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EDGECOMBE HEALTH CENTER BY HARBORVIEW	1000 WESTERN BOULEVARD TARBORO, NC 27886

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 1/22/24 through 1/25/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QTKQ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 1/22/24 through 1/25/24. Event ID# QTKQ11. The following intakes were investigated NC00200602, NC00204295, and NC00211681. One of the five complaint allegations resulted in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the	F 553		2/16/24

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

Electronically Signed | 02/15/2024

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right to sign after significant changes to the plan of care.

§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-
(i) Facilitate the inclusion of the resident and/or resident representative.
(ii) Include an assessment of the resident's strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews with the resident, Responsible Party (RP), and staff, the facility failed to facilitate the inclusion of a cognitively intact resident and her RP in the care planning process for 1 of 1 residents reviewed for the care planning process.

The findings included:

Resident #57 was admitted to the facility on 6/2/22.

The medical record indicated Resident #57's family member was her RP.

The quarterly Minimum Data Set (MDS) dated 12/26/23 indicated Resident #57 was cognitively intact.

A review of the care plan for Resident #57 on 1/22/24 at 1:00 PM revealed it was last revised on 2/28/23.

A record review for Resident #57 revealed the

How will corrective action be accomplished for those residents found to have been affected by Social Worker immediately went and talked with Resident #57 and invited resident and responsible party (RP)to a care plan. Resident and RP both agreed on the date of 1/26/24. Care plan was held with the identified resident, RP and the IDT team on 1/26/24.

The facility identify other residents having the potential to be affected by the Facility social workers will audit care plans for all current residents by 2/16/24. For every resident care plan that wasn't confirmed, the RP will be contacted for confirmation. If facility social workers are unable to reach the RP after several attempts Social Worker will document attempts and mail a certified letter with return receipt. If the RP is unable to attend the IDT team will still hold a care plan to discuss resident's plan of care along with the resident if

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F 553	Continued From page 2 last care plan meeting note was dated 6/6/23. This note indicated the Social Worker and the Rehabilitation Manager spoke with the Resident's RP and updated her on the Resident's progress. There were no other care planning meeting notes after this date. The record further revealed no evidence the resident or RP were incorporated in the care planning process after 6/6/23. In an interview with Resident #57 on 1/22/24 at 11:13 AM the Resident stated she hadn't been invited to a care plan meeting since last Spring. She believed they were to be held quarterly and was very interested in being involved. She further stated she wanted her RP to be involved as well. On 1/23/24 at 1:13 PM an interview with Resident #57's RP revealed she had received care plan notices in the mail every 3 months. She stated they were always scheduled for 11:30 AM and she could not attend due to work. When she would call back to reschedule for a more convenient time, the Social Worker would tell her she didn't have to attend and it was just a courtesy to invite her, or that there were no other times available. The Resident's RP further stated she had been trying to reschedule each care plan meeting invitation for over a year and they were rarely rescheduled. The last meeting she attended was by phone on 6/6/23. The facility called her for other care such as permission to give the Resident a flu shot, or notification of medical appointments. An interview with the Social Worker on 1/24/24 at 12:21 PM revealed she held care plan meetings upon admission, approximately every three months in conjunction with the MDS assessment schedule and in the event of a significant change	F 553	cognitively intact. Measures will be put into place to ensure that the deficient practice will not recur by Social Workers will send letters out each month to the RP, announcing the date and time of the resident's care plan. There is an option to reschedule if the time/date doesn't work for them and resident. If RP does not confirm the careplan date and time Social Worker will call RP to confirm. If Social Worker not able to reach RP after several attempts certified letter with return receipt will be mailed to RP. If RP cannot attend in person or by phone, the IDT team will still conduct the meeting with the resident if cognitively intact and all attempts will be documented in resident's medical record. If the RP confirms the care plan will be held in the resident's room, or staff can escort resident to the social office. Facility Social Worker will audit the careplan calendar weekly times 12 weeks to ensure confirmation, attendance and documentation of careplan is in resident's medical record. The facility plans to monitor its performance by the Administrator monitoring performance to ensure solutions are sustained by discussing the results from the audits at the monthly QAPI meeting times 3 months with compliance date of 2/16/24. The Administrator is responsible for the execution of the plan with compliance date of 2/16/24.	

