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	345008	A. BUILDING _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/19/24 through 02/22/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #ZS5W11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/19/24 through 02/22/24. Event ID# ZS5W11. The following intakes were investigated NC00213533 and NC00213738. Two (2) of the 2 complaint allegations did not result in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		3/22/24

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

Electronically Signed | 03/15/2024

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide a dignified dining experience when staff did not assist residents with meals at eye level or place the meal tray in front of the resident. This failure occurred for 2 of 8 sampled residents reviewed for dignity with dining (Resident #32 and Resident #40). The findings included: a. Resident #32 was admitted to the facility on 8/20/22. Diagnoses included Alzheimer's disease and Parkinson's disease. A care plan, revised 11/8/23, recorded Resident #32 had impaired cognitive function and self-care performance deficit regarding her diagnoses of Alzheimer's disease. Interventions included facing	F 550	1) Residents #32 and #40 were assisted with subsequent meals by the certified nursing assistant (CNA) who sat at eye level with the residents. The wound care nurse and the CNA were re-educated on resident's rights as it related to dignity during meals by the Assistant Director of Nursing (ADON). This education included, but was not limited to how to address a resident repectfully by not referring to the resident as a feeder or by any other description of their needs or diagnosis,calling the resident by their preferred name and to sit at eye level with the resident during assistance with meals. 2) On 2/26/24, a 100% audit of current residents was completed to determine which residents required assistance with	

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F 550	Continued From page 2 the resident when speaking, make eye contact and provide the level of assistance with meals as required. A quarterly Minimum Data Set (MDS) assessment, dated 1/24/24, assessed Resident #32 with clear speech, adequate hearing, adequate vision, severely impaired cognition, and required extensive staff assistance with meals. A continuous observation occurred on 2/19/24 from 12:42 PM until 12:50 PM of Resident #32 in bed and fed lunch by the Wound Nurse. Resident #32 was in a bed positioned low and the head of the bed was elevated while the Wound Nurse stood to the left of Resident #32 to feed her. Resident #32 turned her head up and to her left to receive her lunch meal from the Wound Nurse. The meal tray was on the over bed table in front of the Wound Nurse. The Wound Nurse stated on 2/19/24 at 12:50 PM that she did not typically assist Resident #32 with meals. The Wound Nurse stated she assisted residents with dining that day and described Resident #32 as "a feeder." The Wound Nurse stated that the NA assigned to Resident #32 "has a lot of feeders, so I helped out." The Wound Nurse further stated that she received training to sit down when she assisted residents with their meals, but that she was trying to feed Resident #32 to keep her food from getting cold. The Wound Nurse stated that she should not refer to residents as "feeders." An interview occurred with the Director of Nursing (DON) on 2/22/24 at 9:42 AM. The DON stated that during dining, she expected staff to place the food in front of the resident so that the resident	F 550	consuming their meals. 3) The clinical management team verified that for each residents that required staff assistance with consuming their meal, a chair was available to the staff so that they may sit eye level with the resident. On 2/26/24, the Director of Nursing (DON), ADON and the Unit Managers began educating the staff on resident's rights which included but was not limited to: calling the resident by their preferred name and not their diagnosis or the level of assistance they require, sitting at eye level during assistance with meals, and treating the resident with respect during any encounters. This education will be included in the new hire orientation. 4) For 12 weeks, a weekly audit of all residents who require assistance with consuming meals will be completed to determine if the residents are treated with dignity by following the policy on meal assistance and using the resident□s preferred name when addressing or discussing the resident. 5) The results of the audits will be discussed in the weekly risk meeting and monthly in the facility's Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings. Date of Completion: 03/22/2024	

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F 550	Continued From page 3	F 550		

could see their meal and the resident fed at eye level by staff for a more comfortable and dignified experience for the resident. The DON stated staff should not refer to residents as "feeders."

The Administrator stated in an interview on 2/22/24 at 11:01 AM that when residents ate their meals in bed, staff should set up the tray, and if the staff member helped the resident to eat, the staff should have a chair to sit in so that the staff was at the same level with the resident. The Administrator stated this allowed the resident to eat at their own pace so that so that staff did not rush the resident. The Administrator also stated that the meal tray should be in front of the resident who is eating it. She stated that staff should not use the term feeder, as that is not who the resident is, but rather the help the resident needs. She stated, "that's a dignity issue" and we should respond to the resident by their name and provide them with the assistance they need.

b. Resident #40 was admitted to the facility 1/23/23. Diagnoses included an advanced chronic autoimmune disorder that affects movement, sensation and bodily function and dysphagia, among others.

A quarterly Minimum Data Set (MDS) assessment, dated 12/25/23, assessed Resident #402 with clear speech, adequate hearing, adequate vision with corrective lenses, able to understand, and be understood, intact cognition, and required extensive staff assistance with meals.

A continuous observation occurred on 2/21/24 from 8:34 AM until 8:40 AM of Resident #40 in bed and fed lunch by Nurse Aide (NA) #3.

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Resident #40 was in a bed with the height of the bed positioned at the hip area of NA #3 and the head of the bed elevated while NA #3 stood to the left of Resident #40 to feed her. Resident #40 turned her head up and to her left to receive her lunch meal from NA #3. The meal tray was on the over bed table in front of NA #3.

NA #3 stated in an interview on 2/21/24 at 8:40 AM that she typically stood to feed residents when the resident was in a bed that was "up high", but she sat down to feed residents who were in a bed positioned low.

An interview occurred with the Director of Nursing (DON) on 2/22/24 at 9:42 AM. The DON stated that during dining, she expected staff to place the food in front of the resident so that the resident could see their meal and the resident fed at eye level by staff for a more comfortable and dignified experience for the resident. She stated that "assisted with dining" sounded more respectful, than "feeder." The DON stated that she had heard staff refer to residents as "feeder" and she corrected staff when she heard it, but that the in-services provided to staff did not address referring to residents as feeders.

The Administrator stated in an interview on 2/22/24 at 11:01 AM that when residents ate their meals in bed, staff should set up the tray, and if the staff member helped the resident to eat, the staff should have a chair to sit in so that the staff was at the same level with the resident. The Administrator stated this allowed the resident to eat at their own pace so that staff did not rush the resident. The Administrator also stated that the meal tray should be in front of the resident who was eating it.

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F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with residents	F 565	1) On 02/28/2024 the Interdisciplinary	3/22/24

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F 565	Continued From page 6 and staff and record review, the facility failed to provide a private space for resident council meetings for 11 of 11 months reviewed (April 2023 through February 2024). The findings included: A review of Resident Council meeting minutes from April 2023 through February 2024 revealed Resident Council meetings were held routinely. The minutes did not indicate the location of the meetings and did not record concerns voiced by residents regarding the location of their meetings. During an interview with the Activity Director on 2/20/24 at 3:30 PM she indicated she would arrange for the Resident Council meeting to be held by the Surveyor in one of the two second-floor activity areas. An observation of the area was conducted with the Activity Director. The two activity areas were observed as follows: the first included dining tables and was an open space adjacent to the nurse's station. The area was not enclosed for privacy. The second was an open space with a couch and a couple chairs at the end of the hall next to resident rooms and adjacent to the main elevator utilized by staff, visitors (to include survey team), and residents throughout the day and was not enclosed for privacy. The Activity Director confirmed that this space did not afford privacy. The Activity Director stated that Resident Council meetings were always held in one of these two locations. The Surveyor requested a private space. The Activity Director stated there was a larger private space on the secured unit on the 3rd floor; however, it was utilized as office space by the two administrative nursing personnel. She stated the Resident Council meeting had never been held in	F 565	Team (IDT) toured the facility and found an appropriate place to hold resident meetings so that they would have the necessary privacy needed to hold the Resident Council Meetings. 2) The Resident Council president agreed to the use of the conference room for all private resident meetings. The first meeting was held on 3/12/24 in the new area that provided privacy. 3) On 3/1/2024, the Director of Social Services began educating the facility staff on resident privacy during meetings that included not interrupting resident meetings or activities and maintaining the privacy of residents attending the meetings. 4) A monthly audit for 3 months will be conducted by the Social Services Director to ensure that the residents' meetings are being held in a private location. 5) The results of the audits will be discussed in the monthly (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings.	

