STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	C 01/26/2024

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MOUNTAIN VIEW MANOR NURSING CE	**410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 01/22/24 through 01/26/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZERN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/22/24 through 01/26/24. Event ID# ZERN11. 3 of the 7 complaint allegations resulted in deficiency. The following intakes were investigated NC00207623, NC00197561 and NC00200656.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with residents and staff the facility failed to obtain physician orders and assess the ability to safely use medications observed at the bedside for 2 of 3 residents reviewed for self-administered medications (Resident #35 and #46). Findings included: 1. Resident #35 was admitted to the facility on 12/23/23 with diagnoses including gastro-esophageal reflux disease (GERD). The admission Minimum Data Set (MDS) dated 12/31/23 assessed Resident #35 was cognitively	F 554	Disclaimer: We respectfully request this plan of correction be considered our allegation of substantial compliance. Preparation and/or completion of this plan of correction in general, or any corrective action set forth, herein, in particular, does not constitute an admission of agreement by Mountain View Manor of the conclusions set forth in the Statement of Deficiencies (Form 2567). The Plan of Correction and specific correction action are prepared and/or executed solely as a provision of Federal and/or State law.	3/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/22/2024

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 554	Continued From page 1 intact with the ability to communicate needs and understood others. The comprehensive care plan initiated on 12/23/23 did not address the abilities of Resident #35 to self-administer medication. A review of the medical records revealed no self-administer assessment was completed for Resident #35 to safely administer medications. During an observation and interview on 01/22/24 at 2:35 PM Resident #35 was observed resting in bed and placed on the overbed table within arm's reach was a bottle of calcium carbonate (antacid) ultra strength approximately half full. Resident #35 revealed he took a couple of tablets for heartburn as needed and thought he was not supposed to take more than seven tablets a day. Resident #35 revealed the antacid was purchased over the counter and brought into the facility. Follow-up observations made on 01/23/24 at 1:50 PM and 01/24/24 at 4:55 PM revealed Resident #35 resting in bed. The bottle of calcium carbonate remained on the overbed table within arm's reach of Resident #35. During an observation and interview on 01/24/24 at 5:14 PM the Nurse Consultant observed the bottle of calcium carbonate on the overbed table and stated residents were allowed to keep medication in their room locked up and out of sight. She stated for Resident #35 to keep calcium carbonate in the room an active physician's order was needed and a self-administer assessment completed to ensure the resident was able to safely administer. She	F 554	1. The calcium carbonate tablets were removed from resident #35s room by a licensed nurse on 1/24/24. No other medications were noted in resident #35s room. Resident #35 was discharged from the facility on 1/30/24. No further corrective action can be taken for resident #35. The miconazole powder was removed from resident #46s room by a licensed nurse on 01/24/2024. No other medications were noted in resident #46s room. Upon interview by a licensed nurse on 02/12/2024 resident #46 stated that they had no desire to self-administer any medications. A licensed nurse updated resident #46s medication self-administration evaluation on 02/21/2024. 2. All residents have the potential to be affected by the same practice. Resident rooms will be checked by a licensed nurse by 02/21/2024 to determine if any medication is stored in a residents room without a physician order and a self-administration of medication evaluation. If a medication is found to be stored in a residents room without a physician order and a self-administration medication evaluation; the licensed nurse will assess for the desire and ability to self-administer medications and complete a new self-administration medication evaluation, as necessary. The licensed nurse will obtain a physicians order for the self-administration of the medication, as necessary. If the resident is found to be unable to self-administer medication upon assessment and has a physicians order	

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F 554	Continued From page 2 revealed she was not aware if Resident #35 was assessed to safely self-administer antacid or had a physician's order to use it. The Nurse Consultant removed the antacid from the room and explained the facility's policy for self-administration of medications to Resident #35. During an interview on 01/24/24 at 5:21 PM Nurse #1 confirmed she was the day shift nurse assigned to Resident #35 and administered the resident's scheduled medications on 01/22/24, 01/23/24, and 01/24/23. Nurse #1 stated none of the residents on her assignment had a physician's order to self-administer medications. Nurse #1 reviewed physician orders for Resident #35 and stated there was no order in place for calcium carbonate. Nurse #1 stated she did not notice the bottle of calcium carbonate while in the room of Resident #35. During a telephone interview on 01/26/24 at 1:00 PM the Director of Nursing (DON) stated the nurses should look for medications kept at the bedside and remove them from the room. She stated Resident #35 would need a physician's order and a self-administration assessment to ensure the resident could safely use and keep locked up and out of sight. 2. Resident #46 was admitted to the facility on 08/12/21 with active diagnoses including dementia. The annual MDS dated 01/12/24 assessed Resident #46's cognition was moderately intact with the ability to communicate needs and understand others.	F 554	for the medication, the medication will be stored in the proper medication or treatment cart and will only be administered by a licensed nurse. 3. Education will be provided to the licensed nurses by the Director of Nursing (DON) and/or a Registered Nurse (RN) supervisor regarding medications brought from home, medication storage in resident rooms, and self-administration of medications. The education will include that the nurse needs to complete a self-administration evaluation for any resident who desires to self-administer medication, obtain a physicians order for the medication, education of monitoring for self-administration of medication and proper storage of the medication in the residents room in a locked box or drawer, updating of the residents care plan for self-administration of medication, and monitoring of proper storage of medications including in resident rooms. If the resident does not desire to self-administer their medication, then the medications will be stored in the appropriate medication or treatment cart and will be administered by the licensed nurse. The education will be completed by 03/08/2024. At the time of the education, a signed form from the attending nurses acknowledging that they understand the expectations regarding self-administration of medication, medications at the bedside, and medications that may arrive with the resident on admission will be completed. The admission evaluation requirements will be updated in a nurse reference binder at the nursing station by the	

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F 554 Continued From page 3

The comprehensive care plan did not address the abilities of Resident #46 to self-administer medication.

A review of the medical records revealed no self-administer assessment was completed for Resident #46 to safely administer medications.

Review of the physician orders revealed no active order for the use of miconazole powder (an antifungal medication).

During an observation and interview on 01/22/24 at 3:05 PM Resident #46 was sitting in a wheelchair in her room. A bottle of miconazole nitrate 2% powder was placed on the overbed table and within reach. Resident #46 stated she used the antifungal powder as needed when she had a moisture rash. Resident #46 stated staff gave her the miconazole powder for her to use and she used it until the rash healed.

During an observation and interview on 01/24/24 at 5:02 PM Nurse #2 observed the miconazole nitrate powder that remained on the overbed table. Nurse #2 confirmed she was the assigned nurse for Resident #46 and administered the resident's medications on 01/24/24. Nurse #2 stated an active physician's order and self-administer assessment would need to be in place before Resident #46 could apply and there was not. Nurse #2 stated the miconazole powder was from the facility's house stock and she did not notice the bottle when in the room.

During an interview on 01/24/24 at 5:27 PM the Nurse Consultant stated residents were allowed to keep medication in their room under lock and key and out of sight. The Nurse Consultant stated

F 554

Director of Nursing or RN designee by 03/12/2024. New licensed nursing employees, including agency staff, will have education provided on self-administration of medications during their initial orientation period to the facility. The Human Resource Director will update the orientation checklist by 03/08/2024 to include training on self-administration of medications.
A letter will be sent to residents and/or their responsible parties by the Administrator by 03/12/2024 to inform them of the facility policies and procedures for bedside storage of medication and asking them to not leave medications in residents rooms without approval from the interdisciplinary care plan team. The admission packet will be updated by the Admissions RN to include information on the policies and procedures for bedside storage of medication and asking them to not leave medications in residents rooms without approval from the interdisciplinary care plan team by 03/12/2024.
The Admissions RN or RN supervisor will audit the current residents who self-administer medications for proper storage in a locked box or drawer and audit 5 additional resident rooms for any medications at bedside. The audits will continue weekly for four weeks or until substantial compliance has been achieved and maintained as determined by the Quality Assurance and Performance Improvement (QAPI) committee. Corrective action will be taken for any identified deficient practice by the

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F 554	Continued From page 4 for Resident #46 to safely administer miconazole powder a self-administration assessment would need to be completed and an active physician's order in place and the powder kept out of sight. The Nurse Consultant stated if Resident #46 was considered safe to use miconazole powder the facility would provide a box to lock it up or key to the top drawer of the nightstand. During a telephone interview on 01/26/24 at 1:00 PM the Director of Nursing (DON) stated the nurses should look for medications kept at the bedside and remove them from the room. She stated Resident #46 would need a physician's order and a self-administration assessment to ensure the resident could safely use and keep locked up and out of sight.	F 554	RN at the time of discovery. 4. The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024	
F 641 SS=E	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 (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR), falls, pressure ulcer, skin and ulcer treatments, tobacco use, gradual dose reduction, and respiratory treatments for 7 of 24 sampled residents (Residents #8, #42, #39, #1, #19, #26, and #29).	F 641	The Minimum Data Set (MDS) of Resident # 8 was modified on 01/30/2024 by a Registered Nurse to reflect that Resident # 8 had a Level 2 Preadmission Screening and Resident Review (PASRR). The quarterly MDS of Resident # 42 was modified on 01/30/2024 by a Registered Nurse to reflect that that Resident #42 had a fall with major injury during the	3/12/24

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Findings included:

1. Resident #8 was admitted to the facility on 02/11/20 with diagnoses that included schizophrenia, anxiety, depression, and post-traumatic stress disorder.

A PASRR Level II Determination Notification letter dated 01/08/21 revealed Resident #8 had a Level II PASRR with no expiration date.

a. The annual MDS assessment dated 08/10/23 indicated Resident #8 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions.
b. The significant change MDS assessment dated 01/05/24 indicated Resident #8 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions.

During a telephone interview on 01/25/24 at 2:31 PM, the MDS Coordinator revealed the Social Worker (SW) had always kept up with the residents who had a Level II PASRR and would let her know. She explained she didn't know much about PASRR or understood what the numbers meant and only coded a Level II PASRR on the MDS assessment when she was aware. When she wasn't sure, she looked through the resident's electronic medical record for the PASRR Level II determination letter and if available, went by that to complete the MDS assessment. The MDS Coordinator stated she didn't realize Resident #8 had a Level II PASRR which was why the MDS assessments dated 08/10/23 and 01/05/24 did not accurately reflect she had a Level II PASRR.

F 641

observation period.
The MDS of Resident # 39 was modified on 01/25/2024 by an RN to reflect that the wound was not present on admission. A Significant Change assessment for Resident # 39 has been opened by the MDS Coordinator with an ARD of 02/26/2024 and will be completed by the IDT by 03/11/2024.
The MDS of Resident # 1 was modified on 01/30/2024 by an RN to reflect that the resident had a pressure relieving device for the bed in place during the observation period.
The MDS of Resident # 19 was modified on 01/31/2024 by an RN to reflect that the gradual dose reduction was contraindicated.
The MDS of Resident # 26 was modified on 01/30/2024 by an RN to reflect that the resident used tobacco (snuff).
The MDS of Resident # 29 was modified on 01/30/2024 by an RN to reflect that the resident used a continuous positive airway pressure (CPAP) during the observation period.

Residents # 8, #42, #39, #1, #19, #26, and # 29 will continue to have accurate assessments completed in the electronic health record by the Interdisciplinary Team (IDT) and transmitted by the MDS Coordinator per Resident Assessment Instrument (RAI) guidelines.
All residents have the potential to be affected by the same practice. An MDS audit will be completed by an RN, comparing the residents clinical condition on the assessment reference date to most

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During a telephone interview, the Director of Nursing (DON) stated she would expect for Resident #8's MDS assessments to accurately reflect she had a Level II PASRR. The DON stated she felt the breakdown in MDS accuracy was due to all the new MDS forms/assessments that were now required and the MDS Coordinators were rushing to get the assessments completed and making mistakes.

2. Resident #42 was admitted to the facility on 06/18/21 with diagnoses that included Parkinson's disease and history of falls.

The quarterly MDS assessment dated 07/31/23 assessed Resident #42 with moderate impairment in cognition. He required partial/moderate assistance with sit to stand and could walk 10 feet with supervision or touching assistance. He had two or more falls with no injury and one fall with minor injury since the previous MDS assessment.

A nurse progress note dated 09/03/23 at 9:48 PM revealed in part, Resident #42 fell in his room while attempting to walk to his dresser unassisted and complained of rib pain. The physician was notified and gave orders to send Resident #42 to the Emergency Department (ED) for evaluation.

Review of the ED radiology results dated 09/03/23 revealed Resident #42 had multiple, mildly displaced right rib fractures.

The quarterly MDS assessment dated 10/27/23 assessed Resident #42 with moderate impairment in cognition. He required partial/moderate assistance with sit to stand and

recent MDS assessment for accuracy related to coding of wounds present on admission, Level II PASRRs, falls, gradual dose reductions, pressure relieving devices, tobacco use, and the use of a CPAP. Any resident who has not had an accurate MDS completed will have corrective action taken by the MDS Coordinator either by modification of the assessment or completing a significant correction of the MDS assessment. The audits will be completed by 03/08/2024 and the correction action to any discrepancies identified will be completed by a licensed nurse by 03/12/2024.
The DON will provide in-service education to the MDS Coordinators by February 28, 2024, on the importance of completing an accurate MDS assessment. A posttest will be given to access learning and promote competency with a score of 80% considered passing. New MDS staff including agency staff will be in-serviced on the importance of completing an accurate MDS assessment.
The RN supervisor will conduct random weekly audits of completed MDS assessments, focusing on wounds present on admission, Level II PASRRs, falls, gradual dose reductions, pressure relieving devices, tobacco use, and the use of a CPAP. The audits will be completed weekly for four weeks and then monthly times 3 or as deemed necessary by the Quality Assurance Performance Improvement (QAPI) committee to achieve and maintain substantial compliance.
The Director of Nursing and/or an RN

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F 641	Continued From page 7 could walk 10 feet with supervision or touching assistance. He had two or more falls with no injury and two or more falls with minor injury since the previous MDS assessment. Falls with major injury, such as bone fractures, was coded as 'none.' During a telephone interview on 01/25/24 at 2:31 PM, the MDS Coordinator explained when completing the MDS assessment dated 10/27/23 for Resident #42 she had gone by the facility's fall log which indicated he had only sustained a skin tear from his fall on 09/03/23. The MDS Coordinator stated she overlooked the ED radiology report dated 09/03/23 confirming rib fractures that was scanned into Resident #42's electronic health record on 10/05/23. She stated the MDS assessment dated 10/27/23 should have reflected Resident #42 had one fall with major injury. During a telephone interview, the Director of Nursing (DON) stated she would expect for Resident #42's falls to be recorded accurately on the MDS assessment. The DON stated she felt the breakdown in MDS accuracy was due to all the new MDS forms/assessments that were now required and the MDS Coordinators were rushing to get the assessments completed and making mistakes. 3. Resident #39 was admitted to the facility on 09/12/23 with the current diagnoses including multiple sclerosis. Review of the admission Minimum Data Set (MDS) dated 09/18/23 assessed Resident #39's cognition was moderately impaired and was at risk but had no unhealed pressure ulcers.	F 641	designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action, as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024	

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The Care Area Assessment of the admission MDS dated 09/18/23 read in part, "Resident #39 had no skin breakdown but was at risk for skin breakdown due to incontinence and impaired mobility."

Review of the significant change MDS assessment dated 12/08/23 identified Resident #39 had one stage 4 pressure ulcer that was not present upon admission/entry or reentry.

Review of the quarterly MDS assessment dated 12/18/23 identified Resident #39 had one stage 4 pressure ulcer that was present on admission/entry or reentry.

During a telephone interview on 01/25/24 at 3:14 PM the MDS Coordinator stated Resident #39 did not have a pressure ulcer that was present on admission and had not been discharged from the facility between the assessments dated 12/08/23 (significant change) and 12/18/23 (quarterly). She stated the quarterly MDS dated 12/18/23 was completed and signed by the part-time MDS Coordinator who came once a week to help and incorrectly coded the pressure ulcer was present on admission/entry or reentry. The MDS Coordinator stated she would modify the quarterly MDS dated 12/18/23 to reflect the pressure ulcer was not present on admission.

A telephone interview was conducted on 01/26/24 at 1:03 PM with the Director of Nursing (DON). The DON stated she would expect the quarterly MDS for Resident #39 was correctly coded for a pressure ulcer. The DON revealed the breakdown with incorrect coding of the MDS she thought was due to new requirements on the

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assessments and new state forms and the MDS Coordinators were going fast to complete and were making mistakes.

4. Resident #1 was admitted to the facility 04/28/13 with diagnoses including stroke and aphasia (a language disorder).

Review of Resident #1's physician orders revealed an order dated 07/24/23 to check placement of her air mattress daily.

The significant change Minimum Data Set (MDS) assessment dated 07/28/23 revealed Resident #1 had severely impaired cognition and was at risk but had no unhealed pressure ulcers. The MDS indicated Resident #1 had a pressure reducing device for a chair but not a bed.

Observations of Resident #1 on 01/22/24 at 3:24 PM, 01/23/24 at 9:09 AM, 01/24/24 at 8:53 AM, and 01/25/24 at 12:18 PM revealed she was lying on an air mattress.

A telephone interview with the MDS Coordinator on 01/25/24 at 3:13 PM revealed the Director of Nursing (DON) completed section M on the significant change MDS dated 07/28/24 and it should have reflected Resident #1 had a pressure reducing device for her bed. She stated the coding error was probably an oversight on the DON's part.

A telephone interview with the DON on 01/26/24 at 12:59 PM revealed she did not recall completing Resident #1's significant change MDS but she expected the MDS to be coded correctly.

5. Resident #29 was admitted to the facility

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04/23/21 with diagnoses including anemia and sleep apnea.

Review of Resident #29's physician orders revealed an order dated 04/24/21 to apply his continuous positive airway pressure machine (abbreviated as CPAP and meaning a machine that keeps the airway open) at bedtime.