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F 553	Continued From page 3 in the Resident's health. These meetings were to be documented in care plan notes section of the electronic medical record including everyone that attended the meeting and what was discussed. She further stated any contact, or attempted contact with the Resident or their RP regarding care plan meetings would be documented as well. The Social Worker was unable to state why there were no notes for Resident #57 about care plan meetings since 6/6/23. She further indicated Resident #57 wanted to know when her care plan meetings were scheduled, and she took a written invitation to her room to speak with her about them. The Social Worker stated the Resident declined to attend. She further stated she would leave a voicemail message for the Resident's RP but would not receive a call back, so they were not rescheduled for her to attend. The Social Worker was unable to state the dates of any meetings held since 6/6/23. On 1/24/24 at 1:42 PM an interview with the Administrator revealed Care Plan meetings were held quarterly and annually and were to be documented including all who attended, and the topics discussed. Any contact with the Resident or RP would have been documented in the care plan section of the electronic record. She was unaware there was no documentation related care plan meetings for Resident #57 since 6/6/23.	F 553		
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:	F 641		2/16/24

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F 641	Continued From page 4 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Preadmission Screening and Resident Review Level II (Resident #18) and oxygen therapy (Resident #41) for 2 of 26 residents reviewed for MDS accuracy. Findings included: 1. Resident #18 was admitted to the facility on 12/01/17 with diagnoses which included hypertension and depression. The resident's medical record contained a halted Preadmission Screening and Resident Review (PASRR) Level II determination notification dated 9/23/18 with no end date. The annual MDS dated 7/14/23 indicated Resident #18 was not coded for Level II PASRR. An interview on 1/23/24 at 1:14 PM with MDS Nurse #1 and MDS Nurse #2 revealed they were aware that Resident #18 had a level II PASRR. MDS Nurse #1 stated that it should have been coded as level II PASRR. She also stated that there had been confusion in the past and that the level II halted had been coded as level I in error. An interview on 1/25/24 at 9:35 AM with the Administrator revealed that she expected the MDS to be coded accurately and felt the error was due to staffing changes. 2. Resident #41 was admitted to the facility on 6/23/23 with diagnoses of chronic obstructive pulmonary disease (COPD) and chronic respiratory failure with hypoxia (low oxygen	F 641	Corrective action will be accomplished for the residents affected by the deficient practice by modification completed by MDS Coordinator on Resident #18 on 1/23/24 and Resident #41 on 2/12/24. The facility will identify other residents having potential to be affected by the same deficient practice by the MDS Coordinator completed an audit of all current Level II and all current residents on oxygen for accuracy by 2/13/24. All findings from the Level II and oxygen audits were corrected immediately by MDS Coordinator. Measures put into place to ensure that the deficient practice will not recur, Regional Director of Clinical Reimbursement inserviced facility MDS Coordinators' on Accuracy of Assessments on 1/23/24. MDS Coordinator's will audit 3 MDS's a week for 12 weeks of the other MDS Coordinator to equal 6 per week to check the checker for accuracy for 12 weeks. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained and include dates when corrective action will be completed: The facility will monitor performance to ensure solutions are sustained by the the Regional Director of Clinical Reimbursement monitor the results from	

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F 641	Continued From page 5	F 641		

saturation).

A review of a physician's order for Resident #41 dated 8/4/23 revealed "may apply oxygen (O2) at 2 liters (l) via nasal cannula as needed (prn) to keep O2 saturation above 90 percent (%)".

A review of Resident #41's comprehensive care plan revealed a focus area initiated on 10/3/23 of at risk for alteration in respiratory status related to COPD. The goal was for Resident #41 to remain free from COPD exacerbation. An intervention was to administer oxygen as ordered by the physician.

A review of Resident #41's quarterly Minimum Data Set (MDS) assessment dated 12/14/23 revealed in part he was cognitively intact. He did not use oxygen therapy while a resident.

On 1/23/24 a review of the vital signs section of Resident #41's electronic medical record revealed in part the following documentation:

12/8/23 11:13 PM	97.0%	Oxygen via Nasal Cannula
12/9/23 11:38 AM	97.0%	Oxygen via Nasal Cannula
12/9/23 10:14 PM	98.0%	Oxygen via Nasal Cannula
12/10/23 2:04 AM	96.0%	Oxygen via Nasal Cannula
12/10/23 9:44 AM	96.0%	Oxygen via Nasal Cannula
12/11/23 6:28 AM	95.0%	Oxygen via Nasal Cannula
12/11/23 6:29 PM	97.0%	Oxygen via Nasal Cannula
12/12/23 5:59 AM	97.0%	Room Air

the audits for 12 weeks and discuss in QAPI meeting for 3 months with compliance date of 2/16/24.