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F 565	Continued From page 7	F 565		

this location and she would verify that it was available for use.

During a follow-up interview with the Activity Director on 2/20/24 at 3:47 PM, she stated the Resident Council meeting would be held at 11:00 AM on 2/21/24 on the secured unit on the 3rd floor.

A Resident Council meeting was held on 2/21/24 at 11:00 AM on the third-floor administrative office with ten residents (Resident #1, Resident #4, Resident #18, Resident #19, Resident #27, Resident #36, Resident #42, Resident #44 Resident #52, Resident #69) identified by the Activity Director with intact cognition. The Residents stated that the Resident Council meetings were arranged by the Activity Director and were held in one of the two second floor activity areas but did not give them privacy. The Residents stated staff frequently interrupted the meetings and always had someone "posted" to eavesdrop. The residents all indicated they would like to have privacy and be able to report concerns without having staff know everything that was said.

A follow-up interview with the Activity Director on 2/21/24 at 12:30 PM revealed she was not aware that Resident Council Meetings should be conducted in private.

An interview with the Director of Nursing and Administrator on 2/22/24 at 11:45 AM revealed they were aware the Activity Director arranged the Resident Council Meetings but were unaware the meetings were not provided in a private space. They stated they expected the meetings to be arranged for privacy.

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (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); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		3/22/24

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F 580	Continued From page 9 §483.10(g)(15) 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). This REQUIREMENT is not met as evidenced by: Based on record review, interviews with a resident, medical director, nurse practitioner and staff, the facility failed to notify the physician of a change in condition when a resident complained of a headache, not feeling well and experienced an episode of mild hypoglycemia (low blood sugar with a range of 55 - 70) for 1 of 4 sampled residents reviewed for physician notification (Resident #4). The findings included: Resident #4 re-admitted to the facility on 1/13/24. Diagnoses include diabetes mellitus (DM) type 2 with diabetic neuropathy. A significant change Minimum Data Set assessment dated 1/22/24 assessed Resident #4 with clear speech, adequate hearing, adequate vision with the use of corrective lenses, understood, understands, intact cognition and routine use of insulin (7 of 7 days). A care plan revised 1/24/24 recorded Resident #4 was dependent on insulin due to her diagnosis of DM with goals to experience minimal signs/symptoms of hypoglycemia. Interventions	F 580	1) The nurse completed a late entry progress note for resident # 34 and #4 blood sugar documentation. The physician was notified and the residents' orders were updated to reflect the interventions for hypo/hyperglycemic episodes. The ADON completed education with the nurse on blood sugar documentation, physician and family notification, and following the appropriate interventions determined by the medical provider for hypo/hyperglycemic edpisodes. 2) On 2/20/2024, a 100% audit of residents' diagnosis was completed to identify all residents with a diagnosis of diabetes. On 2/20/2024, the Unit Managers, DON, and ADON entered glucagon/glucose gel orders in the active orders listing for all residents with a diagnosis for diabetes. On 2/20/2024, the Administrator added the documentation of snack percentages as a CNA task for all diabetic residents.	

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F 580	Continued From page 10 included observing resident for low blood sugar symptoms and report to the physician (MD) any abnormal results per parameters. A MD order dated 2/15/24 recorded, Basaglar KwikPen Subcutaneous (under the skin) Solution Pen-injector 100 unit/ml (Insulin Glargine). Inject 56 units subcutaneously at bedtime, 8:00 PM, for DM. A review of the February 2024 Medication Administration Record (MAR) revealed 56 units of insulin were administered per MD order to Resident #4 on 2/18/24 at 8:00 PM. A late entry progress note dated 2/22/24, with an effective date of 2/19/24 recorded by Nurse #3 documented that Nurse #3 was notified by staff that Resident #4 complained of a headache and reported that she did not feel well. The progress note recorded that Nurse #3 assessed Resident #4 as alert, resting in bed and her blood glucose (BG) level was "low." Nurse #3 documented that she stayed with Resident #4 while staff obtained juice and a snack for the Resident. Nurse #3 documented that she rechecked BG levels, the results were "within normal limits," and Resident #4 remained in bed resting. A late entry "follow up" progress note dated 2/22/24, with an effective date of 2/19/24 written by Nurse #3 recorded Nurse #3 entered Resident #4's room around 6:00 AM and her BG level was 56 {gm/dl}. Nurse #3 documented that she rechecked her BG at 6:45 AM and the result was 127 {gm/dl}. Nurse #3 recorded Resident #4 was resting, at baseline by end of shift and that she reported to follow up with the oncoming nurse. The medical record did not record that Nurse #3	F 580	On 2/20/2024, the Umit Managers, DON, and ADON, entered blood sugar monitoring orders, per physician recommendation, for all residents with a diagnosis of diabetes diabetics in the resident's active order listing. 3) By 2/29/2024 all current nurses and medication aides received education by the ADON to include standing order use, hypo/hyperglycemic monitoring and interventions policy, documentation policy and physician/family notification policy. Nurses and medication aides will be added to this education at orientation. 4) The Unit Managers will complete a weekly audit for 12 weeks of eMar documentation to ensure appropriate interventions were used to treat any hypo/hyperglycemic episodes, physician/family notification of changes in condition, and documentation of snack intake. 5) The results of the audits will be discussed in the weekly risk meeting and monthly in the facility□s Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings. Completion Date: 03/22/2024	

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F 580	Continued From page 11	F 580		

notified the MD that Resident #4 complained of a headache, reported that she did not feel well or of the hypoglycemic episode.

A Nurse Practitioner (NP) progress note dated 2/20/24 recorded Resident #4 reported to the NP that she had a hypoglycemic episode the night prior (2/19/24) with BG level of 47 {gm/dl}. Resident #4 reported to the NP that she received her insulin prior to experiencing the hypoglycemic episode, and that her symptoms and BG level improved to the 120's with nursing intervention. The NP recorded that her overall BG range was 79 - 219 {gm/dl}, her current hemoglobin A1C was 6.6% (blood test that reflects blood glucose levels for three months) and that her diabetes was currently well controlled. The NP documented there were no additional concerns reported by Resident #4 or by nursing staff.

Resident #4 reported in an interview on 2/19/24 at 11:47 AM that a Nurse gave her insulin Sunday night (2/18/24) without checking her BG level which caused her BG level to drop to "47"{gm/dl} the next morning (2/19/24) around 6:00 AM. Resident #4 stated Nurse #3 gave her "Boost, pie, and a soda" that morning (2/19/24) to bring her BG level up and checked on her until her shift ended. Resident #4 stated that Nurse #1 also checked her BG level when he arrived at 7AM and it was "157" {gm/dl}. Resident #4 stated this was the only time her BG level dropped so low.

A phone interview with Nurse #3 occurred on 2/20/24 at 3:00 PM. Nurse #3 stated she was the 11P - 7A assigned Nurse for Resident #4 on 2/18/24. Nurse #3 stated she was new to the facility and was not very familiar with Resident #4. Nurse #3 stated she was aware that Resident #4

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received insulin on the 3P - 11P shift. Nurse #3 stated that on 2/19/24 between 6:00 - 6:30 AM, staff reported Resident #4 complained of a headache. Nurse #3 went to assess the Resident and noted that "her speech was slower." Nurse #3 stated she checked Resident #4's BG and the result was 56 gm/dl, which was low, so she gave Resident #4 "a soda, Boost and a candy snack to bring her blood sugar up." Nurse #3 reported she rechecked Resident #4's BG level again around 6:45 AM, the result was 127 gm/dl, she continued to monitor her for the rest of the shift and reported to the oncoming nurse what occurred. Nurse #3 stated this was the first time this occurred, but that she did not notify the MD of what happened because the Resident's BG level came up with the food/fluid she received.

