| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345169 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

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| THE GREENS AT GASTONIA | 969 COX ROAD GASTONIA, NC 28054 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 01/29/24 through 02/01/24. The facility was found in compliance with the requirement CFR 483.71, Emergency Preparedness. Event ID# 186F11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 01/29/24 through 02/01/24. Event ID# 186F11. The following intakes were investigated: NC00212796, NC00212053, NC00211242, NC00211973, NC00211584, NC00211275, NC00210983, NC00210641, NC00210598, NC00210452, NC00210275, NC00209546, NC00209363, NC00209224, and NC00206251.<br><br>12 of the 47 complaint allegations resulted in deficiency. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of | F 580 | | 2/26/24 |

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

Electronically Signed | 02/24/2024

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| F 580 | Continued From page 1<br>treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and nurse practitioner interviews the facility failed to notify the provider when a resident experienced a severely low blood sugar and when a resident experienced a high blood sugar for 2 of 2 | F 580 | Facility failed to notify provider of severely low blood sugar and when a resident experienced a high blood sugar for 2 of 2 residents (Resident #74 and Resident #7) reviewed for notification | |

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| F 580 | Continued From page 2 | F 580 | | |

residents (Resident #74 and Resident #7) reviewed for notification.

Findings included:

1. Resident #74 was admitted to the facility on 11/24/22 with diagnosis which included diabetes and hypertension.

Resident #74's quarterly Minimum Data Set (MDS) dated 12/18/23 revealed he was moderately cognitively impaired. The MDS further revealed Resident #74 was coded for insulin use.

Review of resident #74's physician order dated 01/24/24 revealed the resident required fingerstick blood glucose with meals (ACHS).

Review of Resident #74 physican order dated 01/24/24 revealed the resident required NovoLOG Injection Solution 100 unit/milliliters (ML) to i nject as per sliding scale: if 0 - 150 = 0 Units; 151 - 200 = 2 Units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units; 401+ = 12 Units Recheck Blood Sugar in 2 hours and notify Physician, subcutaneously with meals for DM.

An interview conducted with Nurse #1 on 01/31/24 at 9:30 AM revealed yesterday evening (01/30/24) around 4:00 PM she entered Resident #74's room and observed the resident visiting with a family member. Nurse #1 further revealed the family member advised the Nurse to take the resident's blood sugar and it was 46. Nurse #1 indicated she gave the resident a diabetic supplement and advised the family to give the resident a snack cake. Nurse #1 revealed she checked her blood sugar twenty minutes later at it

How corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 1/30/24, licensed nurse notified the nurse practitioner (NP) of resident #74 blood sugar. No New Orders were given, check Residents Blood Sugar at next Scheduled time blood sugar within normal range.

On 2/22/24, Director of nursing(DON) notified the NP of resident # 7 blood sugar. No Changes in Plan of Care.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

On 2/21/24, infection control nurse (IC) audited all residents with blood sugar results for the past 14 days to ensure severely abnormal (less than 60 or greater than 400) blood sugar results were communicated to the provider. No new negative findings.

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| F 580 | Continued From page 3<br>was around 250. The Nurse stated she did not contact the provider because she felt that it was not necessary.<br><br>Review of Resident #74's medical record revealed no incident of a low blood sugar was documented on 01/30/24 or that the physician was notified of the blood sugar of 46mg/dL (milligrams per deciliters).<br><br>An interview conducted with the Nurse Practitioner (NP) on 01/31/24 at 12:20 PM revealed she had not been notified Resident #74 had a low blood sugar on 01/30/24. The NP further revealed she would have wanted to be notified if the Resident ' s blood sugar was below 70.<br><br>An interview conducted with the Director of Nursing (DON) on 01/31/24 at 2:40 PM revealed the NP or on-call provider should have been notified of the low blood sugar.<br><br>2. Resident #7 was readmitted to the facility on 12/31/23 with diagnoses which included diabetes mellitus.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 12/31/23 indicated Resident #7 was cognitively intact. Resident #7 was coded as receiving insulin on 6 out of the 7 days during the assessment period.<br><br>A physician order dated 1/30/24 read "Insulin aspart solution pen injector 100 units per milliliter (ml) sliding scale at 6:30 AM, 11:30 AM and 4:30 PM. The order indicated if Resident #7's blood sugar was greater than 400 to administer 14 units of insulin, notify a provider and repeat the | F 580 | Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 2/22/2024, assistant director of nursing (ADON) provided education to licensed nurses (including agency) on notification to provider of severely abnormal (less than 60 or greater than 400) blood glucose results. Any licensed nurse (including agency) who has not received education will not be allowed to work after 2/23/2024 until education completed.<br><br>On 2/22/2024, ADON added education on notification to provider of severely abnormal blood glucose results to the newly hired licensed nurses (including agency).<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) will audit 5 diabetic residents weekly x 12 weeks to ensure notification to provider occurred as appropriate for severely abnormal (less than 60 or greater than 400) blood sugar checks. | |

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| F 580 | Continued From page 4<br>residents blood sugar within 30 minutes to 1 hour.<br><br>A review of Resident #7's Medication Administration Record (MAR) dated February 2024 revealed on 2/01/24 at 6:30 AM Resident #7 had a blood sugar reading of 440. Nurse #2 documented he had administered 14 units of insulin.<br><br>A review of Resident #7's nursing progress notes revealed no note regarding notifying the provider of a blood sugar reading of 440 on 2/01/24.<br><br>A telephone interview conducted on 2/01/24 at 11:36 AM with Nurse #2 revealed he had worked the 11:00 PM to 7:00 AM shift on 1/31/24. He stated on 2/01/24 he had checked Resident #7's blood sugar at 6:30 AM and received a reading of 440. Nurse #2 stated he administered 14 units of insulin per the physician order but did not notify a provider or recheck the residents blood sugar. Nurse #2 stated he did not read the order entirely and it was his mistake. He stated he notified Nurse #3 during handoff at 7:00 AM that Resident #7's blood sugar was high but did not recall telling her to recheck the residents blood sugar or to notify the provider.<br><br>An interview conducted on 2/01/24 at 11:34 AM with the Nurse Practitioner (NP) revealed standard orders for insulin were if a blood sugar reading was greater than 400 to administer a sliding scale insulin, notify a provider and recheck the residents blood sugar 30 minutes to 1 hour following administration of the insulin. She stated she was not notified of Resident #7 having an elevated blood sugar that morning but was aware the resident's blood sugar had been elevated in the weeks prior. The NP stated she would have | F 580 | Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 2/26/24 | |

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| F 580 | Continued From page 5<br>wanted staff to recheck Resident #7's blood sugar within the ordered time frame and to let her know it was elevated.<br><br>An interview conducted on 2/01/24 at 12:21 PM with the Director of Nursing (DON) revealed she was not aware of Resident #7 having a high blood sugar that morning. She stated Nurse #2 should have followed the physician order and notified the provider. The DON stated nurses should be following the physician orders and reading the orders entirely. | F 580 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, resident, family member, and staff interviews, the facility failed to provide showers to a dependent resident for 1 of 6 residents (Resident #83) reviewed for activities of daily living.<br><br>The findings included:<br><br>Resident #83 was admitted to the facility on 01/21/22 and readmitted on 01/22/24 with diagnoses which included congestive heart failure, cerebral vascular accident (stroke), dementia and chronic pain.<br><br>The annual Minimum Data Set (MDS) assessment dated 11/24/23 indicated Resident #83 was moderately cognitively impaired and had | F 677 | the facility failed to provide showers to a dependent resident for 1 of 6 residents (Resident #83) reviewed for activities of daily living.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice.<br><br>On 01/31/24 resident # 83 was provided a shower by facility certified nursing assistants (CNA). | 2/27/24 |

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no rejection of care behaviors. The MDS further indicated that Resident #83 required total assistance of 2 staff members with bathing and limited assistance of 1 staff with personal hygiene and grooming.

