STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345549	A. BUILDING ______ B. WING ______	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / BRUNSWICK	1070 OLD OCEAN HIGHWAY BOLIVIA, NC 28422

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 01/23/24 through 01/25/24. Event ID# QU2S11. The following intakes were investigated NC00208312, NC00211416, NC00211622, NC00210186, NC00211090, NC00208767, and NC00202807. 6 of the 25 complaint allegations resulted in deficiency.	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide incontinence care to 4 of 4 residents (Resident #5, #10, #11, and #12) who were unable to carry out activities of daily living (ADL's) without staff assistance and were reviewed for needing assistance with ADLs. Findings included. 1.) Resident #5 was admitted to the facility on 09/13/23 with diagnoses including muscle weakness, chronic pain, neuropathy (dysfunction of the peripheral nerves causing numbness or weakness in the hands or feet), and the need for personal assistance. A care plan dated 12/12/23 revealed Resident #5	F 677	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Incontinence care was provided for residents #5,10, 11, 12 by their assigned nursing assistant on January 23rd, 2024. The facility Director of Nursing (DON) made several attempts on January 23rd, 24th, and 25th to contact CNA #1 to schedule re-education. CNA #1 never returned to the facility. 2. How the facility will identify other residents potentially affected by the same deficient practice. Any resident dependent on incontinence	2/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/14/2024

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

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F 677	Continued From page 1 required staff assistance with toileting and bowel and bladder incontinence. The goal of care was to receive the appropriate level of staff assistance for toileting and incontinence care. Interventions included to provide one person assistance with toileting and incontinence care. The Minimum Data Set (MDS) quarterly assessment dated 01/08/24 revealed Resident #5 was cognitively intact. She was incontinent of bowel and bladder and required substantial maximum assistance by staff with toileting. She had no rejection of care. During an interview on 01/23/24 at 1:30 PM Resident #5 was observed in her room lying in bed. She was oriented to person and place. She stated staff assisted her with her brief change, but she could not recall when her brief was last changed but indicated it had been a while. She stated she had not been up to the bathroom either and she relied on help from staff for her toileting needs. She stated she knew the nurse aide was busy and she was waiting for her to come in and change her incontinence brief. An observation of incontinence care for Resident #5 was conducted on 01/23/24 at 1:40 PM with Nurse Aide #1. The incontinence brief was saturated with a moderate amount of urine. Her skin was intact. During an interview on 01/23/24 at 1:45 PM Nurse Aide #1 stated Resident #5 required one-person assistance with care and required incontinence care. She stated she had not changed Resident #5's brief at all during her shift which started at 7:00 AM this morning. She reported that she was new to the facility, and it	F 677	care could be affected by this alleged deficient practice. The Director of Nursing and the administrative nurses completed observation rounds, January 23rd to ensure that there were no other residents in need of incontinence care. There were no other identified residents in need of incontinence care. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Administrator, Director of Nursing, Unit Coordinators, Weekend Supervisors and/or Charge nurses will make observation rounds to ensure that incontinent care is performed. The director of nursing and/or administrative nurses educated all licensed nurses and certified nursing assistants on the importance of providing incontinence care to meet the needs of the residents. 4. How the facility will monitor its performance to ensure the deficient practice does not recur. The Administrator, Director of Nursing, Unit Coordinators, Weekend Supervisors and/or Charge nurses will make observation rounds to ensure that incontinent care is performed per facility policy by monitoring 5 residents per day 5 times per week x 4 weeks than 5 residents per 3 times per week for 8 weeks. The Administrator will review the	