Nurse #1 stated in an interview on 2/20/24 at 2:50 PM that he was the routine Nurse on the 7A - 3P shift for Resident #4. He described her with intact cognition, and verbally made her needs known. Nurse #1 stated he received shift report from Nurse #3 when he arrived for the 7A - 3P shift on 2/19/24. Nurse #3 reported that Resident #4's "blood sugars dropped" during the 11P - 7A shift. Nurse #3 said she gave the Resident "a bunch of sweet stuff to bring her sugars up and it came up to 127." Nurse #1 stated he rechecked her BG level during the shift, he did not recall the results, but stated "it was not low." He stated he monitored her throughout the shift, she remained at baseline with no further hypoglycemic episodes. Nurse #1 further stated during his nursing rounds on 2/19/24, Resident #4 reported to him that she had a hypoglycemic episode on the night shift, the nurse gave her some sweet stuff which brought her sugar back up. Nurse #1 stated he was not aware of Resident #4 having

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F 580	Continued From page 13 other hypoglycemic episodes. A phone interview with the Medical Director (MD) occurred on 2/21/24 at 4:41 PM. The MD stated that he had not been made aware at the time that Resident #4 experienced a hypoglycemic event on 2/19/24. The MD stated that later, as he understood the events, the Nurse reacted appropriately to elevate the BG level, but that the Nurse should have also notified the provider. The MD stated that if there was no significant impact to the Resident, documentation in the MD communication book would have been fine, otherwise the Nurse should call the provider using the afterhours service. He stated that he did not see this hypoglycemic episode having a significant impact on Resident #4 but that the most likely contributing factor to the hypoglycemic episode was non-compliance with eating enough of her meals. The Administrator and Director of Nursing stated in an interview together on 2/22/24 at 11:11 AM that the MD should be notified of a hypoglycemic episode that occurred for a resident. Review of the MD communication book during the interview revealed there was no documentation to the MD regarding the hypoglycemic episode for Resident #4 that occurred on 2/19/24.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident	F 641	1) The assessments for residents #52	3/22/24

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F 641	Continued From page 14 and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment for 1 of 2 residents reviewed for oxygen usage and 1 of 4 residents reviewed for hospice. 1. Resident #52 was admitted to the facility on 2/11/22 with diagnoses that included chronic obstructive pulmonary disease (COPD), asthma, and dependence on supplemental oxygen. A review of Resident #52's physician's orders revealed an order dated 1/25/24 for oxygen 3L (liters) via nasal cannula continuously for COPD. A review of Resident #52's vital signs revealed oxygen saturations documented from 1/23/24 through 1/29/24 that indicated Resident #52 was wearing oxygen via nasal cannula on 11 documented occurrences throughout the time period. A quarterly Minimum Data Set (MDS) assessment dated 1/29/24 revealed Resident #52 did not receive oxygen while a resident during the reference period (January 16th though January 29th 2024). An observation on 2/20/24 at 3:16 PM revealed Resident #52 was in her room. She was seated in her wheelchair with her nasal cannula intact and delivering oxygen at 3L. An interview with the MDS nurse on 2/20/24 at 3:30 PM revealed she completed Resident #52's quarterly MDS assessment. She stated she was only trained to review the Medication Administration Record (MAR) to determine if a resident received oxygen for purposes of coding	F 641	and #34 were corrected by the Minimum Data Set (MDS) Nurse. 2) On 2/26/2024, an audit of all residents listed as having a Hospice pay source was completed by the Administrator to verify documentation was in place to validate the pay source. On 2/26/2024, the DON audited ten assessments to ensure that any clinically complex or special services such as oxygen was correctly coded on the assessments. 3) On 3/12/2024, the MDS nurse was educated by the Director of Clinical Reimbursement on MDS Coding to ensure that all areas are coded accurately per the resident's medical records, observations and the Resident Assessment Instrument (RAI) manual. 4) Two resident assessments will be audited weekly for 12 weeks by the Administrator to ensure accurate coding has been completed for residents with special services and or clinically complex services. 5) The results of the audits will be discussed in the weekly risk meeting and monthly in the facility□s Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings.	

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the assessment and therefore, she did not review the documented oxygen saturation section listed under the vital signs tab in the medical record.

An interview with the Director of Nursing and Administrator on 2/22/24 at 11:53 AM revealed they expected all MDS assessments to be completed accurately and the oxygen should have been included in the assessment since Resident #52 received oxygen.

2. Resident #34 was admitted to the facility on 10/9/23.

An admission MDS assessment dated 10/16/23 and a quarterly MDS dated 1/12/24 indicated hospice care.

A Care Plan dated 10/30/23 indicated Resident #34 was care planned for hospice (end-of-life) comfort care.

A review of Resident #34's medical record's demographic section revealed the Resident's payor source was "private hospice," since 10/9/23.

A review of the physician's order did not indicate an order for hospice care.

Further review of Resident #34's medical record revealed no hospice documentation.

During an interview on 2/20/24 1:54 PM the MDS nurse revealed she was not made aware Resident #34 should not have been on hospice. She further revealed she typically received payor source information from the business office and added it to the MDS as well as the care plan.

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F 641	Continued From page 16 During an interview on 2/20/24 at 1:30 PM, the Regional Business Specialist indicated Resident #34's payor source should have been entered into the medical record as "private SNF (skilled nursing facility)" not "private hospice." She stated after further review of the medical record, Resident #34 never received hospice services although his payor source indicated "private hospice." During an interview on 2/21/24 at 6:15 PM the Administrator revealed she was unaware Resident #34's medical record displayed incorrect information that he was receiving hospice services. She explained that the Business Officer's role was to enter the payor source into the medical record and provide the MDS nurse with the payor source information. The Administrator stated she expected the MDS nurse to verify the hospice status before she documented on the MDS and the care plan.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		3/22/24

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F 657	Continued From page 17 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to revise the care plan for 2 of 2 (#34 and # 40) residents reviewed for care plans. The finding included: 1. Resident #34 was admitted to the facility on 10/9/23. His diagnoses included dementia, type 2 diabetes, and heart disease. An admission MDS assessment dated 10/16/23 and a quarterly MDS dated 1/12/24 indicated Resident #34 was receiving hospice care. A Care Plan dated 10/30/23 indicated Resident #34 was care planned for hospice (end-of-life) comfort care. A review of Resident #34's medical record's demographic section revealed the Resident's payor source was "private hospice," since 10/9/23.	F 657	1) The care plan for residents #34 and #40 were immedicately corrected by the MDS Nurse. 2) On 2/26/2024, the Social Services Director audited the care plans of 100% of the current residents who smoke to ensure accuracy of the resident's smoking status. No other care plans required revisions. On 2/26/2024, the Social Services Director audited the care plans of 100% of the current residents who receive Hospice services to ensure accuracy. No other care plans required revisions. 3) On 3/12/2024, the Director of Clinical Reimbursement educated the MDS nurse, Unit Managers, Wound Nurse, ADON, and the DON on care plan timing and revision requirements.	

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F 657	Continued From page 18 A review of the physician's order did not indicate an order for hospice care. During an interview on 2/20/24 1:54 PM the MDS nurse revealed she was not made aware Resident #34 should not have been on hospice. She further revealed she typically received payor source information from the business office and used the information to generate the MDS and Care Plan. She could not recall if she reviewed a physician's order that indicated hospice or a hospice contract, although it was her normal practice to review them. During an interview on 2/21/24 at 6:15 PM the Administrator revealed she expected the MDS nurse to verify the hospice status and if there was a hospice contract before she documented on the MDS and the care plan. 2. Resident #40 was admitted to the facility 1/23/23. A quarterly smoking evaluation dated 10/3/23 recorded that Resident #40 did not currently smoke cigarettes, use smokeless tobacco, or electronic cigarettes, had not smoked in the last month and intended to remain non-smoking. An annual Minimum Data Set (MDS) assessment, dated 10/17/23, assessed Resident #40 with clear speech, adequate hearing, adequate vision with corrective lenses, able to understand, and be understood, and intact cognition. The MDS indicated Resident #40 did not smoke cigarettes. An October 2023 smoking care plan documented	F 657	4) Five care plans a week for 12 weeks will be audited by the Administrator and or designee to validate accuracy and timely revisions of residents' needs. 5) The results of the audits will be discussed in the weekly risk meeting and monthly in the facility's Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings. Completetion date: 03/22/2024	

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Resident #40 was a current smoker with goals to maintain safety with smoking and interventions included to assist with smoking during designated smoking times.