Resident #83's care plan dated 12/17/23 indicated that the resident had an activities of daily living self-care performance deficit related to disease processes. The resident requires staff assistance to complete ADL tasks daily. The interventions included resident was totally dependent on 2 staff for showering two times per week and as needed and required limited assistance of 1 staff with personal hygiene and grooming.

A review of the undated facility shower schedule indicated Resident #83 was scheduled to receive bathing and personal hygiene twice weekly on Tuesdays and Fridays during day shift (7:00 AM to 3:00 PM) with the shower team.

A review of the bathing/shower report for January 2024 indicated Resident #83 was recorded as having showers on 01/02/24, 01/16/24, 01/26/24, and 01/30/24. "Not applicable" was documented for Resident #83's showers on 01/05/24, 01/09/24, 01/12/24 and 01/23/24.

A review of the nurse's progress notes from 01/01/24 through 01/31/24 in Resident #83's medical record indicated no notes regarding Resident #83 refusing showers.

An observation and interview with Resident #83 on 01/29/24 at 11:05 AM revealed the resident lying in bed with hair disheveled and appeared oily with white flakes observed on top of his head.

How the facility will identify other residents having the potential to be affected by the same deficient practice.

On 2/22/24, Nurse Manager (UM) audited all residents□ showers for the past 14 days. No additional negative findings.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 2/22/2024, assistant director of nursing (ADON) provided education to licensed nurses and certified nursing assistants (CNA) (including agency) on providing showers per plan of care, and documentation including if unable to complete for any reason notification to licensed nurse and DON/ADON must occur immediately (to allow for immediate intervention and follow up). Any licensed nurse or CNA (including agency) who have not received education will not be allowed to work after 02/23/24 until education completed.

On 2/27/24 the DON, and/or administrator began review staffing at least 3 times

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| F 677 | Continued From page 7<br>Resident #83 stated he had not received all his showers in January and had not had his hair shampooed recently. Resident #83 further stated he had not refused any of his showers.<br><br>A phone interview with Resident #83's family member on 01/30/24 at 2:41 PM revealed during the month of January the resident had not consistently received his showers and when the family member had visited each week, she stated the resident's hair was oily and he looked disheveled and "just appeared to be dirty." The family member stated she had asked Resident #83 if he had refused to take his showers and he told her that he had not refused any of his showers. The family member stated she had asked the NAs when they came into the room about his showers and was told "the shower team does his showers during the week."<br><br>A review of the nursing schedules for 01/05/24, 01/09/24, 01/12/24 and 01/23/24 revealed the following:<br>01/05/24 - there was no shower team - Nurse Aide (NA) #3 who typically worked on the shower team was pulled to a hall to work as NA on that hall and NA #2 who typically worked on the shower team called out. NA #4 and NA #5 worked on Resident #83's hall during 1st shift (7:00 AM to 3:00 PM).<br><br>01/09/24 - there was only 1 shower team member - NA #3 from 7:00 AM to 11:00 AM. NA #4 and NA #5 worked on Resident #83's hall during 1st shift (7:00 AM to 3:00 PM).<br><br>01/12/24 - there was a shower team from 6:00 AM to 2:00 PM and they were assigned to be in the dining room during lunch to assist residents | F 677 | weekly to ensure shower team is adequately staff or staffing adequate to provide showers to designated residents.<br><br>On 2/22/2024, ADON added education on providing showers per plan of care to the newly hired licensed nurses and CNAs (including agency)<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) will audit 5 residents weekly x 12 weeks to ensure shower was provided per plan of care.<br><br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 2/27/24 | |

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with their meals. NA #4 and NA #5 worked on Resident #83's hall during 1st shift (7:00 AM to 3:00 PM).

01/23/24 - there was no shower team - NA #3 who typically worked on the shower team called out and NA #2 who also typically worked on the shower team was pulled to a hall to work as NA on that hall. NA #4 and NA #5 worked on Resident #83's hall during 1st shift (7:00 AM to 3:00 PM).

An interview with Nurse Aide (NA) #4 on 01/31/24 at 9:32 AM revealed she typically worked on the hall where Resident #83 resided. She stated the resident typically did not refuse care and to her knowledge had never refused his showers because he liked to get his showers twice a week. NA #4 stated if the shower documentation was listed as "Not applicable" that typically meant the resident did not get a shower. She further stated it was hard for the NAs on the floor to give showers because a lot of the residents on that floor required mechanical lifts which took 2 staff to get them up and on the shower bed and into the shower room and then 2 staff to get them out of the shower room and back into the bed once they were dried. NA #4 said that meant during that time of getting the resident in and out of the shower room, the floor was left with no NAs to provide care. She explained she could not remember giving the resident a shower during the month of January when assigned to him and if a bed bath was not recorded, she had not given him a bed bath either.

An interview with NA #5 on 01/31/24 at 1:32 PM revealed she typically worked on the hall where Resident #83 resided with NA #4. She stated she

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had never known Resident #83 to refuse his showers because he liked his showers twice a week. NA #4 stated if the shower documentation was listed as "Not applicable" that typically meant the resident did not get a shower that day. She further stated it was hard for the NAs on the floor to give showers in addition to all the other duties but if the residents didn't get a shower, they would try to provide them with a bed bath. NA #5 indicated if a bed bath was provided it was documented as a bed bath and not as "Not applicable." NA #5 stated she did not recall giving the resident a shower for the month of January.

An interview with NA #2 and NA #3 on 01/31/24 at 2:34 PM revealed they typically worked the shower team unless they were pulled to work as a NA on the hall. NA #2 and NA #3 stated they worked Monday through Friday from 6:00 AM to 2:00 PM giving the residents their showers. The NAs stated they were able to get the residents on the list for showers that day done provided they were both there and were not pulled to work as a NA on the halls. NA #2 further stated the showers included their shower, nail care for both men and women unless they were diabetic and included shaving the men and women if they had facial hair, they wanted shaved. The NAs said it also included washing their hair unless they didn't want their hair washed. NA #2 indicated they were sometimes pulled to the hall to work as a NA and on those days, it was up to the NA on the floor to complete the resident's showers or bed baths. NA #2 explained she had showered Resident #83 during the month of January but had not showered him as scheduled twice a week.

An interview with the Director of Nursing (DON)

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| F 677 | Continued From page 10<br>on 02/01/24 at 4:28 PM revealed she was not aware of Resident #83 not receiving all his showers in January. The DON stated the shower team and hall NAs should be following the bath/shower schedule daily and if the shower team was not available or not able to complete the showers, she expected the NAs on the hall to complete them. She stated there were other staff in the facility that could help with showers if the NAs were not able to get them done and all they had to do was ask for help with the showers. The DON indicated Resident #83 should have received his showers no less than twice a week as scheduled. | F 677 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and resident, staff, and Nurse Practitioner interviews, the facility failed to follow a physician order to recheck a resident's blood sugar for 1 of 5 residents (Resident #7) reviewed for unnecessary medication.<br><br>The findings included:<br><br>Resident #7 was readmitted to the facility on | F 684 | The facility failed to follow a physician order to recheck a resident's blood sugar for 1 of 5 residents (Resident #7)<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>On 2/1/2024 resident # 7 was assessed | 2/26/24 |