The quarterly Minimum Data Set (MDS) dated 11/03/23 revealed Resident #29 was moderately cognitively impaired and did not require non-invasive mechanical ventilation (use of a CPAP).
Review of Resident #29's Treatment Administration Record (TAR) from August 2023 through November 2023 revealed his CPAP was initialed as being applied as ordered with few noted exceptions.

A telephone interview with the MDS Coordinator on 01/25/24 at 3:13 PM revealed Resident #29's MDS dated 11/03/23 was coded by a nurse that helped with MDS one day a week. She confirmed Resident #29's quarterly MDS should have been coded to reflect he used a CPAP. The MDS Coordinator stated she felt the wording of the CPAP question on the MDS was confusing and that led to the MDS not being coded correctly.

A telephone interview with the DON on 01/26/24 at 12:59 PM revealed she expected the MDS to be coded correctly. She stated she thought the breakdown of the MDS not being coded correctly was due in part to new requirements on the assessments and new state forms and MDS Coordinators were rushing to complete the assessments and that contributed to making mistakes.

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6. Resident #26 was admitted to the facility 05/23/23 with diagnoses including anemia and muscle weakness.

Review of Resident #26's care plan for tobacco use initiated 05/23/23 revealed she used chewing tobacco.

The significant change Minimum Data Set (MDS) assessment dated 11/07/23 revealed Resident #26 was moderately cognitively intact and did not use tobacco.

Observations of Resident #26's overbed table on 01/22/24 at 3:35 PM, 01/23/24 at 9:18 AM, 01/24/24 at 9:03 AM, and 01/25/24 at 8:42 AM revealed a can labeled "Sweet Snuff" was sitting on the table and the lid was off.

In an interview with Resident #26 on 01/22/24 at 3:35 PM she confirmed she has used snuff since she was thirteen years old.

In a telephone interview with the MDS Coordinator on 01/26/24 at 3:13 PM she stated Resident #26's significant change MDS should have been coded to reflect she used tobacco, and it was an oversight.

A telephone interview with the DON on 01/26/24 at 12:59 PM revealed she expected the MDS to be coded correctly. She stated she thought the breakdown of the MDS not being coded correctly was due in part to new requirements on the assessments and new state forms and MDS Coordinators were rushing to complete the assessments and that contributed to making mistakes.

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7. Resident #19 was admitted to the facility 10/19/17 with diagnoses including depression and psychotic disorder.

Review of Resident #19's physician orders dated 01/31/23 revealed an order for Seroquel (antipsychotic medication) 50 milligrams (mg) every night at bedtime.

Review of a physician progress note dated 05/23/23 revealed a gradual dose reduction (GDR) of Seroquel for Resident #19 was not indicated.

The quarterly Minimum Data Set (MDS) assessment dated 11/08/23 revealed Resident #19 was severely cognitively impaired and received antipsychotic medication on a routine basis. The MDS indicated a GDR was last attempted 06/04/22 and the physician had not documented a GDR was contraindicated (not indicated).

A telephone interview with the MDS Coordinator on 01/25/24 at 3:13 PM revealed Resident #19's MDS dated 11/08/23 was coded by a nurse that helped with MDS one day a week. She confirmed Resident #19's quarterly MDS should have been coded to reflect the physician documented a GDR was contraindicated on 05/23/23 and she felt it was an oversight Resident #19's MDS was not coded correctly.

A telephone interview with the DON on 01/26/24 at 12:59 PM revealed she expected the MDS to be coded correctly. She stated she thought the breakdown of the MDS not being coded correctly was due in part to new requirements on the

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F 641	Continued From page 13 assessments and new state forms and MDS Coordinators were rushing to complete the assessments and that contributed to making mistakes.	F 641		
F 645 SS=D	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 (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.	F 645		3/12/24

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F 645	Continued From page 14 §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 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 submit requests for an evaluation for an updated Preadmission Screening and Resident Review (PASRR) determination for a	F 645	A new Preadmission Screening Resident Review (PASRR) has been completed for resident # 25 on 02/16/2024 by the Social Services Director due to the new use of	

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resident diagnosed with a new mental health disorder (Resident #25) and a resident who was admitted to the facility with mental health disorders (Resident #48) for 2 of 4 residents reviewed for PASRR.

1. Resident #25 was admitted to the facility on 10/17/15 with diagnoses that included anxiety disorder and depression.

An undated North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document provided by the facility on 01/23/24 revealed Resident #25 had a Level I PASRR effective 01/29/16. There were no requests for PASRR evaluation submitted or completed since 01/29/16.

Review of a psychiatric progress note dated 12/20/23 revealed in part, Resident #25's psychotic symptoms, that had been off-and-on for a long time, were increasing. Resident #25 was frequently speaking of seeing alligators and snakes in her room and rats in her water pitcher. It was further noted Resident #25 was not currently on an antipsychotic and since the intensity and duration of her psychotic symptoms were increasing, she would be started on Seroquel (antipsychotic medication) 25 milligrams (mg) every night at bedtime.

Review of Resident #25's physician orders revealed an active order dated 12/21/23 for Seroquel 25 mg at bedtime related to delusional disorder.

The significant change Minimum Data Set (MDS) assessment dated 01/04/24 revealed Resident #25 was not currently considered by the state

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antipsychotic medication for worsening symptoms. A new PASRR has been completed for resident # 48 on 02/16/2024 by the Social Services Director because Resident needs a level 2 PASRR because of diagnosis and antipsychotic medication use.
All residents have the potential to be affected by the same practice. A review of the medical record of current residents will be completed by the social worker verifying that residents have a current and accurate PASRR. Any resident found to have an PASRR that needs updating will have a new PASRR completed by the social worker. The review of current residents will be completed by 03/08/2024 and any necessary corrective action will be completed by the social worker by 03/12/2024.
Inservice education will be given to staff who review or complete PASRRs by the Administrator by 03/01/2024. The education will include the need to have an accurate and complete PASRR including level 2 when indicated for residents on admission and update the residents PASRR with any changes in condition. A posttest will be given to promote competency with a score of 80% being considered passing. When a staff member is newly assigned duties to review and complete PASRRs, the staff member will receive education at the time of assignment by the Administrator or Social Services Director.
A PASRR log will be maintained by the Social Services Director. The PASRR log will be completed at the time of admission

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Level II PASRR process to have a serious mental illness or intellectual disability. Resident #25 received antipsychotics on a routine basis during the MDS assessment period.

During an interview on 01/24/24, the Social Worker (SW) revealed she was told if a resident had a Level I PASRR when admitted to the facility, they were good and she never thought about checking to see if the resident also had mental health diagnoses or receiving psychiatric medications. The SW explained she was new to the role and was still learning the PASRR process to take over once she gained access to NC MUST. She explained the Bookkeeper was the only one who currently had NC MUST access and handled PASRR.

During a telephone interview on 01/25/24 at 12:17 PM, the Bookkeeper revealed she handled the financial piece for new admissions and confirmed they had a PASRR upon admission but did not review their diagnoses and/or medications to see if the resident should be referred for a PASRR evaluation. The Bookkeeper stated there had been some residents that went to a Level II after admission and while she assisted at times, the previous Social Worker was the one who submitted the PASRR evaluation requests.

During a telephone interview on 01/25/24 at 12:40 PM, the Admission/Discharge Nurse revealed she reviewed the clinical piece for new admissions to see if the resident was clinically appropriate for admission to the facility to ensure their needs could be met but did not review the resident's psychiatric medications or diagnoses for PASRR. The Admission/Discharge Nurse explained she knew residents had to have a PASRR number in

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by the Social Services Director with an entry noting the PASRR completion including the end date if applicable and whether the PASRR represents the residents clinical condition. If an end date is present on the PASRR or the residents condition changes, the Social Services Director will complete a new PASRR. Once a new PASRR is completed, the Social Services Director will update the log.
The Admissions RN will perform a random weekly PASRR audit for a minimum of four weeks or until substantial compliance has been achieved and maintained as determined by the QAPI Committee. The audit will review the PASRR log and compare it with the PASRRs of any new Residents who have been admitted during the week. The audit by the Admissions RN will also check for any PASRRs that have had an end date or require updating based on the residents clinical condition. Corrective action will be taken by the Social Services Director or Admissions RN for any identified issues with the PASRR log audit.
The Administrator will review the results of the audits for trends/patterns and will report the results to the Quality Assurance Performance Improvement (QAPI) committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review

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order to be admitted to the facility but she did not submit PASRR evaluation requests.

During a telephone interview on 01/26/24 at 3:06 PM, the Administrator revealed submitting PASRR evaluation requests should be a combined effort between the Bookkeeper, Admission/Discharge Nurse, and Social Woker. He stated the breakdown in not submitting requests for a PASRR Level II evaluation when needed was due to a change in Administrative staff and the Social Woker not being able to get access to NC MUST so that she could take over the process. The Administrator stated PASRR evaluation requests should have been obtained per the regulatory guidelines and they would be more diligent in the future.
2. Record review of the undated North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document revealed Resident #48 had a Level I PASRR effective 02/22/23. There were no requests for an updated PASRR evaluation submitted or completed since 02/22/23.

Resident #48 was admitted to the facility on 4/18/23 with diagnosis that included bipolar disorder and unspecified dementia mild without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

Review of the admission minimum data set (MDS) dated 04/21/23 revealed Resident #48 had not been evaluated by Level II PASRR and determined to have a serious mental illness, intellectual disability or other related condition. Resident #48 received antipsychotic medication on a routine basis.

An interview on 01/24/24 at 3:59 PM with the

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the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024

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Social Worker revealed she was new to the role and was being transitioned into taking over the PASRR process. She explained the Bookkeeper currently completed PASARR requests.

A telephone interview on 01/25/24 at 12:17 PM with the Bookkeeper revealed she handled the financial piece for new admissions and confirmed they had a PASARR upon admission but does not review their diagnosis and/or medications to see if they should have a Level II evaluation. She further revealed she has had some residents that go to a Level II after admission, but the previous Social Worker was the one who submitted PASRR Level II evaluation requests. She further stated she would assist at times but doesn't typically submit evaluation requests.

A telephone interview on 01/25/24 at 12:40 PM with the Admission/Discharge Nurse revealed she reviews the clinical piece for new admissions to see if the resident was clinically appropriate for admission to the facility, i.e. can they meet the resident's needs? She stated she knows they have to have a PASRR for admission, but she does not review psychiatric medications and diagnosis in regard to PASRR or submit evaluation requests.

A telephone interview on 01/26/24 at 3:06 PM with the Administrator revealed submitting PASRR evaluation requests should be a combined effort between the Bookkeeper, Admission/Discharge Nurse, and Social Woker. He stated the breakdown in not submitting requests for a Level II evaluation when needed was due to a change in Administrative staff and the Social Woker not being able to get access to NC MUST so that she could take over the

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F 645	Continued From page 19 process. The Administrator stated PASRR evaluation requests should have been obtained per the regulatory guidelines and they would be more diligent in the future.	F 645		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation after a significant change in physical or mental status for 1 of 4 sampled residents reviewed for PASRR (Resident #8). Findings included: Resident #8 was admitted to the facility on 02/11/20 with diagnoses that included schizophrenia, anxiety, depression, and post-traumatic stress disorder. A PASRR Level II determination notification letter dated 01/08/21 revealed Resident #8 had a Level II PASRR with no expiration date. The significant change in status Minimum Data Set (MDS) assessment dated 01/05/24 revealed Resident #8 was not considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related	F 646	A new Preadmission Screening and Resident Review (PASRR) has been completed for resident #8 by the Social Services Director on 02/16/2024 to reflect the significant change in condition. All residents have the potential to be affected by the same practice. A review of the medical records of current residents will be completed by a registered nurse and/or social worker verifying that residents who have had a significant change had a new PASRR completed. Any resident found to have a significant change since the last PASRR screening will have a new PASRR completed by the Social Services Director. The review and any necessary corrective action will be completed by a licensed nurse by 03/08/2024. Inservice education will be given to staff who complete PASRRs by the Administrator by 03/01/2024. The education will include the need to	3/12/24

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F 646	Continued From page 20 conditions. During an interview on 01/24/24, the Social Worker (SW) revealed she was still learning the PASRR process to take over once she gained access to NC MUST and did not know to request a PASRR re-evaluation when a resident had a significant change in physical or mental status. The SW explained the Bookkeeper was the only one who currently had NC MUST access and handled PASRR. During a telephone interview on 01/25/24 at 12:17 PM, the Bookkeeper revealed she handled the financial piece for new admissions and confirmed they had a PASRR upon admission. The Bookkeeper explained the previous SW was the one who submitted the PASRR Level II evaluation requests. During a telephone interview on 01/26/24 at 3:06 PM, the Administrator revealed submitting Level II PASRR evaluation requests should be a combined effort between the Bookkeeper, Admission/Discharge Nurse, and Social Woker. He stated the breakdown in not submitting requests for a Level II evaluation when needed was due to a change in Administrative staff and the Social Woker not being able to get access to NC MUST so that she could take over the process. The Administrator stated Level II PASRR evaluation requests should have been obtained per the regulatory guidelines and they would be more diligent in the future.	F 646	complete a new PASRR on a resident when a significant change has occurred. A posttest will be given to promote competency with a score of 80% or above to be considered passing. When a staff member is newly assigned duties to review and complete PASRRs, the staff member will receive education at the time of assignment by the Administrator or Social Services Director. A PASRR log will be maintained by Social Services. The PASRR log will be completed upon admission and will indicate if an end date is present. If an end date is present or a significant change occurs during the resident stay, the log will indicate what date the PASRR will need to be completed by. Once a new PASRR is completed, the Social Services Director will update the log. The Social Services Director will attend the morning clinical meeting where changes in condition are discussed. The Social Services Director will update the residents PASRR with any significant changes noted. If unable to attend the morning clinical meeting, the Social Services Director will review the progress reports in the electronic health record system and update the PASRRs for any resident with a significant change necessitating an update of the PASRR. The Admissions RN will perform a weekly PASRR audit for a minimum of four weeks or until substantial compliance has been achieved and maintained as determined by the QAPI Committee. The audit will review the PASRR log and compare the PASRR with the residents current	

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F 646	Continued From page 21	F 646	condition for accuracy or if a significant change has occurred. Corrective action will be taken for any identified issues with the PASRR log/accuracy of the PASRR. The Administrator will review the results of the audits for trends/patterns and will report the results to the Quality Assurance Performance ImprovementQAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action, as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024	
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 -	F 656		3/12/24

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F 656	Continued From page 22 (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 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 interview the facility failed to create a comprehensive care plan related to smoking for 1of 2 residents (Resident #74) reviewed for smoking.	F 656	The care plan of Resident # 74 was updated on 01/26/2024 by the MDS Coordinator to reflect that the resident is a smoker.	

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F 656

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The findings included:

Resident #74 was admitted to the facility on 10/31/23 with diagnosis that included nicotine dependence on cigarettes.

Review of the admission Minimum Data Set (MDS) dated 11/6/23 revealed Resident #74 was cognitively intact with no behaviors. Resident #74 had shortness of breath and current use of tobacco.

Review of the comprehensive care plan dated 11/16/23 revealed that there was no care plan related to smoking.

Review of the facilities smoking policy revealed in part:
The registered nurse completing the initial smoking assessment will complete an Immediate Needs Care Plan to address the resident's smoking safety. The plan of care will be reviewed by the interdisciplinary team (IDT) and updated once a quarter or more frequently as warranted by the resident's condition.

Review of the Smoking Evaluation dated 10/31/23 revealed in part:
Resident utilizes tobacco. Poor vision or blindness: No. Balance problems while sitting or standing: No. Total or limited range of motion in arms or hands: No. Insufficient fine motor skills needed to securely hold cigarette: No. Lethargic / falls asleep easily during tasks or activities: No. Burns skin, clothing, furniture or other: No. Drops ashes on self: No. Follow the facility's policy on location and time of smoking: Yes. Able to light a cigarette safely. Yes. Able to hold a cigarette

F 656

All residents who smoke are at risk of being affected by the same practice. A care plan audit will be completed by the RN supervisor for those residents who smoke to verify the care plan addresses smoking. The care plan audit will be completed by 02/16/2024. A licensed nurse will correct any discrepancies.
The DON/RN Designee will provide education to the care plan team (MDS Coordinator, Activities Director, Certified Dietary Manager, and Social Service Director) by 02/27/2024, on the need to complete a care plan for those residents who smoke.
A smoking evaluation will be completed on new admissions by a licensed nurse. The MDS Coordinator will review the smoking evaluation as part of the clinical record review. The MDS Coordinator will also interview the resident to determine if the resident is using tobacco products and compare the result of the interview with the smoking evaluation completed on admission. The MDS Coordinator will initiate a new care plan problem for smokers or revise the care plan to include smoking for any resident who starts smoking after admission to the facility.
The RN supervisor will weekly complete care plan audits to verify that residents who smoke or use tobacco have a care plan that addresses smoking. The care plan audits will begin on 02/26/2024. Any resident identified on the audit as smoker that does not have a care plan for smoking will have corrective action taken by the RN. The weekly audits will continue for a minimum of four weeks or until

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F 656	Continued From page 24 safely. Yes. Able to extinguish a cigarette safely. Yes. Able to use ashtray to extinguish a cigarette. Yes. Review of the Interim Care Plan dated 10/31/23 revealed in part: INTERIM CARE PLAN SAFETY / RISK Does the resident smoke? Yes - with supervision A phone interview on 01/25/24 at 02:31 PM with the MDS Nurse revealed she does complete the care plans and Resident #74 was coded on the MDS as a smoker, but she just overlooked developing the care plan. An interview on 01/25/24 at 04:17 PM with the Assistant Director of Nursing revealed that staff know a resident is a smoker by the smoking evaluation completed on admission and if the resident voices a desire to smoke (if different from the admission answer) an assessment will be completed. An interview on 01/26/24 at 10:46 AM with the Nurse Consultant revealed there should be a care plan for smoking, and she would expect there to be a care plan in place for all specialized items like smoking. The residents are given a smoking assessment upon admission, and it is passed on in shift report, plus their smoking items are labeled and put in the smoking box at the nurses station on A& B Hall. A phone interview on 01/26/24 at 01:41 PM with the Director of Nursing revealed that all residents who are smokers should have a care plan that reflects that.	F 656	substantial compliance has been achieved as determined by the QAPI committee. The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action, as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024	

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F 656	Continued From page 25 A phone interview on 01/26/24 at 03:36 PM with the Administrator revealed that Resident #74 should be fully care planned with his ability to smoke and document that as appropriate.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff the facility failed to provide nail care for 1 of 1 dependent resident reviewed for activities of daily living (Resident #24). Findings included: Resident #24 was admitted to the facility on 08/21/22. Resident #24's current diagnoses included dementia. The quarterly Minimum Data Set (MDS) dated 01/08/24 assessed Resident #24's cognition as severely impaired and dependent on staff for bathing and personal hygiene. The care plan, revised on 01/08/24, identified Resident #24 as having a self-care deficit related to fatigue and impaired balance. Interventions included check nail length, trim and clean on bath days, and as necessary. During an observation on 01/22/24 at 12:03 PM the fingernails of Resident #24 appeared jagged	F 677	On 01/25/2024, nail care was provided to resident #24 by Nurse Aide (NA) #1. NA#1 was verbally educated on nail care by a Registered Nurse on 01/25/2024 and a was given written education (teachable moment) on 02/13/2024 by a Registered Nurse. All residents have the potential to be affected by the same practice. A licensed nurse checked current residents for proper nail length and cleanliness on 02/14/2024. Corrective action was taken by the nursing staff for any identified discrepancy. The nail care policy was revised by the RN Supervisor on 02/21/2024 and will be reviewed by the IDT by 03/01/2024 to state that certified nursing assistants will have a task displayed in the electronic health record to check nails for cleanliness, clean as needed, and document as part of routine hygiene. Education will be provided to the nursing staff by the Director of Nursing and/or RN	3/12/24

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and dirty. The left thumb nail was long and extended approximately 2-centimeters (cm) past the tip of thumb and had a buildup of thick black colored debris underneath the nail.