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F 677	Continued From page 2 was her first day working on the 200 hallway. She had 14 residents on her assignment and was scheduled to work 7:00 AM to 3:00 PM. She stated after arriving for her shift she managed to get one resident showered and changed before breakfast trays came out. Once the meal trays arrived, she passed meal trays and fed the one resident that required feeding assistance. She stated after breakfast she showered and changed two other residents then it was lunch time for the residents. She indicated after lunch was completed, she was able to start incontinence care rounds which was after 1:00 PM. She stated not all of the 14 residents on her assignment required incontinence care. She missed the morning rounds of incontinence care because she was providing showers during that time. She stated she had received orientation on resident care upon hire and received training by Nurse Aide #6 for a week before being given her own assignment. She indicated that she did not ask for help from other staff, but she should have. During an interview on 01/23/24 at 2:45 PM Nurse #5 stated she was the assigned nurse for the 200 hall. She stated Nurse Aide #1 had not notified her that she needed help with her assignment or asked for assistant with incontinence care. Nurse #5 stated she was unaware that incontinence care had not been provided to Resident #5 during her shift. During an interview on 01/23/24 at 3:00 PM the Director of Nursing (DON) stated that Nurse Aide #1 was new to the facility and received training on resident care upon hire. She stated she would have wanted Nurse Aide #1 to reach out to another staff member for assistance if she was behind or needed help with providing resident	F 677	results of the weekly audit to ensure that incontinent care was provided timely and effectively. The Administrator will complete a summary of the audit results and present at the facility monthly Quality Assurance Performance Improvement (QAPI) committee by the Director of Nursing to ensure continued compliance.	

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F 677	Continued From page 3 care including incontinence care. She indicated Nurse Aide #1 did not ask for help from other staff. She stated residents should be checked for incontinence needs every 2 hours and changed if wet or soiled. She indicated Nurse Aide #1 should have provided incontinence care to Resident #5 sooner and should have asked for help with her assignment. She stated there was enough staff on duty to assist her with her assignment. 2.) Resident #10 was admitted to the facility on 07/03/23 with diagnoses including Rheumatoid Arthritis and Chronic Kidney Disease. The Minimum Data Set (MDS) quarterly assessment dated 01/07/24 revealed Resident #10 was cognitively intact. She had impaired range of motion on one side of her lower extremities. She required supervision or touching/steadying assistance with toileting. She had no rejection of care. A care plan dated 07/11/23 revealed Resident #10 required staff assistance with toileting. The goal of care was to be clean, and dry. Interventions included providing assistance with activities of daily living. During an interview on 01/23/24 at 1:35 PM Resident #10 was observed lying in her bed. She was alert and oriented to person and place. She stated she relied on staff to come in and change her incontinence brief. She was told not to attempt to take herself to the bathroom due to the risk of falling and they put a fall mat by her bed. She reported she was scared to get up unassisted for that reason. She stated her brief had not been changed all morning and she notified the Nurse Aide, but she never came back	F 677		

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F 677	Continued From page 4	F 677		

to change her.

An observation of incontinence care for Resident #10 was conducted on 01/23/24 at 2:00 PM with Nurse Aide #1. The incontinence brief was saturated with a moderate amount of urine and stool. Her skin was intact.

During an interview on 01/23/24 at 2:05 PM Nurse Aide #1 stated Resident #10 required one-person assistance with incontinence care and stated she had not changed her brief during her shift.

During an interview on 01/23/24 at 2:45 PM Nurse #5 stated she was the assigned nurse for the 200 hall. She stated Nurse Aide #1 had not notified her that she needed help with her assignment or asked for assistant with incontinence care. Nurse #5 stated she was unaware that incontinence care had not been provided to Resident #10 during her shift.

During an interview on 01/23/24 at 3:00 PM the Director of Nursing (DON) stated Nurse Aide #1 should have reach out to another staff member for assistance if she was behind or needed help with her assignment. She stated Resident #10 should have been checked for incontinence every 2 hours and provided incontinence care.

3.) Resident #11 was admitted to the facility on 11/29/23 with diagnoses including cerebral vascular accident (CVA) and aphasia (loss of the ability to understand or express speech).