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| F 684 | Continued From page 11<br>12/31/23 with diagnoses which included diabetes mellitus.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 12/31/23 indicated Resident #7 was cognitively intact for decision making. Resident #7 was coded as receiving insulin on 6 out of the 7 days during the assessment period.<br><br>A physician order dated 1/30/24 read "Insulin aspart solution pen injector 100 units per milliliter (ml) sliding scale at 6:30 AM, 11:30 AM and 4:30 PM. The order indicated if Resident #7's blood sugar was greater than 400 to administer 14 units of insulin, notify a provider and repeat the residents blood sugar within 30 minutes to 1 hour.<br><br>A review of Resident #7's Medication Administration Record (MAR) dated February 2024 revealed on 2/1/24 at 6:30 AM Resident #7 had a blood sugar reading of 440. Nurse #2 documented he had administered 14 units of insulin.<br>A review of Resident #7's nursing progress note revealed no note regarding rechecking the resident's blood sugar after 6:30 AM on 2/01/24.<br><br>A telephone interview conducted on 2/01/24 at 11:36 AM with Nurse #2 revealed he had worked the 11:00 PM to 7:00 AM shift on 1/31/24. He stated on 2/01/24 he had checked Resident #7's blood sugar at 6:30 AM and received a reading of 440. Nurse #2 stated he administered 14 units of insulin per the physician order but did not notify a provider or recheck the residents blood sugar. Nurse #2 stated he did not read the order entirely and it was his mistake. He stated he notified Nurse #3 during handoff at 7:00 AM that Resident #7's blood sugar was high but did not recall telling | F 684 | by nurse practitioner (NP) related to blood sugar results. No changes in Plan of Care.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>On 02/22/2024 infection control nurse (IC) audited all residents who have blood sugar monitoring ordered to ensure any highs or lows (<60 or > 400) in the past 14 days have been reported to the medical provider and any orders implemented. All Blood Sugars Audited were reported to the NP, there were no Changes in Plan of Care.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 02/22/2024, ADON provided education to licensed nurses (including agency) on following provider orders including insulin administration, and blood sugar monitoring. Any licensed nurse (including agency) who have not received education will not be allowed to work after 02/23/24 until education completed.<br>On 02/22/24 ADON added education on following provider orders including insulin administration, and blood sugar monitoring. to newly hired licensed nurses (including agency) orientation.<br><br>Indicate how the facility plans to monitor its performance to make sure that | |

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| F 684 | Continued From page 12<br>her to recheck the residents blood sugar.<br><br>An interview conducted on 2/01/24 at 11:02 AM with Resident #7 revealed her blood sugar was high around 6:30 AM that morning. She stated Nurse #2 had administered insulin, but nobody had rechecked her blood sugar to see if it had gone down. Resident #7 stated she would like to know what her blood sugar was because 440 was very high for her. She stated she did not have any symptoms of high blood sugar.<br><br>An observation was conducted on 2/01/24 at 11:29 AM of Nurse #3 checking Resident #7's blood sugar with a reading of 322. Nurse #3 was then observed administering Resident #7 insulin per the physician orders.<br><br>An interview conducted on 2/01/24 at 1:41 PM with Nurse #3 revealed she had received report from Nurse #2 at 7:00 AM. She stated he did not notify her Resident #7's blood sugar was high or to recheck the blood sugar. She stated the first time she had checked Resident #7's blood sugar was at 11:29 AM during the observation with the surveyor. Nurse #2 stated the residents order read if her blood sugar was higher than 400 to notify a provider and recheck the blood sugar 30 minutes to 1 hour following administration of the insulin. She stated Nurse #2 should have told her or at least rechecked the residents blood sugar prior to him leaving the facility that morning.<br><br>An interview conducted on 2/01/24 at 11:34 AM with the Nurse Practitioner (NP) revealed standard orders for insulin were if a blood sugar reading was greater than 400 to administer a sliding scale insulin, notify a provider and recheck the residents blood sugar 30 minutes to 1 hour | F 684 | solutions are sustained:<br>The director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) will audit 5 diabetic residents weekly x 12 weeks to ensure provider orders for low blood sugars were followed.<br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed.<br>The administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 2/26/24 | |

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| F 684 | Continued From page 13<br>following administration of the insulin. She stated she was not notified of Resident #7 having an elevated blood sugar that morning but was aware the resident's blood sugar had been elevated in the weeks prior. The NP stated she would have wanted staff to recheck Resident #7's blood sugar within the ordered time frame.<br><br>An interview conducted on 2/01/24 at 12:21 PM with the Director of Nursing (DON) revealed Nurse #2 should have followed the physician order and notified a provider and rechecked the blood sugar within 30 minutes to 1 hour. The DON stated Nurse #2 was still in the building 30 minutes after he had administered the insulin and there was no reason that he couldn't have rechecked Resident #7's blood sugar. The DON stated nurses should be following the physician orders and reading the orders entirely. | F 684 | | |
| F 687 SS=D | Foot Care<br>CFR(s): 483.25(b)(2)(i)(ii)<br><br>§483.25(b)(2) Foot care.<br>To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:<br>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and<br>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, responsible party and staff interviews, the facility failed to ensure a | F 687 | e facility failed to ensure a resident's toenails were trimmed and podiatry | 2/26/24 |

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| F 687 | Continued From page 14<br>resident's toenails were trimmed and podiatry services were arranged for 1 of 1 resident reviewed for foot care (Resident #56).<br><br>Finding included:<br><br>Resident #56 was admitted on 08/26/2023 with diagnoses that included diabetes mellitus, dementia, high blood pressure, and stage III chronic kidney disease.<br><br>Resident #56 transitioned to Hospice care 10/26/2023 and was discharged home with Hospice services on 01/22/2024.<br><br>Review of the significant change Minimum Data Set (MDS) dated 11/03/2023 revealed Resident #56's cognition was assessed as moderately impaired, and she required extensive to total assistance with all activities of daily living (ADL). The MDS also revealed Resident #56 transitioned to Hospice care with adult failure to thrive.<br><br>Resident #56's care plan revised on 11/07/2023 revealed Resident #56 was care planned for ADL self-care performance deficits related to disease processes. The goals included extensive and total staff assistance in all aspects of daily care to ensure all needs were met. Interventions included staff assistance with grooming and personal hygiene.<br><br>A telephone interview was conducted with Resident #56's responsible party (RP) on 01/29/2024 at 2:21 PM. The RP stated she had requested podiatry care a few months ago when Resident #56 was in the facility because she had thick, sharp, and jagged toenails and her feet were scaly and very dry. The RP confirmed | F 687 | services were arranged for 1 of 1 resident reviewed for foot care (Resident #56).<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>Resident #56 was Discharged home with family on 1/22/2024.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>On 2/22/2024 director of nursing (DON), assistant director of nursing (ADON), unit manager (UM), and infection control nurse (IC)audited all residents to ensure toenails were trimmed and podiatry services had been completed if ordered. Residents in need of Podiatry services were added to the Podiatry roster by social worker to be seen on their next visit in March 2024.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: | |

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| F 687 | Continued From page 15<br>Resident #56 was never seen by a podiatrist. She also indicated Resident #56 was totally dependent on staff for all care needs while she was in the facility.<br><br>A telephone interview was conducted with Resident #56's Hospice Nurse on 02/01/2024 at 2:45 PM. Hospice nurse indicated that she had assessed Resident #56's feet whike the resident was in the facility and noted her toenails were very long and thick and that her legs and feet were scaly and dry. She further revealed she had spoken to the Social Worker (SW) and asked her to have Resident #56 seen by the podiatrist when Resident #56 was in the facility.<br><br>An interview was conducted with the SW on 02/01/2024 at 3:15 PM. The SW stated the Hospice nurse had asked her to add Resident #56 to the podiatry list while the resident resided in the facility. The SW indicated the SW Director handled all podiatry requests and referrals and managed the podiatry list and scheduled the podiatry clinics. The SW stated that she asked the SW Director to add Resident #56 to the next podiatry clinic.<br><br>An interview was conducted with the SW Director on 02/01/2023 at 3:30 PM. The SW Director confirmed that the SW asked her to add Resident #56 to the next podiatry clinic. The SW Director further stated that it must have slipped her mind because Resident #56 was not on the list and was not seen by the podiatrist.<br><br>Review of the facility's podiatry clinic schedules for September 2023 and November 2023 revealed Resident #56 was not scheduled to be seen by the podiatrist. There were no | F 687 | On 2/22/24 the ADON provided education to licensed nurses and CNAs (including agency) on ensuring resident toenails are trimmed and procedure for arranging podiatry services. Any licensed nurse or CNA (including agency) who have not received education will not be allowed to work after 02/23/24 until education completed.<br><br>On 2/23/24 ADON added education on ensuring resident toenails are trimmed and how to obtain podiatry consults to the newly hired licensed nurses and CNAs (including agency).<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) will audit 5 residents weekly x 12 weeks to ensure toenails have been trimmed and podiatry consults completed if ordered.<br><br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues identified are corrected. | |