Review of the Nurse Aide (NA) activities of daily living documentation included to check nails for cleanliness and clean as needed as part of routine hygiene. The documentation indicated Resident #24 received nail care on 01/22/24 and twice on 01/23/24.

An interview was conducted on 01/24/24 at 4:24 PM with Nurse #1. Nurse #1 confirmed she was the assigned nurse for Resident #24 on Monday (01/22/24) and Wednesday (01/24/24). Nurse #1 revealed the shower schedule for residents was placed in shower room and showed Resident #24 was to receive a bath or shower on day shift Mondays and Thursdays. Nurse #1 stated NA staff inform the nurse when a resident refused nail care during their scheduled bath days, and she had not received report a resident refused care.

During an observation and interview on 01/25/24 at 2:08 PM NA #1 confirmed she was assigned to provide activities of daily living care for Resident #24 on 01/23/24 and initialed nail care was provided on the activities of daily living task by error. NA #1 stated she was assigned to provide care for Resident #24 and gave a bed bath on 01/24/24 and bed baths include nail care. NA #1 observed the fingernails of Resident #24 were jagged and dirty and the left thumbnail was extended long past the tip of the thumb with a buildup of a thick black colored debris underneath the nail. NA #1 stated usually there were 3 NA staff but today (01/24/24) there were two and she

F 677

supervisor by 03/04/2024 on proper nail care and nail hygiene. A posttest will be given to assess learning with a passing score of 80%. Make up education and a post test will be given by the Director of Nursing and/or RN supervisor for any employee that is unable to attend the first education session. All new nursing staff, including agency, will receive training during their initial orientation period on nail care.

A weekly random audit of residents fingernails will be done by an RN supervisor and/or Admissions Nurse. The audit will continue weekly for a minimum of 4 weeks or until substantial compliance has been achieved as determined by the QAPI Committee. Corrective action will be taken for any identified deficient practice. The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action, as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024

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F 677	Continued From page 27 did not provide nail care for Resident #24 during the bed bath. NA #1 stated she would provide nail care for Resident #24 who agreed to the care. An interview was conducted on 01/25/24 at 2:31 PM with the Nurse Consultant. The Nurse Consultant stated she would expect fingernail care be provided as needed and when the NA provided a bed bath or shower on the scheduled bath days. The Nurse Consultant stated if the thumb nail was long past the tip of thumb with a buildup of a thick black colored debris it would appear nail care was not provided for Resident #24 for longer than a week or two. During a telephone interview on 01/26/24 at 1:27 PM the Director of Nursing (DON) stated she excepted nails to be clean and filed on baths days or when needed.	F 677		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		3/12/24

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Based on observations, record review, interviews with the Medical Doctor and staff the facility failed to set the alternating pressure air mattress at the correct setting based on the resident's weight for 3 of 4 residents reviewed for pressure ulcers (Resident #39, #24, and #1).

Findings included:

1. Resident #39 was admitted to the facility on 09/12/23. Resident #39's current diagnoses included adult failure to thrive, a sacral stage 3 pressure ulcer (full-thickness loss of skin) and right buttock stage 3 pressure ulcer.

A physician's order with an active date 09/20/23 was for the placement of an air mattress to the bed and indicated it was for wound healing and preventative measure. The physician orders included check the placement of the air mattress daily at bedtime.

The care plan revised on 10/03/23 identified Resident #39 had the potential and actual skin impairment involving the sacrum and right gluteal fold related to impaired mobility. Interventions included an air mattress to the bed and indicated it was for wound healing and a preventative.

Review of the significant change Minimum Data Set (MDS) dated 10/09/23 assessed Resident #39 was cognitively intact and required substantial/moderate assistance with bed mobility and was dependent on staff for transfers. The MDS indicated a stage 2 pressure ulcer (partial skin loss with exposed dermis) was not present on admission and a pressure reducing device was used for the bed and hospice care was in place while a resident.

F 686

On 01/26/2024 residents� #39, #24, and #1 alternating pressure air mattresses were set to the correct weight based on the residents� most recent weights by a licensed nurse. A licensed nurse will monitor each shift to ensure the alternating pressure mattresses for residents #39, #24, and #1 are properly set based on the residents weight and document the check on the treatment record.
All residents who utilize an alternating pressure mattress have the potential to be affected by the same practice. A review of the alternating pressure air mattress settings with a comparison to the residents current weight was conducted by a licensed nurse on 01/29/2024. If the setting of the alternating pressure air mattress was incorrect, the licensed nurse corrected the setting based on the residents most recent weight or residents preference with a physicians order and updating of the residents care plan.
Education will be provided to the licensed nursing staff by the Director of Nursing and/or designee by 03/4/2024 on the proper setting of alternating pressure air mattresses based on the residents weight. A post test will be given to assess learning with a score of at least 80% to be considered passing. Make up education and post testing will be provided by the Director of Nursing and/or designee for any employee that is unable to attend the first education session. New licensed nursing staff and agency staff will be educated during orientation on importance of setting the alternating pressure air

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F 686	Continued From page 29 Review of the documented weights for Resident #39 revealed on 01/20/24 the resident weighed 115 pounds (lbs.). The January 2024 Treatment Administration Record (TAR) revealed the nurses initialed to indicate they checked the placement of the air mattress per the physician's order from 01/01/24 through 01/23/24 at 8:00 PM. Observations on 01/22/24 at 11:49 AM and 01/23/24 at 2:08 PM revealed Resident #39 was in bed with an alternating pressure air mattress in place that was functioning. The air mattress settings were locked, and the weight set at 250 lbs. During an interview on 01/25/24 at 5:01 PM Nurse #2 stated when she initialed the TAR for the air mattress, she checked if the lights were on, and the machine was on but did not check the weight settings the accuracy. An observation and interview were conducted on 01/25/24 at 5:48 PM with the Nurse Consultant. The Nurse Consultant observed Resident #39 in bed with the alternating pressure air mattress functioning and the settings locked and the weight at 250 lbs. The Nurse Consultant stated Resident #39 did not weigh 250 lbs. and the air mattress was not helping when the weight setting was incorrect. During a telephone interview on 01/26/24 at 1:03 PM the Director of Nursing (DON) stated it was unclear what the nurses checked when they initial the TAR. She was unsure who was responsible for the weight settings when the air mattress was	F 686	mattress correctly for a residents weight. The licensed nurse will document every shift on the Treatment Administration Record that the alternating pressure mattress is in place, functioning, and set to the correct weight range. A weekly random audit of residents alternating pressure air mattress settings and documentation will be conducted by the RN supervisor. The audits will continue weekly for a minimum of 4 weeks or until substantial compliance has been achieved and maintained. Corrective action will be taken by a licensed nurse for any identified deficient practice. The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024	

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set up and stated the air mattress was not doing any good if the setting for weight was incorrect. The DON stated the nurses need education to ensure weight settings upon placement and the continued checks were correct when initialing the TAR.

A telephone interview was conducted on 01/26/24 at 2:58 PM with the Medical Doctor (MD). The MD stated he would want the pressure alternating air mattress weight settings to be correct for the mattress to be effective and if not, there was a problem with the facility's process.

During a telephone interview on 01/26/24 at 3:24 PM the Administrator stated the air mattress settings for Resident #39 at 250 lbs. was far from the resident's actual weight and was not a benefit to wound healing or prevention. The Administrator stated the nurse staff need more education related to the weight settings on the alternating pressure air mattress.

2. Resident #24 was admitted to the facility on 08/21/22. Resident #24's current diagnoses included vascular dementia, contractures of the left and right hip and left and right knee.

The physician's order with an active date of 09/20/23 was for the placement of an air mattress to the bed and indicated it was for wound healing and preventative measures. The orders included checking placement of the air mattress daily at bedtime.

The January 2024 Treatment Administration Record (TAR) revealed the nurses initialed to indicate they checked the placement of the air mattress per the physician's order from 01/01/24

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through 01/23/24 at 8:00 PM.

Review of the documented weights for Resident #24 revealed on 01/04/24 the Resident weighed 128 pounds (lbs.).

The care plan revised on 01/08/2024 identified Resident #24 had the potential for skin integrity impairment related to fragile skin and had a history of a right heel pressure ulcer that resolved on 01/19/23. Interventions included monitoring the skin while providing care.

The quarterly Minimum Data Set (MDS) dated 01/08/24 assessed Resident #24's cognition as severely impaired and dependent on staff for bed mobility and transfers. The MDS indicated there were no unhealed pressures ulcers and a pressure reducing device was used for the bed.

Review of the most recent skin evaluations dated 01/16/24 and 01/24/24 revealed Resident #24 had no new skin issues reported or noted.

Observations made on 01/22/24 at 11:49 AM and 01/23/24 at 2:08 PM revealed Resident #24 in bed with a functioning alternating pressure air mattress. The air mattress settings were locked, and the weight was set at 250 lbs.

An interview was conducted on 01/25/24 at 6:03 PM with Nurse #3. Nurse #3 confirmed the nurses signed off on the resident's TAR when an air mattress was in place. Nurse #3 stated if the weight setting was incorrect that could affect wound healing, but she was not aware weight settings were supposed to be checked by the nurse.

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An observations and interview were conducted on 01/26/24 at 12:12 PM with the Nurse Consultant. The Nurse Consultant observed Resident #24 in bed with the alternating pressure air mattress functioning and the settings locked, and the weight set at 250 lbs. The Nurse Consultant stated Resident #24 did not weigh 250 lbs. and the air mattress was not helping when the setting was incorrect. The Nurse Consultant stated Resident #24 did not currently have a pressure ulcer and the air mattress was used as a preventative.

During a telephone interview on 01/26/24 at 1:03 PM the Director of Nursing (DON) stated it was unclear what the nurses checked when they initial the TAR. She was unsure who was responsible for the weight settings when it was placed and stated the air mattress was not doing any good if the setting for weight was incorrect. The DON stated the nurses need education to ensure weight settings upon placement and the continued checks were correct when initialing the TAR.

A telephone interview was conducted on 01/26/24 at 2:58 PM with the Medical Doctor (MD). The MD stated he would want the pressure alternating air mattress weight settings to be correct for the mattress to be effective and if not, there was a problem with the facility's process.

During a telephone interview on 01/26/24 at 3:24 PM the Administrator stated the air mattress setting for Resident #24 at 250 lbs. was far from the resident's actual weight and was not a benefit to wound healing or prevention. The Administrator stated the nurse staff need more education related to weight settings on the alternating

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F 686	Continued From page 33 pressure air mattress. 3. Resident #1 was admitted to the facility 04/28/13 with diagnoses including stroke, diabetes, and hemiplegia (paralysis of one side of the body). Review of Resident #1's physician orders dated 07/24/23 revealed an order to check placement of air mattress daily. The quarterly Minimum Data Set (MDS) assessment dated 10/27/23 revealed Resident #1 was rarely or never understood and was at risk for developing a pressure ulcer. Review of the documented weight for Resident #1 on 01/04/24 was 146 pounds. Resident #1's January 2024 Treatment Administration Record (TAR) revealed nursing staff initialed to indicate they checked the placement of the air mattress per the physician's order from 01/01/24 through 01/24/24 on night shift. Review of Resident #1's skin integrity care plan last revised 01/22/24 revealed she had the potential for pressure ulcer development related to diabetes and immobility. Interventions included administering treatments as ordered and ensuring an alternating pressure mattress was in place at all times. Observations of Resident #1 on 01/22/24 at 3:24 PM, 01/23/24 at 9:09 AM, and 01/24/24 at 8:53 AM revealed she was in bed with an alternating pressure air mattress in place that was functioning. The air mattress settings were	F 686		

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locked and the weight was set at 250 pounds.

A telephone interview with Nurse #7 on 01/26/24 at 11:23 AM revealed when she initialed Resident #1's TAR for the air mattress she usually checked to make sure it was in place and was lit up. She stated the only time she checked the weight setting was when she completed her skin assessments. Nurse #7 stated sometimes the weight setting was not correct and she corrected the setting.

A telephone interview with Nurse #6 on 01/26/24 at 8:10 PM revealed when she initialed Resident #1's TAR for the air mattress she was checking to make sure it was in place and the lights were on. She stated she was not aware the settings on the air mattress were weight-based and could be adjusted.

A telephone interview with the Director of Nursing (DON) on 01/26/24 at 12:59 PM revealed when nurses initialed the TAR for a resident's air mattress, they should be checking to make sure it was on the correct setting in accordance with the resident's weight. She stated she felt the breakdown in the process was that nurses needed to be educated to make sure the air mattress matched the weight setting.

F 689 SS=G Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) F 689

§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

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supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and Responsible Party, staff, and Medical Doctor interviews, the facility failed to safely transfer a resident from the bed to the chair when one staff member used a mechanical lift resulting in the resident falling to the floor for 1 of 6 sampled residents reviewed for accidents (Resident #30). On 05/17/23, while being transferred one of the clasps attaching the sling to the mechanical lift malfunctioned resulting in Resident #30 falling out of the sling onto the floor. Upon initial nurse assessment, Resident #30 complained of no pain and had no obvious injuries but later that same day he complained of hip pain, was sent out to the hospital for evaluation, x-rays obtained revealed no hip fracture and he returned to the facility on 05/18/23. On 05/22/23 additional x-rays were obtained due to complaints of neck pain that revealed Resident #30 had sustained a C7 (one of the cervical vertebrae that support the head and connect it to the shoulders and body) and T1 (vertebrae that make up the spine and located in the upper part of the back) fracture.

Past noncompliance: no plan of correction required.

Findings included:

Resident #30 was admitted to the facility on 08/09/22 with diagnoses that included progressive neurological conditions (refers to a progressive deterioration in function that can be gradual over time or rapid), Parkinson's disease, and dementia with Lewy Bodies.

The annual Minimum Data Set (MDS) dated 05/11/23 assessed Resident #30 with moderate

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impairment in cognition and had impairment on both sides of the upper and lower extremities. Resident #30 required substantial/maximal staff assistance for bed mobility (roll left and right) and total staff assistance with transfers.

An Activity of Daily Living (ADL) care plan, last revised 05/18/23, revealed Resident #30 had an ADL self-care performance deficit related to Lewy Body dementia, fatigue, impaired balance, limited mobility, and Parkinson's disease. Included was an intervention initiated on 08/09/22 that noted Resident #30 required a mechanical lift with a sling and two-person assistance for all transfers.

The quarterly Minimum Data Set (MDS) dated 12/21/23 assessed Resident #30 with moderate impairment in cognition. Resident #30 had impairment on both sides of the upper and lower extremities and was totally dependent on staff for self-care and mobility.

During a telephone interview on 01/25/24 at 10:13 AM, Resident #30's Responsible Party (RP) revealed on 05/17/23 Resident #30 was dropped from the mechanical lift during a transfer due to a malfunction of the machine. The RP stated she learned of the incident when she arrived at the facility on 05/17/23 around lunchtime and recalled Resident #30 was in pain and that afternoon he was sent out to the hospital for evaluation. The RP stated he was first sent to the county hospital and was informed the x-rays obtained revealed a hip fracture. Resident #30 was then transferred to another hospital where the x-ray results were reviewed again and this time she was informed there was no hip fracture, and he returned back to the facility. The RP recalled two days later, Resident #30 was sent back out to the hospital

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for evaluation due to complaints of neck pain, a Computed Tomography (abbreviated as CT and defined as a scan that uses x-rays to create pictures) was done that showed a spinal fracture and he was placed in a neck collar. The RP stated Resident #30 was later evaluated by the Neurosurgeon who recommended surgery but Resident #30 refused. The RP stated the neck collar Resident #30 was given at the hospital was uncomfortable for him and the Neurosurgeon ordered him a new one but even then, she as well the facility staff had a hard time getting him to wear it. The RP stated Resident #30's fractures just took time to heal and he did not suffer a decline from his baseline as a result. The RP stated she understood accidents happened, the staff involved in the incident were no longer employed at the facility and she felt the facility was taking good care of Resident #30.

