STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. BUILDING ______ B. WING ______	C 07/25/2024

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DAVIDSON HEALTH & REHAB CENTER	**4748 OLD SALISBURY ROAD LEXINGTON, NC 27295**

(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 07/21/24 through 07/25/24.. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RVF911.	E 000		
F 000	INITIAL COMMENTS A recertification survery and complaint investigation investigation were conducted 7/21/24 through 7/25/24. The following intakes were investigated:NC00207838, NC00209409, NC00217155, NC00207873, NC00207869, NC00211332, NC00213084, NC00215503, NC00212158 and NC00217065. Eighteen of the 32 allegations resulted in a deficiency. See Event #RVF911.	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	F 550		8/15/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/15/2024

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

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all 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 record review, observations, resident, and staff interviews the facility failed to provide incontinent care in a manner to maintain the residents' dignity for Resident #71. A reasonable person expects to be treated with respect and dignity by their caregivers in their home environment. This deficient practice was for 1 of 4 residents reviewed for dignity (Resident #71). Findings include: Resident #71 was admitted to the facility on 09/07/21. Review of the annual Minimum Data Set (MDS) dated 07/04/24 revealed Resident #71's cognition	F 550	On 7/25/2024 after it was brought to the attention of the facility, incontinence care was provided to resident #71. A skin assessment was completed and resident had no skin break down noted due to the delay in providing incontinence care. On 7/26/2024, an audit of all other residents in the facility was completed to review that all other residents were provided with incontinence care. Care was provided to any resident identified. On 8/4/24 the Director of Nursing or designee educated all licensed nurses and certified nurse aides on resident	

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F 550	Continued From page 2 was severely impaired. He required moderate assistance with toileting hygiene, personal hygiene, maximum assistance with shower/bath and was dependent on staff for transfers. He was also frequently incontinent of bladder and always incontinent of bowel. On 07/24/24 from 2:05 PM through 2:20 PM a continuous observation was conducted of Resident #71 sitting at nurses' station in his wheelchair. He was wearing red pants that appeared to have a small wet area to the top right inner leg. It looked as if he had spilt water on his pants. On 07/24/24 at 3:15 PM an observation of Resident #71 and an interview was conducted with Nurse #1 present. Resident #71 was sitting at the 200 hall nurses' station in his wheelchair. He was wearing red jogging pants that were saturated with wetness to the front, between his legs, the top portion of his thighs, the sides of his thighs and the seat of the wheelchair. Resident #71 stated, "I'm wet, I need to be changed." During this observation, Nurse #1 verified Resident #71's pants were saturated with urine. Nurse #1 indicated Resident #71 should not have been left with urine soaked brief and clothing. On 07/25/24 at 10:11 AM an interview was conducted with Nursing Assistant (NA) #1. She verified she was Resident #71's NA on 07/24/24 from 7 AM-3 PM. She indicated she did not see him when she did her round around 2 PM, and she did not go back to check him before she left for the day. On 07/25/24 at 9:20 AM an interview was conducted with the Administrator. She stated her	F 550	rights to be treated with dignity to include, the right to have incontinence care provided. Any licensed nurse, certified nurse aides, new or agency nurse or certified nurse aide will receive this same education prior to their next shift. Beginning the week of 8/11/24 the Director of Nursing or designee will audit 5 residents per week to ensure that incontinence care was provided. Audits will continue for 12 weeks .The results of the audits will be reviewed by the QAPI committee and changes to the plan of correction will be made as needed,	

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F 550	Continued From page 3 expectation was for all residents to be provided incontinent care as needed and to be treated with dignity and respect.	F 550		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, the facility failed to display pertinent State Agencies and other advocacy group information in an accessible and visible location. The observation occurred for 3 of 5 days of the recertification survey.	F 575	On 7/26/24 the facility moved the postings for the contact information to state agencies and advocacy groups lower to be accessible to residents in wheelchairs. On 7/31/24 the state agency contact	8/15/24

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F 575	Continued From page 4 Findings included: During a Resident Council meeting on 7/23/24 at 3:00 PM, the 13 Resident Council members (Resident #1, #4, #16, #19, #21, #35, #42, #62, #65, #72, #80, #84, and #343) who attended the meeting revealed they were not able to see the signs for the State Agencies and advocacy groups as the bulletin board was not at eye level for all residents. An observation on 7/23/24 at 3:50 PM revealed the bulletin board which included State Agencies and other advocacy groups was located in a hallway outside the kitchen near the main dining room and was not at eye level for residents who utilized wheelchairs. An interview and observation of the bulletin board with Resident #80 on 7/24/24 at 11:47 AM revealed she could not see the bulletin board from her wheelchair which contained State Agency and other advocacy group information. She attempted to read the documents on the board by sitting upright in her wheelchair but was unable to view the documents. A tour of the facility, with the Maintenance Director on 7/25/24 at 11:04 AM, revealed the bulletin board which contained the postings for State Agencies and other advocacy groups was not at eye level for all residents who used wheelchairs. The Maintenance Director agreed the bulletin board placement would not be visible for some residents in the facility who utilized wheelchairs. An interview with the Administrator on 7/25/24 at 12:33 PM revealed she had the expectation that	F 575	numbers were reviewed in resident council meeting. On 7/30/24 the Regional Director of Clinical Services educated the Administrator on the resident right to have access to state facility contact information and the need to have the contact information visible to residents in wheelchairs. Beginning the week of 8/11/24 the administrator or designee will audit weekly that all postings for state reporting agency contact information is accessible to all residents. Audits will continue for 12 weeks .The results of the audits will be reviewed by the QAPI committee and changes to the plan of correction will be made as needed,	

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F 575	Continued From page 5 residents and visitors should have the ability to view the state agency and advocacy group information. She stated she would have the Maintenance Director move the bulletin board to make it more accessible and visible.	F 575		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, and family member, physician and staff interviews, the facility failed to meet the resident's care needs upon discharge by not ensuring the needed medical equipment was provided for 1 of 1 resident (Resident #95) reviewed for a safe and orderly discharge. The findings included: Resident #95 was admitted to the facility on 4/18/24 with diagnoses including pneumonia and muscle weakness. Resident #95 was discharged home with family on 5/11/24. Review of the admission Minimum Data Set (MDS) dated 5/11/24 revealed Resident #95 was cognitively intact. She required supervision or touch assistance with toileting and walking and partial assistance when sitting to standing. The MDS further revealed Resident #95 planned to	F 624	On 5/16/24 resident was delivered a wheelchair and raised toilet seat from the facility. On 5/17/24 the wheelchair and raised toilet seat arrived from Family Medial Supply. On 7/30/24 the administrator audited the last 30 days of residents who discharged home to ensure they were discharged with the appropriate equipment, and their equipment was delivered timely. No other issue were identified. On 7/30/24 the Social Worker was educated by the Regional Director of Clinical Services on the discharge process to include providing resident's equipment at discharge, and the requirements of the equipment company for physician's orders and physician's	8/15/24

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F 624	Continued From page 6 discharge back to the community and was involved in the discharge process. A review of the therapy discharge summary dated 5/10/24 revealed Resident #95's discharge location was to the family member's home, as she had a good prognosis to continue current level of functioning, with support from others and with Home Health Occupational Therapy. There was no recommendation for durable medical equipment in the therapy discharge summary. An interview with Occupational Therapist #1 on 7/25/24 at 1:05 PM revealed he did not recall working with Resident #95 and had to refer to the therapy notes. He stated Resident #95 was back to her prior level of functioning and was discharged from therapy services on 5/10/24. He stated neither Resident #95 nor her family indicated to the therapy team that she required a standard wheelchair. He further stated Resident #95 already had a transport wheelchair. A review of the Transition of Care Discharge Summary created on 5/10/24 and signed by the family member and Nurse #5 on 5/11/24 revealed the Durable Medical Equipment (DME) documented for Resident #95 was a standard wheelchair. An attempt to interview Nurse #5 on 5/25/24 was made and was unsuccessful. A telephone interview was conducted with Resident #95's family member on 7/24/24 at 11:08 AM. She stated Resident #95 was planned to discharge on 5/11/24, a Saturday, a standard wheelchair with footrests were to be delivered to the facility on 5/10/24. She indicated she drove	F 624	notes to be able to complete the delivery. Beginning 8/11/24 the Administrator or designee will audit 3 resident records who have discharged home weekly to ensure they have received their medical equipment. Audits will continue for 12 weeks. The results of the audits will be reviewed by the QAPI committee and changes to the plan of care will be made as needed.	