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| F 687 | Continued From page 16<br>consultation reports or notations in Resident #56's medical record that she had been seen by a podiatrist.<br><br>An interview was conducted with the Director of Nursing (DON) on 02/01/2024 at 4:00 PM. The DON stated the SW Director was responsible for scheduling residents for podiatry services and the podiatry clinic was held every 3 months. She further added that depending on the condition, the resident could be sent out for an outpatient podiatry appointment if needed. The DON indicated she expected all residents to receive podiatry services when needed. | F 687 | Completion date: 2/26/24 | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, and interviews with resident and staff, the facility failed to provide care in a safe manner for 1 of 4 residents (Resident #49) reviewed for supervision to prevent accidents. On 05/10/23, Resident #49's lower half of his body went off the other side of the bed during incontinence care but did not result in an injury.<br><br>The findings included: | F 689 | facility failed to provide care in a safe manner for 1 of 4 residents (Resident #49) reviewed for supervision to prevent accidents. On 05/10/23, Resident #49's lower half of his body went off the other side of the bed during incontinence care but did not result in an injury.<br><br>How corrective action will be | 2/26/24 |

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| F 689 | Continued From page 17<br>Resident #49 was admitted to the facility on 08/04/22 and readmitted on 10/12/23 under Hospice services. His admission diagnoses included nontraumatic spinal cord injury resulting in paraplegia, spondylosis, myelopathy at level of thoracic spine and neurogenic bladder.<br><br>Resident #49's significant change Minimum Data Set (MDS) assessment dated 03/31/23 revealed he was cognitively intake. The MDS also revealed the resident required extensive assistance of 2 staff members with bed mobility, transfers, and had impairment on both sides of lower extremities.<br><br>Review of a fall report dated 05/10/23 and written by Nurse #5 revealed Resident #49 rolled out of his bed while being provided incontinence care by Nurse Aide (NA) #6. According to the report, Resident #49 was found on the side of the bed between the bed and window. NA #6 stated for the report that she was turning him for care and his legs slipped off the bed and the resident continued to roll off the bed. The report indicated the resident did not have any injuries except an abrasion inside his left upper arm. The abrasion was cleaned and Resident #49's family member was notified of the fall. The resident was assisted back to bed via mechanical lift.<br><br>Several attempts were made to contact Nurse #5 and voicemails and text messages left with no return call.<br><br>An interview with Resident #49 on 01/31/24 at 11:10 AM revealed he remembered his fall and said the Nurse Aide (NA) assigned to him on 05/10/23, NA #6 was new and had never taken care of him before that day. Resident #49 stated | F 689 | accomplished for those residents found to have been affected by the deficient practice;<br><br>On 5/10/2023 resident #49 was assessed by facility nurse with no significant change.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>On 02/21/2024 Unit Manager (UM) audited all residents falls for past 30 days to ascertain supervision/staff assistance was not involved in occurrence. No staff involvement was noted on any fall in the last 30 days.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 02/23/2024 assistant director of nursing (ADON) provided education to licensed nurses and CNAs (including agency) on ensuring staff assistance is provided at level needed based on current | |

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| F 689 | Continued From page 18<br>he remembered she was providing him with incontinence care (before he had gotten a colostomy) and when she rolled him, his legs slid off the bed and the momentum caused him to fall off the bed. He stated he thought because she was new, she didn't understand how to turn him and provide care to him and caused him to fall off the bed.<br><br>Review of the nursing schedule for 05/10/23 revealed the staff caring for Resident #49 on 1st shift (7:00 AM to 3:00 PM) were Nurse #5, NA #6 and NA #7.<br><br>A phone interview was attempted with NA #6 on 02/01/24 at 1:08 PM but her number had been disconnected and the facility had no other phone number on file for the NA and she was no longer an employee at the facility.<br><br>A phone interview with NA #7 on 02/01/24 at 1:13 PM revealed if he was on the schedule that he had worked on that date. He stated that he recalled Resident #49 but stated he could not recall anything about his fall because it had been months since he had worked on the hall where Resident #49 resided.<br><br>An interview with the Unit Manager for 100 hall on 02/01/24 at 2:33 PM revealed she recalled Resident #49's fall and recalled when she entered his room on 05/10/23 the resident was found on the floor between his bed and the window. The Unit Manager stated NA #6 had been providing care to Resident #49 and when she rolled him over to clean him his legs slid off the bed and the momentum of his legs falling off the bed caused him to fall off the bed. She further stated the resident at the time was extensive assistance of 2 | F 689 | resident status if different than level of care on Kardex notify licensed nurse and obtain assistance needed to ensure safety. (Level of assistance information is located on each resident Kardex in the electronic medical record and is updated by licensed nurse when a change occurs) Any licensed nurse or CNA (including agency) who have not received education will not be allowed to work after 2/23/24 until education completed.<br><br>On 02/23/2024 ADON added education on ensuring staff assistance is provided at level needed to prevent resident incident to the newly hired licensed nurses and CNAs (including agency).<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) will audit 5 resident care opportunities to ensure appropriate staff assistance is being provided based on current resident status weekly x 12 weeks to ensure personal care provided with safe level of assistance.<br><br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues identified are corrected. | |

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| F 689 | Continued From page 19<br>staff members with bed mobility and said there should have been 2 staff members in the room while providing him care. The Unit Manager indicated since NA #6 was new and not familiar with Resident #49 she may not have known he needed 2 staff members at the bedside while being provided care but should have known based on the Kardex (communication for NAs regarding care needs of residents) for the resident.<br><br>An interview with the Director of Nursing (DON) on 02/01/23 at 4:33 PM revealed she was not at the facility at the time of the fall but said if Resident #49 was indicated as extensive assistance of 2 staff members with bed mobility she would have expected 2 staff members to have been with the resident during the resident's care.<br><br>Several attempts were made to contact the former Director of Nursing (DON) who was at the facility on 05/10/23 and voicemails and text messages left with no return call. | F 689 | Completion date: 2/26/24 | |
| F 725 SS=D | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required | F 725 | | 2/27/24 |

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| F 725 | Continued From page 20<br>at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, resident, family member and staff interviews, the facility failed to provide sufficient nursing staff to provide showers to a dependent resident for 1 of 6 residents reviewed for staffing (Resident #83).<br><br>This tag was cross-referenced to:<br><br>F677 - Based on record review, observations, resident, family member, and staff interviews, the facility failed to provide showers to a dependent resident for 1 of 6 residents (Resident #83) reviewed for activities of daily living.<br><br>An interview with NA #2 and NA #3 on 01/31/24 at 2:34 PM revealed they typically worked the shower team unless they were pulled to work as a NA on the hall. NA #2 indicated they were sometimes pulled to the hall to work as a NA and on those days, it was up to the NA on the floor to complete the resident's showers or bed baths. NA | F 725 | facility failed to provide sufficient nursing staff to provide showers to a dependent resident for 1 of 6 residents reviewed for staffing (Resident #83)<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>On 01/31/24 resident #83 was provided a shower by facility CNA.<br><br>How the facility will identify other residents having the potential to be affected by the | |