During a telephone interview on 01/26/24 at 2:22 PM, Nurse Aide (NA) #6 confirmed she attempted to transfer Resident #30 using a mechanical lift without additional staff assistance on 05/17/23 and he had fallen to the floor during the transfer. NA #6 recalled Resident #30 asked to get up in his recliner, which he did from time-to-time, and she asked the other NA working with her on the hall to assist with the transfer because they had been instructed to always have 2-person assist when using the mechanical lift. NA #6 stated the other NA was busy and she had waited for her as long as she could but Resident #30 was getting anxious so she made the decision to go ahead and transfer him by herself. NA #6 explained after she had gotten Resident #30 positioned in the sling, she made sure the sling straps were all positioned correctly and the clasps locked in place and then proceeded with the transfer. She

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F 689	Continued From page 38 recalled his bed was already in a high position so she didn't have to lift him any higher and used the lift to move him horizontally off the bed. He was suspended approximately 2 to 3 feet from the floor and as she moved the lift toward his chair, she held on to the sling with one hand. When she let go of the sling to push the feet open on the mechanical lift so that it would go around the chair, Resident #30 fell out of the sling onto his back on the floor. NA #6 stated she told Resident #30 not to move and she immediately informed Nurse #5 who came to the room to assess Resident #30. NA #6 stated the only thing she could figure happened prior to transferring Resident #30 was when she connected the sling clasps to the mechanical lift all but one made a 'click' sound when the top of the clasp was locked into place. NA #6 restated she was instructed to always have 2-person assist when using the mechanical lift and she made the wrong decision to go ahead and transfer Resident #30 without waiting for help. A nurse progress note dated 05/17/23 at 1:00 PM and written by Nurse #5 revealed in part, called to Resident #30's room by staff. Upon entering the room, Resident #30 was observed on the floor in front the bed with the lift sling underneath him. NA #6 stated she was transferring Resident #30 to the chair with the mechanical lift when his weight shifted and the sling came out of the hook. Upon assessment, no obvious injuries were observed, Resident #30 denied pain and stated he was fine. The Medical Doctor (MD) and family were notified of Resident #30's fall. Resident #30 was secured back into the sling and placed back into bed by staff. When securing the sling to the mechanical lift, three of the hooks were noted to be "snapping" into place but the fourth one did not	F 689		

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"snap." The mechanical lift was taken to maintenance for repair and the hook was replaced. The Administrator and Director of Nursing (DON) were also made aware of Resident #30's fall, lift issue and replacement of hook.

A second nurse progress note dated 05/17/23 at 4:10 PM and written by Nurse #5 revealed Resident #30 was sent to the hospital for evaluation due to a fall via Emergency Medical Services (EMS) transport.

During a telephone interview on 01/26/24 at 9:01 AM, Nurse #5 revealed she was no longer employed at the facility and confirmed she was Resident #30's assigned nurse on 05/17/23 when she notified by the NA (could not recall her name) that Resident #30 had fallen during a transfer. When she asked the NA what had happened, the NA told her Resident #30 was on the mechanical lift when one of the clasps for the sling malfunctioned and he fell to the floor. The NA also stated she knew she shouldn't have but she had tried to transfer Resident #30 independently using the mechanical lift. Nurse #5 seemed to recall when she arrived at the room, Resident #30 was lying on his right side on the floor and he wasn't complaining of any pain. She did a full body assessment which included checking Resident #30's hips, completed a neuro assessment and there were no signs of any obvious injuries identified. She and the NA assisted Resident #30 back up into bed, she checked him thoroughly again and he voiced no complaints of pain or displayed any non-verbal indicators such as moaning or grimacing. Nurse #5 was not sure how Resident #30 fell out of the sling and stated she seemed to recall the NA had

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F 689	Continued From page 40 showed her how one of the sling clasps wouldn't snap closed properly. Nurse #5 immediately notified the Administrator and DON of the incident and they came to Resident #30's room to assess the situation, had maintenance inspect the lift, and pretty much took things over from there. Nurse #5 stated later that afternoon (05/17/23), the Administrator and DON made the decision to send Resident #30 out to the hospital for evaluation, even though he still was not complaining of any pain, just for precautionary measures. Nurse #5 could not recall what time Resident #30 returned from the hospital but stated a few days after his fall, he was sent back to the hospital for a full CT scan because he had started to complain of pain in his neck and being sore all over. She didn't remember what the x-rays revealed but he had returned wearing a neck collar. Nurse #5 stated prior to the fall on 05/17/23, Resident #30 required total staff assistance with ADL and when he returned to the facility after his second hospital evaluation, he was pretty much at his normal baseline. Nurse #5 stated she never noticed any change in his physical or mental condition as a result of the fall. He rarely complained of pain other than soreness in his neck and did not like wearing the neck collar because it was uncomfortable. During a telephone interview on 01/26/24 at 3:44 PM, the Director of Nursing (DON) stated on 05/17/23 she was informed by a staff member, could not recall whom, that Resident #30 had fallen during a transfer. The DON immediately informed the Administrator and they both went to Resident #30's room to assess the situation. By the time they arrived at the room, Resident #30 had already been placed back into bed. The DON stated she had maintenance inspect the	F 689		

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mechanical lift and it did have a faulty sling clasp that was immediately replaced. The DON stated upon initial assessment following the fall Resident #30 was ok but then he started complaining of a headache, was given Tylenol and monitored. She explained anytime you asked him how he was feeling he stated he was ok but just for precautions, she and the Administrator decided to send him out to the hospital for evaluation. The DON stated when she talked with NA #6 on 05/17/23 about what had happened she seemed to recall NA #6 stating she had asked another NA to help assist her with transferring Resident #30 and they had told her they would but if would be a little bit before they could assist and then for whatever reason, she chose not to wait. The DON stated NA #6 was immediately suspended and her contract with the staffing agency was terminated. The DON stated it was an unfortunate, isolated event and while she did not feel NA #6 had any malicious intent when she attempted to transfer Resident #30 independently, NA #6 made the bad decision not to follow facility protocol. The DON stated she started immediate re-education of nursing staff on 05/17/23 regarding mechanical lift transfers with an emphasis on always having 2-person assist when using a mechanical lift.

During telephone interviews on 01/25/24 at 11:47 AM and 01/26/24 at 3:06 PM, the Administrator confirmed he was notified of the incident involving Resident #30 and immediately went with the DON to Resident #30's room to assess. He stated the DON took NA #6 out in the hall to discuss what happened while he stayed in the room to talk with Resident #30. The Administrator stated although Resident #30 wasn't complaining of any pain at the time of the fall, he and the DON decided to go

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F 689	Continued From page 42 ahead and send Resident #30 out to the hospital for an evaluation just as a precaution. The Administrator stated the hospital initially thought he had a hip fracture but then determined he did not and Resident #30 returned to the facility. A few days later, Resident #30 started complaining of a headache and was sent back to the hospital for CT scan which revealed spinal fractures. The Administrator stated it was facility protocol for staff to always have 2-person assist for mechanical lift transfers and felt it was neglectful on NA #6's part because she attempted to transfer Resident #30 without additional staff assistance. NA #6 was immediately suspended due to her not following facility protocol and her contract with the staffing agency was terminated. The Administrator stated he felt the incident involving Resident #30 was an isolated event, they implemented an internal plan of correction and put measures in place that included audits and monitoring with no further concerns identified. As part of the monitoring process, the Administrator stated he visited with Resident #30 daily to ask him if he was having any pain and Resident #30 had no complaints nor did he decline from his baseline as a result of the injury he sustained from the fall. A Hospital Discharge Summary dated 05/18/23 for Resident #30 read in part, "was reported he was being transferred at the skilled nursing facility using a mechanical lift when it broke and Resident #30 landed on his hip. Reports of hip pain. Original x-ray was read as negative and CT scan of the hip was ordered which was read as equivocal (result could not be interpreted as positive or negative) and correlate clinically. CT scan showed no visible fracture of proximal right femur (hip) or right pelvis, there was reported	F 689		

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posterior angulation of the intertrochanteric (point where the muscles of the thigh and hip attach) right femur as well as advanced osteoarthropathy (disease of the joints or bones) of the right hip. Pelvic and right hip x-rays were read as negative for fracture by Radiology. Resident #30 was evaluated today with his relative at bedside and is reporting no pain. His baseline is bed-bound and usually does not ambulate. He was discharged in stable medical condition back to the skilled nursing facility."

A nurse progress note written on 05/19/23 at 6:54 AM revealed in part, Resident #30 was complaining of discomfort to the right hip and lumbar region. The MD was contacted and pain medication requested.

Review of Resident #30's May 2023 Medication Administration Record (MAR) revealed a physician's order dated 05/19/23 for Tylenol 325 milligrams (mg) two tablets every 6 hours as needed for pain. Resident #30 received doses on 05/19/23 at 7:35 AM, 1:08 PM with a pain level of 05/10 (numerical pain rating scale with 10 being the worst level of pain), and 8:25 PM with a pain level of 05/10; 05/20/23 at 8:15 PM with a pain level 08/10; 05/21/23 at 11:46 PM with a pain level 07/10; and 05/22/23 at 7:59 AM with a pain level 05/10. All doses administered were noted to be effective.

A nurse progress note written on 05/21/23 at 11:06 AM revealed in part, Resident #30 was displaying pain to the left upper back, neck and shoulder which made it hard for him to turn. The nurse contacted the hospital to have the x-rays sent to the skilled nursing facility and was informed x-rays were only taken on the lower

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body, none were completed of the shoulder or back. The MD was notified and orders were obtained for x-rays of the neck, back and rib area.

A nurse progress note written on 05/21/23 at 6:38 PM revealed in part, the mobile X-ray Tech arrived at the facility to take Resident #30's x-rays and was unable to obtain views. The MD was notified and orders received to send Resident #30 for outpatient x-rays. A message was left with outpatient radiology for an appointment.

A nurse progress note written on 05/22/23 at 8:35 AM revealed in part, x-ray orders were clarified and the MD will fax the order to outpatient radiology for the appointment to be scheduled.

A nurse progress note written on 05/22/23 at 10:10 AM written by Nurse #5 revealed in part, outpatient radiology confirmed receipt of the faxed physician's order for x-rays and an appointment was made for 2:00 PM. RP was notified. Resident #30 received Tylenol this morning per physician order and reported good results.

A Hospital Discharge Summary dated 05/22/23 for Resident #30 read in part, "fell from a mechanical lift 3 days ago and was evaluated here with complaints of hip pain on the right side. Imaging studies were equivocal and hip fracture was suspected and he was transferred to another hospital for further evaluation by orthopedics. Hip fracture was not confirmed and he was sent back to the skilled nursing facility that day. Since then, he has complained of posterior neck and bilateral posterior shoulder pain. He is bed-bound with dementia, Parkinson's disease and rheumatoid arthritis. Because of ongoing complaints of pain,

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the patient was sent by the skilled nursing facility for CT scans of the cervical spine, chest, abdomen and pelvis today. The Radiologist read the study showing acute fractures at C7 and T1. Case discussed with the Neurosurgeon who recommends placement of a cervical collar. He expects these injuries to heal completely without surgical intervention." Resident #30 returned to the skilled nursing facility on 05/22/23.

During an interview on 01/26/24 at 1:13 PM, the facility's Maintenance Director revealed on 05/17/23 he was called down to Resident #30's room after the incident to inspect the mechanical lift. He checked the hydraulics, hooks and all the components to make sure everything was working properly. He stated the mechanical lifts had four hooks which he described as U-shaped with a safety clasp across the top to ensure the sling straps stayed in place when attached to the lift. Upon inspecting the mechanical lift used to transfer Resident #30, he discovered the safety clasp on one of the lift hooks had malfunctioned, it had either collapsed or broke completely, which was how the sling strap came loose from the hook on the mechanical lift. The Maintenance Director explained when a person was suspended in the sling, the weight of the person caused the string straps to pull down and tighten but when the mechanical lift was lowered, the sling straps loosen and rise up and when functioning properly, the safety clasps prevented the sling straps from coming out of the top of the hook. The Maintenance Director stated either he or the Maintenance Assistant checked the mechanical lifts daily and when the lifts were inspected on 05/17/23 the hooks all appeared fine. He stated he kept a supply of replacement hooks in stock and the hook on the lift used to

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transfer Resident #30 was immediately replaced.

During a telephone interview on 01/26/24 at 4:03 PM, the Medical Director (MD) stated he recalled being informed Resident #30 had a fall from a mechanical lift but did not remember all the exact details of the incident. The MD stated prior to his fall on 05/17/23 Resident #30 required total staff assistance with ADL. The MD stated he would expect there be some sort of decline for anyone who fell from a mechanical lift but did not recall anyone mentioning Resident #30 experiencing increased pain or further decline from his normal baseline as a result of the fall.

The facility provided the following Corrective Action Plan with a completion date of 05/29/23:

On 05/17/23, Resident #30 was lowered to the floor by a Nurse Aide during a transfer using a Hoyer lift. The Nurse Aide reported Resident #30's weight shifted and the sling came out of the clip that holds the sling in place. Resident #30 did not initially complain of pain but did later in the shift. The physician was notified of the incident by the Charge Nurse on 05/17/23 and received an order for Resident #30 to be evaluated in the Emergency Room (ER) due to the new complaints of pain.

Resident #30 was evaluated at the hospital on 05/17/23 and returned to the facility on 05/18/23. On 05/22/23, additional x-rays were completed on an outpatient basis and revealed a C7/T1 fracture. He had a referral to see a neurosurgeon and is to wear a neck collar until released by the neurosurgeon. Resident #30 was seen on 06/08/23 by Spine and Neurosurgery. Resident #30 remains at the facility and has pain

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F 689	Continued From page 47 medication ordered with effective results noted. Maintenance replaced the clip on the lift on 05/17/23 that was used by Resident #30. The Nurse Aide was working under a contract with an agency and her contract was terminated on 05/18/23. The Nurse Aide had completed competency training on mechanical lifts on 03/07/23 that was competed by a Registered Nurse. All residents that are transferred with a mechanical lift have the potential to be affected by the same practice. The clips had been checked by the maintenance assistant at the beginning of the shift on 05/17/23. The clips on the other mechanical lifts were checked again on 05/17/23 by the Maintenance Assistant and no issues were found upon visual inspection after the incident. The Medical Records/Central Supply Clerk performed a visual inspection of the slings and all slings were in good condition on 05/17/23. The Director of Nursing initiated staff education on 05/17/23 on mechanical lifts with the staff on duty. Education was continued by a Registered Nurse with additional nursing staff on the proper use of mechanical lifts by 05/18/23. Nursing staff members not present during the initial training had education completed on the first day back to work. Education with the nursing staff was completed by 05/29/23. Mechanical lift education was added to new employee orientation by the Human Resources Director on 05/18/23.	F 689		

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F 689	Continued From page 48 A visual cue (laminated sign) was added to the mechanical lifts as a reminder to staff that two staff members must be present to use the mechanical lift. Written reminders were posed in different areas of the building stating that two staff members are required to use mechanical lifts. The visual cue and written reminders were added to the mechanical lift by the Director of Nursing on 05/18/23. The Maintenance Director and/or Maintenance Assistant will perform a visual inspection of the mechanical lifts, focusing on the clips, daily for two weeks, then three times a week, then reducing to weekly. Maintenance will repair/replace any issues noted on the inspection or will remove the lift from use if necessary. The inspections were initiated by the maintenance department on 05/18/23. The Director of Nursing, Assistant Director of Nursing or other Registered Nurse will perform mechanical lift transfer audit weekly for a minimum of 4 weeks then monthly until the QAPI committee changes the frequency of the audits. The assigned Registered Nurse will review at least 4 transfers per week for the audit. The mechanical lift audits will be documented on the mechanical lift audit form and will review that the sign is present on the lift and that two Nurse Aides are using the lift during the transfers properly. Re-education and/or return demonstration will be completed as needed based on the transfer observations. Any deficient practice will have corrective action taken at the time of discovery by the Registered Nurse. The mechanical lift audits were initiated on 05/26/23 by the Director of Nursing and will continue until substantial compliance has been achieved as	F 689		

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deemed by the QAPI committee.

The facility held an ad-hoc QAPI meeting on 05/29/23 with the Medical Director in attendance by phone. The topic of the meeting was a review of the mechanical lift issue and further development of the performance improvement plan.

The Director of Nursing reviewed the results of the audits with the QAPI committed on July 31, 2023 when the facility held the quarterly meeting. No trends, patterns or issues were identified during the audits. The audit will continue at a minimum of monthly per recommendation of the committee.

Date of compliance: 05/29/23

The Corrective Action plan was validated on 01/26/24 and concluded the facility had implemented an acceptable corrective action plan on 05/29/23. Interviews with nursing staff, including agency staff, revealed the facility had provided education and training on use of mechanical lift transfers that included requiring two-person assistance for all transfers, proper positioning in the sling and checking the security of the sling hooks and clasps to the mechanical lift. Staff interviewed all verbalized they were observed performing a mechanical lift transfer after receiving reeducation.

Review of the monitoring tools of mechanical lift transfers that began on 05/26/23 and continued weekly through 09/26/23 were completed as outlined in the corrective action plan with no concerns identified. Review of the mechanical lift inspection audits 05/18/23 through 01/24/24

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F 689	Continued From page 50 revealed inspections were completed daily and any issues identified were immediately repaired.	F 689		
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 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 record review and staff, Registered Dietician (RD), and Medical Director (MD) interviews the facility failed to address weight loss for 1 of 3 residents reviewed for nutrition (Resident #29). Findings included: Resident #29 was admitted to the facility 04/23/21 with diagnoses including anemia and diabetes.	F 692	1. Resident # 29□s primary care physician was notified by the Admissions RN on 02/02/2024 of the residents weight loss. The Registered Dietician (RD) saw Resident #29 on 02/02/2024 and provided dietary recommendations related to weight loss. The recommendations of a dietary supplement and appetite stimulant were communicated to the physician by	3/12/24

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Review of Resident #29's physician orders revealed an order dated 04/24/21 for furosemide (a diuretic) 20 milligrams (mg) once a day for fluid retention.