The MDS Coordinators will be responsible for the execution of this plan with compliance date of 2/16/24

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12/12/23 5:42 PM 99.0% Oxygen via Nasal Cannula
12/13/23 1:46 AM 95.0% Oxygen via Nasal Cannula
12/13/23 9:07 AM 96.0% Oxygen via Nasal Cannula
12/14/23 2:41 AM 95.0% Oxygen via Nasal Cannula
12/14/23 5:05 PM 96.0% Oxygen via Nasal Cannula

On 1/23/24 at 1:45 PM an interview with MDS Nurse #1 indicated she coded the Special Treatments and Programs section of Resident #41's MDS assessment dated 12/14/23. She stated the look-back period for coding this section was 14 days. She went on to say she coded the section to indicate Resident #41 did not use oxygen because when she saw Resident #41 on 12/20/23, he was not wearing oxygen.

On 1/23/24 at 2:21 PM an interview with Nurse #1 indicated she was the Unit Manager. She stated the documentation in the vital signs section of Resident #41's medical record reflected Resident #41's oxygen saturation and whether or not he was receiving oxygen at the time the oxygen saturation was obtained.

On 1/25/24 at 9:35 AM an interview with the Administrator indicated Resident #41's MDS assessment should have been coded accurately. She stated because Resident #41 had not been wearing oxygen when he was observed by MDS Nurse #1, that might explain why she coded that MDS section the way she had.

F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		2/16/24

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F 684	Continued From page 7 § 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 observation, record review, staff, family, and resident interview the facility failed to complete an assessment with wound measurements when a reopened wound was identified and to transcribe standing orders for wound care into the resident's treatment record to ensure the orders were implemented. This deficient practice was for 1 of 1 resident (Resident #29) reviewed for skin conditions. The findings included: Resident #29 was admitted to the facility on 12/31/23 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting left side, Type II Diabetes Mellitus, and dementia. The standing orders for a skin tear stated clean with normal saline, apply xeroform (a petroleum saturated gauze product) and cover with a dry dressing daily. A review of the care plan dated 1/8/24 revealed there was no care plan for alteration in skin integrity or risk for alteration in skin integrity.	F 684	Corrective action will be accomplished for resident found to have been affected by assessment completed immediately for Resident #29 with order completed and notification of agent and attending physician by wound nurse. All residents on 700hall were immediately assessed for skin integrity with no new skin tears found by Wing Manager. Residents with the potential to be affected by this practice will be identified by completing a skin sweep of all residents to assess skin integrity by Clinical Staff to be completed by 2/16/24 with follow up discussed with Director of Nursing. Measures put into place to ensure that the deficient practice does not recur is the staff developer will inservice clinical staff regarding Skin Integrity (factors that could contribute to skin damage, causes and prevention) and Wound Communication book for clinical staff to document any new changes in skin that need to be further assessed by 2/16/24. Initiated stop and watch for all change of condition for	

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F 684	Continued From page 8 A unsigned skin check for Resident #29 completed on 1/16/24 indicated there was "some bruising noted to both upper extremities" only noted. A review of the quarterly Minimum Data Set (MDS) dated 1/17/24 revealed Resident #29 was severely cognitively impaired and had no skin impairment. On 1/22/24 at 4:28 PM it was observed that Resident #29 had a wound dressing to her right upper arm that was initialed and dated 1/21/24 by Nurse #3 who applied the dressing. The dressing was white, and blood could be seen having soaked the center. During an interview with Resident #29 on 1/22/24 at 4:30 PM, she stated her skin was very fragile and she got a skin tear. She could not recall how or when the wound happened. The medical record for Resident #29 through 1/21/24 revealed no evidence of any documentation related to the wound that was dressed on her right upper arm. On 1/22/24 at 4:30 PM an interview with Resident #29's husband, who was also a resident and was alert and oriented to person, place, time, and situation, revealed Resident #29 got up and walked around alone, although she was supposed to ask for help with walking. He further stated she often bumped into things and got bruises and skin tears, and this also happened when they lived at home. He did not recall how or when Resident #29 got the wound to her right upper arm.	F 684	CNA to improve communication to Nurse on changes with resident by 2/16/24. The facility will monitor its performance by the wing managers will bring wound communication book and stop and watch to clinical start up to review the results for follow up of any resident with change of condition and new skin areas for 12 weeks and the results of the monitoring will be taken to monthly QAPI x 3 months. The Director of Nursing is responsible for the execution of this plan with a compliance date of 2/16/24.	