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| F 725 | Continued From page 21<br>#2 and NA#3 stated they had often been pulled from the shower team to a hall assignment due to staffing or call outs in the facility.<br><br>An interview with NA #9 on 01/31/24 at 9:37 AM revealed since the end of September she had often been on the hall alone to care for 21 or more residents but could not recall the dates. She stated on the days that she was alone on the resident hall she was unable to complete every 2-hour incontinence rounding or showers on the hall because she was watching and answering call lights. NA #9 stated it was hard because residents were complaining, and she felt outnumbered by the amount of residents to herself. She stated the shower team was unable to complete the assigned showers and would say they would get to the residents the next day, however they would not because they were being pulled to work as NAs on a resident hall.<br><br>An interview with NA #1 on 02/01/24 at 8:43 AM revealed staffing had been rough, but she felt like it was getting better. She stated in the last few weeks she had worked as the only NA on the 300 hall and cared for 21 to 22 residents. She stated if the shower team was pulled to hall due to staffing that she was unable to complete the assigned showers for the day.<br><br>An interview with NA #10 on 02/01/24 at 9:28 AM revealed that she sometimes had to work on a hall by herself. She stated she could not recall an exact date. She stated when she was by herself, she was unable to get task completed such as getting residents out of bed or showers. She stated often the nurses on the unit did not want to assist the NAs. | F 725 | same deficient practice;<br><br>On 02/22/24 Unit Manager (UM) audited all residents□ showers for the past 14 days. No negative findings.<br><br>On 02/22/24Director of nursing (DON) reviewed the staffing grid to ensure staffing is sufficient to provide ADL care for dependent residents including showers.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 02/22/2024 Administrator provided education to the director of nursing (DON), and scheduler on sufficient staffing to ensure ADL care including showers for dependent residents.<br><br>On 02/23/24 Administrator added education on ensuring staffing is sufficient to provide ADL care to dependent residents including showers to the orientation for any new scheduler and DON.<br><br>Effective 2/27/24 the DON and/or | |

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| F 725 | Continued From page 22<br>An interview with the Assistant Director of Nursing (ADON) on 01/30/23 at 2:55 PM revealed she had been in charge of the schedule for the facility. She stated the facility was agency free for nurse aides and was currently using agency staffing for nurses. The interview revealed the facility staffed two NAs on the 100, 200, 300 and 500 halls. She stated there were three NAs assigned to 400 hall. The ADON stated if there was a call out then they would take the shower team NAs and move them to a hall assignment. She stated the second shift was typically scheduled the same and third shift there were 1 NA to each hall from the 11 PM to 7AM shift.<br><br>An interview with the Director of Nursing (DON) on 02/01/24 at 4:28 PM revealed she felt staffing in the facility was overall good. She stated the NAs have been working hard and she could not recall a date there was only one NA to a hall. She stated staff had not been doing what she told them to regarding letting someone know if they needed extra assistance or help. The interview revealed sometimes the shower team was pulled to a hall assignment when they had staff call out. | F 725 | administrator will review staffing at least 3 times a week to ensure staffing is sufficient to provide showers per plan of care (including shower team or sufficient staffing levels to provide showers per schedule and/or resident preference). During this review the DON and/or administrator will review open positions, call out trends/tracking, and recruitment progress.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) will audit 5 residents weekly x 12 weeks to ensure staffing was sufficient to provide showers were provided per plan of care.<br><br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 2/27/24 | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary | F 761 | | 2/26/24 |

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| F 761 | Continued From page 23<br>instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, and record review the facility failed to date opened multi-dose vials of medications in 1 of 3 medication administration carts (400 Hall).<br><br>The findings included:<br><br>An observation of the 400 Hall medication cart on 01/31/2024 at 11:14 AM with Nurse #1 revealed two opened and unlabeled vials of Lidocaine (injectable numbing medication). Both vials were available for use in the top drawer of the medication cart. A review of the manufacturer's literature indicated to discard Lidocaine multi-dose vials 28 days after opening. During the observation, an interview with Nurse #1 revealed she was not sure if the open vials of | F 761 | facility failed to date opened multi-dose vials of medications in 1 of 3 medication administration carts (400 Hall).<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>On 1/31/24 the facility nurse discarded open lidocaine vial on 400 hall medication cart. | |

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| F 761 | Continued From page 24<br>Lidocaine were currently being used. She also stated vials of Lidocaine were usually used to dilute antibiotics. Nurse #1 also indicated that both vials should have been discarded since they were not labeled or dated but she did not notice them when she administered medications from the medication cart that morning. She further stated that the nurses should check the medications in the medication carts when they had time to do so.<br><br>An interview with the Director of Nursing (DON) on 01/31/2024 at 11:54 AM revealed the open vials of Lidocaine should have been labeled when opened for use. She also indicated that all nurses were responsible for putting the date of opening on multi-dose medication vials and checking all the medications in the medication cart. She stated that she expected all multi-dose vials to be labeled when opened and discarded 28 days after opening. | F 761 | How the facility will identify other residents having the potential to be affected by the same deficient practice.<br><br>On 2/23/24 Director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) audited all medication storage areas for expired, or unlabeled medications. Any expired or discontinued medications were discarded and reordered as needed.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 02/23/2024 ADON, provided education to licensed nurses (including agency) on medication storage including labeling of multidose vials. Any licensed nurse (including agency) who have not received education will not be allowed to work after 02/23/2024 until education completed.<br><br>On 2/23/24 the IC will add education on medication storage including labeling of multiuse vials to the newly hired licensed nurses (including agency).<br><br>Indicate how the facility plans to monitor | |

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| F 761 | Continued From page 25 | F 761 | its performance to make sure that solutions are sustained:<br><br>The director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) will audit 5 medication storage areas for appropriate storage including labeling of multiuse vials weekly x 12 weeks.<br><br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 2/26/24 | |
| F 809 SS=E | Frequency of Meals/Snacks at Bedtime<br>CFR(s): 483.60(f)(1)-(3)<br><br>§483.60(f) Frequency of Meals<br>§483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.<br><br>§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. | F 809 | | 2/26/24 |

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| F 809 | Continued From page 26<br>§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, and resident and staff interviews the facility failed to have systems in place for providing evening snacks to residents' in 5 of 5 halls. The deficient practice had the potential to affect all residents requesting a evening snack.<br><br>The findings included:<br>a. Observations of Nourishment Room #1 on 1/29/24 at 3:30 PM revealed snacks available and dated for 1/29/24 in the refrigerator. There were sandwiches, applesauce, pudding, juice, and milk. The sandwiches were on a tray stacked in three rows, two sandwiches on top of each other. The puddings were in four packs and the applesauce were in bowls on the tray with the sandwiches. There was an undated box full of cookie and crackers sitting next to the refrigerator.<br><br>When the nourishment room refrigerator was checked on 1/30/24 at 9:00 AM the sandwiches, pudding, apple sauce, juice and milk remained on the tray as observed on 1/29/24. There was still a full box of cookies and crackers observed next to the refrigerator.<br><br>An observation of Nourishment Room #1 on 1/30/24 at 4:00 PM revealed snacks dated 1/30/24 in the refrigerator. There were sandwiches, applesauce, pudding, juice, and milk. The sandwiches were on a tray stacked in | F 809 | facility failed to have systems in place for providing evening snacks to residents' on 5 of 5 halls. The deficient practice had the potential to affect all residents requesting an evening snack.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>On 02/02/2024 all residents were offered a bedtime snack by licensed nurse staff.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>On 2/08/2024 Director of nursing (DON) completed an interview with capable residents to ensure residents are currently pleased with their snacks. No change in Plan of Care, Residents were currently pleased that HS snacks were being | |

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| F 809 | Continued From page 27<br>three rows, two sandwiches on top of each other. The puddings were in four packs and the applesauce were in bowls on the tray with the sandwiches. There was an undated box full of cookie and crackers sitting next to the refrigerator.<br><br>When the nourishment refrigerator was checked on 1/31/24 at 8:00 AM the sandwiches, pudding, apple sauce, juice and milk remained on the tray as observed on 1/30/24. There was still a full box of cookies and crackers observed next to the refrigerator.<br><br>An observation of Nourishment Room #1 on 2/01/24 at 4:15 PM revealed snacks dated 2/01/24 in the refrigerator. There were sandwiches, applesauce, pudding, juice, and milk. The sandwiches were on a tray stacked in three rows, two sandwiches on top of each other. The puddings were in four packs and the applesauce were in bowls on the tray with the sandwiches. There was an undated box full of cookie and crackers sitting next to the refrigerator.<br><br>When the nourishment refrigerator was checked on 2/02/24 at 7:45 AM the sandwiches, pudding, apple sauce, juice and milk remained on the tray as observed on 1/30/24. There was still a full box of cookies and crackers observed next to the refrigerator.<br><br>b. Observations of Nourishment Room #2 on 1/29/24 at 3:40 PM revealed snacks available and dated for 1/29/24 in the refrigerator. There were sandwiches, applesauce, pudding, juice, and milk. The sandwiches were on a tray stacked in three rows, two sandwiches on top of | F 809 | offered.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 02/23/24 Assistant director of nursing (ADON) provided education to licensed nurses and CNAs (including agency) on offering all residents a bedtime snack per their preference. Any licensed nurse or CNA (including agency) who have not received education will not be allowed to work after 02/23/2024 until education complete.<br><br>On 2/23/24 infection control nurse (IC) added education on providing bedtime snack per their preference to the newly hired licensed nurses (including agency).<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) will audit/interview 5 residents weekly x 12 weeks to bedtime snacks have been offered.<br><br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues | |

