from the audits performed will be reviewed and reported to the QAPI committee for recommendations and to ensure ongoing compliance is met and adjustments made as needed thereafter. Compliance date 12/29/23	

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she did not usually change her gloves after removing a used dressing and before cleaning a wound.

An interview with the Infection Preventionist (IP) on 11/30/23 at 10:21 AM revealed she expected a barrier to be placed between dressing change supplies and the surface on which they were placed. She stated staff should perform hand hygiene after removing gloves and should change their gloves after removing used dressings and before cleaning wounds.

An interview with the Director of Nursing (DON) on 11/30/23 at 11:13 AM revealed she expected a barrier to be placed between dressing change supplies and the surface on which they were placed. She stated staff should perform hand hygiene after removing gloves and should change their gloves after removing used dressings and before cleaning wounds.