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F 624	Continued From page 7 Resident #95 to her home without the wheelchair on 5/11/24 as it had not been delivered to the facility. The family member stated no one working on 5/11/24 knew where the wheelchair was located when she asked for it and no one from Administration was there on the weekend. The family member stated she contacted the facility on 5/14/24 and left messages for the SW and Administrator. She indicated she left a message a message on the corporate hotline and a representative from the corporate office returned the call on 5/17/24. The family member confirmed the wheelchair was delivered to her home, but she could not recall the date.. No negative outcome was reported by the family member due to not having the wheelchair. An interview with the SW on 7/24/24 at 2:50 PM revealed Resident #95 was discharged on Saturday, 5/11/24. She stated the wheelchair had been ordered by the physician with a form she sent to the durable medical equipment (DME) company on 5/9/24 with an anticipated delivery of the wheelchair on 5/10/24. She stated the DME company had a new process for ordering DME which included faxing a copy of the discharge summary. The SW explained she was not made aware of this process and the equipment order was not processed before the discharge. A Social Work note dated 5/10/24 revealed the SW called the family member to inform her that the wheelchair had not been delivered on 5/10/24 due to needing the discharge summary form and was unable to leave a message. An additional Social Work note dated 5/14/24 revealed the SW spoke to the Family Member over the phone and explained she was waiting on	F 624		

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F 624	Continued From page 8 the discharge summary to complete the order for the wheelchair. An interview was conducted with the Medical Director on 7/25/24 at 9:39 AM. He explained the DME company wanted very specific verbiage to qualify for the wheelchair to include a discharge summary. He stated the DME company was one the facility did not use often, and he amended the verbiage on the order form for Resident #95 to fit their requirements on 5/16/24. He revealed the process for ordering DME had changed to include orders and the discharge summary. The Medical Director expected DME to be available at the time of discharge. An interview with the Administrator on 7/25/24 at 9:50 AM revealed she had the expectation Resident #95 should have had the equipment she needed upon her discharge. The Administrator explained the DME company changed the information required to obtain the equipment.	F 624		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of medications for Resident #16 and #45, indwelling catheter for Resident #57, and dental status for Resident #18. This was for 4 of 20 residents reviewed for MDS accuracy.	F 641	On 8/12/24 a modification MDS assessment was completed for resident #16, and #45 section N, resident # 57 section H, and resident #18 section L. On 7/31/24, to protect residents in similar situations, an audit was completed by the Clinical Quality Specialist on the last MDS	8/15/24

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F 641	Continued From page 9 The findings included: 1. Resident #16 was admitted to the facility on 02/05/24 with diagnosis that included major depressive disorder. Review of Resident #16's June 2024 Physician orders did not include an order for an antipsychotic medication. A quarterly MDS assessment dated 06/10/24 indicated Resident #16's cognition was intact. The medications section was coded that she was receiving an antipsychotic medication on a routine basis. On 7/25/24 at 12:30 PM, an interview occurred with the MDS nurse. She explained she had been working alone until recently, with help from corporate remotely to complete the MDS assessments. The MDS nurse reviewed the quarterly MDS assessment for Resident #16 and verified it was incorrectly coded for receiving antipsychotic medications. 2. Resident #45 was admitted to the facility on 06/16/21 with diagnosis that included type 2 diabetes mellitus. Review of Resident #45's May 2024 Physician orders included an order for insulin glargine, insulin pen; 100 unit/mL (3 mL); inject 26 units subcutaneously two times a day for diabetes mellitus. Review of Resident #45's May 2024 medication administration record revealed insulin was received on 6 days during the look back period.	F 641	assessment completed for all residents in the facility to ensure section N injections, L, and H were correctly coded. On 8/2/24 a correction modification MDS was completed for all MDS incorrectly coded On 7/26/24 the MDS coordinators were educated by the Regional Director of Reimbursement on the RAI guidelines for coding section N injections, L, and H on the MDS assessment. Beginning 8/11/24 Director of Nursing or designee will audit 5 resident records per week to ensure that section N injections, L and H are coded correctly on the MDS assessment. Audits will continue for 12 weeks. Results of the audits will be reviewed by the QAPI committee and the plan of correction will be revised as needed.	

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F 641

Continued From page 10

The quarterly Minimum Data Set (MDS) assessment dated 05/31/24 indicated Resident #45's cognition was moderately impaired. The medications section was coded for receiving 4 out of 7 injections of any type and 4 out of 7 insulin injections during the lookback period. However, Resident #45 received insulin injections on 6 out of 7 days during the lookback period.

On 7/25/24 at 12:30 PM, an interview occurred with the MDS nurse. She explained she had been working alone until recently, with help from corporate remotely to complete the MDS assessments. The MDS nurse reviewed the quarterly MDS assessment for Resident #45 and verified it was incorrectly coded for receiving injections medications.

3. Resident #57 was admitted to the facility on 10/10/23 with diagnosis that included a chronic non-healing stage 4 pressure ulcer of the sacral region.

Review of Resident #57's April 2024 Physician orders included an order for a urinary catheter due to stage 4 pressure ulcer and incontinence.

The quarterly Minimum Data Set (MDS) assessment dated 04/23/24 indicated Resident #57's cognition was severely impaired. Resident #57 ' s bladder and bowel section were coded as having an indwelling urinary catheter and was also coded as always incontinent of bladder.

On 7/25/24 at 12:30 PM, an interview occurred with the MDS nurse. She explained she had been working alone until recently, with help from corporate remotely to complete the MDS assessments. The MDS nurse reviewed the MDS

F 641

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F 641	Continued From page 11	F 641		

assessment for Resident #57 in bowel and bladder section and verified Resident #57 had an indwelling urinary catheter and it was an error to have coded her with bladder incontinence. This area should have been coded as "Not Rated".

An interview was completed on 7/25/24 at 9:50 AM with the Administrator. She stated regardless of who was completing the MDS and regardless of which program was used, the MDS should be coded accurately.

4. Resident # 18 was admitted on 10/8/23 with a diagnosis of spondylosis (a degenerative condition that affects the spine with resulting pain and muscle spasms).

The annual Minimum Data Set (MDS) dated 6/27/24 indicated Resident #18 was cognitively intact, exhibited no behaviors and required set up assistance with oral hygiene. His oral/dental status indicated he had no oral or dental issues or concerns.

Review of Resident #18's care plan included a care area for dental care related to decaying teeth on 10/9/23 and last revised on 7/13/24.

An interview and observation was completed on 7/21/24 at 1:30 PM. Resident #18 stated his teeth were a "mess". He stated he had missing teeth, rotting teeth and somebody was supposed to be doing something about it. Resident #18 denied pain or any issues with eating at present.