On 2/19/24 at approximately 11:00 AM, the facility provided a smoking list, updated 2/16/24 to the survey team for review. Resident #40 was not included on this list as a current smoker.

An observation of smoking lockers for residents occurred on 2/19/24 at 1:15 PM and revealed there was no smoking locker for Resident #40.

Observations of residents in the smoking area occurred on 2/19/24 at 1:15 PM and on 2/20/24 at 2:20 PM. Resident #40 was not observed in the smoking area during these observations.

Resident #40 was interviewed on 2/21/24 at 8:33 AM. During the interview, she stated that she no longer smoked cigarettes and had not smoked cigarettes in a long time. She did not recall exactly how long it had been since she smoked. Resident #40 stated that she did not have cigarettes, a cigarette lighter or a smoking locker.

An interview on 2/21/24 at 3:26 PM with the Social Worker (SW) revealed he set up smoking lockers for residents who smoked cigarettes. He stated that Resident #40 was not a current smoker, did not have a smoking locker or smoking supplies. The SW stated Resident #40 attended the last three care plan meetings, April 2023, July 2023, and October 2023, but that she did not bring up a desire to resume smoking. The SW provided documentation of the care plan meetings for review.

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F 657	Continued From page 20 The MDS Coordinator stated in an interview on 2/22/24 at 1:11 PM that she was responsible for revising care plans as needed. The MDS Coordinator stated that she reviewed smoking evaluations and section J 1300, Tobacco Use on the MDS when preparing or revising care plans. The MDS Coordinator reviewed the 10/3/23 smoking evaluation and the annual MDS dated 10/17/23 which both documented Resident #40 did not smoke cigarettes. The MDS Coordinator further stated that she would not resolve the smoking care plan for a resident if staff reported that the resident was still a smoker. She stated that staff reported that Resident #40 still smoked at times. The MDS Coordinator could not recall which staff reported this to her, when this was reported and stated that she could not recall the last time she observed Resident #40 smoking. The MDS Coordinator stated that if Resident #40 was no longer a smoker, the smoking care plan should be resolved. The Administrator stated in an interview on 2/22/24 at 2:34 PM that Resident #40 was not a current smoker and had not smoked in over a year. The Administrator stated that her smoking care plan should be resolved.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident interview and staff interviews, the facility failed to provide	F 677	1) The nursing staff trimmed the fingernails of resident # 5.	3/22/24

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F 677	Continued From page 21 fingernail care for 1 of 1 resident (Resident #5) reviewed for activities of daily living (ADL). The findings included: Resident #5 was admitted to the facility on 7/13/2010. An annual minimum data set assessment (MDS) dated 12/1/23 indicated Resident #5 had moderate cognitive impairment, required supervision with eating, moderate assistance with oral and toileting hygiene, and maximum assistance with showering/ bathing. A revised care plan dated 12/15/23 for bathing/showering indicated Resident #5's nail length should be checked, cleaned, and trimmed on bath day and as necessary due to the potential for ADL/ self-care performance deficit. An observation conducted on 2/19/24 at 12:14 PM revealed Resident #5 fingernails on both hands were overgrown and extended beyond the nail beds about ½ inch. During a follow-up observation on 2/21/24 at 9:38 AM it was revealed Resident #5's fingernails on both hands remained overgrown and extended beyond the nail beds, as observed on 2/19/24. During an interview on 2/21/24 at 10:06 AM Nurse Aide (NA) #3 indicated she began working at the facility at the beginning of February 2024 and was assigned to Resident #5 for the second time on 2/21/24. She further indicated she did not assess nor trim the Resident's fingernails when she gave him a bed bath, combed his hair, and assisted him with getting dressed on 2/20/24 or	F 677	2) On 2/26/2024, the Wound Care nurse and Unit Managers completed an audit of 100% of the residents who are dependent on staff for adl assistance with nail care. Those residents who desired their nails to be trimmed or who needed their nails trimmed was completed by the nursing staff. 3) On 2/26/2024, the ADON, Unit Managers, and the DON started educating the staff on adl care and grooming for dependent residents that included, but not limited to when to check for nail trimming needs and who to notify if nails are long, thick, or if a resident refuses care. 4) The Unit Managers and Wound Care nurse will conduct a weekly audit for 12 weeks of ten dependent residents to ensure that nail care is completed per the facility policy. 5) The results of the audits will be discussed in the weekly risk meeting and monthly in the facility's Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings. Completion Date: 03/22/2024	

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F 677	Continued From page 22 2/21/24. NA#3 observed the length of the Resident's fingernails and revealed Resident #3's fingernails needed to be trimmed. During an interview and observation on 2/21/24 at 10:23 AM, Nurse #1 assessed Resident #5's fingernails and revealed the nails were overgrown and needed to be cut. He further revealed nail care was part of ADL care and should be trimmed on shower days and as needed. His expectation was for the NA who provided ADL care to check, clean, and trim all residents' fingernails if needed. During an interview on 2/21/24 at 6:23 PM the Director of Nursing revealed NAs were expected to trim residents' nails if needed during ADL care on shower days or as needed, unless the resident was a diabetic and nurses were expected to trim fingernails of diabetic residents. Her expectation was for all nursing staff to assess a resident's need for nail care and provide care or communicate those needs to another nursing staff member, who may be able to fulfill the task.	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (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 (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.	F 687		3/22/24

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F 687	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to ensure resident's toenails were trimmed and podiatry services were arranged for 2 of 2 diabetic residents reviewed for foot care (Resident #34 and Resident #63). Finding included: 1. Resident #34 was admitted to the facility on 10/9/23 with diagnoses inclusive of type 2 diabetes, dementia, and heart disease. A Care Plan dated 10/30/23 indicated Resident #34 had diabetes and his feet were to be inspected daily for open areas, sores, blisters, edema, or redness. A quarterly Minimum Data Set (MDS) dated 1/12/24 indicated Resident #34's cognition was moderately impaired, and he required supervision with eating, moderate assistance with oral hygiene and dressing; maximum assistance with toileting, showering and personal hygiene. A review of the physician's order dated 10/9/23 indicated Resident #34 had a standing order for the initiation of podiatry services. Attempts were made to interview Nurse #4, who worked the night shift and conducted the last weekly skin assessment for Resident #34 on 2/14/24. Nurse #4 did not return a call for an interview. An observation and interview conducted on 2/20/24 at 9:44 AM revealed Resident #34's big	F 687	1) Resident #34 was seen by the podiatrist on 3/1/2024. Resident #63 had his toenails filed and cleaned by the RN Wound nurse and an order for a podiatry consultation for a podiatry appointment outside the facility was obtained and a visit is scheduled for 04/04/2024. 2) On 2/26/24, the Wound Care Nurse assessed the residents who have the diagnosis of diabetes to determine if any residents required additional foot care needs and if any resident needed a podiatrist consults/orders. Any resident requiring orders or visits was scheduled by the managing clinical staff. 3) On 2/26/2024, the ADON started education with the nursing staff on determining resident's footcare needs and how to determine if podiatry consults, orders, and visits were needed. Staff were also instructed on the foot care policy for residents with a diagnosis of diabetes. 4) The Unit Managers and the Wound Care nurse will audit three residents with a diagnosis of diabetes and three residents that are dependent on foot care weekly for 12 weeks to validate that staff are following the facility foot care policyand to determine any additional foot care needs. 5) The results of the audits will be discussed in the weekly risk meeting and	

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F 687	Continued From page 24 (great) toenails on both feet were overgrown beyond the nail beds about 1/2 inch, curved, and grown into the skin. Resident #34 stated staff had informed him months ago that the podiatrist would cut his toenails, but they never cut them. The Resident further stated his toenails were not painful but needed to be cut. A review of the in-house podiatry list for September, November and December of 2023 revealed Resident #34 was not on the list to receive podiatry services. During an interview on 2/20/24 at 3:28 PM the Social Worker (SW) revealed he was responsible for contacting the provider and adding residents to the in-house podiatry list after nursing staff informed him of residents in need of podiatry services or after the resident and/or family representative requested to be added. During an interview on 2/20/24 3:00 PM the Nurse Practitioner indicated Resident #34 had a standing order for podiatry services and she could not recall if she noticed the resident's feet needed foot care when she assessed him on 2/13/24. She further indicated if she had assessed his feet, she may not have documented it in the medical record. Her expectation was for Resident #34 to be seen by the podiatrist quarterly. During a follow up interview on 2/20/24 at 4:48 PM, the SW stated he contacted the podiatry provider and was told Resident #34 had not been on their list in the past year, to receive podiatry services. The SW further stated he was able to add Resident #34 to the 3/1/24 podiatry list.	F 687	monthly in the facility's Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings	

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During an interview and follow-up observation on 2/21/24 at 10:54 AM the Unit Manager removed Resident #34's socks and assessed his feet to be very dry and big toenails on both feet to be overgrown. The Unit Manager indicated the Resident needed podiatry care and she expected the nurse who conducted weekly skin assessments to have identified the need and communicated the need for the Resident to be added to the podiatry list.