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| F 809 | Continued From page 28<br>each other. The puddings were in four packs and the applesauce were in bowls on the tray with the sandwiches. There was an undated box full of cookie and crackers sitting next to the refrigerator.<br><br>When the nourishment room refrigerator was checked on 1/30/24 at 9:10 AM the sandwiches, pudding, apple sauce, juice and milk remained on the tray as observed on 1/29/24. There was still a full box of cookies and crackers observed next to the refrigerator.<br><br>An observation of Nourishment Room #2 on 1/30/24 at 4:10 PM revealed snacks dated 1/30/24 in the refrigerator. The sandwiches were on a tray stacked in three rows, two sandwiches on top of each other. The puddings were in four packs and the applesauce were in bowls on the tray with the sandwiches. There was an undated box full of cookie and crackers sitting next to the refrigerator.<br><br>When the nourishment room refrigerator was checked on 1/31/24 at 8:10 AM the sandwiches, pudding, apple sauce, juice and milk remained on the tray as observed on 1/30/24. There was still a full box of cookies and crackers observed next to the refrigerator.<br><br>Observation of Nourishment Room #2 on 2/1/24 at 4:25 PM revealed snacks dated for 2/1/24 in refrigerator. There were sandwiches, applesauce, pudding, cookies, crackers, juice, and milk. The sandwiches were on a tray stacked in three rows, two sandwiches on top of each other. The puddings were in four packs and the applesauce were in bowls on the tray with the sandwiches. There was an undated box full of | F 809 | identified are corrected.<br><br>Completion date: 2/26/24 | |

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| F 809 | Continued From page 29 | F 809 | | |

cookie and crackers sitting next to the refrigerator.

When the nourishment room refrigerator was checked on 2/2/24 at 8:10 AM the sandwiches, pudding, apple sauce, juice and milk remained on the tray as observed on 2/1/24. There was still a full box of cookies and crackers observed next to the refrigerator.

An interview conducted during a Resident Council Meeting on 01/30/24 at 4:00 PM revealed multiple residents expressed concerns they had not received snacks in the evening. The residents further revealed this was an ongoing issue and had been discussed at last month's meeting. Residents that were vocal were resident council president (Resident #80) and vice president and (Resident #31). Both residents stated they had asked nursing staff on multiple evenings and staff would state that they could not get snacks because they were busy due to low staffing.

An interview on 2/2/24 at 11:00 AM with the District Dietary Manager (DDM), revealed when she checked the Nourishment Room refrigerators every morning the week of 1/29/24 through 2/1/24 the previous days evening snacks were still present in refrigerator in both nourishment rooms had to be thrown away. The DDM stated, the night snacks were placed in the nourishment rooms everyday by 3:00 PM. The DDM explained she did not report this to anyone in administration since she was filling in the week of survey and was unsure if this was an ongoing issue.

An interview on 2/2/24 at 3:00 PM with Nurse Aid (NA) #1 stated that she will give resident snacks if they ask for something. When asked if she offers

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| F 809 | Continued From page 30<br>snacks to every resident, she responded that if residents want something they will ask so she generally does not ask each resident. If a resident requested snacks from her, she would go to the nourishment room and get them something.<br><br>An interview on 2/2/24 at 4:00 PM with the Director of Nursing (DON) stated that the expectation was that every resident would be offered a bedtime snack. The DON stated she was not aware that the nighttime snacks were not being passed. The DON also stated they did not have diabetic list since all residents were supposed to be offered a snack.<br><br>An interview on 2/2/24 at 5:15 PM with the Administrator revealed that her expectation was that evening snacks would be offered to all residents. | F 809 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility. | F 812 | | 2/26/24 |

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| F 812 | Continued From page 31<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to date and label fresh vegetables in 1 of 1 kitchen walk-in refrigerators, store a bucket of counter cleaning solution away from food items in kitchen, date and label a resident's food item in 1 of 2 nourishment room refrigerators, and prevent possible cross contamination by storing a dirty meal tray on a cart with trays that had not been served for 1 of 5 tray carts.<br><br>The findings included:<br><br>Observations in the kitchen with District Dietary Manager (DDM) revealed the following:<br>1.a. An observation of the kitchen walk-in refrigerator on 1/29/24 at 9:35 AM revealed a bag of unlabeled and undated assortment of fresh vegetables. The bag full of fresh vegetables were tied off at the top, the vegetables did not appear to be rotten.<br><br>During an interview with the DDM on 1/31/24 at 8:00 AM, she stated that the vegetables should not have been placed in an unlabeled bag, due to not being able to tell when they were opened and what was in the bag. Dietary staff were expected to label and date all food items before being placed into the refrigerators.<br><br>b. An observation in the kitchen on 1/29/24 at 9:35 AM revealed a red bucket with clear solution sitting on a bottom shelf in the kitchen next to covered bowls of dry cereal. The DDM stated | F 812 | the facility failed to date and label fresh vegetables in 1 of 1 kitchen walk-in refrigerators, store a bucket of counter cleaning solution away from food items in kitchen, date and label a resident's food item in 1 of 2 nourishment room refrigerators, and prevent possible cross contamination by storing a dirty meal tray on a cart with trays that had not been served for 1 of 5 tray carts.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>On 1/29/24 the dietary manager dated and labeled fresh vegetables in the kitchen walk in refrigerator.<br><br>On 1/29/24 the dietary manager removed the bucket of counter cleaning solution from food items in kitchen and placed away from food items.<br><br>On 1/29/24 the facility licensed nurse removed the resident personal food item from nourishment room. This item was then discarded. | |

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| F 812 | Continued From page 32<br>that the red bucket contained cleaning solution for the counter tops. When the surveyor inquired about the red bucket it was removed by the DDM immediately and staff instructed to redo cereal bowls.<br><br>2. An observation of the 500-hallway nourishment room refrigerator on 1/29/24 at 4:16 PM revealed a blender container with a brown liquid substance. The container was not dated or labeled with any identifying information.<br><br>The Director of Nursing (DON) was present during the observation and stated that a family member was known to make his mother vegan shakes and store the remaining shake in the nourishment room. The DON stated the family member had been educated that this was not allowed and should have staff date and label anything that was put in the refrigerator.<br><br>During an interview with the DDM on 1/31/24 at 8:00 AM, revealed if residents or family members store any food items in the nourishment room it should be labeled and dated. She stated that either the nursing or dietary staff should have identified the container and removed it from the refrigerator.<br><br>3. On 1/30/24 at 8:30 AM an observation on the 500-hallway revealed a dirty breakfast tray stored on the tray cart with four unserved clean breakfast trays. Nursing Aide #4 was asked about the dirty trays that was placed directly above the clean trays, and she responded, "I did not even think about it, I should have placed it on top of the cart not in the cart."<br><br>During an interview on 1/31/24 at 8:00 AM the | F 812 | On 1/30/24 the certified nursing assistant (CNA) removed the soiled tray from the clean tray cart and returned it to the kitchen for cleaning.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>On 1/29/24 the dietary manager will audit kitchen Walkin refrigerator for dating and labeling of fresh vegetables. No additional negative findings.<br><br>On 1/29/24 the dietary manager audited kitchen for cleaning solutions near or with food items. No additional negative findings.<br><br>On 1/30/24 the dietary manager audited all nourishment rooms for labeling of resident personal food items. No additional negative findings.<br><br>On 1/30/24 the director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) audited all clean tray carts during lunch to ensure soiled trays were not stored with clean trays. No negative findings.<br><br>Address what measures will be put into | |