An interview was completed on 7/25/24 at 12:06 PM with MDS Nurse. She stated her assistant left in February 2024 and had not been replaced until recently and in the meantime, remote people had

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F 641	Continued From page 12 been helping. She further stated there was a change in ownership in April and the facility switched to a new computer program in April 2024. The MDS Nurse stated she felt that was the likely reason for the coding mistake. An interview was completed on 7/25/24 at 9:50 AM with the Administrator. She stated regardless of who was completing the MDS and regardless of which program was used, the MDS should be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		8/15/24

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F 656	Continued From page 13 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to develop an individualized person-centered comprehensive care plan in the area of a range of motion for Resident #7. This was for 1 of 20 residents reviewed for comprehensive care planning. The findings included: Resident #7 was admitted on 1/27/24 with diagnoses of Cerebral Vascular Accident (CVA) with right sided hemiplegia and aphasia. The quarterly Minimum Data Set (MDS) dated 5/24/24 indicated Resident #7 had severe cognitive impairment, exhibited no behaviors, was dependent on staff for her personal care needs	F 656	On 8/12/24 the care plan for resident #7 was updated to include a right hand contracture and the use of a right hand splint. On 8/2/24, to protect residents with similar situations, the director of nursing completed an audit of all other residents in the facility to ensure they had a care plan for contractures and splints On 7/26/24 the MDS coordinators were educated by the Regional Director of Reimbursement on the RAI guidelines for creating and updating comprehensive care plans, to include care planning splints and contractures.	

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F 656	Continued From page 14 and was coded for impairment to one side for both upper and lower extremities. An observation on 7/24/24 at 11:00 AM completed in the common area. Resident # 7 was sitting in her wheelchair wearing her right resting hand splint. Review of Resident # 7's comprehensive care plan last revised on 7/14/24 did not include a care plan for her right hand contracture. An interview was completed on 7/25/24 at12:06 PM with MDS Nurse. She stated her assistant left in February 2024 and had not been replaced until recently and in the meantime remote people had been helping. She further stated there was a change in Electronic Medical Records (EMR) system in April of 2024 and the facility switched to a new computer program in April 2024. The MDS Nurse stated the way they were electronically transferring all the residents care plans into the new program was manually when their next MDS was due. She stated since Resident #7 had a MDS completed after the changeover in May 2024, her care plan from the previous program should have been typed again into the new system but it was not. A review of the care plan with the MDS Nurse in the previous computer program did not include a care plan for contractures either. The MDS Nurse stated it was an oversight. An interview was completed on 7/25/24 at 9:50 AM with the Administrator. She stated she expected Resident #7's contracture and splint to be care planned and it appeared it was not related to the change in ownership.	F 656	Beginning 8/11/24 the Director of Nursing, or designee will audit 5 resident records per week to ensure that they have an updated comprehensive care plan. Audits will continue for 12 weeks. Results of the audits will be reviewed by the QAPI committee and the plan of correction will be revised as needed.	

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F 657	Continued From page 15	F 657		
F 657 SS=E	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. (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, observations, resident and staff interviews, the facility failed to review and revise the care plan after the completion of a Minimum Data Set (MDS) assessment in the areas of falls (Resident #7), Activities of Daily Living (Residents #7, #51), contractures (Resident #13), medications (Resident #27) and	F 657	On 8/2/24 the care plan for resident #7 and #51 were updated to include their ADLs, #7 the fall care plan was updated with interventions, the care plan for resident #13 was updated to include her contracture, the care plan for resident #27 was updated to include his psychotropic	8/15/24

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nutrition (Resident #40). The facility also failed to contact the resident and/or Resident Representative regarding a care plan meeting (Residents #73, #80). This was for 7 of 20 residents reviewed.

The findings included:

1) Resident #27 was admitted to the facility on 2/2/21 with diagnoses of dementia, Parkinson's disease and major depressive disorder.

Resident #27's active care plan, last reviewed and revised on 5/29/24, included a problem area for received antidepressant and antipsychotic medications as ordered.

A quarterly MDS assessment dated 7/3/24 indicated that Resident #27 received antidepressant and antipsychotic medications.

A review of Resident #27's physician orders and July 2024 Medication Administration Record (MAR) revealed Resident #27 received Seroquel (an antipsychotic medication) 25 milligrams (mg) a half tablet by mouth twice a day and Sertraline (an antidepressant medication) 50 mg one tablet by mouth daily.

The Administrator was interviewed on 7/25/24 at 9:00 AM and stated she expected the care plans to be reviewed and revised after each MDS assessment.

On 7/25/24 at 12:05 PM, an interview occurred with the MDS nurse. She explained she had been working alone until recently, with help from corporate remotely to complete the MDS assessments, but they didn't update the care

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medications, the care plan for resident # 40 was updated to include his nutritional status. Residents were provided with a meal according to the community menu and cooked according to the facility recipe. If a resident did not like the main dish, they were offered and alternate meal.

On 8/2/24, to protect residents in similar situations an audit was completed by the Clinical Quality Specialist and Director of Nursing on all other residents in the facility to ensure their care plans were updated in Matrix. Any care plan identified that had not been updated was updated by 8/2/24. On 7/31/24 the social worker informed all other alert and oriented residents or resident representatives for non-alert residents of their next scheduled care plan meeting. Care plan meeting invitations were mailed to the resident representatives.

On 7/26/24 the MDS coordinators were educated by the Regional Director of Reimbursement on the RAI guidelines for creating and updating comprehensive care plans. On 7/31/24 the social worker and MDS coordinators were educated by the administrator on the requirement to have quarterly care plan meetings and to inform and invite the resident and the resident representative to the care plan meeting.

Beginning 8/11/24 the RDCS (Regional Director of Clinical Services) or designee will audit 5 resident records per week to

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F 657	Continued From page 17 plans. In addition, the facility had switched Electronic Medical Record (EMR) providers on 4/9/24 and the goal was to update the care plans in the new EMR with new MDS assessments. The MDS nurse reviewed the care plan for Resident #27 and acknowledged the MDS assessment was completed on 7/3/24 and the care plan should have been reviewed and revised after that. 2) Resident #40 was originally admitted to the facility on 8/14/19 with diagnoses that included dysphagia (difficulty swallowing). Resident #40 was hospitalized from 6/13/24 to 6/15/24 for malfunctioning gastrojejunostomy (GJ) tube. On 6/14/24 the GJ tube was removed and replaced with a gastrostomy (G) tube. The hospital records also indicated that Resident #40 had been eating by mouth without difficulty. Resident #40's active care plan included the following problem areas last reviewed and revised on 4/9/24: - Resident requires a therapeutic diet related to medical diagnosis. Less than optimal enteral nutrition related to jejunostomy tube and recent gastric outlet obstruction as evidenced by placement of gastro-jejunostomy. Resident is at nutritional risk related to malnutrition, chronic kidney disease, diabetes, bed bound status and dysphagia with nothing by mouth status. - Resident requires feeding tube related to oropharyngeal dysphagia. Type of tube gastro-jejunostomy. An annual MDS assessment dated 6/26/24 indicated that Resident #40 was cognitively intact	F 657	ensure that they have an updated comprehensive care plan and that the resident and the resident representative have been invited to the quarterly care plan meeting. Audits will continue for 12 weeks .The results of the audits will be reviewed by the QAPI committee and changes to the plan of correction will be made as needed,	

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and received nutrition/fluids via a feeding tube and set up assistance for eating.

A review of the June 2024 physician orders included the following:
- An order dated 6/10/24 for high concentrated snacks, small portions four times a day and as requested.
- An order dated 6/15/24 tube feed formula continuous at 40 milliliters per hour for 22 hours.

An observation and interview occurred with Resident #40 on 7/23/24 at 1:20 PM. He had a bottle of lemonade, cup of ice water and oatmeal cookie at bedside. Resident #40 stated that he had started eating a little by mouth but still received his tube feedings.

The Administrator was interviewed on 7/25/24 at 9:00 AM and stated she expected the care plans to be reviewed and revised after each MDS assessment.

On 7/25/24 at 12:05 PM, an interview occurred with the MDS nurse. She explained she had been working alone until recently, with help from corporate remotely to complete the MDS assessments, but they didn't update the care plans. In addition, the facility had switched Electronic Medical Record (EMR) providers on 4/9/24 and the goal was to update the care plans in the new EMR with new MDS assessments. The MDS nurse reviewed the care plan for Resident #40 and acknowledged the MDS assessment was completed on 6/26/24 and the care plan for nutrition should have been reviewed and revised after that.