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On 1/23/24 at 9:00 AM it was observed that Resident #29 had a wound dressing to her right upper arm that was initialed and dated 1/22/24 by Nurse #3 that applied the dressing. The dressing was white, and blood could be seen having soaked the center.

An interview with the Unit Manager on 1/23/24 at 3:44 PM revealed the process for documenting new wounds. The Nurse was to use the communication book to look at standing orders and choose the appropriate treatment from the list on the front of the book. They would document the date, time, Resident, type of wound and treatment in the communication book for the treatment Nurse (Nurse #1) to follow up on. The Nurse would then treat the wound and write the chosen standing order in the electronic record to alert other Nurses to the new wound. The Unit Manager further stated the Nurse was to write a nurses note in the electronic record regarding the wound and its treatment. Nurse #1 would follow up by measuring and assessing the wound, assuring the correct treatment was started, and would follow the wound until healed.

A review of Resident #29's chart with the Unit Manager on 1/23/24 at 3:50 PM revealed no documentation of the new wound to Resident #29's right upper arm.

During an interview with Nurse #1 on 01/23/24 at 02:35 PM, she revealed she did the wound management for the facility (treatment Nurse), and she was not aware Resident #29 had a wound. She further stated the nurses were to document new wounds in the communication book at the Nurse's station, or the one hanging on her office door and they wrote orders based

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on the list of standing orders in the book so that she could follow up. She revealed that she did not find documentation for Resident #29's wound care. She further stated when a wound was not documented in the communication book, she would not have known a wound assessment needed to be completed and a dressing change needed to be done. She added that a wound could become infected over time if not treated properly.

A review of the communication books on 01/23/24 at 2:45 PM with Nurse #1, both at the Nurse's station and hanging on her door revealed Resident #29's wound had not been reported.

An observation of Resident #29's dressing change was made on 1/23/24 at 3:15 PM with Nurse #1. Nurse #1 stated it was the initials of Nurse #3 on the dressing. Nurse #1 stated the wound appeared to be in the beginning stages of healing, as the wound bed was a yellow color but still had blood-tinged drainage. She further stated it was about one inch by one inch in size and appeared to be a skin tear.

On 01/23/24 at 04:04 PM an interview with Nurse #3 revealed she did not document an assessment with measurements, or a progress note when she identified the new wound for Resident #97 on 1/21/24. Her reasoning was she "forgot". She further stated she did do wound care on 1/21/24 and 1/22/24 and that it was an old wound that had reopened. Nurse #3 noticed the wound on the night of 1/21/24 and stated it was a skin tear. She revealed she knew the process was to write it in the communication book, write an order in the electronic record, write a nurse's note regarding the wound, and notify

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F 684	Continued From page 11 the Responsible Party and the Physician. She further revealed she understood Nurse #1 would not be able to assess the wound and change the dressing since she was not made aware of the wound. During an interview on 1/25/24 at 11:03 AM, the Administrator stated Nursing staff were trained to document all wounds including orders, and notification of Responsible Party and Physician, as soon as possible after a new wound is discovered.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff and Medical Director interviews the facility failed to obtain a physician's order for the use of supplemental oxygen for 1 of 3 residents reviewed for respiratory care (Resident #101). The findings included: Resident #101 was admitted to the facility on 2/16/22 with diagnoses that included heart failure and oxygen dependent.	F 695	Corrective action was accomplished for resident found to be affected by the Wing Manager putting in the oxygen order immediately for Resident #101. The facility will identify other residents having the potential to be affected by this practice by Wing Manager completing an audit of all residents receiving oxygen with any corrections made as needed by 2/16/24.	2/16/24