A care plan dated 12/29/23 revealed Resident #11 required staff assistance for toileting related to generalized weakness, and CVA. The goal of

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F 677	Continued From page 5 care was to receive the appropriate level of staff assistance with toileting. Interventions included to provide assistance with activities of daily living. The Minimum Data Set (MDS) quarterly assessment dated 01/01/24 revealed Resident #11 had severely impaired cognition. She was dependent on staff with toileting. She required substantial maximum assistance with activities of daily living. She had no rejection of care. During an interview on 01/23/24 at 2:15 PM Resident #11 appeared confused and could not recall the last time her incontinence brief was changed. An observation of incontinence care for Resident #11 was conducted on 01/23/24 at 2:15 PM with Nurse Aide #1. The incontinence brief was saturated with a moderate amount of stool. Dried stool was noted on Resident #11's bottom and upper leg. Her skin was intact. During an interview on 01/23/24 at 2:20 PM Nurse Aide #1 stated that Resident #11 required one-person assistance with incontinence care . She stated she had not changed her brief during her shift. During an interview on 01/23/24 at 3:30 PM Nurse #5 stated she was the assigned nurse for the 200 hall. She stated Nurse Aide #1 had not notified her that she need help with her assignment or asked for assistant with incontinence care. Nurse #5 stated she changed Resident #11's brief herself around 9:45 AM when she was in Resident #11's room with the physician. She stated she was unaware that incontinence care had not been provided to	F 677		

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F 677	Continued From page 6	F 677		

Resident #11 since that time.

During an interview on 01/23/24 at 3:00 PM the Director of Nursing (DON) stated Nurse Aide #1 should have reach out to another staff member for assistance if she was behind or needed help with her assignment. She stated Resident #11 should have been checked for incontinence every 2 hours and provided incontinence care.

4.) Resident #12 was admitted to the facility on 12/31/20 with diagnoses including Multiple Sclerosis and heart failure.

A care plan date 11/28/22 revealed Resident #12 required assistance with activities of daily living which included toileting. The goal of care was to be clean, and dry. Interventions included providing assistance with activities of daily living.

The Minimum Data Set (MDS) quarterly assessment dated 01/05/24 revealed Resident #12 had moderately impaired cognition. She required total dependence with one-person physical assistance for toileting. She had an indwelling urinary catheter and was incontinent of bowel.

During an interview on 01/23/24 at 2:30 PM Resident #12 stated she could not recall the last time her incontinence brief was changed but indicated it had been a while.

During an interview on 01/23/23 at 2:30 PM Nurse Aide #1 stated Resident #12 required one person assistance with incontinence care. She stated she had not changed her brief during her shift until now.

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F 677	Continued From page 7 An observation of incontinence care for Resident #12 was conducted on 01/23/24 at 2:30 PM with Nurse Aide #1. The incontinence brief was saturated with a moderate amount of stool. Her skin was intact. During an interview on 01/23/24 at 2:45 PM Nurse #5 stated she was the assigned nurse for the 200 hall. She stated Nurse Aide #1 had not notified her that she needed help with her assignment or asked for assistant with incontinence care. Nurse #5 stated she was unaware that incontinence care had not been provided to Resident #12 during her shift. During an interview on 01/23/24 at 3:00 PM the Director of Nursing (DON) stated Nurse Aide #1 should have reach out to another staff member for assistance if she was behind or needed help with her assignment. She stated Resident #12 should have been checked for incontinence every 2 hours and provided incontinence care.	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		2/15/24

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F 692	Continued From page 8 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff, Registered Dietician and Physician interviews, the facility failed to: a) follow the physician orders to administer a nutritional supplement twice daily with lunch and dinner for weight loss; and b) obtain weekly weights as ordered for a resident (Resident #2) who had a weight loss. This was for 1 of 1 residents reviewed for weight loss. Findings included: Resident #2 was admitted to the facility on 06/28/23. Diagnoses included Alzheimer's disease, dementia, and dysphagia (difficulty with swallowing). A review of Resident #2's care plan dated 07/12/23 revealed a plan of care for weight loss with interventions to include: provide verbal encouragement/cueing, quiet dining environment, snacks in between meals, to monitor assistance needed with nutritional intake and notify physician of changes, maintain list of food likes and dislikes, allow sufficient time to feed/eat, and serve diet as ordered. The Minimum Data Set quarterly assessment dated 11/07/23 revealed Resident #2's cognition was severely impaired and he exhibited	F 692	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #2 was assessed by the Registered dietician on 01/26/24. New orders were obtained for additional dietary supplements. A weight for Resident #2 was obtained on 1/24/2024. He was assessed by the Director of Nursing and attending Physician to determine weight loss interventions. 2. How the facility will identify other residents potentially affected by the same deficient practice. An audit of diet orders compared to the tray cards was completed by the unit managers on 2/3/2024. Any discrepancies were corrected. DON and Administrative nurses completed a review of current resident electronic medical records to ensure that weights were recorded and were up to date. This was completed on 2/1/2024	