3a. Resident #7 was admitted on 1/27/24 with

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diagnoses of Cerebral Vascular Accident (CVA) with right sided hemiplegia and aphasia.

The quarterly Minimum Data Set (MDS) assessment dated 5/24/24 indicated Resident #7 had severe cognitive impairment and required maximum to total staff assistance with her activities of daily living (ADLs).

Review of Resident #7's current care plan last revised 7/14/24 did not include a care area for assistance with ADLs but a review of the care plan from the previous computer program used prior to April 2024 included a care plan for ADL assistance.

An interview was completed on 7/25/24 at 12:06 PM with the MDS Nurse. She stated her assistant left in February 2024 and had not been replaced until recently and in the interim remote staff helped with entering care plans. She further stated there was a change in ownership and the facility switched to a new computer program in April 2024. The MDS Nurse stated the way they were electronically transferring all the resident care plans into the new program was manually when their next MDS was due. She stated since Resident #7 had a MDS completed after the changeover, her care plan from the previous program should have been typed again but it was not entered into the new system.

An interview was completed on 7/25/24 at 9:50 AM with the Administrator. She stated she expected Resident #7's ADL care plan to have been pulled from the previous computer system into the current one after the May 2024 MDS assessment was completed.

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3b. Resident #7 was admitted on 1/27/24 with diagnoses of CVA with right sided hemiplegia and aphasia.

The quarterly MDS assessment dated 5/24/24 indicated Resident #7 had severe cognitive impairment and was coded for two or more falls.

Review of Resident #7's current fall care plan last revised 7/14/24 did not include all the interventions implemented and mentioned in the fall investigations but a review of the care plan from the previous computer program used prior to April 2024 included the missing interventions.

An interview was completed on 7/25/24 at 12:06 PM with the MDS Nurse. She stated her assistant left in February 2024 and had not been replaced until recently and in the interim remote staff helped with entering care plans. She further stated there was a change in ownership and the facility switched to a new computer program in April 2024. The MDS Nurse stated the way they were electronically transferring all the resident care plans into the new program was manually when their next MDS assessment was due. She stated since Resident #7 had a MDS completed after the changeover, her care plan from the previous program should have been typed again but it was not entered into the new system.

An interview was completed on 7/25/24 at 9:50 AM with the Administrator. She stated she expected Resident #7's fall care plan to have been pulled from the previous computer system into the current one after the May 2024 MDS assessment was completed.

4. Resident #13 was admitted on 10/13/12 with

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diagnosis of a Cerebral Vascular Accident with right sided hemiplegia.

The significant change Minimum Data Set (MDS) assessment dated 6/27/24 indicated Resident #13 was cognitively intact and impaired on one side for both upper and lower extremities.

An observation was completed on 7/22/24 at 9:20 AM. Resident #13 was lying in bed with her right hand on top of the sheet. Her hand was contracted into a fist. She stated she had a contracture and wore a splint but she wasn't always good about leaving it on. She demonstrated she was able to use her left hand to open her right hand and stated she did that throughout the day.

Review of her Resident #13's current care plan last revised on 7/14/24 did not include a care area related to her contracture but a review of Resident #13's care plan in the previous computer program did include a care plan for her contracture.

An interview was completed on 7/25/24 at 12:06 PM with the MDS Nurse. She stated her assistant left in February 2024 and had not been replaced until recently and in the interim remote staff helped with entering care plans. She further stated there was a change in ownership and the facility switched to a new computer program in April 2024. The MDS Nurse stated the way they were electronically transferring all the resident care plans into the new program was manually when their next MDS assessment was due. She stated since Resident #13 had a MDS completed after the changeover, her care plan from the previous program should have been typed again

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but it was not entered into the new system.

An interview was completed on 7/25/24 at 9:50 AM with the Administrator. She stated she expected Resident #13's contracture care plan to have been pulled from the previous computer system into the current one after the June 2024 MDS assessment was completed.

5. Resident #51 was admitted to the facility on 05/24/22 with diagnosis of major depressive disorder, type 2 diabetes mellitus, Vascular Dementia, and chronic obstructive pulmonary disease.

A quarterly MDS assessment dated 04/30/24 indicated Resident #51's cognition was moderately impaired. She required maximum assistance with toileting hygiene, shower/bath, personal hygiene, and transfers. She also required moderate assistance with dressing and bed mobility.

Resident #51's active care plan, last revised on 07/09/24, did not include a focus for activities of daily living.

On 7/25/24 at 12:30 PM, an interview occurred with the MDS nurse. She explained she had been working alone until recently with help from corporate remotely to complete the MDS assessments, but they didn't update the care plans. In addition, the facility had switched Electronic Medical Record (EMR) providers on 04/09/24 and the goal was to update the care plans in the new EMR with new MDS assessments. The MDS nurse reviewed the care plan for Resident #51 and verified it was not complete on 07/21/24 but has since been

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corrected.

6. Resident #73 was admitted to the facility on 1/4/23 with diagnoses including chronic systolic (congestive) heart failure. A review of the quarterly Minimum Data Set (MDS) dated 4/16/24 revealed he was moderately cognitively impaired.

An interview with Resident #73 on 7/21/24 12:01 PM revealed he had never been invited to a care plan meeting regarding his care at the facility and he would be interested in attending. He was not aware of any such meetings and received no verbal or written notice of the meetings.

A review of Resident #73's chart revealed no care plan meeting notices, and the Social Worker (SW) was unable to produce documentation.

An interview with the SW occurred on 07/24/24 at 3:03 PM. She revealed the previous MDS Nurse would verbally invite alert residents and mail care plan meeting invitations to families. The previous MDS Nurse left two months ago and what had been scheduled continued, but no further notifications have been sent or quarterly care plan meetings held. The SW indicated the MDS Nurse would take over the task of sending out care plan meeting notices.

An interview with the MDS Nurse on 7/25/24 at 12:47 PM revealed the care plan meeting notices had been sent by the previous MDS Nurse who left in March 2024. It was her understanding that since March the SW had taken over the task of sending out care plan meeting notices to families and verbally inviting alert residents.

An interview with the Administrator was

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F 657	Continued From page 24	F 657		

completed on 7/25/24 at 9:50 AM. She expected residents and families to be notified of all care plan meetings.

7. Resident #80 was admitted to the facility 11/23/2022 with diagnoses including type 2 diabetes mellitus. A review of the quarterly Minimum Data Set (MDS) dated 5/13/2024 revealed she was cognitively intact.

An interview with Resident #80 on 7/24/24 at 11:47 AM revealed she was not aware of any recent care plan meetings regarding her care. She stated her son received a notice at the beginning of her stay at the facility and she attended one care plan meeting since her admission. Resident #80 stated she would like to attend a quarterly care plan meeting but did not receive a notification or was aware one was held this last quarter.
A review of Resident #80's chart revealed no care plan meeting notices, and the SW was unable to produce documentation.

An interview with the SW occurred on 07/24/24 at 3:03 PM. She revealed the previous MDS Nurse would verbally invite alert residents and mail care plan meeting invitations to families. The previous MDS Nurse left two months ago and what had been scheduled continued, but no further notifications have been sent or quarterly care plan meetings held. The SW indicated the MDS Nurse would take over the task of sending out care plan meeting notices.