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| F 812 | Continued From page 33<br>DON indicated that dirty trays were not picked up until all the trays were passed and staff should never place dirty and clean trays on the same cart.<br>During an interview with the Administrator on 2/1/24 at 5:35 PM, she stated that that she was made aware of the food storage concerns identified in the dietary department and expected the dietary staff to maintain food storage per manufacturer recommendations. The Administrator stated that anything placed in the nourishment room refrigerators should be labeled and dated. | F 812 | place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 2/23/24 the ADON will provide education to dietary staff, licensed nurses and CNAs (including agency) on labeling of resident personal food items in nourishment rooms and keeping clean and soiled trays on separate carts for meals. Any dietary staff, licensed nurse or CNA (including agency) who have not received education will not be allowed to work after 2/25/24 until education received.<br><br>On 2/23/24 ADON will add education on labeling of resident personal food items in nourishment rooms and keeping clean and soiled meal trays on separate on carts to the newly hired dietary staff, licensed nurses (including agency).<br><br>On 2/23/23 the dietary manager provided education to dietary staff on labeling of fresh vegetables, and storage of chemicals (away from food). Any dietary staff who have not received education will not be allowed to work after 2/25/24 until education is received.<br><br>On 2/23/23 the dietary manager will add education for newly hired dietary staff on labeling of fresh vegetables, and storage of chemicals away from food to orientation. | |

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| F 812 | Continued From page 34 | F 812 | Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The director of nursing (DON), assistant director of nursing (ADON), and/or unit manager (UM) will audit/interview 5 residents weekly x 12 weeks to bedtime snacks have been offered.<br><br>The dietary manager and/or administrator will observe kitchen for any chemicals near food 2 times weekly x 12 weeks.<br><br>The dietary manager, administrator, and/or DON will audit nourishment rooms 2 times weekly x 12 weeks to ensure resident personal food items are labeled.<br><br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 2/26/24 | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and | F 867 | | 2/26/24 |

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| F 867 | Continued From page 35 | F 867 | | |

procedures must include, at a minimum, the following:

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

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

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

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

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success,

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and track performance to ensure that improvements are realized and sustained.

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

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§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

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| F 867 | Continued From page 37<br>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.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§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:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations, and family and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following a complaint investigation that occurred on 06/26/23 and a recertification and complaint investigation survey that occurred on 10/03/22 for a deficiency that was cited in the area of Activities of Daily Living for Dependent Residents (F677), a recertification and complaint investigation survey that occurred on 10/03/22 for | F 867 | The center failed to maintain implemented procedures and monitor interventions the committee put into place following a complaint investigation that occurred on 06/26/23 and a recertification and complaint investigation survey that occurred on 10/03/22 for a deficiency that was cited in the area of Activities of Daily Living for Dependent Residents (F677), a recertification and complaint investigation survey that occurred on 10/03/22 for a deficiency that was cited in the area of | |

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| F 867 | Continued From page 38<br>a deficiency that was cited in the area of Free of Accidents/Hazards (F689), a recertification and complaint investigation survey that occurred on 04/15/21 for a deficiency cited in the area of Label/Storage of Drugs Biologicals (F761), a recertification and complaint investigation that occurred on 10/03/22 in the area of Food Procurement/Storage/Preparation/Serve Under Sanitary Conditions (F812), a recertification and complaint investigation survey that occurred on 10/03/22 for a deficiency that was cited in the area of Resident Records - Identifiable Information (F842), a complaint investigation survey that occurred on 12/08/21 and a recertification and complaint investigation that occurred on 04/15/21 for a deficiency cited in the area of Infection Control (F880) and these were subsequently recited on the current recertification and complaint investigation survey of 02/01/24. The repeat deficiencies during five consecutive surveys of record show a pattern of the facility's inability to sustain an effective QA program.<br><br>The findings included:<br><br>This tag is cross referred to:<br><br>F677: Based on record review, observations, resident, family member, and staff interviews, the facility failed to provide showers to a dependent resident for 1 of 6 residents (Resident #83) reviewed for activities of daily living.<br>During the complaint investigation survey completed on 06/26/23, the facility failed to provide incontinent care on a dependent resident to prevent them from soaking through their briefs, turn sheet, and fitted sheet for 2 of 4 residents.<br><br>During the recertification and complaint | F 867 | Free of Accidents/Hazards (F689), a recertification and complaint investigation survey that occurred on 04/15/21 for a deficiency cited in the area of Label/Storage of Drugs Biologicals (F761), a recertification and complaint investigation that occurred on 10/03/22 in the area of Food Procurement/Storage/Preparation/Serve Under Sanitary Conditions (F812), a recertification and complaint investigation survey that occurred on 10/03/22 for a deficiency that was cited in the area of Resident Records - Identifiable Information (F842), a complaint investigation survey that occurred on 12/08/21 and a recertification and complaint investigation that occurred on 04/15/21 for a deficiency cited in the area of Infection Control (F880) and these were subsequently recited on the current recertification and complaint investigation survey of 02/01/24. The repeat deficiencies during five consecutive surveys of record show a pattern of the facility's inability to sustain an effective QA program.<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>The facility received repeated deficiency tags on 2/1/24 for F677, F689, F761, | |

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| F 867 | Continued From page 39<br>investigation survey completed on 10/03/22, the facility failed to provide a dependent resident with their preferred method of bathing and the number of showers per week for 2 of 3 residents.<br><br>F689: Based on record reviews, and interviews with resident and staff, the facility failed to provide care in a safe manner for 1 of 4 residents (Resident #49) reviewed for supervision to prevent accidents. On 05/10/23, Resident #49's lower half of his body went off the other side of the bed during incontinence care but did not result in an injury.<br><br>During the recertification and complaint investigation survey completed on 10/03/22, the facility failed to provide care in a safe manner resulting in a resident falling from bed to floor sustaining a fracture to the left ulna (forearm) for 1 of 2 residents.<br><br>F761: Based on record review, observations and staff interviews, the facility failed to date opened multi-dose vials of medications in 1 of 3 medication administration carts (400 Hall).<br><br>During the recertification and complaint investigation survey completed on 04/15/21 the facility failed to remove 14 blister cards (contained 265 tablets) and 1 bottle (contained 500 tablets) of expired medications for 3 of 6 medication carts.<br><br>F812: Based on observations and staff interviews, the facility failed to date and label fresh vegetables in 1 of 1 kitchen walk-in refrigerators, store a bucket of counter cleaning solution away from food items in kitchen, date and label a resident's food item in 1 of 2 | F 867 | F812, and F842.<br><br>Appropriate plans of correction implemented for each deficiency with repeat citation.<br><br>On 2/22/24 Quality Assessment and Assurance committee and IDT reviewed previous Quality Assessment and Assurance minutes, and plans of correction to determine trends and opportunities for improvement including repeat deficiencies. As a result of this audit root causes were identified for F677, F689, F761, F812, and F842.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>On 02/22/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F677 to be Change in leadership, and Lack of continued follow up.<br><br>On 02/22/24 the interdisciplinary team IDT | |