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F 692	Continued From page 9 behavioral symptoms not directed toward others and rejection of care. This occurred 4 to 6 days during this look back period. He had no functional impairments with range of motion and required supervision or touching assistance with eating. Weight was recorded as 127 pounds (lbs.) and he received a mechanically altered diet. a) A review of the physician orders revealed an order was written on 10/10/23 for a nutritional supplement (an ice cream textured nutritional supplement to increase weight) two times a day with lunch and dinner to meet needs for weight maintenance; document the percent consumed. An observation of Resident #2 in the dining room on 01/23/24 from 12:05 - 1:25 PM revealed Resident #2 received his meal tray at 12:05 PM. Resident #2 was noted sitting at a table with other residents that were dependent on staff for assistance with eating. A staff member was observed offering resident bites which he consumed and Resident #2 ate 3 bites of food independently with encouragement. Resident #2 was noted to have eaten about 25% of his meal. The food tray was removed at 1:25 PM. There was no nutritional supplement on Resident #2's lunch tray and he was not offered any nutritional supplement throughout the observation. An observation of Resident #2 on 01/23/24 at 4:50 PM until 5:30 PM revealed Resident #2 was seated at a table where residents were eating independently. Resident #2 received his tray at 5:05 PM. He was observed taking sips of his tea and taking the food off his tray with a spoon and dumping it on the table. No staff were watching or encouraging Resident #2 to eat at this time. At 5:10 PM one staff member walked by the table	F 692	Weight orders were reviewed by unit managers on 2/1/2024 to assure all orders had been completed. 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing and/or administrative nurses will be reviewing weights and assessing for weight loss in the daily clinical meeting using the system check for weight loss tool. Any resident identified with weight loss will be reviewed by the Registered dietician or attending physician for appropriate interventions. All licensed nurses and the dietary manager were educated by unit managers on 2/02/2024 regarding assuring all diet orders match the tray card. All licensed nurses were educated by unit managers on following weight orders and documenting refusals in the electronic health record on 2/02/2024. 4. How the facility will monitor its performance to ensure the deficient practice does not rec All new dietary orders and completed weights will be reviewed by the Director of Nursing and/or administrative nurse, 5 times per week for 4 weeks then 3 times per week for 8 weeks to assure the order and the tray card coincide. The Director of Nursing will complete a summary of audit results and present at facility monthly QAPI meeting to ensure continued compliance.	

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F 692	Continued From page 10 and stated "[Resident #2] you are not eating." The staff member did not encourage the resident to eat or assist him with eating. Resident #2 continued to take food from his plate with a spoon and dump it to the side of his plate. At 5:20 PM, Resident #2 was noted to have taken a total of 5 bites of his food independently and then proceeded to place the food on the side of his tray again. There was no nutritional supplement on his dinner tray. Review of his dietary ticket did not indicate a nutritional supplement was to be served with dinner. During the observation, no staff assisted or verbally encouraged Resident #2 to eat or offered him his ordered nutritional supplement. An interview was conducted with the Nurse #1 at 1:30 PM on 01/24/24. Nurse #1 stated she did not realize Resident #2 was not eating on 01/23/24 and just because he was at the table with other residents who were independent eaters did not mean the staff should not assist or encourage him to eat. Nurse #1 stated she had been assisting two other residents in the dining room and did not realize he needed assistance. She added, she did not give a nutritional supplement from the freezer on the evening of 01/23/24 to give to Resident #2. She stated, "I just forgot too." A continuous observation of Resident #2 conducted in the dining room on 01/24/24 from 12:05 PM until 1:30 PM revealed the following: - 12:05 PM through 12:45 PM: Resident #2 was eating at the dining room table where residents required assistance with eating. Review of his dietary ticket did not indicate a nutritional supplement was to be served with	F 692		