An interview with the MDS Nurse on 7/25/24 at 12:47 PM revealed the care plan meeting notices had been sent by the previous MDS Nurse who left in March 2024. It was her understanding that

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F 657	Continued From page 25 since March the SW had taken over the task of sending out care plan meeting notices to families and verbally inviting alert residents. An interview with the Administrator was completed on 7/25/24 at 9:50 AM. She expected residents and families to be notified of all care plan meetings.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to obtain Physician orders for the use of a right resting hand splint and for a pommel cushion (a cushion used to improve posture and hip positioning). This was for 1 of 2 reviewed for professional standards (Resident # 7). The findings included: Resident #7 was admitted on 1/27/24 with diagnoses of a Cerebral Vascular Accident (CVA) with right sided hemiplegia and aphasia. The quarterly Minimum Data Set (MDS) dated 5/24/24 indicated Resident #7 had severe cognitive impairment, exhibited no behaviors and was coded for impairment to one side for both upper and lower extremities.	F 658	On 7/26/24 a physician□s order was placed for her pommel cushion and on 7/22/24 a physician□s order was obtained for a hand splint. On 8/6/24, to protect residents in similar situations, an audit was conducted by the Director of Nursing or designee on all other residents in the facility to ensure there was a physician□s order for all adaptive equipment to include hand splints and specialty cushions. There were no negative findings. On 8/4/24 the Director of Nursing or designee educated all licensed nurses and evaluating licensed therapist that a physician□s order was required for all adaptive equipment to include specially cushions and hand splints. All new	8/15/24

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F 658	Continued From page 26 An observation was completed on 7/24/24 at 11:00 AM in the common area. Resident #7 was sitting in her wheelchair with a pommel cushion and wearing her right resting hand splint. a. An interview was completed on 7/25/24 at 11:00 AM with Nursing Assistant (NA) #5. She stated Resident #7 had been wearing the right hand splint for approximately 3 months and that therapy had placed the pommel cushion in her wheelchair because she was sliding onto the floor. A review of Resident #7's comprehensive care plan was completed on 7/22/24. There was no care plan for the use of a resting hand splint. A review of Resident #7's July 2024 Physician orders was completed on 7/22/24 at 8:45 AM. There was no order for a resting hand splint. A review of the electronic medical record was completed on 7/23/24 at 2:40 PM. There was a Physician order for Resident #7's right resting hand splint dated 7/23/24. An interview was completed on 7/24/24 at 3:15 PM with the Nurse Manager. She confirmed there was no Physician order for Resident #7's resting hand splint but the facility had since obtained the Physician order. She stated there was some confusion between nursing and therapy about who was to write the orders regarding the use of therapy devices. A telephone interview was completed on 7/24/24 at 2:10 PM with the Rehabilitation Manager. He stated therapy initiated the use of the resting	F 658	nurses and agency nurses not educated by 8/4/24 will received this same education prior to working their next scheduled shift. Beginning 8/11/24 the Director of Nursing or designee will audit 3 resident records per week to ensure that there is an order for adaptive equipment to include hand splints and specialty cushions. Audits will continue for 12 weeks .The results of the audits will be reviewed by the QAPI committee and changes to the plan of correction will be made as needed.	

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F 658	Continued From page 27 hand splint in April of 2024. He stated there should have been Physician orders written for the resting hand splint and there may have been some uncertainty on who was to write the orders. An interview was completed with the Medical Director on 7/25/24 at 9:15 AM. He stated there should have been orders for Resident #7's right resting hand splint. b. An observation was completed on 7/24/24 at 11:00 AM in the common area. Resident #7 was sitting in her wheelchair with a pommel cushion. Nursing Assistant (NA) #5 stated Resident #7 that therapy had placed the pommel cushion in her wheelchair a few weeks ago because she was sliding onto the floor. A review of Resident #7's comprehensive care plan was completed on 7/22/24. The fall care plan last revised 7/14/24 the implementation of fall interventions/devises. A review of Resident #7's July 2024 Physician orders was completed on 7/22/24. There was no order for the use of a pommel cushion. An interview was completed on 7/24/24 at 3:15 PM with the Nurse Manager. She confirmed there were no Physician order for Resident #7's pommel cushion. She stated the pommel cushion was a recent intervention that therapy put in place and it may have been they were waiting to write the order until they were sure the intervention was appropriate. The Nurse Manager stated it seemed to be working better than anything else that the facility had attempted. A telephone interview was completed on 7/24/24	F 658		

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F 658	Continued From page 28 at 2:10 PM with the Rehabilitation Manager. He stated therapy initiated the use of the pommel cushion within the last few weeks. He stated it was for a trial to see if it worked. He stated there should be Physician order for pommel cushion when it was implemented. An interview was completed with the Medical Director on 7/25/24 at 9:15 AM. He stated there should be an order for the pommel cushion.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to provide nail care and incontinence care for 2 of 5 residents reviewed for activities of daily living (ADL) (Resident #71 and #7). Findings include: 1. Resident #71 was admitted to the facility on 09/07/21 with diagnoses that included the need for assistance with personal care, dementia with psychotic disturbance, and late onset Alzheimer's Disease. Review of the annual Minimum Data Set (MDS) dated 07/04/24 revealed Resident #71's cognition was severely impaired. He required moderate assistance with toileting, was dependent on staff for transfers, and was frequently incontinent of	F 677	On 7/25/24 after it was brought to the attention of the facility, incontinence care was provided to resident #71. A skin assessment was completed and resident had no skin break down noted due to the delay in providing incontinence care. On 7/23/24 nail care was provided to resident #7, resident did not have any skin break down due to nail care not being provided. On 7/26/24, to protect residents in similar situations, an audit of all other residents in the facility was completed by the Regional Director of Clinical Services to review that all other residents were provided with incontinence care. Care was provided to any resident identified. On 7/26/24 nail care was provided to all residents in the facility.	8/15/24

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F 677

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bladder and always incontinent of bowel.

Resident #71's care plan, last revised on 07/04/24, included a focus for activities of daily living (ADLs)/self-care deficit related to limited mobility, poor coordination, and dementia. The interventions included he required assistance of 1 person for toileting and he wears briefs for dignity. Resident #71 had another focus that he was at risk for pressure ulcer due to moisture. The interventions included for staff to check incontinence pads frequently and change as needed.

On 07/24/24 from 2:05 PM through 2:20 PM a continuous observation of Resident #71 sitting at nurses' station in his wheelchair. He was wearing red pants that appeared to have a small wet area to the top right inner leg. It looked as if he had spilt water on his pants.

On 07/24/24 at 3:15 PM an observation of Resident #71 and an interview was conducted with Nurse #1 present. Resident #71 was sitting at the 200 hall nurses' station in his wheelchair. He was wearing red jogging pants that were saturated with wetness to the front, between his legs, the top portion of his thighs, the sides of his thighs and the seat of the wheelchair. Resident #71 stated, "I'm wet, I need to be changed." During this observation, Nurse #1 verified Resident #71's pants were saturated with urine. She stated that the 1st shift (7 AM-3 PM) Nursing Assistant (NA) had already left for the day. The resident was taken to his room and changed by the 2nd shift (3 PM-11 PM) NA. Nurse #1 indicated Resident #71 should not have been left with urine soaked brief and clothing.

F 677

On 8/4/24 all licensed nurses, and certified nurse aides were educated by the Regional Director of Clinical Services on the requirement to provide ADL care (activities of daily living) to include nail care and incontinence care. All new and agency staff who have not been educated by 8/4/24 will be educated prior to their next shift.

Beginning 8/11/24 the Director of Nursing or designee will audit 5 residents per week to ensure that they have been provided nail care and incontinence care. During concierge rounds, the interdisciplinary team will observe for nail care and incontinence and communicate for follow up with nursing. Audits will continue for 12 weeks. The results of the audits will be reviewed by the QAPI committee and changes to the plan of correction will be made as needed.

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On 07/25/24 at 10:11 AM an interview was conducted with Nursing Assistant (NA) #1. She verified she was Resident #71's NA on 07/24/24 from 7 AM-3 PM. She indicated she last provided incontinence care at approximately 12:00 PM prior to lunch being served. She stated she did not see him when she did her round at 2 PM and she did not go back to check him before she left for the day. She gave no explanation of why she did not check on him prior to her shift ending.

On 07/25/24 at 9:20 AM an interview was conducted with the Administrator. She stated her expectation was for all residents to be provided incontinent care every 2 hours and as needed.