Review of Resident #29's weights are as follows:

09/03/23 207 pounds
09/25/23 191 pounds
10/02/23 188.5 pounds
10/04/23 191 pounds
10/23/23 190 pounds
11/02/23 190 pounds
12/04/23 191 pounds
01/04/24 176 pounds
01/15/24 175 pounds

The quarterly Minimum Data Set (MDS) assessment dated 11/03/23 revealed Resident #29 was moderately cognitively impaired and was dependent on staff assistance for eating. The MDS indicated Resident #29 had a stage 2 pressure ulcer (partial skin loss with exposed dermis) that was not present on admission and was not receiving a nutrition or hydration intervention to manage skin problems. The MDS further revealed Resident #29 received diuretic medication.

Review of Resident #29's nutrition care plan initiated 11/06/23 revealed he had unplanned/unexpected weight loss related to diuretic use, dependence on staff for eating, and poor intake at times. Interventions included providing his diet as ordered and monitoring and evaluating any weight loss.

Review of Resident #29's skin integrity care plan

F 692

the Admissions RN on 02/02/2024 and orders were received and processed on 02/08/2024. The supplement recommended by the RD was implemented on 02/02/2024, and the appetite stimulant recommendation order was received and processed by a licensed nurse on 02/08/2024.
Resident # 29 remains on weekly weights and his weight has remained stable.
2. All residents have the potential to be affected by the same practice. An audit of current residents will be completed by Admissions RN for any significant weight changes that were not previously reported to the RD or physician for the past 90 days. The audit will be completed by 03/08/2024. Corrective action will be taken for any resident not found to have appropriate notifications to the RD or physician during the audit by the Admissions RN or RN supervisor by 03/12/2024.
3. Education will be provided to the licensed nursing staff by the Admissions RN or RN supervisor by 03/09/2024 regarding the significant weight change notification procedures. Make-up education sessions will be provided until 100% of nursing staff have attended educated. Starting 03/10/2024, any licensed nursing staff that has not attended the weight loss notification education will be required to attend the education prior to working. A posttest will be given to assess learning with a passing score of 80% or above. New licensed nursing staff will be educated on significant weight loss notification

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F 692	Continued From page 52 last revised 11/17/23 revealed he had potential/actual impairment to skin integrity of the sacrum (bone in the lower back) related to fragile skin. Interventions included encouraging good nutrition and hydration to promote healthier skin and monitoring his skin for injury. A telephone interview with the Registered Dietician (RD) on 01/24/24 at 3:56 PM revealed she had been employed at the facility since August 2023 and spent 8 to 16 hours in the facility each month. She explained when she visited the facility, she was provided with a list of residents with weight gain, weight loss, or new admissions by the Dietary Manager and those were the residents she evaluated. The RD stated she had only recently been invited to attend risk meetings. She stated she did not have access to the computerized medical record to run a weight report and that was shy she depended on the Dietary Manager to notify her of any residents with weight changes or new admissions. The RD confirmed she was not asked to evaluate Resident #29 for weight loss until 11/11/23 and again on 01/12/24. She stated she had no recommendations when she evaluated Resident #29 in November 2023 and added Juven (a nutritional supplement that aids in wound healing) when she evaluated him in January 2024. The RD stated it was difficult to manage Resident #29's weight loss because there was "only so much you can do to get a patient to eat". She stated she had concerns that weights were not accurate and she had been working with the Admissions Nurse to address possible weight inconsistencies, but had not made written recommendations that residents be re-weighed. The RD confirmed she had not notified the physician of Resident #29's weight loss because	F 692	procedures during the initial orientation to the facility. The Admissions RN will review the residents current weight and the weight portal in the electronic health record to determine if a significant weight change has occurred. If a significant weight change has occurred, the primary care physician and the RD will be notified by the Admissions RN or RN supervisor by 03/12/2024. The Admissions RN will document the notification in the electronic health record, update the care plan, and process any recommendations received based on the notifications by 03/12/2024. The RN supervisor will complete random weekly audits of the residents documented weight in the electronic health record and review the nurses notes for proper physician and RD notification. Corrective action will be taken by the RN supervisor/Admissions RN or licensed nurse designee for any significant weight change that was not previously communicated with the physician and/or RD. The weekly audits will continue weekly times 4 weeks or until substantial compliance has been achieved and maintained as determined by the QAPI committee. 4. The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other	

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F 692	Continued From page 53 she did not have time to do so, and he was never in the facility at the same time she was. A telephone interview with the Dietary Manager on 01/25/24 at 9:25 AM revealed she was not always able to attend weekly risk meetings, but if she was unable to attend the meeting another staff member could run a weight report and notify the RD of weight loss. She stated significant weight loss was considered to be 5% in a month or 10% in 180 days. The Dietary Manager stated if she saw a significant weight change she notified the RD and she was not sure why Resident #29's September 2023 weight loss was not addressed until November 2023. An interview with the Admissions Nurse on 01/25/24 at 12:43 PM revealed she had been working on a plan with the RD to ensure accurate weights which included trying to ensure the same staff member obtained all weights, but that was not always possible. She stated a risk meeting was conducted each week and residents with weight concerns were discussed and placed on a list for the RD to see when she was in the facility. The Admissions Nurse stated she was not sure why Resident #20's weight loss was not addressed with the RD until November 2023. A telephone interview with the Director of Nursing (DON) on 01/26/24 at 12:59 PM revealed a weekly risk meeting was conducted to address weight concerns and the RD attended the meetings. She stated any concerns with weight accuracy were addressed by re-weighing residents and the Nurse Practitioner (NP) or Medical Director were notified by the Admissions Nurse of any weight concerns. The DON stated she was not sure why Resident #29 was not	F 692	staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024	

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F 692	Continued From page 54 evaluated by the RD for weight loss until November 2023. A follow-up interview with the Admissions Nurse on 01/26/24 at 2:10 PM revealed she was unsure who notified the NP or Medical Director of weekly weight concerns. A telephone interview with the Medical Director (MD) on 01/26/24 at 2:47 AM revealed he would expect to be notified of Resident #29's weight loss at the time the weight loss was noted. He stated had he been notified of the weight loss he would have ordered a RD consult and possibly some supplements.	F 692		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		3/12/24

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F 700	Continued From page 55 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to attempt alternatives, review the risks and benefits, and obtain informed consent from the resident's Responsible Party (RP) prior to use of bed rails; comprehensively assess the risk of entrapment after the placement of an alternating pressure air mattress; and accurately assess the continued need for bed rails for 2 of 6 residents reviewed for bed rail use (Resident #1 and Resident #24). Findings included: 1. Resident #1 was admitted to the facility 04/28/13 with diagnoses including stroke, hemiplegia (paralysis on one side of the body), aphasia (a language disorder that affects a person's communication ability), contracture to the right hand (a disorder that affects normal movement), and non-Alzheimer's dementia. Resident #1 had a physician order dated 07/24/23 to check placement of air mattress daily on night shift. Review of the quarterly Minimum Data Set (MDS) assessment dated 10/27/23 revealed Resident #1 was rarely or never understood, had severely impaired cognition for daily decision making, impaired range of motion (ROM) to both upper and lower extremities, and was dependent on staff assistance for rolling from right to left sides. Review of the most recent side rail assessment dated 07/28/23 and completed by the Assistant	F 700	Resident # 1 has had an updated side rail evaluation completed on 02/21/2024 by a licensed nurse Education will be provided by a licensed nurse to the responsible party regarding the use of bedrails and verbal informed consent will be obtained on 02/20/2024. Resident # 24 has had an updated side rail evaluation completed on 02/20/2024 by a licensed nurse. The licensed nurse will obtain informed consent after education is provided to the responsible party regarding the use of bed rails by 03/12/2024. Education will be provided by a licensed nurse to the responsible party on the risk and benefits of the use of side rails, including how the risks will be mitigated based on the medical needs of the resident, and any alternatives that were considered. The education was completed for responsible parties of Resident #1 and Resident #24. The side rail evaluation considers the residents physical abilities, cognitive status, and related medical diagnosis. All residents have the potential to be affected by the same practice. The RN supervisor will complete an audit of the current residents to review the clinical record and complete a bed rail evaluation for the residents, evaluating any alternatives that can be used. Based on the results of the evaluation, the RN will obtain physicians orders and informed	

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F 700	Continued From page 56 Director of Nursing (ADON) revealed Resident #1 requested side rails for safety, security, and to assist with bed mobility. The assessment indicated bed rails were used with turning side to side in bed and would assist Resident #1 from falling out of the bed and provide a sense of security for her. The assessment determined there were no fluctuations in consciousness, but there were uncontrolled or involuntary movements. The assessment concluded quarter side rails were recommended for the right and left upper portion of Resident #1's bed. Review of Resident #1's falls care plan last revised 01/22/24 revealed she was at risk for falls related to a history of right hemiplegia, having no use of her lower extremities, and having no safety awareness. Interventions included anticipating and meeting her needs, ensuring her call light was within reach, and ensuring she had bilateral (both sides) quarter side rails at all times since she was totally dependent on staff for all activities of daily living (ADL). Observations of Resident #1 on 01/22/24 at 3:24 PM, 01/23/24 at 9:09 AM, 01/24/24 at 8:53 AM, and 01/25/24 at 12:18 PM revealed she was in bed with both quarter side rails in the upright position and an alternating pressure air mattress was in place. An additional observation of Resident #1 on 01/24/24 at 10:11 AM revealed she was repositioned in bed by Nurse Aide (NA) #4 and NA #5. When Resident #1 was rolled onto her right side she was able to lay her left hand on the side rail while she was being repositioned, but was unable to grasp the side rail or use it to aid in repositioning herself in bed.	F 700	consents for any resident that requires the use of side rails on the bed. The audit will be completed by 03/08/2024 and corrective action for any discrepancies identified during the audit will be completed by 03/12/2024. The IDT reviewed and updated the policy regarding use of side rails on 02/21/2024 to include the need for informed consent, use of alternatives, and education related to use of side rails. The DON will provide education to the licensed nursing staff regarding (informed signed consent) use of side rails and the updated side rail policy by 03/08/2024. Any licensed nurse unable to attend the education will have training completed on the use of side rails before their next shift by 03/12/2024. The Human Resource Director will update the new employee orientation guide for licensed nurses to include training on the use and documentation required for side rails. This will be completed by 02/21/2024. A licensed nurse will complete the side rail evaluation upon admission to the facility. Based on the results of the evaluation, the licensed nurse will look for alternatives that can be used. If side rails are used, the licensed nurse will obtain a physicians order and informed consent for use of side rails. Nursing Administration or the RN supervisor will notify the maintenance director when the resident has an order for a different type of mattress than they are currently using. The Maintenance Director or maintenance assistant will	

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F 700

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An interview with NA #4 on 01/25/24 at 1:50 AM revealed Resident #1 was not able to use the quarter side rails to aid with repositioning herself.

An interview with the ADON on 01/25/24 at 3:39 PM revealed she usually completed all bed rail assessments in conjunction with the assessment reference date (ARD) for the MDS, but was unable to state why the last side rail assessment for Resident #1 was in July 2023. She stated she physically assessed each resident for safety of side rail use and the indication for side rail use was not solely based on coding of the MDS. The ADON stated Resident #1 would be able to assist with repositioning herself in bed if she was not lying on her unaffected arm, otherwise she would not be able to assist with repositioning herself. She further stated bed rails should not be used for residents who had no mobility or lacked the ability to ask for help.

An interview with the Maintenance Director on 01/26/24 at 10:48 AM revealed all beds in the facility had side rails and the type of side rail used depended on the type of bed being used. He stated the maintenance department checked for side rail entrapment annually with a tool designed to assess the risk of entrapment. The Maintenance Director stated he kept a written log of each assessment for side rail entrapment. When he was asked if he was ever notified of the need to remove side rails from a resident's bed because they were no longer capable of using the rails, he stated he had not because the situation had never come up.

A telephone interview with the Director of Nursing (DON) on 01/26/24 at 12:59 PM revealed

F 700

check the mattress and bed for compatibility and for any safety issues, including entrapment prior to exchanging the mattress. If a safety or entrapment issue is noted, the primary care physician will be notified by a licensed nurse for an order for a different type of mattress.
A chart review will be completed by the Medical Records clerk, and he will notify the DON of any new admissions that do not have a side rail evaluation and consent for use of side rails if indicated by the evaluation. Corrective action will be taken by the RN supervisor for any issues identified by the Medical Records clerk during the chart review for the newly admitted resident.
The RN unit manager will conduct random weekly audits comparing the side rail evaluation with what the resident has in place on the bed, along with any alternatives attempted or recommended, the presence of a physicians order and informed consent for the bed rails in use. The audits will continue weekly for 4 weeks or until the QAPI committee has deemed that substantial compliance has been achieved and maintained.
The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will

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Resident #1 would not be able to reposition herself or call for assistance if she became trapped in either of her side rails and she needed to be re-evaluated to assess the continued need for side rails.

2. Resident #24 was admitted to the facility on 08/01/22. Resident #24's current diagnoses included vascular dementia, contractures of the left and right hip and left and right knee.

The initial bed rail assessment dated 08/01/22 listed the reasons Resident #24 needed bed rails were weakness, bed mobility to assist turning side to side, moving up and down the bed, and pulling from a laying to sitting position. The assessment indicated bed rails were not considered a restraint and recommended left and right quarter rails.

A physician's order dated 07/24/23 was for an air mattress to be placed on the bed of Resident #24.

Review of the facility's bed safety check titled, "Bed System Measurement Device Test Result Worksheet" revealed the type of bed Resident #24 used including the model number and type of mattress. The document indicated Resident #24's bed passed the check completed on 11/28/23 for two quarter bed rails installed at the head of the bed.

Review of the manual for the type of bed Resident #24 used provided a list of mattresses including air mattresses that comply with entrapment guidelines for the use of beds and rails.

review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024

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During an interview on 01/26/24 at 10:48 AM the Maintenance Director stated bed rail checks for entrapment were done annually. He revealed all the beds in the facility come with preinstalled bed rails and if not used by the resident were lowered out of the way. The Maintenance Director stated he was not notified when a resident had a decline and was no longer able to use the bed rail. Either he or the Maintenance Assistant were notified when an air mattress was ordered, and they placed it on the bed. The Maintenance Director stated the air mattress was checked to ensure there were no leaks when placed on the bed but the bed rail safety check for Resident #24 was completed 11/28/23 not when the air mattress was placed.

The most recent bed rail evaluation dated 01/04/24 was completed and signed by the Assistant Director of Nursing (ADON). The evaluation listed the reasons Resident #24 needed to use bed rails were safety, security, and to assist with bed mobility and turning side to side and assist the resident from rolling out of bed and provide a sense of security for the resident. The evaluation indicated bed rails were not considered a restraint and recommended to use at all times when in bed and as an enabler for the resident to assist with bed mobility. The evaluation did not contain information about the risks that were reviewed, or consent given by Responsible Party (RP) of Resident #24 to use bed rails.

An interview was conducted on 01/25/24 at 4:13 PM with the ADON. The ADON stated Resident #24 had a recent decline and was newly admitted to hospice (01/16/24). She stated when first admitted Resident #24 was able to use the bed

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rails and alternatives tried was therapy and prior to going on hospice demonstrated she could use the bed rail to assist in rolling over during care. The ADON stated the type of resident she did not recommend bed rails had no mobility or did not have the ability to alert or ask for help either cognitively or physically. She stated for a cognitively impaired resident she did not get consent prior to the use of bed rails and were added based on the assessment. She was unsure if the RP of a cognitively impaired resident was informed or not and stated it was a team effort and could have been discussed during the care plan meeting or when the RP was notified of the physician's order for bed rails. The ADON revealed bed rail assessments were completed upon admission and quarterly, but she was not prompted to reassess the use of bed rails when an air mattress was placed or if a resident declined in their ability to use rails for bed mobility.

The quarterly Minimum Data Set (MDS) dated 01/08/24 assessed Resident #24 was severely impaired cognitively and dependent on staff for bed mobility and transfers with range of motion impairment affecting one side of her upper extremities and both sides of the lower extremities. No falls had occurred since the previous assessment and bed rails were not used as a restraint.

The care plan revised on 01/08/2024 revealed Resident #24 had a deficit in her ability to perform activities of daily living related to fatigue and impaired balance and required extensive assistance with bed mobility and total assistance using a mechanical lift for transfers. Interventions included quarter rails up for assistance with bed

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mobility and observe for injury or entrapment related to bed rail use.

Review of the hospice admission contract signed 01/16/24 indicated Resident #24 was eligible for and accepted for services.

Review of the physician's order dated 01/17/24 revealed Resident #24 would be admitted to hospice.

During an observation and interview on 01/23/24 at 1:54 PM Resident #24 was observed in the bed with bilateral quarter bed rails in an up position and an alternating pressure air mattress in place. Resident #24 stated she could grab hold of the bed rails on each side and demonstrated she could reach the rail and touch it. When asked if she used the bed rails for mobility to roll over onto her side Resident #24 did not answer or demonstrate she could use the bed rails for bed mobility.

An interview was conducted on 01/24/24 at 4:51 PM with the RP of Resident #24. The RP stated Resident #24 was able to use the bed rails when first admitted but now has contractures and only grabs hold, and staff physically roll her over on to her side. The RP stated the bed rails were used to keep Resident #24 from falling from the bed, but she did not recall the risk of bed rails was discussed. The RP stated she wanted the bed rails in place to keep Resident #24 from falling on the floor.

During an interview on 01/25/24 at 2:08 PM Nurse Aide (NA) #1 stated Resident #24 did not use the bed rails to roll over or adjust while in bed. She stated staff had to physically roll

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Resident #24 and hold in position when providing care.

A follow-up interview and observation were conducted on 01/26/24 at 11:31 AM with the Maintenance Director. The Maintenance Director observed Resident #24 in bed with bilateral quarter bed rails in an up position. The Maintenance Director demonstrated the areas he checked for safety and entrapment include the space between the air mattress and rails and stated the space between the air mattress and rail was not enough for Resident #24 to become entrapped. He revealed Resident #24's bed had bolsters (a support cushion) placed around the bed and both the bed rails and bolsters were to help prevent the resident from falling out of bed. The Maintenance Director stated all bed safety checks were done on 11/2023 with no issues found.