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F 692	Continued From page 11	F 692		

lunch. During this lunch observation, Resident #2 did not take any initiative to eat his meal independently. A staff member was observed encouraging him and assisting with offering bites. When assisted, Resident #2 would take some bites of his meal and would refuse some bites. During this observation Resident #2 was not offered any nutritional supplements.

- 12:45 PM: During this continuous observation in the dining room Nurse #1 was interviewed. When asked about the nutritional supplement, Nurse #1 stated usually the nutritional supplement would come on the meal trays, but she had some in the refrigerator and she would offer Resident #2 one now. Nurse #1 removed the nutritional supplement from the freezer and placed it on his meal tray. Nurse #1 stated it was frozen and as soon as it thawed out, she would give it to him.

- 12:45 PM through 1:30 PM: The dining room observation continued and staff were observed to clear Resident #2's lunch tray at 12:45 PM of which only bites were taken from his plate and sips of tea. At no time during this observation did any staff offer Resident #2 his nutritional supplement.

A follow up interview was conducted with the Nurse #1 in the dining room at 1:30 PM on 01/24/24 at the conclusion of the observation of Resident #2. Nurse #1 was asked when Resident #2 would receive his nutritional supplement and she stated "Oh, yes it is thawing out. I will give it to him now." The nutritional supplement was removed from the cabinet and given to Resident #2. Resident #2 was noted to have taken 5 bites of the nutritional supplement

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by himself. Nurse #1 stated she thought the nutritional supplements came from the kitchen and did not know why it was not on his tray last night or today. Nurse #1 added, Resident #2 liked the ice cream supplement but he needed encouragement with eating it and she asked a nurse aide to sit with him. The nurse aide offered encouragement but Resident #2 refused to have any more of the supplement.

An interview was conducted with the Dietary Manager (DM) on 01/25/24 at 2:00 PM. The DM revealed the process to include nutritional supplements from the kitchen. The nurses filled out a 3 part form which included a yellow copy for the Dietary Department. She stated once the Dietary Department received the yellow form, the order was entered into the system under the Resident's name to show up on their dietary ticket. She stated she would not enter anything into the computer if she did not have the yellow form and the supplements would not be on the tray if it was not entered in the computer. The Dietary Manager reviewed Resident #2's dietary ticket and confirmed there was no nutritional supplement listed to be delivered with lunch and dinner.

A phone interview was conducted with Nurse #7 on 01/25/24 at 4:20 PM. Nurse #7 reported she recalled assisting Resident #2 with his dinner meal on 01/24/24. She stated he fed himself with encouragement last night and ate about 25% of his meal. She stated he did like the nutritional supplements and ate about 50% of the supplement last night. She added Resident #2 would eat better if he was encouraged to do so. She stated if she saw that he was not eating she would provide assistance to help him.

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An interview was conducted with Nurse #6 at 3:13 PM on 01/25/24. Nurse #6 stated she did not offer Resident #2 his ice cream nutritional supplement at lunch time on 01/25/24 and it did not come on his lunch tray. Nurse #6 confirmed that there are nutritional supplements in the freezer, but she just forgot to give him his supplement. Nurse #6 reported if the supplement came on the tray, as it should, from the kitchen, she would be more likely to remember to offer it to him.

A phone interview was conducted with the facility's Physician on 01/25/24 at 4:30 PM. The Physician stated the nurses should be following the physician order but if he was refusing to eat the nutritional supplements, the order should be discontinued. The physician stated she believed that Resident #2 was having a progressive decline with his dementia and that the nutritional supplements were not going to help.