During an interview on 2/21/24 at 6:15 PM the Administrator revealed she was unaware Resident #34 had not received podiatry services. Her expectation was for all residents to be offered podiatry services if nursing saw an issue during skin assessments or if there were other existing clinical needs.

2. Resident #63 was admitted on 08/22/2023 with diagnoses that included diabetes mellitus, dementia, and epilepsy.

Review of the significant change Minimum Data Set (MDS) dated 1/03/2024 indicated Resident #63 had severe cognitive impairment and required extensive assistance with bed mobility, transfers, mobility, and personal hygiene.

Resident #63's care plan dated 12/11/2023 revealed Resident #63 was care planned for activities of daily living (ADL) self-care performance deficits related to dementia and disease processes. The goals included extensive staff assistance in all aspects of daily care to ensure all needs were met. Inventions included staff assistance with grooming and personal hygiene.

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Review of the Resident #63's weekly skin assessments from 08/23/2023 through 2/13/2024 revealed no notation that the resident's toenails were long and thick and needed trimming or a referral for podiatry care.

Review of the facility's podiatry clinic schedules for September 2023, November 2023, December 2023, and February 2024 revealed Resident #63 was not scheduled to be seen by the podiatrist. The February 2024 podiatry clinic was noted to have been canceled due to the podiatrist being ill and was re-scheduled for March 2024. There were no consultation reports or notations in Resident #63's medical record that he had been seen by a podiatrist.

A wound care observation of Resident #63's left heel wound was conducted on 02/21/2024 at 1:14 PM with the Wound Care Nurse. The observation revealed Resident #63's feet had very long, thick, and jagged toenails and his feet were very dry and scaly. Resident #63 exhibited no verbal or non-verbal signs of pain or discomfort.

An interview was conducted with Resident #63's responsible party on 02/19/2024 at 11:44 AM. The RP revealed no issues or concerns with Resident #63 toenails.

An interview was conducted with the wound care nurse at 02/21/2024 at 2:30 PM. The Wound Care Nurse stated she saw Resident #63's toenails and they were very thick and long. She also stated his feet were scaly and very dry. She further revealed she thought she asked the Social Worker (SW) to add Resident #63 to the podiatry

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list, but she did not remember when.

An interview was conducted with NA #1 on 02/21/2024 at 2:50 PM. NA #1 stated she was aware Resident #63 needed podiatry services because his toenails were very long and thick and he was diabetic. She further revealed that she had reported that to a nurse about 2 weeks ago but did not recall which nurse she reported to.

An interview was conducted with Unit Manager #1 (UM #1) on 02/21/2024 at 3:10 PM. UM #1 stated that she had no knowledge that Resident #63 had any issues with his toenails. UM #1 further revealed that staff let her know when a resident needed podiatry services and she would ask the SW to add the resident to the podiatry list. She further revealed that any staff member or family member could request podiatry services.

An interview was conducted with the SW on 02/21/2024 at 3:25 PM. The SW stated he had no knowledge that Resident #63 needed podiatry services. He further added that he had not received any concerns from any staff member regarding Resident #63 toenails. The SW also verified the podiatry schedules from August 2023 through December 2023 and confirmed that Resident #63 had not received podiatry services while in the facility. He further indicated any staff member or family member can let him know that a resident needs podiatry services and he would get the resident on the list to be seen. He also added that the podiatrist usually came to the facility every month.

An interview was conducted with the Director of Nursing (DON) on 02/21/2024 at 3:45 PM. The DON revealed that she was unaware Resident

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F 687	Continued From page 28 #63 needed podiatry services. The DON also revealed Resident #63 was diabetic and would have needed to be seen by a podiatrist for toenail care. She indicated she expected all residents to receive podiatry services when needed.	F 687		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		3/22/24

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F 690	Continued From page 29 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to keep a catheter drainage bag from touching the floor to reduce the risk of infection for 1 of 1 sampled resident reviewed for the use of a urinary catheter (Resident #40). The findings included: Resident #40 was admitted to the facility 1/23/23. Diagnoses included recurrent urinary tract infections (UTI), and neuromuscular dysfunction of bladder with chronic suprapubic catheter, among others. A care plan revised 10/12/23 indicated Resident #40 had a suprapubic catheter. The goal was to remain free from signs/symptoms of a UTI and interventions that included securing the catheter to prevent infections. A physician order dated 12/21/23 recorded Resident #40 had a suprapubic urinary catheter related to a diagnosis of neuromuscular dysfunction of bladder. A quarterly Minimum Data Set assessment, dated 12/25/23, assessed Resident #40 with intact cognition, and the use of a urinary catheter. Resident #40 was observed in her room positioned in a low bed on 2/21/24 at 10:50 AM with her catheter drainage bag with privacy cover	F 690	1) The catheter bag for resident #40 was changed to a new catheter bag and placed below the resident's bladder without touching the floor by the wound care nurse. 2) The Wound Nurse audited all residents with urinary catheters to ensure that the catheter bags were appropriately placed to prevent infection controll issues by not touching the floor. 3) On 2/26/2024, the ADON started educating the nusing staff on infection control and appropriate urinary catheter placement according to the facility policies on catheter care. This education will be added to new hire orientation. 4) The Unit Managers and Wound Care nurse will complete an audit weekly for 12 weeks for all residents with catheters to ensure bag placement is appropriate and the infection control policy is followed. 5) The results of the audits will be discussed in the weekly risk meeting and monthly in the facility's Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings.	

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F 690	Continued From page 30	F 690	Completion Date: 03/22/2024	

hooked to the bed frame on the right side of the bed. The catheter drainage bag was positioned on the floor. The Wound Nurse entered the room at 11:00 AM, raised the height of the bed and provided wound care to Resident #40 from the left side of the bed until 11:30 AM. After completing the wound care, the Wound Nurse lowered the Residents bed which placed the catheter drainage bag back on the floor. The Wound Nurse exited the Resident's room.

An interview occurred on 2/21/24 at 11:47 AM with Nurse Aide (NA) #2. She stated that she was the NA for Resident #40 that day (2/21/24) on the 7A - 3P shift. NA #2 stated that when she arrived on shift that day, she provided Resident #40 a bed bath, peri care, catheter care, colostomy care and returned her bed to a low position before leaving the room at about 9:30 AM. NA #2 stated Resident #40 had remained in bed so far that shift. NA #2 stated she did not realize her catheter drainage bag was on the floor and stated that the catheter drainage bag should not be on the floor because that could increase the Resident's risk of having a UTI from contamination. NA #2 stated "we should watch for that, but I did not realize it."

An observation and interview with the Wound Nurse on 2/21/24 at 12 PM revealed the catheter drainage bag was lying on the base of the over bed table which was positioned across the Resident's bed. The Wound Nurse removed the over bed table and the catheter drainage bag fell to the floor. The Wound Nurse stated that the catheter drainage bag should not rest on the floor, because the floor was dirty and that could increase her risk of developing a UTI. The Wound Nurse stated, "I lowered her bed too low."