2. Resident #7 was admitted on 1/27/24 with diagnoses of Cerebral Vascular Accident with right sided hemiplegia and aphasia.

The quarterly Minimum Data Set dated 5/24/24 indicated Resident #7 had severe cognitive impairment, exhibited no behaviors, was dependent on staff for her personal hygiene and was coded for impairment to one side for both upper and lower extremities.

There was a care plan last revised 3/14/24 for her ADLs in the current computer program. It include a care area for assistance with Resident #7's ADLs.

An observation was completed on 7/21/24 at 12:50 PM. Resident #7 was sitting up in her bed. She was dressed for the day and appeared to be groomed. There was no signs of incontinence. She was unable to speak and her hands remained under the sheet.

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Another observation was completed on 7/22/24 at 9:20 AM while Nursing Assistant (NA) #4 was in the room preparing to feed resident breakfast. NA #4 was asked to show surveyor Resident #7's left hand and finger nails. Resident #7's palm and fingers were clean, absent of debris and odor. Her finger nails were trimmed and polished. She was then asked to reveal Resident #7's right hand which was balled up into a fist. NA #4 gently opened Resident #7's hand to reveal long jagged finger nails pressing into the palm of her hand. There was some yellowish colored debris observed along with a strong odor. NA #4 stated this was her first time working with Resident #7 and she under the impression her nail care was done on her shower days.

An observation was completed on 7/23/24 at 2:00 PM in the hallway near the entrance. Resident #7 was in her wheelchair being propelled to an activity by a volunteer. She was wearing her right hand splint allowing observation of her finger nails. Her fingernails had been trimmed.

An interview was completed on 7/24/24 at 11:00 AM with NA #5. She stated she was normally the only person who showered Resident #7 so she was responsible for Resident #7's unkempt finger nails. NA #5 stated for some reason, she had not been paying attention to her finger nails.

An interview was completed on 7/24/24 at 3:15 PM with the Nurse Manager. She stated that what NA #5 said did not sound like NA #5 but the nurses should be following up to make sure nail care gets done.

An interview was completed with the Administrator on 7/25/24 at 9:50 AM. She stated

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she was not aware that only NA #5 gave Resident #7 her showers but that NA #5 had been working at the facility for a considerable time and was good with difficult residents. She stated the staff should have noticed Resident #7's long finger nails cutting into her palm earlier when they were applying the hand splint long before it got to what it appeared like on 7/21/24.

F 684 SS=D — Quality of Care — F 684 — 8/15/24

CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and interviews with the Wound Care provider and staff, the facility failed to discontinue an order for a healed venous stasis ulcer on the lower extremity and initiate a new order for protective skin care to a healed venous stasis ulcer on the lower extremity (Resident #40). This was for 1 of 1 resident reviewed for well-being.

The findings included:

Resident #40 was admitted to the facility on 8/14/19 with diagnoses that included diabetes and peripheral vascular disease.

A review of Resident #40's active physician

Provider's Plan of Correction:

On 7/22/24 the wound order for resident #40 was discontinued and the new order for preventive skin care was initiated on 7/24/24.

On 8/1/24 the Director of Nursing or designee completed an audit of all other wound orders to ensure the correct order was in place. No other issues were identified.

On 8/4/24 the wound nurse and licensed nurses were educated by the Regional Director of Clinical Services that to prevent from reoccurring, nurses are to have a second nurse verify all new orders

F 684

Continued From page 33

orders included an order dated 6/22/24 to cleanse wound to right heel with normal saline, pat dry, apply calcium alginate to the wound bed and cover with foam dressing every three days.

An annual Minimum Data Set (MDS) assessment dated 6/26/24 indicated Resident #40 was cognitively intact and had open lesions to the foot.

Review of a Wound Nurse Practitioner (NP) progress note dated 7/10/24 revealed the vascular wound to Resident #40's right heel was resolved. A new order to apply skin prep and leave open to air was indicated.

The July 2024 Medication Administration Record (MAR) was reviewed and included an order to cleanse Resident #40's right heel with normal saline, pat dry, apply calcium alginate to the wound bed and cover with foam dressing every three days. This order continued until 7/22/24. There was no order to provide skin prep to Resident #40's right heel.

On 7/24/24 at 12:15 PM, an interview occurred with the Wound Care nurse who reviewed Resident #40's July 2024 MAR and wound care progress note dated 7/10/24, acknowledged the vascular wound to Resident #40's right heel was resolved on 7/10/24 and the order for wound care should have been discontinued by her. She explained that the wound NP came to the facility weekly, and she received verbal instructions if treatment orders were to change, as well as the written progress note. In addition, the Wound Care nurse verified the order for skin prep to the right heel was not showing in Resident #40's active physician orders. She felt this was an oversight.

F 684

written by the wound provider during wound rounds. All licensed nurses were educated to have two nurses verify the wound orders that the provider completes weekly with wound rounds. After 8/4/24 all new licensed nurses and agency nurses will receive this same education prior to their next shift.

Beginning 8/11/24 the Director of Nursing or designee will audit 3 resident records per week to ensure that the order is in place for wound care and ensure treatment orders are accurate and verified by two nurses. Audits will continue for 12 weeks .The results of the audits will be reviewed by the QAPI committee and changes to the plan of correction will be made as needed.

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F 684	Continued From page 34 The Wound NP was interviewed on 7/24/24 at 12:20 PM who reviewed the wound care progress note dated 7/10/24 as well as Resident #40's active physician orders. He stated there was no harm with that occurred from the delay in the wound care treatment change but wanted the skin prep to be used to provide extra protection on a newly healed venous ulcer. An observation of wound care on Resident #40 occurred on 7/24/24 at 12:40 PM with the Wound Care nurse. An area of pink closed skin was present to the right heel. An interview occurred with the Administrator on 7/25/24 at 9:00 AM and stated that she would expect the wound care to Resident #40's right heel be correct as ordered by the Wound Care NP.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		8/15/24

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F 686	Continued From page 35 by: Based on record review, observations, and staff interviews, the facility failed to ensure the low air loss mattress was set according to the resident's weight for 1 of 2 residents (Resident #57) reviewed for pressure ulcers. The findings include: Resident #57 was admitted to the facility on 10/10/23 with diagnosis that included a chronic non-healing stage 4 pressure ulcer of the sacral region. Review of Resident #57's active Physician orders included an order dated 10/24/23 for an air mattress: check every day shift for proper functioning. The quarterly Minimum Data Set (MDS) assessment dated 04/23/24 indicated Resident #57's cognition was severely impaired. The skin conditions section was coded for one unhealed pressure ulcer, stage 4 and skin treatments included a pressure reducing device for bed. Resident #57's active care plan, last reviewed on 06/03/24, included a focus area for having a stage 4 wound to sacrum. The interventions included air mattress as ordered. Medication administration and treatment administration records revealed no order listed for checking the function of the air mattress daily. Resident #57's medical record included a weight of 136.6 pounds (lbs) on 07/09/24. On 07/21/24 at 12:32 PM Resident #57's air	F 686	On 7/27/24 the wound nurse corrected resident # 57 air mattress setting. On 8/7/24 the Director of Nursing or designee completed an audit of all resident□s with an air mattress to ensure they were set at the correct setting. No other issues were identified. By 8/4/24 the Director of Nursing or designee educated all other licensed nurses on ensuring that air mattresses were on the correct setting. After 8/4/24 any new licensed nurse or agency nurse will received this same education prior to their next shift. Beginning 8/11/24 the Director of Nursing or designee will audit 3 resident records and ensure the mattress is at the appropriate setting, per week to ensure that their air mattresses are set to the correct setting. Audits will continue for 12 weeks. The results of the audits will be reviewed by QAPI committee and change to the plan will be made as needed.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 686

Continued From page 36

mattress setting was observed with a light at 450 pounds. The device box had a pressure level that ranged from 250 to 1000+ weight in pounds. The weight setting had a light beside it which indicated the current setting. Resident #57 was in bed with eyes closed.