During an interview on 01/26/24 at 2:50 PM the Medical Doctor stated the RP for cognitively impaired residents should be made aware of the benefits and risks of using bed rails.

A telephone interview was conducted on 01/26/24 at 1:03 PM with the Director of Nursing (DON). The DON stated bedrails were left down if a resident did not want to use. The DON stated the evaluation did not include the physical ability of Resident #24 to use the bed rail or consent was obtained from the RP prior to installing. The DON stated she was unsure if signed consent for the use of bed rails was obtained prior to use.

During an interview on 01/26/24 at 3:24 PM the Administrator stated education needed to be done related to the bed rails assessments and

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F 700	Continued From page 63 consent obtained from the RP for a cognitively impaired resident. He stated the RP would need to be informed of the risk for a resident that cannot physically roll or assist with rolling by grabbing and holding onto the bed rail. The Administrator stated Resident #24 was contracted and would want the RP to be aware of the risk if Resident #24 was caught against the rail and might not be able to free herself when bed rails were in use.	F 700		
F 803 SS=C	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make	F 803		3/12/24

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F 803	Continued From page 64 personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations of the meal service tray line, record review, and Registered Dietician (RD) and staff interviews the facility failed to provide portions of food from a standardized meal planning guide such as a spreadsheet. This failure had the potential to affect 77 out of 78 residents. Findings included: Review of a menu for the Fall/Winter cycle of 2021-2022 revealed spaghetti with meat sauce, vegetable blend, and garlic toast were going to be served for the lunch meal on 01/24/23. An interview with Cook #1 on 01/24/24 at 11:00 AM revealed she did not have the spreadsheet that provided portion sizes, but the Assistant Dietary Manager would be able to provide them when he arrived. She stated she was serving the spaghetti with meat sauce, regular spaghetti noodles, pureed spaghetti noodles, Italian blend vegetables, and pureed vegetables in a 4-ounce portion for each item. An observation of the meal tray line on 01/24/24 at 12:01 PM revealed each menu item was served in 4-ounce portions. In an interview with the Assistant Dietary Manager on 01/24/24 at 3:26 PM he stated he was unable to provide a spreadsheet with portion sizes that were served for the lunch meal on 01/24/24. He explained at the beginning of 2024 the facility's food suppliers were going to start charging them for menus, so they began to recycle menus that	F 803	Updated five-week cycle menus that include the appropriate portion serving size to meet the nutritional needs of residents have been ordered by the Certified CDM (CDM) from a food service vendor; standardized recipes will be included with the updated menus. The new menus with portion sizes will be reviewed and approved by the Registered Dietitian by 03/12/2024. Residents will be served appropriate portion serving sizes according to the menu approved by the RD. All residents have the potential to be effective and education will be provided by the CDM by 03/12/2024 with the dietary staff on the need to serve appropriate portion sizes as approved by the RD on the tray line. A post-test will be given to dietary staff to assess learning and 80% will be the passing score. Make up education and a post test will be provided by the CDM for any dietary employee who is unable to attend the first education session by 3/12/2024. Staff who have not completed the education will be unable to work until the education is completed. New dietary staff will receive education on following menus and serving the appropriate portion sizes as part of the dietary staff orientation program. The orientation program for dietary cooks and aides will include training on following menus and serving appropriate portion sizes. The orientation checklists for dietary staff will be updated by the HR	

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F 803	Continued From page 65 had previously been approved by a dietician from the food supplier. The Assistant Dietary Manager stated since the menus were recycled, he did not have the corresponding spreadsheet that listed portion sizes. A telephone interview with the RD on 01/24/24 at 3:56 PM revealed she had been employed at the facility since August 2023 and had not been asked to develop or review menus for the facility. She stated she was not aware the facility was using recycled menus with no correlating portion sizes. A telephone interview with the Dietary Manager on 01/25/24 at 9:25 AM revealed at the beginning of 2024 the facility food suppliers were going to start charging them for use of their menus, so they started using recycled menus that had previously been approved by a food supplier dietician. She stated since they were recycling menus, they did not always have the correlating spreadsheet that listed portion sizes, but the standard industry guideline for portion size was 3-ounces of protein and 4-ounces of vegetables. The Dietary Manager stated the facility's former Registered Dietician (RD) would review the menus, even though they had already been approved by the food supplier dietician. The Dietary Manager stated she could not recall how long the new RD had been employed at the facility, but when she asked her about developing menus for the facility, she stated she wasn't comfortable doing that. A telephone interview with the Administrator on 01/26/24 at 3:25 PM revealed menus should not be recycled, and portion size information should be provided.	F 803	Director to include following menus and serving appropriate portion sizes. A daily spreadsheet with the portion sizes for menu items as approved by the RD will be maintained at the tray line work area for review by the dietary staff prior to meal service and as a reference as needed while serving by 03/12/2024. CDM, or CDM designee, will complete random audits weekly x 4 or longer until substantial compliance is achieved as determined by the QAPI Committee to assess that menus approved by the RD are in use, the daily spreadsheet with portion sizes is available in the tray line work area and followed by dietary staff. The CDM or Administrator will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024	

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F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to provide drinks consistent with the resident's preference for 1 of 1 sampled resident (Resident #55). Findings included: Resident #55 was admitted to the facility on 08/24/21. A physician's diet order dated 06/01/22 for Resident #55 noted a regular diet, regular texture and regular liquids. The quarterly Minimum Data Set (MDS) assessment dated 12/01/23 assessed Resident #55 with intact cognition and requiring setup or cleanup assistance only with eating and drinking. During an interview on 01/24/23 at 9:53 AM, Resident #55 revealed there was a soft drink dispenser out in the main dining room for everyone to access but the sweet tea ran out frequently, most recently yesterday at lunch and two times last week. She explained when the sweet tea ran out dietary didn't have any more and she was offered unsweet tea with a sugar packet, but it didn't taste the same because the	F 807	Dietary Assistant Manager on 1/24/2024 ordered 2 cases of sweet tea syrup. The Assistant Manager has updated the food/beverage inventory to include a minimum of 2 cases of sweet tea syrup will be on hand, with one of the cases being in the food storage area. Food/Beverages are ordered 4 times weekly. On 02/12/24 a case of sweet tea syrup concentrate was ordered and added to Disaster Foods inventory. The Disaster Food inventory is checked monthly to maintain adequate supply. The CDM or CDM designee will be available to attend Resident Council meetings when food concerns are discussed. All current residents will be updated with preferences regarding food and beverages by the CDM or CDM designee by 03/10/2024. The CDM or CDM designee will continue to interview new residents who are cognitively aware, the responsible party or significant other during the admission process for beverage preference and document preferences in the resident's medical record and on the resident's meal ticket. The CDM will audit the supply of sweet	3/10/24

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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 807

Continued From page 67

sugar didn't dissolve completely. Resident #55 explained the dietary department had run out of sweet tea for most of the past year and she had personally discussed the issue with the Administrator on several occasions but couldn't recall when the last time that was. She recalled he told her there should be no issue with getting sweet tea, as there was enough money in the budget, and referred her back to dietary. Resident #55 stated she didn't ask for much and felt having sweet tea available was such a little thing, but it made her happy and completed her meal.

During an interview on 01/24/24 at 1:05 PM, the Assistant Dietary Manager (DM) revealed he was aware of the concerns of Resident #55 as well as a few other residents with the sweet tea running out. He explained dietary staff did not brew tea for the residents to drink but there was a soft drink dispenser out in the main dining area for residents and staff to use that had several flavored drinks including both sweet and unsweet tea. The soft drink dispenser had tubes that connected to flavored syrup containers in the kitchen and when those ran out, he placed an order and once received, he refilled the soft drink dispenser. The Assistant DM stated with the soft drink dispenser being out in the main dining room, it was hard for him to monitor usage to determine how many flavored syrups he needed to order each week since it was hit or miss as to who was drinking more of the sweet tea, residents or staff. The Assistant DM stated although he understood it wasn't the same, the best he could do was substitute unsweet tea with sugar packets when the sweet tea ran out until he was able to refill the soft drink dispenser.

F 807

tea syrup on Mondays and Thursdays to ensure that 2 extra cases of syrup are on hand x 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QAPI Committee. CDM and Assistant Manager will continue to audit Disaster Food inventory monthly. The CDM and Administrator will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024

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F 807	Continued From page 68 During a telephone interview on 01/26/24 at 3:06 PM, the Administrator revealed while it wasn't on a frequent basis, Resident #55 had talked to him on occasion when there was not any sweet tea available and let him know it was an issue for her. The Administrator explained he talked with the Assistant DM about the issue and they would put sugar in the unsweet tea for the residents or offer them something else. He stated there may have been times they were out of sweet tea in the drink dispenser for a few days or so, depending on how soon the delivery could get the order to the facility. The Administrator stated he had discussed with the Assistant DM about ordering more sweet tea refills for the soft drink dispenser each week but was not sure if that had been implemented yet.	F 807		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with the Registered Dietitian and staff the facility failed to follow the physician's diet order for double portions of protein with meals for 1 of 3 residents reviewed for nutrition (Resident #39). Findings included:	F 808	1. A telephone order for double portions for resident #39 was obtained by a licensed nurse on 01/26/2024. Resident #39 will be served double portions as ordered by the dietary and nursing staff. 2. A registered nurse will review the	3/12/24

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F 808

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Resident #39 was admitted to the facility on 09/12/23. Resident #39's current diagnoses included adult failure to thrive, a sacral stage 3 pressure ulcer (full-thickness loss of skin) and right buttock stage 3 pressure ulcer.

Review of the quarterly Minimum Data Set (MDS) dated 12/18/23 assessed Resident #39 was cognitively intact and required supervision with eating. Resident #39 weighed 113 pounds with known weight loss and not on a regimen to lose weight. The MDS identified a stage 4 pressure ulcer (full-thickness skin loss).

The Registered Dietitian (RD) progress note dated 01/03/24 revealed Resident #39 was encouraged to consume as much protein as possible to increase wound healing and recommended double protein of meat at meals.

Review of the physician's diet order dated 01/03/24 revealed Resident #39 was to receive a regular diet with instructions for double portion of meat on each tray.

The care plan revised on 01/04/24 identified Resident #39 had unplanned or unexpected weight loss related to diagnoses and poor food intake. Interventions included provide diet as ordered: regular diet with double meat protein at meals.

Review of the most current documented weight for Resident #39 revealed on 01/20/24 the resident weighed 115 pounds (lbs.).

During an observation on 01/24/24 at 5:45 PM the dinner meal tray for Resident #39 had 1 slice of

F 808

dietary progress notes and the physicians orders of active residents by 03/08/2024. The attending physician and/or registered dietitian (RD) will be notified by a licensed nurse of any discrepancies identified to obtain dietary order and/or recommendation clarification by 3/12/24. Corrective action to any identified discrepancies after the clarification will be completed by a licensed nurse and/or CDM as necessary by 03/12/2024.

3. The RD, the CDM, and licensed nursing staff will receive education by the Director of Nursing by 3/8/2024 on the importance of accurate and complete implementation of nutritional recommendations and orders from the RD and/or MD along with education on the process of how to implement recommendations. The RD will provide a list of residents seen during her consultations to the CDM or Admissions Nurse. The Admissions RN or RN designee will review the progress notes of the residents seen by the RD for new recommendations and take action as necessary to implement them. New licensed nursing staff will be educated on importance of accurate and complete implementation of nutritional recommendations and orders from the RD and/or MD along with education on the process of how to implement recommendations during the initial orientation to the facility.

The RN Supervisor will conduct random audits of the dietary recommendations

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F 808	Continued From page 70	F 808		

country fried steak and no other meat protein. The meal ticket on the tray read regular diet with no instructions to provide double protein of meat with each meal.

During a telephone interview on 01/25/24 at 9:18 AM the Certified Dietary Manager (CDM) stated she ran a progress report that listed the residents the RD saw and what recommendations were made. She explained the process was for the RD to add recommendations to the resident's diet order by inputting the information into the electronic medical record. The CMD stated the previous diet orders were not consistently removed from residents' electronic medical records and she was unsure who was responsible for removing the previous diet orders.

During an observation and interview on 01/25/24 at 12:44 PM the Nurse Consultant observed two pieces of turkey on the lunch meal tray for Resident #39 and the meal ticket that read regular diet with no instructions to provide double meat protein with meals.

An interview was conducted on 01/25/24 at 12:56 PM with the Cook. The Cook reviewed the meal ticket for Resident #39 had no instructions for double meat proteins with meals. The Cook stated Resident #39 received the regular portion of meat based on the meal ticket and the serving was 2 pieces of turkey. The Cook stated for Resident #39 to receive double meat portions with meals the meal ticket would have those directions included. The Cook stated she would correct the meal ticket to ensure the correct diet order was updated to reflect Resident #39 received double protein meats with meals.

weekly x 4 or until substantial compliance has been achieved and maintained as determined by the QAPI Committee. Corrective action will be taken for any identified discrepancy by a licensed nurse as necessary. Administrator to follow up with dietary and Admission RN.

4. The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct completion of corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends.
Completion date 03/12/2024

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F 808	Continued From page 71 During an interview on 01/25/24 at 12:56 PM the Nurse Consultant stated the nurse who received the physician's diet order filled out a communication diet card and gave it to dietary staff. If the RD inputs the diet order the Nurse Consultant stated she was unsure how the nurses would know a new diet order needed to be communicated and there was breakdown in communication between the RD, nursing, and dietary staff. An interview was conducted on 01/26/24 at 10:11 AM with the RD. The RD stated on 01/03/24 she added her recommendations for a regular diet with instructions for Resident #39 to receive double meat proteins with meals in the electronic medical record and filled out a diet order card slip and gave it to the kitchen with the same instructions. The RD stated she increased Resident #39 receive double meat protein to help with healing existing wounds and wanted the recommendation implemented. A telephone interview was conducted on 01/26/24 at 1:03 PM with the Director of Nursing (DON). The DON stated the RD recommendation Resident #39 receive double meat protein with meals she would expect was in place to help with healing existing wounds.	F 808		
F 812 SS=E	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.	F 812		3/12/24

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F 812	Continued From page 72 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to cover and date an open food item in 1 of 1 walk-in freezer; ensure food items were labeled and dated in 2 of 2 nourishment rooms (A/B Hall and C/D Hall); and maintain a clean refrigerator and freezer in 1 of 2 nourishment rooms (C/D Hall). These practices had the potential to affect food served to residents. Findings included: 1. An initial tour of the walk-in freezer on 01/22/24 at 10:37 AM revealed a box of hamburger patties open to air with no open date. An interview with the Assistant Dietary Manager on 01/22/24 at 10:37 AM revealed the hamburger patties should be covered and dated when they were opened. He stated it was the responsibility of the person that opened the item to date it and cover it, so it was not left open to air. The Assistant Dietary Manager stated he was not sure why the hamburger patties were not covered and dated.	F 812	On 01/22/2024 Assistant Food Service Manager covered and dated a box of open hamburger patties. On 01/23/2024 Assistant Food Service Manager provided a stock date to multiple packs of sausage biscuits in the nourishment room. The ice cream sandwich box that was found in the A/B nourishment room has been labeled and dated with resident information by the Certified Dietary Manager (CDM) on 01/29/2024. On 01/29/2024, the CDM cleaned the refrigerators located on A/B and C/D hall. The CDM did a complete audit on 02/19/2024 to determine that all food/beverages were labeled and dated correctly and corrected any identified discrepancies on 02/19/2024. Food items in the food storage areas including the walk-in freezer, cooler, dry storage area, and nourishments rooms were checked by the CDM, Assistant Food Service Manager and the dietary staff for proper storage including dating and cleanliness on 02/20/2024.	

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A telephone interview with the Dietary Manager on 01/25/24 at 9:25 AM revealed all food in the freezer should be covered, labeled, and dated when opened. She stated it was the responsibility of the person placing the item in the freezer to cover, label, and date the item.

2. (a). An observation of the A/B Hall nourishment room freezer on 01/22/24 at 10:59 AM revealed 5 unlabeled and undated packs of mini sausage biscuits and one unlabeled and undated ice cream sandwich.

(b). An observation of the C/D Hall nourishment room freezer on 01/22/24 at 11:02 AM revealed 5 packs of unlabeled and undated packs of mini sausage biscuits.

An interview with the Assistant Dietary Manager on 01/22/24 at 11:02 AM revealed the dietary department placed the mini sausage biscuits in the freezer and should have labeled and dated them at the time they were placed in the freezer. He stated the ice cream sandwich was probably placed in the freezer by a member of nursing staff and they should have labeled and dated the item when it was placed in the freezer. The Assistant Dietary Manager stated the nourishment room refrigerators and freezers were checked daily for unlabeled and undated food by the dietary department. He explained he was responsible for checking the nourishment room freezers on 01/21/24 and he was not able to recall if he checked the freezers or not.