A phone interview with the interim Registered Dietician (RD) on 01/25/24 at 4:35 PM revealed unless Resident #2 was refusing his nutritional supplements, the nursing staff should be following the physician orders to give the nutritional supplements.

An interview with the Director of Nursing (DON) on 01/25/24 at 4:40 PM, revealed the DON stated the nutritional supplement showed up on the MAR to be administered and she would have expected the nursing staff to administer the nutritional supplement two times a day as ordered. She further added, if the supplement was not showing up on the lunch and dinner trays she would have expected the nursing staff to

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notify the kitchen. The DON stated if the resident had been refusing the supplements she would have expected the nursing staff to document that and let the physician know.

b) Review of a progress note written by the Nurse Practitioner (NP) on 10/23/23 revealed, in part, Resident #2 was seen today for follow up to weight loss. Resident has been taking Remeron (an appetite stimulant) daily with no increase in appetite. Family was requesting Dronabinol (used to treat loss of appetite and weight loss). Will start Dronabinol at 2.5 milligrams (mg) twice a day and continue with weekly weights. Will reevaluate in 3- 5 weeks to see if medication was beneficial.

On 10/23/23 a physician order was written for Dronabinol 2.5 mg one tablet twice daily for appetite, and an order written on 10/25/23 for weekly weights and to document under the vital sign tab.

Review of the weights recorded under the vital sign tab since 10/25/23 included the following weights were completed and recorded.

" 11/01/23 at 8:26 PM 127 lbs.
" 11/09/23 at 3:06 PM 124 lbs.
" There was no weight recorded for 11/16/23 or 11/23/23
" 11/29/23 at 11:00 AM 130 lbs.
" There were no weights recorded for the month of December 2023
" 01/03/24 at 4:33 PM 109 lbs.

A progress note written by the Nurse Practitioner on 11/29/23 revealed, in part, Resident #2 was seen today as a follow up to weight loss. In

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F 692	Continued From page 15 review of his weight, he had gained 6 pounds in the last two weeks and has tolerated the Dronabinol without side effects and to continue the Dronabinol 2.5 mg twice daily. An interview was conducted with Nurse #6 on 01/25/24 at 3:15 PM. Nurse #6 stated the process for obtaining weights was if a weight was ordered, it was entered in the system by the nurse. The order would then carry over to the MAR. Nurse #6 stated she did not put the order in to obtain weights for Resident #2 but reviewed the MAR and saw that weights were not obtained. She stated when an order carries over to the MAR it would show up under the orders for the nurses to carry out and required a signature. Nurse #6 explained for an example that on Wednesday, December 6, the order to obtain Resident #2's weight would trigger on the daily orders for that day. She added, this was how the nurses would know there was a weight due that day. Review of the Medication Administration Record (MAR) for the month of November on 11/16/23, Nurse #5 indicated the weight was obtained by a checkmark, but the weight was not recorded under the vital sign tab and on 11/23/23 the letter "N" was recorded by Nurse #1. Review of the Medication Administration Record for the month of December revealed on 12/6, 12/13, 12/20 and 12/27 revealed the letter "N" under weekly weight and was signed by Nurse #1.	F 692		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		2/15/24

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F 867	Continued From page 16 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but 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.	F 867		

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§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to 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.

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F 867	Continued From page 18 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) program failed to maintain implemented procedures and monitor interventions the committee put in place following the complaint investigation survey of 3/8/21, the	F 867	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility Administrator and Quality	

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recertification survey of 10/26/21, and the recertification and complaint investigation survey of 12/16/22. This was for two deficiencies in the areas of Activities of Daily Living (ADL) Care Provided to Dependent Residents (F677) and Nutrition and Hydration Status Maintenance (F692). These areas were subsequently recited during the current revisit and complaint investigation survey of 01/25/24. The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program.

Findings included.

This tag is cross-referenced to:

F677: Based on observations, record review, and staff interviews the facility failed to provide incontinence care to 4 of 4 residents (Resident #5, #10, #11, and #12) who were unable to carry out activities of daily living (ADL's) without staff assistance and were reviewed for needing assistance with ADLs.