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F 690	Continued From page 31 Unit Manager (UM) #2 stated in an interview on 2/21/24 at 1:35 PM that catheter drainage bags should be positioned below the resident's bladder, and attached to the bed frame if the resident was in bed. UM #2 further stated that if the bed was in a low position, the bed height should be such that the catheter drainage bag was not on the floor to prevent the bag from becoming contaminated with bacteria and increase the risk of infection to the resident. The Director of Nursing (DON) stated in an interview on 2/22/24 at 9:42 AM that there should a barrier to keep the catheter drainage bag off the floor, to prevent infection because the floor was dirty, and we don't want to introduce any bacteria in the bladder. The DON stated that Resident #40 had a diagnosis of neurogenic bladder with a history of recurrent UTI which placed her at greater risk for developing infections. The Administrator stated in an interview on 2/22/24 at 11:06 AM that the catheter should be positioned lower than the bladder, tubing secured, the privacy cover should be in place, and there should be no contact of the catheter drainage with the floor to reduce the risk of infection.	F 690		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable,	F 804		3/22/24

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F 804	Continued From page 32 attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on an observation of the lunch meal tray line, a lunch meal test tray, 2 of 5 residents sampled for palatable foods (Resident #4 and Resident #54), a Resident Council meeting, and record review, the facility failed to provide foods per resident preferences for taste and temperature. The findings included: 1a. Resident #4 re-admitted to the facility on 1/13/24. A significant change Minimum Data Set (MDS) assessment dated 1/22/24 assessed Resident #4 with clear speech, adequate hearing, adequate vision with the use of corrective lenses, understood/understands, and intact cognition. During an interview on 2/19/24 at 11:43 AM, Resident #4 stated that her breakfast meal was often cold, and when she received soup, like chicken noodle, the soup had a lot of water in it and only a little bit of chicken and noodles. Resident #4 was observed on 2/21/24 at 8:12 AM in her room eating her breakfast meal. She received bacon, grits, sausage gravy and biscuits. Resident #4 described her breakfast as "cold not hot," and stated, "it could definitely be hotter." 1b. Resident #54 was admitted to the facility on 11/2/23. A quarterly MDS assessment dated 11/9/23 assessed Resident #54 with clear speech, adequate hearing, adequate vision, understood/understands, and moderately	F 804	1) On 2/23/2024, the meals were served as soon as they were received from the kitchen to ensure hot foods were serve hot and cold foods were cold by the nursing staff. The maintenance assistant checked each meal cart for any issues with the closures. One meal cart required maintenance to ensure that the cart would stay closed to aid in maintaining appropriate meal temperatures. 2) The clinical administrative staff monitored the meal delivery system from the kitchen to the floor. Meal trays were served as soon as they were received from the kitchen to ensure that the appropriate temperatures were maintained. After the meal, several residents were asked about the meal and no concerns were voiced. Additional meal time notifications were posted throughout the facility to encourage residents and staff to be prepared to receive the meal as soon as possible after it is delivered to the floor. 3) On 02/23/2024, the ADON started education with the nursing staff concerning food palatability as it pertains to cold food. This education includes but is not limited to preparing the residents for meal delivery prior to the meal carts coming to the floor, ensuring that when the meals are delivered it is served in a	

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F 804	Continued From page 33 impaired cognition. During an interview and observation of Resident #54 with his lunch meal on 2/19/24 at 12:30 PM, Resident #54 described "all meals" as "always cold." He stated that his oatmeal for breakfast was cold that morning (2/19/24). Resident #54 was interviewed in his room on 2/21/24 at 11:33 AM and stated that he received cold oatmeal that morning, so he only ate his yogurt. 1c. During a Resident Council meeting on 2/21/24 at 11:38 AM, some of the Residents in attendance expressed that the food was "terrible" and requested not to have their names given when the surveyor shared their food concerns with the facility. These Residents described the meats as "substandard quality." They expressed that foods were often served cold, especially the breakfast meal. They described vegetables, particularly green vegetables, were not always cooked, and often still hard, the ends of French fries were hard and macaroni noodles were not served soft. They said grits were served so hard/cold you could stick a fork or finger in them and pick up everything from the bowl. The Residents stated that when they asked staff to reheat the cold food, staff responded that they could not reheat their cold food because the staff might get burned with the microwave. 1c. A continuous observation of a lunch meal tray line occurred on 2/21/24 from 8:09 AM until 8:16 AM. Turkey sausage links were observed on a sheet pan, and stored across the steam table, and did not make direct contact with the steam from the steam table well.	F 804	timely manner, keeping the doors of the meal carts closed as much as possible to preserve the temperature of the food, and offering to reheat food according to the residents preferences. This education will be added to new hire orientation. On 02/23/2024, the dietary department started receiving education from the Regional Director of Operations for the dietary department that included information such as following the recipes for menu items, serving foods at the appropriate temperature, delivery of the meal cart to the floor in a timely manner, and reporting any maintenance needs such as carts not fully closing to the maintenance department via the facilities electronic maintenance request system. 4) The Administator and/or designee in the Administrator's abscense will receive a test tray weekly to audit the meals palatability, attractiveness, and appetizing temperature as determined by the type of foods served to help improve residents satisfaction with the meals served. The interim Maintenance Director will check the meal carts weekly to ensure proper closure of the doors and complete repairs to the meal carts as required. A clinical member of the IDT will audits two meals a week for 12 weeks on each of the three floors to ensure timely delivery of meals to the residents. 5) The results of the audits and	

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F 804	Continued From page 34 A test tray was requested by the surveyor on 2/21/24 at 8:14 AM. The test tray was plated at 8:15 AM on a stoneware plate that was stored in the lowerator (plate warmer) and placed in an insulated tray system (insulated lid and bottom). The tray was placed on a metal cart and left the kitchen at 8:16 AM. The metal cart was observed with a latch secured with a lock, that left a gap of approximately two inches which did not allow the door of the cart to close. The cart arrived on the 2nd floor at 8:18 AM. A second cart arrived on the 2nd floor at 8:28 AM with one meal tray identified by the Food Service Manager (FSM) as a meal tray dietary staff had missed. All residents on the 2nd floor received their meal trays by 8:53 AM, and the test tray was sampled at 8:54 AM with the FSM and the Vice President (VP) of Operations for the dietary contract provider. The FSM and VP of Operations agreed there was no visible steam coming from the test tray when the insulated lid was removed. The FSM added butter to each food item which remained congealed. The FSM, VP of Operations and surveyor tasted each food item. The foods were described by the FSM and VP of Operations as: - Grits were described as cool with a little warmth, but not as hot as we would like. - Biscuits with sausage gravy were described as cold, gravy congealed, biscuits were hard. - Turkey link sausage was described as cold. The FSM stated during the observation that she was aware of resident concerns regarding cold foods expressed from either the January 2024 or February 2024 Resident Council meeting. The FSM and VP of Operations stated that because of cold food expressed during Resident Council, the staffing for the dietary department was increased,	F 804	observations will be discussed in the weekly risk meeting and monthly in the facility□s Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings. Completion Date: 03/22/2024	

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	345008	A. BUILDING _____ B. WING _____	C 02/22/2024

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F 804	Continued From page 35 and the FSM developed a meal delivery log that required nursing staff to record the time and their initials when meals were delivered to the unit. The VP of Operations stated she also identified a need to replace/repair some of the meal delivery carts and that she was in the process of discussing the purchase of a hot pellet system with the corporate office. The Director of Nursing was interviewed on 2/22/24 at 10:13 AM and stated that she expected nursing staff to deliver meal trays to residents as soon as the meal cart arrived on the unit, reheat resident meals when asked, and do all they could to give the resident a hot, palatable meal. The Administrator stated in an interview on 2/22/24 at 10:51 AM that she expected dietary to follow the meal delivery schedule, and nursing staff to serve meal trays as soon as possible when they come to the floor. The Administrator stated she was not aware that some of the meal carts needed repair. The Administrator also stated that she was aware that Residents expressed concerns with cold food during Resident Council and that this concern was addressed through the facility's grievance process. She stated that nursing staff were educated to serve meal trays as soon as the cart was delivered to the unit and that dietary would track delivery of the meal carts with a tracking log. The Administrator reviewed the meal tracking log for February 2024 and stated it would need to be revised to include a column to record the time the meal was delivered.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		3/22/24