A telephone interview with the Dietary Manager on 01/25/24 at 9:25 AM stated she placed the mini sausage biscuits in both nourishment rooms

F 812

Discrepancies identified were immediately corrected at the time of discovery by the CDM, Assistant Food Service Manager, or dietary staff.
Education will be provided to the nursing and dietary staff on proper food storage in the cooler, freezer, and nourishment rooms by the CDM by 03/12/2024. A post-test will be given to assess the nursing and dietary staffs understanding of proper food storage procedures with a score of at least 80% to be considered passing. Make-up education and post-testing will be provided by the CDM or designee for nursing and dietary employees unable to attend by 03/12/2024. Nursing and dietary staff who are unable to complete education and post-testing by 03/12/2024 will be unable to work until it is completed. New dietary staff will receive training on proper food storage and maintaining cleanliness of the food storage areas as part of the dietary staff orientation program. The orientation program for dietary cooks and aides will include training on proper food storage including open dating and maintaining cleanliness of the food storage areas. The orientation checklists for dietary staff will be updated by the HR Director to include proper food storage including open dating and maintaining cleanliness of the food storage areas.
A dietary staff member will check the walk-in freezer, the cooler, the dry food storage area and the nourishment rooms daily for proper food storage including open dating and cleanliness. Any discrepancies identified at the time of the

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F 812	Continued From page 74 and forgot to label and date them. She stated all items in the nourishment room refrigerators and freezers should be labeled and dated by the person placing the item in the refrigerator or freezer and the dietary department was responsible for checking the nourishment rooms daily. 3. An observation of the C/D Hall nourishment room refrigerator and freezer on 01/22/24 at 11:02 AM revealed multiple areas of dried debris to the shelves and inside of the refrigerator and freezer doors. In an interview with the Assistant Dietary Manager on 01/22/24 at 11:02 AM he confirmed the refrigerator and freezer should be clean, but he was not sure if the dietary department or the housekeeping department was responsible for cleaning the nourishment room refrigerators and freezers. A telephone interview with the Dietary Manager on 01/25/24 at 9:25 AM revealed the nourishment room refrigerators and freezers should be clean and free of debris and it was the dietary departments' responsibility to clean them when they noticed they were dirty.	F 812	check will receive immediate corrective action by the dietary staff. The check of the food storage areas daily for cleanliness and proper food storage including open dating will be documented by the dietary staff on a spreadsheet. The cleaning of the freezer, cooler, dry food storage area and nourishment rooms will be on the weekly cleaning schedule; the dietary staff member cleaning each area weekly will document the cleaning by initialing the completion of the cleaning on a spreadsheet. Proper food storage including open dating and the cleanliness of the food storage areas (e.g., the Freezer, Cooler, dry food storage area, and the Nourishment Rooms) along with a review of the corresponding spreadsheets for completion will be audited by CDM or Assistant Manager randomly weekly x 4 or until substantial compliance is achieved and maintained as determined the QAPI Committee. The CDM or Administrator will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and	

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F 812	Continued From page 75	F 812	maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion Date 03/12/2024	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		3/12/24

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F 842	Continued From page 76 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document self-administered medications for 1of 3 residents reviewed for self-administration (Resident #55).	F 842	1. Resident #55 was reevaluated by a licensed nurse on 02/14/2024 for unsupervised self-administration of her Sumatriptan tablets and injectable when needed as ordered by the attending	

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The findings included:

Resident # 55 was admitted to the facility on 8/24/21 with a diagnosis that included migraine.

Review of the quarterly Minimum Data Set (MDS) dated 12/1/23 revealed she was cognitively intact with no behaviors. She did not receive scheduled pain medications but did receive as needed (prn) pain medications. Resident #55 did have frequent pain that interfered with her day-to-day activities, but not her sleep.

Review of the care plan dated 11/30/23 revealed in part:
Resident #55 had a physician's order for unsupervised self-administration of Sumatriptan tablets and Sumatriptan injection. Interventions included, Resident #55 will take medication safely and as prescribed through the review date. Resident #55 will demonstrate the ability to take medications at the correct dose, route, time, frequency and for the right reason, verbalize possible side effects, and possible drug interactions. Staff will assess resident's ability to safely self-administer medications specified on admission/re-admission, quarterly, with change in medication orders and with significant changes in condition. Resident #55 will keep both medications in top locked drawer of dresser at all times.

Resident #55 had a physician's orders for Sumatriptan Succinate Solution 6 MG/0.5 milliliter (ML). Inject 0.5 ml subcutaneously every 24 hours as needed for migraines with start date of 8/25/2021 and Sumatriptan Succinate Tablet 100 milligram (MG). Give 1 tablet by mouth every 24 hours as needed for migraine, may repeat in 2

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physician; she was determined by the IDT to be safe for unsupervised self-administration of Sumatriptan on 02/14/2024. Tasks will be entered into the electronic health record for a licensed nurse to check with Resident #55 each shift to determine self-administration of oral or injectable Sumatriptan and the medication effect. The licensed nurse will document Resident #55□s self-report of oral and injectable Sumatriptan and the medication effectiveness in the electronic health record each shift.

2. A licensed nurse will review the electronic health records of all residents to identify residents approved by the interdisciplinary team for self-administration of medication by 03/12/2024. Tasks will be created in the electronic health records of residents approved for self-administration of medication for a licensed nurse to check with the resident each shift to determine the residents self-report of medication and, for prn medication, the effect of the medication. A licensed nurse will document each shift in the electronic health record the residents□ self-reports of self-administration of medication and, for prn medication use, the effect of the medication.

3. Licensed Nurses will be educated by the Director of Nursing by 03/08/2024 on the need to have accurate medical records for residents approved by the interdisciplinary team for self-administration of medications and the policies and procedures for documentation of resident

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hours if needed with a start date of 8/25/2021. Resident #55 also had a physician's order that read, "Resident #55 may keep sumatriptan tablets and injections in her room in a locked drawer to self-medicate. Needles, alcohol pads and sharps container may be kept in locked drawer also". The order had a start date of 8/13/2022.

Review of the self-administration assessment dated 8/13/2024 indicated Resident #55 was capable of self administering medication.

An interview on 1/25/24 at 2:15 PM with Resident #55 revealed she tells the staff when she needs more medication ordered. Resident #55 further revealed that none of the nurses came in and asked if she has used the migraine medication daily. Resident #55 makes herself a calendar where she keeps track of the number of her migraine medications and what day and time, she administers her medication. Resident #55 stated she does not keep the paper she tracks it on past that month.

Record review of Resident #55's personal administration calendar revealed her only self-administered injection for January was on 1/10/24 at 7:30AM.

Record review of the Medication Administration Record from January 2024 shows no documentation of the self- administration of Sumatriptan Succinate Solution 6 MG/0.5ML Inject 0.5 ml subcutaneously every 24 hours as needed for migraines on 1/10/24.

An interview was conducted on 1/25/24 at 2:01 PM with Nurse #4 and revealed Resident #55 can

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self-administration of medication in the electronic health record. A post-test will be administered with a passing score of 80%. Make-up education and a post test will be provided by the Director of Nursing and/or designee for any employee that is unable to attend the first education session by 03/12/2024. New licensed nurses will receive education about the need for an accurate medical record for resident self-administration of medications by a licensed nurse as part of the licensed nurse orientation program. The orientation checklist for licensed nurses will be updated by the Human Resources (HR) Director to include accuracy of medical records.

Upon approval of the resident for self-administration by the interdisciplinary team and receipt of physician orders for self-administration of medication, the licensed nurse will create the task in the residents electronic health for a licensed nurse to check with the resident each shift to determine the residents self-report of medication administration and, for prn medication, the effect of the medication. A licensed nurse will document each shift in the residents electronic health record the residents self-reports of self-administration and, for prn medication use, the effect of the medication.

A log will be developed and maintained by nursing administration by 03/12/2024 to monitor residents approved by the interdisciplinary team for medication self-administration including that the electronic medical record has documentation of the residents self-report

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F 842	Continued From page 79 have her medication every 24 hours and it was last documented on 10/19/22 at 9:11 AM. She further stated that Resident #55 should tell staff when she administers her migraine medication so it can be charted in the medication administration record (MAR). An interview on 01/25/24 at 2:06 PM with the Nurse Consultant revealed the nurses should ask Resident #55 once a shift if she had self-administered her migraine medications. That is how they would know to chart in the MAR. The Nurse Consultant further stated she expected the nurse to document each use of the medication by resident in the MAR or progress notes. An interview on 01/25/24 at 5:17 PM with the Assistant Director of Nursing revealed she expected the nurse to follow-up with Resident #55 to see if she had administered any medication to herself in order to chart it appropriately in the MAR. A phone interview on 01/26/24 at 1:43 PM with the Director of Nursing revealed the staff nurses should know they have a resident who self-administers medications by reviewing the orders to see if there is an order. She expects the nurses to print off a MAR sheet so Resident #55 can document on it. Resident #55 should let staff know each time she administered her medication and staff should be checking Resident #55's documentation paper on Sundays. A phone interview on 01/26/24 at 3:37 PM with the Administrator revealed his expectation is that staff give Resident #55 a weekly sheet to document her medication self-administrations on and the staff should check each shift and	F 842	of medication administration, and for prn medication use, the effect of the medication. The RN Supervisor or licensed nurse designee will conduct an audit by reviewing the log and comparing to the electronic health records of residents approved for self-administration for accuracy and completeness weekly x 4 or until substantial compliance is achieved and maintained as determined by the QAPI Committee. 4. The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion date 03/12/2024	

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F 842	Continued From page 80 document weather or not Resident #55 used her medication. Then the nurse should document the medication administration appropriately in the MAR.	F 842		
F 867 SS=E	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: §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,	F 867		3/12/24

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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.

§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.

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§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 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.

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F 867	Continued From page 83 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey completed on 07/15/22. This was for one repeat deficiency originally cited in the area of infection prevention and control that was subsequently recited on the current recertification and complaint investigation survey of 01/26/24. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This tag is cross referenced to: F 880: Based on observations, record review, and staff interviews, the facility failed to ensure staff implemented their infection control policy for Personal Protective Equipment (PPE) and hand hygiene when Nurse Aide (NA) #2, the Admissions Director, the Maintenance Director, and Nurse #4 failed to don N-95 facemasks and/or goggles upon entering and/or removing N-95 facemasks and sanitizing goggles upon exiting 3 of 3 resident rooms on special droplet contact precautions for COVID-19 (Rooms 106, 141 and 159); when Nurse #3 failed to perform hand hygiene after removing dirty gloves and before donning clean gloves during wound care for 1 of 3 residents reviewed for pressure ulcers (Resident #29); and when the Nursing Consultant and NA #3 failed to assist 3 of 3 residents with	F 867	Staff will properly wear PPE in accordance with CDC guidelines and facility policies and procedures when entering Resident Rooms 106, 141, and 159. Staff will follow the facility�s policies and procedures for hand hygiene when providing wound care to Resident #229. Staff will offer Residents #21, #46, and #229 assistance with hand hygiene before meals. All residents are deemed to have the potential to be affected by the practices of not offering assistance with hand hygiene at meals, not properly performing hand hygiene during wound care, and not properly wearing Personal Protective Equipment (PPE) in accordance with the CDC guidelines and facility policies and procedures. An adhoc QAPI meeting will be held on 02/26/2024 to review the events and contributing factors surrounding infection control deficiencies. The clinical and administrative team participating in the meeting will put additional interventions in place to address the identified issues. The next scheduled QAPI meeting will be held on 03/04//2024 at noon. QAPI training will be completed with the administrative staff by the Administrator by 03/08/2024 with a posttest to assess learning with a score of 80% considered passing. All staff present for the QAPI training will be required to successfully pass the posttest with a score of 80%. A make up education session will be conducted by the Administrator with any	

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hand hygiene before meals for 2 of 2 dining observations (Residents #21, #46, and #229). These failures occurred during a COVID-19 outbreak at the facility.

During the recertification and complaint investigation survey of 07/15/22, the facility failed to implement their infection control policies and procedures for special droplet contact precautions when three of four staff members failed to wear the required personal protective equipment parentheses (PPE) when entering two Residents shared room for 2 of 2 residents reviewed for infection control practices.

An interview with the Administrative Assistant/ Human Resources on 1/26/24 at 4:00 PM revealed the incident with Nurse #4 needing a hood was an isolated incident with one employee who should have been more vocal, they were unaware of her need for one. Generally other departments do not go into isolation rooms. The facility should have done more education with the other departments. She felt more consistent day-to-day education would have been beneficial. She stated they were hit so hard and so fast with COVID the facility lost a lot of staff and administration staff quickly which provided fewer eyes to watch for mistakes. QAPI meetings are held quarterly, and they review performance improvement plans (PIPs), review and discuss comprehensive reports and outside resources, review and/or develop new PIPs. They review previous meeting results and summaries and establish the next meeting date and time. The team identified problems and looked at quality measures previously in place. They utilized trends and patterns to create metrics, then used the metrics to build new PIPs. She stated that that

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administrative staff unable to attend the training on 03/08/2024 by 03/12/2024. Facility staff will be educated by the Administrator by 03/08/2024 on the role of the QAPI Committee and the importance of QAPI activities and staff participation in QAPI and infection control practices. A pre and posttest will be administered to evaluate learning effectiveness. A passing score will be 80%. Staff who have not completed the training on QAPI by 03/08/2024 will not be permitted to work until they have completed the required training and successfully completed the posttest.
New employees will receive training about the QAPI process and the importance of staff participation in effective infection control practices and improvement efforts during their initial orientation period. The general facility orientation checklist will be updated by the HR Manager by 03/12/2024 to include training for new employees about QAPI and participation in performance improvement plans.
The QAPI Committee will conduct a meeting to review the survey findings related to infection control and the corrective action plan/implementation including audit results quarterly at a minimum thereafter. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to

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F 867	Continued From page 85 this is an issue they will continue to discuss in their monthly Quality Assurance and Performance Improvement (QAPI) meetings.	F 867	discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Any further infection control performance improvement plans will be initiated and/or conducted by the Infection Preventionist or RN designee. Completion Date 03/12/2024	
F 880 SS=E	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,	F 880		3/12/24

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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 IPCP and update their program, as necessary.

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This REQUIREMENT is not met as evidenced by:

Based on observations, record review, and staff interviews, the facility failed to ensure staff implemented their infection control policy for Personal Protective Equipment (PPE) and hand hygiene when Nurse Aide (NA) #2, the Admissions Director, the Maintenance Director, and Nurse #4 failed to don N-95 facemasks and/or goggles upon entering and/or removing N-95 facemasks and sanitizing goggles upon exiting 3 of 3 resident rooms on special droplet contact precautions for COVID-19 (Rooms 106, 141 and 159); when Nurse #3 failed to perform hand hygiene after removing dirty gloves and before donning clean gloves during wound care for 1 of 3 residents reviewed for pressure ulcers (Resident #29); and when the Nursing Consultant and NA #3 failed to assist 3 of 3 residents with hand hygiene before meals for 2 of 2 dining observations (Residents #21, #46, and #229). These failures occurred during a COVID-19 outbreak at the facility.

Findings included:

The facility's policy, Transmission-based Precautions (Special Droplet Contact Precautions), last revised 08/01/23, read in part, "any resident with suspected or confirmed COVID-19 should be placed on Special Droplet Contact Precautions, which include: gown: donned (apply) before entering room and removed before exiting room and then hand hygiene performed, gloves: donned before entering room and removed before exiting room, respiratory protection: employee should use a fit-tested (verifies the respirator is comfortable and provides the expected protection) NIOSH

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1. Staff will properly wear PPE in accordance with CDC guidelines and facility policies and procedures when entering Resident Rooms 106, 141, and 159. Staff will follow the facility□s policies and procedures for hand hygiene when providing wound care to Resident #229. Staff will offer Residents #21, #46, and #229 assistance with hand hygiene before meals.

2. All residents are deemed to have the potential to be affected by the practices of not offering assistance with hand hygiene at meals, not properly performing hand hygiene during wound care, and not properly wearing Personal Protective Equipment (PPE) in accordance with the CDC guidelines and facility policies and procedures.

3. On 01/22/2024 Infection Preventionist provided education on Covid-19 Isolation room policy and procedures to NA #2 and Nurse #4, who all verbalized understanding. On 01/23/2024 Infection Preventionist provided education on Covid-19 Isolation room policy and procedures to Admissions Director, and Maintenance Director, who all verbalized understanding. Nurse #3 was immediately inserviced by the Infection Preventionist on 01/24/2024 on the facility policy for hand hygiene and wound dressing change, and she verbalized understanding. After the reeducation, NA #2, the Admissions Director, the

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(National Institute for Occupational Safety and Health) certified N95 respirator or higher, applied prior to entry and removed after exiting, and eye protection: use either ventless goggles or a face shield that covers the front and side of face and don before entering the room and remove after leaving the resident room. To remove PPE: move to doorway, remove gloves and gown and dispose in trash, perform hand hygiene using soap and water or alcohol-based hand rub, exit room, go no more than one step outside of door, remove and sanitize eye protection, remove facemask or respirator, perform hand hygiene, and put non-isolation mask on."

The facility's undated policy titled "Hand Hygiene" read in part: "Hand hygiene is a general term that applies to either handwashing, antiseptic handwash, or alcohol-based handrub. Hand hygiene with either waterless sanitizer or soap and water is required before putting on gloves and after removal and after handling soiled or used dressings."

1. Review of the facility's document titled, January 2024 COVID outbreak, revealed both residents residing in room 106 tested positive for COVID-19 on 01/22/24.

A continuous observation was conducted on 01/22/24 from 11:29 AM to 12:16 PM. The door of room 106 was closed with special contact droplet precaution signage posted on the outside of the door with instructions, that noted in part, to clean hands before entering and when leaving the room, wear a gown and gloves when entering the room and remove before leaving, wear N95 or higher-level respirator before entering the room and remove after exiting and wear protective

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Maintenance Director, and Nurse #3 began following transmission-based precautions when appropriate and will continue to follow transmission-based precautions in accordance with the CDC guidelines and facility policies and procedures. Nurse #4 informed Infection Preventionist that she was unable to wear a standard N95 respirator and had always needed a Powered Air Purifying Respirator (PAPR) Hood. A PAPR was immediately ordered for Nurse #4 with the fastest shipping possible. Nurse #4 was instructed to not enter into a Covid isolation room until she had the PAPR and another nurse was assigned to take care of Nurse #4s Covid positive residents. PAPR arrived on 01/24/2024 and Nurse #4 began using PAPR on 01/25/2024 and appropriately followed transmission-based precautions in accordance with CDC guidelines and facility policies and procedures. Signs have been posted at the time clock and at the nurses station for staff to contact Nursing Administration or the Infection Preventionist if they have any PPE concerns.

The Infection Preventionist (IP) provided education to staff in all departments that includes a review of hand hygiene including offering assistance before meals, transmission-based precautions, and appropriate PPE use on 02/19/2024. The education also included information that the staff member or residents vaccination status does not determine PPE use. A posttest will be administered with a passing score of 80% required.