During the recertification and complaint investigation survey completed on 12/16/22 the facility was cited for failure to provide ADL care to a dependent resident by not cleaning and trimming fingernails that were long and dirty.

F692: Based on observations, record review and staff, Registered Dietician and Physician interviews, the facility failed to: a) follow the physician orders to administer a nutritional supplement twice daily with lunch and dinner for weight loss; and b) obtain weekly weights as ordered for a resident (Resident #2) who had a

F 867

Assurance Performance Improvement (QAPI) team during our monthly QAPI meeting on 1/26/2024 and reviewed citation F677 from 12/16/22 and 1/25/24. We also reviewed citation F692 from 3/8/21, 10/26/21, 12/16/22 and 1/25/24. The Team worked through the 5 whys and determined the root cause analysis during this meeting.

Incontinence care was provided for residents #5,10, 11, 12 by additional nursing staff.
Resident #2 was assessed by the Registered dietician on 01/26/24. New orders were obtained for additional dietary supplements.

2. How the facility will identify other residents potentially affected by the same deficient practice.
The administrator completed a review of annual and complaint surveys for the prior 3 years to identify areas of repeat deficient practice as of 02/13/24.

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

The facility will be completing ambassador rounds and reviewing in their morning meetings daily 5 x/week to identify any areas of non-compliance. As areas of non-compliance are identified the facility Administrator and the department manager will develop a Quality Assurance

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F 867	Continued From page 20 weight loss. This was for 1 of 1 residents reviewed for weight loss. During the complaint investigation on 03/08/21 the facility failed to implement dietary recommendations for ice cream to be served with lunch and dinner meals. During the recertification survey completed on 10/26/21 the facility was cited for failure to obtain a physician ordered weight for a resident with weight loss. During the recertification and complaint investigation survey completed on 12/16/22 the facility was cited for failure to obtain physician ordered weekly weights, obtain, and record accurate weights, and identify and verify the accuracy of weights. During an interview on 01/25/24 at 6:00 PM the Administrator stated the key factor involving the repeat deficiencies was due to having a large turnover in clinical staff over the last several months. He stated they had staffing changes within the dietary department including the Registered Dietician and the Dietary Manager. Also, repeat deficiencies were due to nursing staff turnover and they recently hired a new Director of Nursing. He stated ad hoc meetings were held along with the monthly QAPI meetings. The next QA ad hoc would be held the following day on 01/26/24 or early the following week. He indicated education would be provided and these areas would be reviewed in QAPI until improvements occurred.	F 867	Performance Improvement Action Plan for the area identified. This plan will be reviewed by the corporate support staff to ensure compliance with this area identified. Regional Clinical Nurse and/or the Regional Director of Operations completed retraining with the Facility Administrator on 12/9/23, on the identification, completion, and monitoring of the QAPI Action Plan. This included understanding the importance of having a robust QAPI program for identification of areas of opportunity for improvement. All department managers, including Social Work, Director of Nursing, Business Office Manager, Activities Director, Housekeeping Manager, Maintenance Director, Admissions Director, Medical records coordinator, Rehab Director, MDS nurses, Human Resources, and Central Supply received education on 12/9/23 by the regional clinical nurse on F867 and the facility QAPI program. Any new facility department manager will receive this training during their orientation by the facility Administrator and/or Director of Nursing. Regional Director of Operations and/or Corporate Clinical Nurse will review QAPI minutes monthly to ensure improvement and monitoring of areas of deficient practice.	

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F 867	Continued From page 21	F 867	4. How the facility will monitor its performance to ensure the deficient practice does not recur. The Regional Clinical Nurse and/or Regional Director of Operation will review the QAPI Action Plans weekly for 4 weeks, then monthly for 3 months, then quarterly. This will include a review of the facility monthly QAPI meetings and reports. The facility Administrator will complete a summary of these review results and present them at the facility monthly QAPI meeting to ensure continued compliance.	