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F 695	Continued From page 12 Review of the medication administration record (MAR) and physician orders revealed that Resident #101 did not have an order for oxygen and oxygen was not listed on the MAR as being administered. Review of the quarterly Minimum Data Set (MDS) assessment dated 12/27/23 revealed that Resident #101 was cognitively intact and had a diagnosis of oxygen dependent but was not coded for oxygen use. An observation of Resident #101 was made on 1/23/24 at 8:43 AM, she was resting in bed watching television. Resident #101 had an oxygen canula in her nose with oxygen being delivered at 2 liters per minute. In an interview with Resident #101 on 1/23/24 at 8:43 AM, she stated that she had used oxygen since admission and that she took it off and on by herself when she wanted to. She stated that she thought she received oxygen at 2 liters per minute. In an interview with the Medical Director on 1/24/24 at 11:58 AM he revealed that he was the attending physician for Resident #101. He stated that Resident #101 received oxygen at 2 liters per minute. He further added she received oxygen when she was originally admitted to the facility and attempts to wean her were unsuccessful. The interview further revealed that the Medical Director would expect that a resident would have an order for oxygen use and that it would be on the MAR for continued monitoring. He reviewed Resident #101's order list and stated that there was not an order for oxygen.	F 695	Measures put into place to ensure deficient practice will not recur will be the staff developer will inservice clinical staff regarding PCC (Point Click Care) documentation required for residents with oxygen by 2/16/24. Wing Managers will monitor weekly audits x 12 weeks of resident oxygen orders/documentation and care plan are in place. The facility plans to monitor its performance to make sure that the solutions are sustained by the Wing Managers will discuss the results from the audits in clinical start up with IDT. The results of PCC documentation regarding residents on oxygen will be discussed and monitored in our monthly QAPI x 3 months. The Director of Nursing is responsible for the execution of this plan with a compliance date of 2/16/24.	

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F 695	Continued From page 13 At 12:19 PM on 1/24/24 an interview with Medication Aide #1 revealed that Resident #101 received oxygen per nasal cannula at 2 liters per minute. He stated that she did not have an order for oxygen use, and it was not listed on her MAR. He stated that it should be on her MAR and there should have been an order for it. On 1/24/24 at 12:21 PM in an interview with Nurse #1 revealed that Resident #101 received oxygen. She stated that when a physician wrote an order for oxygen, the nurse transcribed (transferred) the order to the MAR. She further indicated there was no oxygen order for Resident #101 on the physician order list and it was not listed on the MAR. She stated that Resident #101's oxygen should have been on the MAR and it would be signed by the nurse on each shift to indicate oxygen was administered. The Administrator was interviewed on 1/24/24 at 1:00 PM, she stated that she was not aware that Resident #101 did not have an order for oxygen until the physician made her aware today. She further stated that residents that received oxygen should have a physician's order for oxygen, and it should be on the MAR for nurses to sign off on.	F 695		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		2/16/24

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F 867	Continued From page 14 §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 15 §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 16 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, family and resident interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the recertification and complaint investigation surveys of 12/02/21 and 12/22/22. This was for two deficiencies in the areas of Accuracy of Assessments (F641) and Quality of Care (F684) that were subsequently recited on the current recertification and complaint investigation. The continued failure of the facility during 2 or more federal surveys of record showed a pattern of the facility's inability to	F 867	Corrective action will be accomplished for the repeat citations as he facility has had repeat deficiencies in accuracy of assessments and quality of care. All residents have the potential to be affected by this practice. The facility held Adhoc Quality assurance process improvement (QAPI) meeting with the committee on 2/14/24 to develop the plan for improvement in these areas. The committee will include additional licensed nurses and corporate support in the discussion for the improvement plan. The	

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F 867	Continued From page 17 sustain an effective Quality Assurance Program. Findings included: This tag is cross-referenced to: F641: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of Preadmission Screening and Resident Review Level II (Resident #18) and oxygen therapy (Resident #41) for 2 of 26 residents reviewed for MDS accuracy. During the recertification and complaint investigation survey on 12/02/21 the facility was cited for failing to accurately code the Preadmission Screening and Resident Review (PASRR) and hospice status of residents. During the recertification and complaint investigation survey on 12/22/22 the facility was cited for failing to accurately code the PASRR. F684: Based on observation, record review, staff, family, and resident interview the facility failed to complete an assessment with wound measurements when a reopened wound was identified and to transcribe standing orders for wound care into the resident's treatment record to ensure the orders were implemented. This deficient practice was for 1 of 1 resident (Resident #29) reviewed for skin conditions. During the recertification and complaint investigation survey on 12/02/21 the facility was cited for failing to obtain daily weights as ordered by the physician and for abruptly discontinuing an antidepressant medication.	F 867	facility utilizes the Quality Improvement Organization (QIO) for additional training and resources. Measures put into place to ensure that the deficient practice will not recur will be the QAPI committee will meet twice monthly for three months with the additional meeting focusing only on the repeat deficiencies. The facility plans to monitor its performance to make sure the solutions are sustained by the results from the audits will be discussed in detail twice monthly at the QAPI meeting with attention noted to the repeat deficiencies for 3 months. The QAPI plan will be adjusted according to the results and success of the plans implemented. The Administrator is responsible for the execution of this plan with a compliance date of 2/16/24.	