On 07/22/24 at 9:36 AM Resident #57's air mattress setting was observed and was set at 450 pounds. Resident #57 was in bed with eyes closed.

On 07/23/24 at 9:45 AM Resident #57's air mattress setting was observed and was set at 450 pounds. Resident #57 was on bed with eyes closed.

An observation and interview were conducted on 07/23/24 at 10:01 AM with the Wound Nurse. She stated she sets the original air mattress settings then she monitors them daily Mon-Fri on 1st shift. The nurses would monitor them when she's not here. She verified that Resident #57's air mattress was set on 450 pounds. She corrected the settings and locked the screen. She then stated she did not know how or why the settings were changed. She also indicated she was not aware the order for the air mattress was not on the treatment record.

An interview was conducted with the Wound Physician Assistant on 07/24/24 at 10:44 AM. He indicated the air mattress should be always set at the residents' weight to aide in wound healing.

F 689 SS=G

Free of Accident Hazards/Supervision/Devices
CFR(s): 483.25(d)(1)(2)

F 689 — Completion date: 8/15/24

§483.25(d) Accidents.

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F 689	Continued From page 37 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide care in a safe manner which resulted in a resident (Resident #21) falling from the bed. One of two falls from bed resulted in Resident #21 being sent to the emergency department for a laceration to her forehead that required 5 stitches. This was for 1 of 5 residents reviewed for accidents. The findings include: 1. Resident #21 was originally admitted to the facility on 09/10/23 with diagnoses that included cellulitis of right and left lower limbs, morbid obesity, and anxiety. Record review revealed Resident #21 had a closed care plan initiated on 09/11/23, last reviewed 02/29/24, and closed on 03/11/24, that included a focus that Resident #21 was at risk for falls characterized by history of falls, injury and/or multiple risk factors. The interventions included for staff to implement preventative fall interventions/devices and to educate resident/family regarding preventative fall interventions/safety devices as appropriate. An intervention was added on 09/27/23 for staff to encourage and assist Resident #21 to toilet after meals. The care plan also included a focus that read that Resident #21 had activities of daily	F 689	Resident #21 still remains in the facility and has no long term injuries from falling from bed. On 7/17/24 resident #21 was provided with a Bariatric bed. On 7/26/24, to protect residents in similar situations, the interdisciplinary team(Director of Rehab Services, Director of Nursing, Unit Manager, Administrator, Social Services, MDS coordinators, and Maintenance Director) audited all other residents in the building to ensure each resident had the appropriate bed size. Ten residents in the facility were identified to require a bariatric bed. Eight were already on a bariatric bed, one resident was provided with a larger bed, and one resident declined to change beds. On 7/30/24 the administrator or designee audited the last 30 days of falls to ensure there were no other falls during patient care. No other residents were identified with falls related to care. By 8/4/24 all licensed nurses, and certified nurse aids were educated by the Director of Nursing or designee on bed positioning and resident handling with bed mobility. All licensed nurses, and certified nurse aides were educated to inform the	

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living (ADL)/selfcare deficit related to impaired mobility. The interventions included Resident #21 required assistance of 1 staff member for bed mobility and toileting.

Review of the quarterly Minimum Data Set (MDS) dated 07/02/24 indicated Resident #21 was cognitively intact. She had range of motion (ROM) limitations to both sides of her lower extremities. She required set-up/clean-up assistance with personal hygiene, moderate assistance with bed mobility, and maximum assistance with toileting hygiene and transfers. She was frequently incontinent of bowel and bladder.

a. Review of incident report completed by the Wound Care Nurse, dated 09/26/23, revealed Resident #21 fell from the bed when Nursing Assistant (NA) #2 rolled her to her side while providing incontinence care. Resident #21 rolled off the bed and was noted face down on her abdomen. A small laceration was noted to Resident #21's forehead and a cut on her bottom lip. Under the "notes" section it stated the fall was reviewed by the interdisciplinary team (IDT) and a new intervention was added to the care plan for staff to encourage Resident #21 to toilet after meals.

Nursing notes revealed a note dated 09/26/23 written by the Wound Care Nurse indicating Resident #21's family/responsible party (RP) and the Physician were notified of the occurrence, and Resident #21 was sent to the emergency department for a laceration to her forehead.

Emergency room notes dated 09/26/23 revealed Resident #21 received 5 sutures to her forehead.

F 689

Administrator or the Director of Nursing if they feel a resident requires a large bed. All new or agency licensed nurses, certified nurse aides who were not educated by 8/4/24 will receive this same education prior to working their next shift.

Beginning 8/11/24 the Director of Nursing or designee will audit 3 resident records per week to ensure there are no falls related to care and the resident has the adequate size bed, and there is an appropriate intervention for the fall in place.

Beginning 8/11/24 the Director of Nursing or designee will audit 3 residents to ensure staff use appropriate technique for bed mobility. Audits will continue for 12 weeks. The results of the audits will be reviewed by QAPI committee and changes to the plan will made as needed.

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A computerized tomography (CT) scan of the head and spine was negative for fracture or intracranial hemorrhage. No other treatments were rendered.

An interview with Resident #21 was conducted on 07/21/24 at 2:43 PM. She stated she remembers the fall on 09/26/23. She then stated when Nursing Assistant (NA) #2 was going to provide incontinence care and she rolled her onto her side, she rolled her too far causing her to fall from the bed onto the floor. She explained she landed on her abdomen and that she hit her head and face on the floor. She further explained that she was sent to the emergency department and had to get 5 stitches to her forehead. She also explained that the bed she was utilizing at the time was a regular sized bed and she was a big woman. She stated she did not have room on the bed to lay her arms down beside her body. She stated she got a bigger bed on 07/15/24 and she's glad the staff talked her into it because she was hesitant about it before due to being embarrassed about her weight. Resident #21 could not recall if a larger bed had been offered to her or if one had been offered and she refused it.

An interview with the Nurse Manager was conducted on 07/24/24 at 2:35 PM. She stated Resident #21 fell from the bed when Nursing Assistant #2 rolled her to her side. She verified that Resident #21 would have benefitted from a bariatric bed due to her weight and height, however she did not have one at the facility until last week. She also stated she could have ordered one, however she doesn't know why but she did not do so. She further stated Resident #21's bed was switched out to a bariatric bed last week. She indicated she added an intervention

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for staff to toilet her after meals it would decrease the number of times staff would have to change her in the bed.

A phone interview with Nursing Assistant #2 was conducted on 07/24/24 at 6:38 PM. NA #2 verified she was assigned Resident #21 on 09/26/23. She stated she was getting ready to provide incontinence care and when she turned her onto her right side, she rolled off the bed onto the floor. She further stated Resident #21 was laying on her side, holding onto the side of the bed frame to prevent herself from rolling off the bed. Resident #21 could not hold herself up and rolled off the edge of the bed onto the floor. She immediately yelled for assistance and other staff members came in to assist. She had a laceration of her head and was sent to the emergency department (ER) for stitches and to be evaluated. She stated at the time she was in a regular sized bed however she needed to be in a bigger bed. She verified Resident #21 did not have much room on each side of her body and the edge of the bed.

An interview with the Wound Care Nurse was conducted on 07/25/24 at 11:54 AM. She verified she was Resident #21's nurse on 09/26/23 when the fall from bed occurred. She indicated she fell due to not having enough room in her bed to safely turn her due to her height and weight. She stated she did notify the Nurse Manager and physician at the time of the fall.

b. Review of incident report completed by Nurse #4, dated 12/18/23, revealed Nursing Assistant (NA) #3 was providing care to Resident #21. When NA #3 turned Resident #21 onto her side she fell out of the bed onto the floor on her stomach. Resident was alert and oriented and

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stated, "I rolled out of the bed while I was being changed". Resident #21 was noted with an abrasion to the right knee and bruising to her right elbow. Under the "notes" section it stated the fall was reviewed by the interdisciplinary team (IDT) and a new intervention was added to the care plan for 2 staff members to assist with activities of daily living (ADLs) and transfers.