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F 812	Continued From page 36 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to store cold foods at or below 41 degrees Fahrenheit for 1 of 1 walk in coolers, store frozen foods in a closed/sealed container to prevent freezer burn for 1 of 1 freezers and maintain 1 of 1 commercial can opener free of food debris, metal shavings and paper. This failure had the potential to affect 73 of 75 residents who received food from the kitchen. The findings included: 1a. During an observation with the Food Service Manager (FSM) of the walk-in cooler on 2/21/24 at 9:30 AM, the external thermometer and internal thermometer both registered a temperature of 50 degrees Fahrenheit (F). A second internal	F 812	1) On 2/21/2024 the Maintenance Director reset the walk-in cooler thermostat to maintain a temperature at or below 41 degrees Fahrenheit. Any opened foods in the freezer were discarded and the can opener was cleaned to remove any debris. 2) The freezer and walk-in cooler were checked for any foods that may not maintain the appropriate temperature throughout the rest of the day and evening shift. A service call was placed to determine if there were any other maintenance needs or requirements. 3) The dietary staff was educated by the	

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F 812	Continued From page 37 thermometer registered a temperature of 56 degrees F. The February 2024 temperature log posted outside the walk-in refrigerator recorded on 2/21/24 a temperature of 32 degrees F at 6:00 AM and 38 degrees F at 6:30 AM. The FSM identied five left-over foods that were stored in the walk-in cooler overnight. Temperature monitoring was conducted on 2/21/24 at 9:53 AM by the FSM at the request of the surveyor. The results revealed the following temperatures: - Buttered noodles, 51.3 degrees F - Macaroni and cheese, 49.1 degrees F - Tossed salad (lettuce, tomatoes), 48.2 degrees F - Pureed mixed vegetables, 47.5 degrees F - Fortified mashed yams, 47.9 degrees F - Vegetable soup, 48.8 degrees F The FSM stated during the observation on 2/21/24 that the temperature of the walk-in cooler should be monitored throughout the day, staff were educated to observe the external temperature gauge when they walked by and the internal temperature gauge when they went inside the walk-in cooler. Any concerns with the temperature should be reported to the FSM for followup. The FSM stated that she had been in/out of the walk-in cooler that day but did not see the temperature of the thermometers. An interview with dietary aide (DA) #1 occurred on 2/21/24 during the observation. DA #1 stated she arrived to work at 5:55 AM, and observed the walk-in cooler at 32 degrees F, at 6:00 AM. DA #1 stated she had been in/out of the walk-in cooler that morning but did not notice the temperature of the thermometer.	F 812	Regional Director of Operations on 2/22/24 concerning appropriate cleaning of equipment and food storage. Included in this education is the appropriate temperature for the walk-in cooler to be from 33 degrees Fahrenheit to 41 degrees Fahrenheit. This education will be added to new hire orientation. The temperature of the walk-in cooler was audited daily, and it was determined on 03/13/204 from the daily audits that a new thermostat would be needed due to multiple adjustments required to keep the walk-in cooler set to maintain temperatures at or below 41 degrees Fahrenheit. On 3/14/2024, a new thermostat was installed in the walk-in cooler and the appropriate temperature has been maintained since it was installed. 4) The Dietary Manager will conduct weekly audits for 12 weeks of the cleaning schedule to ensure that the equipment is cleaned and maintained. The Dietary Manager or designee will conduct daily audits for 12 weeks of the temperature of the walk-in cooler to ensure that the walk-in cooler maintains temperatures at or below 41 degrees Fahrenheit. The Dietary Manager or designee will conduct audits three times a week for 12 weeks of the freezer to ensure the frozen foods are stored and sealed to prevent freezer burns. 5) The results of the audits will be discussed monthly for three months in the	

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F 812	Continued From page 38 During an interview with the VP of Operations for the dietary contract provider on 2/21/24 during the observation, she stated that she arrived that morning (2/21/24) and observed the walk-in cooler temperature 38 degrees F at 6:30 AM, but that she had not noticed any other concerns with the walk-in cooler that morning. On 2/21/24 at 10:05 AM, dietary staff were observed to monitor the temperate of sour cream which registered 49 degrees F and an 8 ounce carton of milk which registered 43 degrees. The FSM instructed dietary staff to discard the sour cream and milk and to maintain the walk-in cooler closed from 10:05 AM until 11:05 AM. The FSM placed a new thermometer inside the walk-in cooler which also registered 50 degrees F at 11:05 AM. 1b. During an observation with the FSM of the freezer, a 10 pound box of kielbasa skinless sausage was observed stored in a plastic bag that was open to air. Ice crystals were observed in the box of sausage. The thermomoter in the freezer registered -1 degrees F. The FSM stated during the observation that she monitored the freezer with each vendor delivery twice weekly and checked behind the dietary staff to ensure foods were sealed when placed back in the freezer. She stated the sausage was served over the weekend, but she missed it during her last check of the freezer. 1c. During an observation with the FSM of the cook's prep area on 2/21/24 at 9:41 AM, the blade of a commercial can opener was observed	F 812	facility□s Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings. Completion Date: 03/22/2024	

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F 812	Continued From page 39 with a build up of food debris, a dark sticky substance, metal shavings and a piece of paper. The FSM stated during the observation that the can opener should be cleaned after each use and based on the degree of buildup she saw, it did not look like it was being cleaned after each use. During a follow up interview on 2/21/24 at 5:32 PM, the FSM stated that the morning chef had to leave and was unavailable for interview. The Administrator stated in an interview on 2/22/24 at 10:51 AM the walk-in cooler should be monitored to ensure that the temperature is maintained, frozen foods should be stored in sealed containers and kitchen sanitation should be monitored and maintained.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		3/22/24

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F 842	Continued From page 40 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 41 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain the accuracy of the medical record for 2 of 2 residents (Resident #34 and Resident #4) reviewed for accuracy of medical records. The findings included: 1. Resident #34 was admitted to the facility on 10/9/23. A review of Resident #34's medical record's demographic section revealed the Resident's payor source was "private hospice," since 10/9/23. A review of the physician's order did not indicate Resident #34 had an order for hospice care. Further review of Resident #34's medical record revealed no hospice documentation. During an interview on 2/20/24 at 1:30 PM, the Regional Business Specialist indicated Resident #34's payor source should have been entered into the medical record as "private SNF (skilled nursing facility)", not "private hospice." She stated after further review of the medical record, Resident #34 never received hospice services although his payor source indicated "private	F 842	1) The nurse completed a late entry progress note for resident # 34 and #4 blood sugar documentation. The physician was notified and the residents' orders were updated to reflect the interventions for hypo/hyperglycemic episodes. The ADON completed education with the nurse on blood sugar documentation, physician and family notification, and following the appropriate interventions determined by the medical provider for hypo/hyperglycemic edpisodes. 2) On 2/20/2024, a 100% audit of residents' diagnosis was completed to identify all residents with a diagnosis of diabetes. On 2/20/2024, the Unit Managers, DON, and ADON entered glucagon/glucose gel orders in the active orders listing for all residents with a diagnosis for diabetes. On 2/20/2024, the Administrator added the documentation of snack percentages as a CNA task for all diabetic residents. On 2/20/2024, the Umit Managers, DON, and ADON, entered blood sugar	