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| F 867 | Continued From page 40<br>nourishment room refrigerators, and prevent possible cross contamination by storing a dirty meal tray on a cart with trays that had not been served for 1 of 5 tray carts.<br><br>During the recertification and complaint investigation survey completed on 10/03/22, the facility failed to maintain a clean and sanitary kitchen to prevent ice build up and repair a damaged door seal for a freezer, remove expired food ingredients stored ready for use in dry storage, cover and/or seal food left open to air in the walk-in refrigerator and not store staff food in resident food areas in reach in refrigerator. The facility also failed to repair leaking sink drains in 3-compartment sink, prevent standing water from accumulating on the kitchen floor, maintain clean ice coolers for 1 of 4 coolers, prevent the buildup of debris above the meal tray line and maintain intact ceiling above the clean dish area of the dish room.<br><br>F842: Based on record review and staff interviews, the facility failed to maintain complete and accurate medical records related to a resident's blood sugar for 1 of 2 residents reviewed (Resident #74).<br><br>During the recertification and complaint investigation survey completed on 10/03/22, the facility failed to document in the medical record a resident's death for 1 of 1 resident.<br><br>F880: Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies for the safe handling of soiled laundry when 1 of 5 staff members (Laundry Staff) failed to follow standard precautions during the infection control | F 867 | met and determined the root cause for repeat deficiency F689 to be Change in leadership, and Lack of continued follow up.<br><br>On 02/22/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F761 to be Change in leadership, and Lack of continued follow up.<br><br>On 02/22/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F812 to be Change in leadership, and Lack of continued follow up.<br><br>On 02/22/24 the interdisciplinary team IDT met and determined the root cause for repeat deficiency F842 to be Change in leadership, and Lack of continued follow up.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 2/27/24 the regional clinical director provided education to the administrator and director of nursing on quality assurance meetings and the quality assurance process.<br><br>On 2/22/2024 Administrator educated | |

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| F 867 | Continued From page 41<br>observation.<br><br>During the complaint investigation survey completed on 12/08/21, the facility failed to follow CDC guidelines when staff failed to wear eye protection while performing direct care during a COVID-19 pandemic.<br><br>During the recertification and complaint investigation survey completed on 04/15/21, the facility failed to follow infection control policies and procedures by not sanitizing the injection site with antiseptic pad for 1 of 2 residents observed for insulin administration. This occurred during a COVID-19 pandemic.<br><br>During an interview with the Administrator on 02/01/24 at 4:00 PM she revealed she had not been at the facility for the other surveys of record but said she attributed the repeat deficiencies to changes in leadership and staff. She stated the facility was working diligently to replace agency staff in the building with facility staff so there would be more continuity of resident care. The Administrator further stated they were constantly doing in-services and providing education to staff and would be initiating process improvement plans and monitoring to ensure residents received appropriate care. | F 867 | management interdisciplinary team (IDT) team on ensuring procedures are implemented and monitored per the plan of correction for repeat tags, and newly identified areas.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The administrator will audit results of plan of correction audits for F677, F689, F761, F812, and F842 weekly x 12 weeks.<br><br>The administrator will audit Quality Assurance monthly x 3 months to ensure procedures are implemented and monitored.<br><br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>The regional director of operations and/or regional clinical director will review quality assurance meeting to ensure compliance is maintained in identified areas of deficiency x6 months.<br><br>Completion date: 2/27/24 | |
| F 880 SS=E | Infection Prevention & Control | F 880 | | 2/26/24 |

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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 |
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| F 880 | Continued From page 42<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345169 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

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| F 880 | Continued From page 43<br>resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies for the safe handling of soiled laundry when 1 of 5 staff members (Laundry Staff) failed to follow standard precautions during the infection control observation.<br><br>The findings included: | F 880 | F880<br><br>facility failed to implement their infection control policies for the safe handling of soiled laundry when 1 of 5 staff members (Laundry Staff) failed to follow standard precautions during the infection control observation<br><br>How corrective action will be | |

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| F 880 | Continued From page 44<br>The facility's policy on Handling, Transport and Storage of Laundry dated July 22, 2020, stated "Staff should handle all used laundry as potentially contaminated and use standard precautions (i.e., gloves). Laundry workers must always wear the proper protective equipment when handling the soiled linen. Contaminated linen and laundry bags are not held close to the body or squeezed."<br><br>On 1/30/24 at 3:02 pm, the Laundry Staff was observed wearing a short rubber glove while sorting out the soiled laundry in the dirty side of the laundry room. The soiled laundry containing white sheets, towels, and personal clothes were in a black buggy. The staff was leaning closely over the buggy while sorting. The soiled laundry was touching his forearm and shirt, and the side of the black buggy was in contact with his pants.<br><br>During an interview on 1/30/24 at 3:06 pm, the Laundry Staff stated he always wore gloves when sorting the soiled linens.<br><br>During an interview on 01/31/24 at 10:37 am, the Laundry Supervisor stated all laundry staff should wear long rubber gloves and wear nursing gloves underneath it while sorting the soiled laundry. They also used an apron and mask. When staff were onboarding, they watched videos on laundry infection.<br><br>During an interview on 2/1/24 at 5:00 pm, the Director of Nursing stated all staff should follow instructional signs for personal protective equipment. She stated she would discuss with the infection Preventionist and plan on follow up training with staff. | F 880 | accomplished for those residents found to have been affected by the deficient practice;<br><br>On 02/06/24 the laundry worker was educated by Director of Housekeeping on proper handling of soiled laundry.<br><br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>On 02/07/24 Director of Housekeeping observed soiled laundry handling in the laundry room. Proper handling of soiled laundry and proper PPE was in use.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>On 02/22/24 Director of Housekeeping provided education to laundry staff members on correct soiled laundry handling. Any laundry staff member who has not received education will not be allowed to work after 02/23/24 until education completed. | |

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| F 880 | Continued From page 45<br>During an interview on 2/1/24 at 6:05 pm, the Administrator stated the staff should follow the infection control guidelines, especially during an outbreak. She stated it was her goal to improve performance in the facility for the residents to receive quality care. | F 880 | On 02/23/24 Director of Housekeeping added education on soiled laundry handling to the newly hired laundry staff members.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:<br><br>The administrator, or director of housekeeping will complete 5 soiled laundry handling occurrences weekly x 12 weeks to ensure proper soiled laundry handling is occurring.<br><br>Results of these audits will be reviewed at monthly Quality Assurance Meeting X 3 for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any issues identified are corrected.<br><br>Completion date: 2/26/24 | |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
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| | 345169 | A. BUILDING: _____ B. WING _____ | 2/1/2024 |

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| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| F 842 | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(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.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§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-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, 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.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted |

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

The above isolated deficiencies pose no actual harm to the residents

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| F 842 | Continued From Page 1 |

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 maintain complete and accurate medical records related to a resident's blood sugar for 1 of 2 residents reviewed (Resident #74).

Findings included:

Resident #74 was admitted to the facility on 11/24/22 with diagnosis which included diabetes.

Resident #74's quarterly Minimum Data Set (MDS) dated 12.18.23 revealed he was cognitively impaired and required extensive assistance with the majority of Activities of Daily Living (ADL). The MDS further revealed Resident #47 received insulin.

Review of resident #74's physician order dated 01/24/24 revealed the resident required fingerstick blood glucose with meals (ACHS).

An interview conducted with Nurse #1 on 01/31/24 at 9:30 AM revealed on 1/30/2024 around 4:00 PM she entered Resident #74's room and observed the resident visiting with a family member. Nurse #1 further revealed the family member advised the Nurse to take the residents blood sugar and it was 46. Nurse #1 indicated she gave the resident diabetic supplement and advised the family to give the resident a snack cake. Nurse #1 revealed she checked her blood sugar twenty minutes later at it was around 250. The Nurse stated she did not record the blood sugars and stated she did not know why they were not documented.

Review of resident #74's medical record /vitals revealed there was no documented blood sugar on 1/30/2024 at 4:00PM or 20 minutes later.

Review of Resident #74's progress notes revealed no documentation of the incident that occurred on 01/30/24 with the resident ' s blood sugar.

An interview conducted with the Nurse Practitioner (NP) on 01/31/24 at 12:20 PM revealed she had not been notified of Resident #74 had received a low blood sugar on 1/30/24. The NP further revealed she would have wanted to be notified of the resident ' s blood sugar and it should have been documented in the residents ' chart.

An interview conducted with the Director of Nursing (DON) on 01/31/24 at 2:40 PM revealed Resident 74's blood sugars should have been documented and the NP or on-call provider should have been notified of the low blood sugar. The DON further revealed it was stated in the facility policy and education had been provided to nursing staff.

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