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F 867	Continued From page 18 An interview with the Administrator on 1/25/24 at 10:06AM revealed that staff turnover had resulted in the MDS coding errors, and she did not know what had caused the quality of care repeat deficiency.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		2/16/24

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F 880	Continued From page 19 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 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 implement their infection control policy when Nurse Aide (NA) #1	F 880	Corrective action be accomplished for those residents found to have been affected by the deficient practice by	

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F 880	Continued From page 20 did not perform hand hygiene during meal delivery and set-up after handling bed linens and moving the overbed table for 1 of 2 NAs observed passing meal trays on 1 of 8 halls. This had the potential to result in the cross contamination of microorganisms between residents. Findings included: A review of the facility's policy titled "Hand Hygiene" dated last revised on 7/1/23 revealed in part the following: "Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to staff working in all locations within the facility. Policy Explanation and Compliance Guidelines: 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table." A review of the attached hand hygiene table revealed in part the following: "Between resident contacts, After handling contaminated objects, Before and after handling clean or soiled dressings, linens, etc.". On 1/22/24 from 12:59 PM to 1:04 PM a continuous observation of the lunch meal tray delivery service was conducted in the facility on the 900 Hall. Hand sanitizing dispensers were observed in place at intervals on the wall of this hall. During this observation NA #1 removed a meal tray from the meal cart, entered Resident #122's room, placed the meal tray on the resident's overbed table, removed the resident's blanket from the resident's legs, and repositioned the resident's overbed table in front of the resident. NA #1 was then observed to exit the room and returned to the meal cart without performing hand hygiene. NA #1 pushed the meal	F 880	Assistant Director of Nursing/Infection Preventionist immediately placed hand sanitizer for staff and hand sanitizing wipes for residents on all food. Reeducation started immediately with staff regarding hand hygiene protocol by the Staff Developer being completed by 2/16/24. The facility will identify other residents having the potential to be affected by the same deficient practice by the staff developer will inservice clinical staff on hand hygiene policy by 2/16/24. The kitchen will audit all food carts sent out of the kitchen to ensure hand sanitizer and hand sanitizing wipes are present before are delivered to the hallway. Reminder education sheets will be placed on top of all carts reminding staff to be mindful of potential cross contamination and practices to avoid it. Measures that will be put into place to ensure that the deficient practice will not recur will be the Assistant Director of Nursing ADON/Infection Preventionist will complete 5 meal tray pass observations a week for 12 weeks and will provide 1 to 1 reeducation as needed based on these observations and discuss findings and follow up in clinical start up. The facility plans to monitor its performance to ensure the solutions are sustained by the ADON/Infection Preventionist will monitor the Results from the meal tray pass observations for 12	

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F 880	Continued From page 21 cart farther down the 900 Hall and removed Resident #102's meal tray from the cart. NA #1 was stopped in the doorway of Resident #102's room before she could deliver the meal tray to the resident. On 1/22/24 at 1:04 PM an interview with NA #1 indicated she should have performed hand hygiene after contact with a resident's linen and environment before removing another meal tray from the meal cart. She stated there was hand sanitizer available. She went on to say she had been educated on doing this to prevent the spread of infection. She further indicated she just hadn't been thinking. On 1/22/24 at 1:29 PM an interview with the Assistant Director of Nursing indicated she was the facility's Infection Preventionist. She stated the facility standard was that hand hygiene should be performed after touching a resident's environment and in between passing meal trays to decrease the risk of cross contamination. She went on to say NA #1 participated in a skills fair in November 2023 that included hand hygiene. On 1/25/24 at 9:35 AM an interview with the Administrator indicated NA #1 should have performed hand hygiene in accordance with the facility's policy. She went on to say NA #1 had been educated on this and should have known better.	F 880	weeks and discuss in QAPI for 3 months. The ADON/Infection Preventionist is responsible for the execution of this plan with a compliance date of 2/16/24.	