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F 842	Continued From page 42 hospice." During an interview on 2/21/24 at 6:15 PM the Administrator revealed she was unaware Resident #34's medical record displayed incorrect information that he was receiving hospice services. She explained that the Business Officer's role was to enter the payor source into the medical record and provide the MDS nurse with the payor source information. The Administrator stated she expected the MDS nurse to verify the hospice status before documenting the medical record. 2. Resident #4 re-admitted to the facility on 1/13/24. Diagnoses include diabetes mellitus type 2 with diabetic neuropathy, gastroesophageal reflux disease (GERD), dry eyes syndrome, unintentional weight loss, glaucoma, hypertension, and hyperlipidemia. A significant change Minimum Data Set assessment dated 1/22/24 assessed Resident #4 with clear speech, adequate hearing, adequate vision with the use of corrective lenses, understood/understands, and intact cognition. The February 2024 Medication Administration Record (MAR) for Resident #4 recorded the following medications, with no indication that the evening dose of nine medications was administered on 2/17/24: - Physician (MD) order dated 2/15/24, Basaglar KwikPen Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine). Inject 56 units subcutaneously at bedtime, 8:00 PM, for diabetes. - MD order dated 1/14/24, Omeprazole Oral Capsule Delayed Release 20 mg. Give one	F 842	monitoring orders, per physician recommendation, for all residents with a diagnosis of diabetes diabetics in the resident's active order listing. 3) By 2/29/2024 all current nurses and medication aides received education by the ADON to include standing order use, hypo/hyperglycemic monitoring and interventions policy, documentation policy and physician/family notification policy. Nurses and medication aides will be added to this education at orientation. 4) The Unit Managers will complete a weekly audit for 12 weeks of eMar documentation to ensure appropriate interventions were used to treat any hypo/hyperglycemic episodes, physician/family notification of changes in condition, and documentation of snack intake. 5) The results of the audits will be discussed in the weekly risk meeting and monthly in the facility□s Quality Assurance Performance Improvement (QAPI) meeting for three months. Any recommendations based on the audit findings will be made during the QAPI meetings. Completion Date: 03/22/2024	

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F 842	Continued From page 43	F 842		

capsule by mouth at bedtime, 8:00 PM, for GERD.
- MD order dated 1/14/24 Rosuvastatin Calcium Oral Tablet 20 mg. Give one tablet by mouth at bedtime, 8:00 PM, for hyperlipidemia
- MD order dated 1/14/24 Brilinta Oral Tablet 60 mg (Ticagrelor). Give one tablet by mouth two times a day, 9:00 AM, 8:00 PM, for hypertension.
- MD order dated 1/14/24, Artificial Tears Ophthalmic Solution 0.2-0.2-1 % (Glycerin-Hypromellose-Polyethylene Glycol 400). Instill one drop in both eyes two times a day, 8:00 AM, 7:00 PM, for dry eyes syndrome.
- MD order dated 1/14/24, Dorzolamide/Timolol 2.0/0.5% Ophalmic Solution. Instill one drop in both nostrils two times a day, 8:00 AM, 7:00 PM for glaucoma.
- MD order dated 1/30/24, Emollient Lotion. Apply to arms and legs topically two times a day, 9:00 AM, 5:00 PM, for dry skin.
- MD order dated 1/14/24, Lanolin Ointment. Instill one application in both nostrils two times a day, 9:00 AM, 8:00 PM, for nasal dryness.
- MD order dated 2/6/24, Glucerna 1.5 three times a day, 9:00 AM, 2:00 PM, 8:00 PM, for unintentional weight loss.

The medical record for Resident #4 did not record a progress note regarding administration of these medications on 2/17/24.

Resident #4 stated in an interview on 2/19/24 at 11:47 AM that she received her evening medications from Nurse #1, on Saturday 2/17/24.

Nurse #1 was interviewed on 2/21/24 at 9:30 AM. Nurse #1 stated he was the assigned Nurse for Resident #4 on the 3P - 11P shift on Saturday, 2/17/24. Nurse #1 stated he may have forgotten

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F 842	Continued From page 44 to document all the medications he gave to Resident #4 that evening because he got distracted during the medication pass and may have forgotten to come back to her MAR and record all the medications he gave. Nurse #1 reviewed the medical record and MAR for Resident #4 during the interview and said he did not record a progress note or initial the MAR for all the medications he gave the Resident on 2/17/24. The Administrator was interviewed on 2/22/24 at 11:11 AM and stated that when a prescribed medication was administered the nurse should record the administration of the medication in the medical record.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §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	F 867		3/22/24

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F 867	Continued From page 45	F 867		

information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

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

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

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

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

§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

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of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

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

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

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's

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F 867	Continued From page 47 governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, 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 the recertification and complaint survey conducted on 3/16/23 and a recertification survey on 3/26/21. This failure was for four deficiencies that were originally cited in the areas of Residents Right (F550), Quality of Life (F677), and Food and Nutrition Services (F804) and (F812) that were subsequently recited on the current recertification on survey on 2/22/24. The repeat deficiencies during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This tag is cross referred to: F550: Based on observations, staff interviews and record review, the facility failed to provide a	F 867	On 3/12/2024, the Director of Clinical Services and the Director of Clinical Reimbursement educated the Administrator, the Director of Nursing and the Assistant Director of Nursing on the appropriate function of the Quality Assurance Performance Improvement (QAPI) committee that included identifying issues and correction of repeat deficiencies, use of rounding tools, daily review of documentation, and observations during leadership rounds. On 3/15/2024, the Quality Assurance Committee held an Ad Hoc meeting to review the purpose and function of the QAPI committee as well as review the ongoing compliance related issues regarding repeat F Tags from surveys. The Director of Clinical Services educated the members of the committee that consists of the Medical Director, Director of Nursing, Administrator, Assistant Director of Nursing, Unit Managers, MDS nurse, Dietary Manager, Activities	

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F 867	Continued From page 48 dignified dining experience when staff did not assist residents with meals at eye level or place the meal tray in front of the resident. This failure occurred for 2 of 8 sampled residents reviewed for dignity with dining (Resident #32 and Resident #40). During a recertification survey completed on 3/16/23 the facility failed to maintain a resident's dignity by not providing clean clothing for 1 of 2 residents reviewed for resident rights. A resident was not provided with clean clothing which resulted in the resident not wanting to get out of bed to participate in daily activities as he normally would and a reasonable person would expect to be dressed in their home when they wanted to be. F677: Based on observations, resident interview and staff interviews, the facility failed to provide fingernail care for 1 of 1 resident (Resident #5) reviewed for activities of daily living. During a recertification survey completed on 3/26/21 the facility failed to provide fingernail care to 1 of 3 sampled residents dependent on staff for assistance with activities of daily living (ADL). F804: Based on an observation of the lunch meal tray line, a lunch meal test tray, 2 of 5 residents sampled for palatable foods (Resident #4 and Resident #54), a Resident Council meeting, and record review, the facility failed to provide foods per resident preferences for taste and temperature. During a recertification survey completed on 3/26/21 the facility failed to provide foods that met	F 867	Director, Social Services Director and the Director of Rehabilitation, on the potential risk review and of the audit findings for compliance and/or revisions when necessary. The Director of Clinical Services will provide weekly oversight for 12 weeks and will validate the facility□s process, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns.	

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resident preferences for taste and temperature and prepared foods to prevent the loss of nutrients. This was evidenced by resident complaints of cold foods during the January 2021 Resident Council meeting, foods prepared that did not include ingredients per the recipe (powdered garlic, Worcestershire sauce, soy sauce, heavy cream, carrots, cheddar cheese and sour cream) and hot foods held on the steam table for up to 2 hours prior to the tray line (mashed potatoes, mixed vegetables, and steamed rice).

F812:
Based on observations, interviews and record review, the facility failed to store cold foods at or below 41 degrees Fahrenheit for 1 of 1 walk in coolers, store frozen foods in a closed/sealed container to prevent freezer burn for 1 of 1 freezers and maintain 1 of 1 commercial can opener free of food debris, metal shavings and paper. This failure had the potential to affect 73 of 75 residents who received food from the kitchen.

During a recertification survey completed on 3/16/23 the facility failed to maintain a clean and damage free kitchen for food production.

During a recertification survey completed on 3/26/21 the facility failed to follow USDA guidelines to refreeze a potentially hazardous food, follow USDA guidelines to store hot foods to prevent the growth of bacteria, discard expired produce with signs of spoilage, and date opened food. A pork roast that thawed under cold running water was refrozen, tomatoes were stored for use discolored and with signs of spoilage, and one half bag of sausage patties were undated. This

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F 867	Continued From page 50 occurred for 1 of 1 walk-in refrigerators and 1 of 1 walk-in freezers. During an interview with the Director of Nursing and the Administrator on 2/22/24 at 11:53AM they felt they were continuing to try to implement new systems since the new ownership felt that the improvements had made a difference. They have recently added new management staff ensure systems can be effectively monitored and maintained.	F 867		