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eyewear. At 11:58 AM, NA #2 was observed donning PPE per posted instructions and entered room 106 to answer the call light. At 12:00 PM, NA #2 was observed exiting the room without doffing (removing) PPE and walked to the nurse standing at her medication cart, approximately 3 rooms away, immediately returned to room 106, and reentered without changing PPE. When exiting the room again, NA #2 had removed all PPE except for her goggles and N95 mask. NA #2 was not observed sanitizing her hands or googles or removing the N95 mask upon exiting the room. NA #2 then proceeded down the hall toward the main dining room. At approximately 12:05 PM, NA #2 was observed returning to room 106 with drinks and a cup of ice. NA #2 donned a new gown and gloves without sanitizing her hands, the googles were pushed up on top of her forehead and she did not change N95 masks prior to reentering room 106. Upon re-exiting room 106, NA #2 had removed her gown and gloves, the googles were still pushed up on her forehead and she did not sanitize the goggles or remove the N-95 facemask prior to entering another resident's room on the same hall.

During an interview on 01/22/24 at 12:16 PM, NA #2 confirmed she walked out of room 106 into the hall to ask the nurse a question without removing her PPE and did not change her N95 facemask or sanitize her goggles when exiting the room to go and get drinks for the resident, when she reentered the resident's room and upon re-exiting the room and entering another resident's room. NA #2 stated she didn't pay attention to the special contact droplet precaution signage posted on the door of room 106 and should have removed her PPE and sanitized her hands and goggles upon exiting the room but forgot.

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This education was repeated by the Infection Preventionist on 02/20/2024 and will be repeated on 02/25/2024 for staff unable to attend the first training session. A posttest will be given to assess learning with a passing score of at least 80%. Any staff who has not received the infection control education by 03/12/2024 will not be allowed to work until after successful completion.

Licensed nurses will perform hand hygiene appropriately during wound dressing changes according to facility policy and procedures. The Infection Preventionist or Director of Nursing will educate the licensed nurses on hand hygiene during wound dressing changes by 03/01/2024. Licensed nurses will have a competency check by a RN on wound dressing changes including appropriate hand hygiene by 03/12/2024 and annually at a minimum thereafter.

New employees will be provided education by a licensed nurse that includes discussion of hand hygiene including offering assistance before meals, transmission-based precautions, and demonstrations of hand hygiene and PPE use with a return demonstration during the orientation period prior to job assignment. New licensed nurses will have a competency check during the orientation period by an RN on wound dressing changes to include proper hand hygiene.

Staff will follow transmission-based

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During an interview on 01/24/24 1:54 PM, the Infection Preventionist revealed NA #2 should have followed the special droplet contact precaution signage on the door of room 106 regarding donning/doffing PPE when entering and exiting the room.

During a telephone interview on 01/25/24 at 11:47 AM, the Administrator explained facility staff have had frequent, extensive training on infection control and knew what to do when entering rooms on special contact droplet precautions. The Administrator stated he expected staff to follow the facility's infection protocols and don/doff PPE as indicated on the isolation precaution signage.

During a telephone interview on 01/26/24 at 12:18 PM, the Director of Nursing (DON) revealed facility staff had received a lot of infection control training and were aware of what needed to be done. The DON stated she felt the breakdown with staff not donning/doffing PPE was due in part to staff being overwhelmed, with so many staff being out due to testing positive for COVID-19 as well as the number of residents testing positive, and staff just panicked and didn't pay attention to the instructions on the signage. The DON stated staff were expected to follow the special contact droplet precaution signage for donning/doffing PPE when entering and exiting rooms on isolation precautions.

2. Review of the facility's document titled, January 2024 COVID outbreak, revealed both residents residing in room 106 tested positive for COVID-19 on 01/22/24.

A continuous observation was conducted on

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precautions when entering and exiting resident rooms and wear PPE appropriately including donning and doffing. New colored and laminated signage will be used on resident room doors to alert the staff of the type of transmission-based precautions in use and the steps for PPE use by 03/12/2024.

Residents will be offered hand hygiene before meals by a facility staff member. A policy and procedure regarding providing hand hygiene to residents who feed themselves before meals will be developed and implemented by the Director of Nursing and Infection Preventionist by 02/19/2024. Residents who dine in the dining room will be offered a choice of wet wipe or hand sanitizer before meals by a staff member. Residents who feed themselves in their rooms at mealtime will be offered the use of hand sanitizer, or a wet wipe before meals by a nursing staff member.

The Infection Preventionist or designated RN will conduct random audits on all shifts of the proper use of hand hygiene during wound dressing changes, the proper following of transmission-based precautions and appropriate wearing of PPE including donning and doffing, and the offering of hand hygiene assistance before meals a minimum of three times per week x4 weeks or until substantial compliance is achieved and maintained as determined by the QAPI Committee. Corrective action will be taken at the time of discovery by a licensed nurse for any

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01/23/24 from 9:22 AM to 9:42 AM. The door of room 106 was closed with contact droplet precaution signage posted on the outside of the door with instructions, that noted in part, to clean hands before entering and when leaving the room, wear a gown and gloves when entering the room and remove before leaving, wear N95 or higher-level respirator before entering the room and remove after exiting and wear protective eyewear. At 9:38 AM, the Admissions/Marketing Director was observed entering room 106 wearing a gown, gloves, surgical facemask, and glasses to deliver fresh ice water to the residents in the room. She was not observed wearing a N-95 facemask and goggles or face shield. While standing in the hall, the Nursing Consultant reviewed the instructions on the contact droplet precaution signage with the Admissions Director, who remained at the doorway inside the room. The Admissions/Marketing Director removed her gown and gloves before exiting the room and changed facemask and sanitized her hands upon exiting the room.

During an interview on 01/23/24 at 9:42 AM, when asked if she should have donned a N-95 facemask and googles prior to entering the room, the Admissions/Marketing Director stated she did not think she had to wear a N-95 facemask when entering COVID-19 positive rooms since she was fully-vaccinated. The Admissions/Marketing Director explained she was only trying to help the floor staff since so many were out sick and she hadn't looked at the special contact droplet precaution signage posted on the door before entering the room.

During an interview on 01/23/24 at 9:49 AM, the Nursing Consultant explained the

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discrepancies identified during the audits.

On 02/13/2024, the facility partnered with Alliant Health Solutions in a Quality Improvement Initiative (QII) for infection control, with a focus on achieving greater compliance on PPE usage. This QII will last for a minimum of 6 weeks.

4. The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends.
Completion Date 03/12/2024

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Admissions/Marketing Director was trying hard to help the staff on the hall with so many out sick; however, the isolation precaution signage regarding PPE still had to be followed.

During an interview on 01/24/24 1:54 PM, the Infection Preventionist explained being fully-vaccinated does not exempt staff from donning the appropriate PPE when indicated and stated the Admissions/Marketing Director should have donned a N95 mask and goggles in addition to the gown and gloves when entering room 106 that was on isolation precautions for COVID-19.

During a telephone interview on 01/25/24 at 11:47 AM, the Administrator explained facility staff have had frequent, extensive training on infection control and knew what to do when entering rooms on contact droplet precautions. The Administrator stated he expected staff to follow the facility's infection protocols and don/doff PPE as indicated on the isolation precaution signage.

During a telephone interview on 01/26/24 at 12:18 PM, the Director of Nursing (DON) revealed facility staff had received a lot of infection control training and were aware of what needed to be done. The DON stated she felt the breakdown with staff not donning/doffing PPE was due in part to staff being overwhelmed, with so many staff being out due to testing positive for COVID-19 as well as the number of residents testing positive, and staff just panicked and didn't pay attention to the instructions on the signage. The DON stated staff were expected to follow the special contact droplet precaution signage for donning/doffing PPE when entering and exiting rooms on isolation precautions.

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F 880	Continued From page 93 3. A continuous observation of Nurse #3 on 01/24/24 from 12:49 PM through 1:01 PM revealed she removed Resident #29's old dressing from his sacrum (lower back) and removed her gloves and placed them in a plastic bag. Without performing hand hygiene Nurse #3 put on a clean pair of gloves, cleaned Resident #29's wound with normal saline (salt water), patted the wound dry, and applied a clean dressing. Nurse #3 removed her gloves and placed them in a plastic bag, removed the plastic bag and placed it in the trash bin in the hall, and performed hand hygiene. In an interview with Nurse #3 on 01/24/24 at 1:03 PM she confirmed she did not perform hand hygiene after removing her used gloves and before putting on clean gloves after she removed Resident #29's dressing. She stated she had been trained to perform hand hygiene each time she removed her gloves and before putting on clean gloves, but she got nervous when she changed Resident #29's dressing and forgot. An interview with the Infection Preventionist (IP) on 01/24/24 at 1:54 PM revealed hand hygiene should be performed any time gloves were removed and before putting on clean gloves. A telephone interview with the Director of Nursing (DON) on 01/26/24 at 12:59 PM revealed she expected staff to perform hand hygiene any time gloves were removed. 4. (a). An observation of Resident #21 revealed she propelled herself to the main dining room on 01/22/24 at 12:32 PM. Resident #21's lunch meal tray was set up by the Nurse Consultant and consisted of mashed potatoes, green beans, a	F 880		

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peanut butter sandwich, and a cookie. The Nurse Consultant did not offer Resident #21 hand hygiene before she began feeding herself.

(b). An observation of Resident #46 revealed she propelled herself to the main dining room on 01/22/24 at 12:43 PM. Resident #46's lunch meal tray was set up by the Nurse Consultant and consisted a peanut butter and jelly sandwich. The Nurse Consultant did not offer Resident #46 hand hygiene before she began feeding herself.

An interview with the Infection Preventionist (IP) on 01/24/24 at 2:45 PM revealed the facility did not have a policy regarding residents being offered hand hygiene before meals, but hand hygiene should be offered or performed by staff before each meal. She stated at one point in time staff did offer hand hygiene before meals, but it had gotten lost in the chaos of so many staff and residents becoming sick with COVID-19 recently.

An interview with the Nurse Consultant on 01/26/24 at 1:18 PM revealed she should have offered Resident #21 and Resident #46 hand hygiene before they began eating lunch on 01/22/24 but forgot due to so many staff members being out sick with COVID-19.

(c). An observation of Nurse Aide (NA) #3 on 01/25/24 at 12:05 PM revealed she set up Resident #229's lunch meal tray and did not offer the resident hand hygiene before she began feeding herself.

In an interview with NA #3 on 01/25/34 at 2:25 PM she confirmed she did not offer Resident #229 hand hygiene before she began eating her meal. She stated she had been employed at the

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facility since May 2023, and had not received education to offer/perform hand hygiene for residents before they began feeding themselves.

A telephone interview with the Director of Nursing (DON) on 01/26/23 at 12:59 PM revealed hand hygiene should be offered or provided to residents before meals.

5. Review of the facility's document titled, January 2024 COVID outbreak, revealed both residents residing in room 141 tested positive for COVID-19 on 01/21/24.

An observation of the Maintenance Director on 01/23/24 from 10:49 AM through 11:07 AM revealed he entered room 141 with gloves, a gown, and an N-95 mask. A sign on the door of room 141 revealed the resident was on "Special Droplet Precautions" and anyone entering the room should wear a gown, gloves, goggles, and N-95 mask. A supply of gowns, goggles, gloves, and masks was hanging on the door. When the Maintenance Director exited room 141, he was not wearing goggles.

In an interview with the Maintenance Director on 01/23/24 at 11:07 AM he confirmed he had not worn goggles when he entered room 141. He stated he had been trained to follow the signage on the door and just forgot to wear goggles.
An interview with the Infection Preventionist on 01/24/24 at 2:45 PM revealed the Maintenance Director should have followed the "Special Droplet Precautions" signage on the door of room 141 by wearing all personal protective equipment (PPE) indicated by the sign.

A telephone interview with the Director of Nursing

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(DON) on 01/26/24 at 12:59 PM revealed she expected staff to follow signage for donning (applying) and doffing (removing) PPE when entering and exiting isolation rooms.

6. Review of the facility's document titled, January 2024 COVID outbreak, revealed both residents residing in room 159 tested positive for COVID-19 on 01/19/24.

An observation on 01/22/24 at 12:13 PM of Nurse #4 entering room 159 with medications that had a sign "Special Droplet Contact Precautions" posted on the outside of the door revealed she was wearing a standard surgical mask and not a N95 respirator mask.

An interview with Nurse #4 on 01/22/24 12:15 PM revealed that she could not wear N95 respirator masks because they did not fit her. She further stated that she had requested a respiratory device that fits over the entire head in place of a facemask and had not received one. She stated that she had never worn respiratory device that fits over the entire head in any other facility she had worked.

An interview on 01/22/24 at 12:26 PM with the Infection Preventionist revealed the facility was due for fit testing this month and she did not have any respiratory devices that fit over the entire head, they were all gone. She stated someone threw them away or they were placed in an unknown location. The Infection Preventionist stated she was going to talk to Medical Records who orders supplies about getting some respiratory devices that fit over the entire head overnighted for Nurse #4 and the meantime, they had another nurse take over the COVID rooms

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F 880	Continued From page 97 on that hall. She stated that her expectation was that Nurse #4 should have alerted her to the fact that she did not have the appropriate PPE to enter those rooms. An interview on 01/26/24 at 10:50 AM with the Nurse Consultant revealed that staff should wear the PPE as listed on the sign posted to the doors. She stated if any staff have specialized PPE requirements the facility should be made aware and order the necessary PPE for staff. She indicated that until the specialized PPE was available for use the staff should not go into the Infection Precaution rooms. A phone interview on 01/26/24 at 01:32 PM with the Director of Nursing revealed she was never told that Nurse #4 needed specialized PPE. She stated her expectation was that the staff tell her when they need specialized PPE so it could be ordered. She further revealed that Nurse #4 had worn an N95 respirator mask previously with no voiced concerns about the fit. A phone interview on 01/26/24 at 03:01 PM with the Administrator revealed his expectation was that the staff followed the signs, protocols and policy when entering isolation precaution rooms.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		3/12/24

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potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative

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was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to include documentation in the medical record of education on the benefits, and possible side effects of the influenza vaccination and document refusal or acceptance of the influenza vaccination for 3 of 5 residents (Resident #17, Resident #19, Resident #55) reviewed for immunizations.

The findings included:

Record review of the following residents' immunizations and consents revealed in part:
1a. Resident #17 was admitted on 7/24/17 with the quarterly minimum data set (MDS) revealing she was severely cognitively impaired and was administered the flu vaccine on 10/9/23 with the only flu consent signed by the resident's Responsible Party (RP) was dated 7/25/17.

1b. Resident #55 was admitted on 8/24/21 with the quarterly minimum data set (MDS) revealing she was cognitively intact and was administered the flu vaccine on 10/9/23 with the only flu consent signed by the resident was dated 6/20/22.

1c. Resident #19 was admitted on 7/3/19 with the quarterly minimum data set (MDS) revealing she was severely cognitively impaired and was

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1. Resident #17, Resident #55 and Resident #19 will be provided with education by a licensed nurse to include the Vaccine Information Statement (VIS) provided by the Centers for Disease Control (CDC) with information about potential side effects of the vaccine and a consent from the resident or the residents legal health care decision maker will be obtained prior to the administration of any future influenza vaccine. A licensed nurse will file the completed vaccine consent form or document of the residents refusal of influenza vaccination in the residents medical record.
2. Influenza vaccination for current residents has been concluded for the 2023-2024 influenza season. No corrective action can be taken at this time.
3. The Infection Preventionist RN will provide education for the licensed nurses by 03/12/2024 about the potential side effects of the influenza vaccination and the need to: a) provide the resident or their legal health care decision maker the applicable Vaccine Information Statement (VIS) provided by the CDC which contains information about potential side effects of the vaccine, (b) obtain consent prior to influenza vaccination, and (c) document a

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administered the flu vaccine on 10/10/23 with the only flu consent signed by the resident's Responsible Party (RP) was dated 10/11/20.

An interview with the Infection Preventionist on 1/24/24 at 3:15 PM revealed the consent for immunizations of flu and pneumonia are obtained on admission and that is what the facility used for the residents stay. She further stated that she sends the Vaccine Information Sheet out at the beginning of the flu season to let them know the vaccine is coming up and assumes that if the resident or their family doesn't call, they are consenting to receive the vaccination. She acknowledged she had no way to verify they received the information. She did not know that they needed to get a new consent for flu and pneumonia every year. She stated she got verbal consent from the resident, but she had not documented those acceptances.

A phone interview on 01/26/24 at 1:32 PM with the Director of Nursing revealed her expectation was that each annual vaccination got its own consent form.

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resident or legal health care decision makers influenza declination in the medical record. A post-test will be given to assess learning with a score of at least 80% to be considered passing. Make up education and post testing will be provided by the Infection Preventionist RN or Director of Nursing for any employee that is unable to attend the first education session by 03/12/2024. Residents offered influenza vaccines at the facility will be provided with education by a licensed nurse to include the Vaccine Information Statement (VIS) provided by the Centers for Disease Control (CDC) with information about side effects of the vaccine and a consent from the resident or the residents legal health care decision maker will be obtained prior to the administration of any future influenza vaccine. A licensed nurse will file the completed influenza vaccine consent or declination form in the residents medical record.
A log will be maintained by the Infection Preventionist RN for each influenza season beginning with the remainder of the current influenza season to track the provision of education and whether the influenza vaccine has been accepted or declined by the resident or their legal health care decision maker. The Director of Nursing or RN designee will randomly audit the log maintained by the Infection Preventionist RN and compare to the documentation in the medical record to identify discrepancies weekly x4 or until substantial compliance is achieved and maintained as determined by the QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	**410 BUCKNER BRANCH ROAD** **BRYSON CITY, NC 28713**

(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 883	Continued From page 101	F 883	Committee. Any discrepancies identified during the audit will receive corrective action by a licensed nurse. 4. The Director of Nursing and/or an RN designee will review the results of the audits for trends/patterns and will report the results to the QAPI committee for review and corrective actions as deemed necessary. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, Pharmacist, Infection Control Preventionist, and at least 3 other staff members and meets at a minimum of quarterly. The QAPI committee will review the results of the audits and direct corrective action as necessary. The QAPI may choose to discontinue the audits if compliance is deemed substantial and maintained. The committee may also choose to revise or continue to maintain the audits based on any identified trends. Completion Date 03/12/2024	