An interview with Resident #21 was conducted on 07/21/24 at 2:43 PM. She verified she remembered the fall on 12/18/23. She stated the same thing happened as it did on 09/26/23 but explained that this time she was holding onto the frame of the side of the bed however she could not hold herself any longer and fell. She indicated she only had minor injuries and did not require to go to the emergency department. She only had an abrasion to her right knee and her right elbow was bruised. She stated she got a bigger bed last Monday and she's glad the staff talked her into it because she was hesitant about it before due to being embarrassed about her weight.

An interview with the Nurse Manager was conducted on 07/24/24 at 2:35 PM. She stated Resident #21 fell from the bed when Nursing Assistant #3 rolled her to her side. She verified that Resident #21 would have benefitted from a bariatric bed due to her weight and height, however she did not have one at the facility until last week. She also stated she could have ordered one, however she doesn't know why but she did not do so. She further stated Resident #21's bed was switched out to a bariatric bed last week. She indicated she added an intervention that required assistance of 2 staff members for bed mobility and toileting.

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F 689	Continued From page 42 Multiple unsuccessful attempts were made to contact Nursing Assistant #3. An interview with the Medical Director was conducted on 07/25/24 at 9:15 AM. He stated he had suggested Resident #21 get a larger bed on several occasions including her original admission date of 09/10/23, however she refused the larger bed. An interview with the Administrator was conducted on 07/25/24 at 9:30 AM. She indicated all residents should be assessed for equipment, devices, and/or interventions to safely provide care.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		8/15/24

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(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and staff interviews, the facility failed to post accurate staffing information as compared to the daily staff schedule for licensed and unlicensed nursing staff for 24 out of 32 days (6/20/24 to 7/2/24, 7/5/24 to 7/9/24 and 7/12/24 to 7/17/24). The facility also failed to ensure the daily nurse staffing sheets were completed and posted for 4 out of 30 days reviewed (7/18/24, 7/19/24, 7/20/24 and 7/21/24) for staffing.

The findings included:

1) A review of the facility's daily posting for nursing staff for the past 32 days as compared to the daily staffing schedule included an inaccurate total number of nursing staff worked, which included the following:

a. The nursing schedule for 6/20/24 indicated that 5 Licensed Practical Nurses (LPNs) were

F 732

On 7/21/24 the staff posting was correctly posted for that day.

On 7/26/24 the Administrator or designee assessed the last 30 days of staff postings and any inconsistencies were corrected.

One 7/26/24 the scheduler was educated by the Regional Director of Clinical Services on the requirements to post the staff posting daily and policy on how to complete the staff posting.

Beginning 8/11/24 the Administrator or designee will audit the staff posting 3 days weekly to ensure the staff posting is posted and completed correctly. Audits will continue for 12 weeks. Results of the audits will be reviewed by the QAPI committee and the plan of correction will

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scheduled to work the day shift (7:00 AM to 3:00 PM), 9 nursing aides (NAs) were scheduled to work the day shift and 4 NAs were scheduled to work the night shift (11:00 PM to 7:00 AM). The daily posted nurse staffing sheet for 6/20/24 documented that 4 LPNs worked the day shift, 9 NAs worked the day shift, and 5 NAs worked the night shift.

b. The nursing schedule for 6/21/24 indicated that 6 LPNs were scheduled to work the day shift, 1 Registered Nurse (RN) was scheduled to work the night shift and 6 NAs were scheduled to work the night shift. The daily posted nurse staffing sheet for 6/21/24 documented that 3 LPNs were working the day night, no RN worked the night shift, and 5 NAs worked the night shift.

c. The nursing schedule for 6/22/24 indicated that 2 RNs were scheduled to work the day shift, 1 RN was scheduled to work the night shift, 2 LPNs were scheduled to work the night shift and 7 NAs were scheduled to work the night shift. The daily posted nurse staffing sheet for 6/22/24 documented that 1 RN was working on day shift, no RN worked night shift, 1 LPN worked the night shift, and 5 NAs worked the night shift.

d. The nursing schedule for 6/23/24 indicated that 2 RNs were scheduled to work the day shift, 2 RNs were scheduled to work the evening shift (3:00 PM to 11:00 PM) and 1 RN was scheduled to work the night shift. The daily posted nurse staffing sheet for 6/23/24 documented that 1 RN was working the day shift, 1 RN worked the evening shift, and no RN was working the night shift.

e. The nursing schedule for 6/24/24 indicated that

Provider's plan of correction (F 732): be revised as needed.

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F 732	Continued From page 45 5 LPNs were scheduled to work the evening shift, and 5 NAs were scheduled to work the night shift. The daily posted nurse staffing sheet for 6/24/24 documented that 4 LPNs worked the day shift, and 4 NAs were working the night shift. f. The nursing schedule for 6/25/24 indicated that 5 LPNs were scheduled to work the day shift and 6 NAs were scheduled for the night shift. The daily posted nurse staffing sheet for 6/25/24 documented that 4 LPNs worked the day shift, and 5 NAs were working the night shift. g. The nursing schedule for 6/26/24 revealed that 6 LPNs were scheduled to work the day shift and 6 NAs were scheduled for the night shift. The daily posted nurse staffing sheet for 6/26/24 documented that 4 LPNs worked the day shift, and 5 NAs were working the night shift. h. The nursing schedule for 6/27/24 revealed that 6 LPNs were scheduled to work the day shift. The daily posted nurse staffing sheet for 6/27/24 documented that 4 LPNs were working the day shift. i. The nursing schedule for 6/28/24 revealed that 5 LPNs were scheduled to work the day shift. The daily posted nurse staffing sheet for 6/28/24 documented that 3 LPNs were working the day shift. j. The nursing schedule for 6/29/24 revealed that 2 RNs were scheduled to work the day shift, 3 RNs were scheduled to work the evening shift and 1 RN was scheduled to work night shift. The daily posted nurse staffing sheet for 6/29/24 documented that 1 RN was working day shift, 1 RN was working the evening shift, and no RN	F 732		

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worked the night shift.

k. The nursing schedule for 6/30/24 indicated that 1 RN and 3 LPNs were scheduled to work the night shift. The daily posted nurse staffing sheet for 6/30/24 documented that no RN and 7 LPNs were working the night shift.

l. The nursing schedule for 7/1/24 indicated that 4 LPNs and 9 NAs were scheduled to work the day shift. The daily posted nurse staffing sheet for 7/1/24 documented that 3 LPNs, and 8 NAs worked the day shift.

m. The nursing schedule for 7/2/24 indicated that 4 LPNs and 10 NAs were scheduled to work the day shift. The daily posted nurse staffing sheet for 7/2/24 documented that 3 LPNs, and 9 NAs worked the day shift.

n. The nursing schedule for 7/5/24 indicated that 5 LPNs were scheduled to work the day shift, 8 NAs were scheduled to work the day shift and 7 NAs were scheduled to work the night shift. The daily posted nurse staffing sheet for 7/5/24 documented that 3 LPNs were working the day shift, 9 NAs worked the day shift, and 5 NAs worked the night shift.

o. The nursing schedule for 7/6/24 indicated that 11 NAs were scheduled to work the day shift, 1 RN was scheduled to work the night shift and 6 NAs were scheduled to work the night shift. The daily posted nurse staffing sheet for 7/6/24 documented that 10 NAs were working the day shift, no RN worked the night shift, and 5 NAs worked the night shift.

p. The nursing schedule for 7/7/24 indicated that

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F 732	Continued From page 47 5 LPNs were scheduled to work the day shift, 10 NAs were scheduled to work the day shift and 1 RN was scheduled to work the night shift. The daily posted nurse staffing sheet for 7/7/24 documented that 4 LPNs worked the day shift, 9 NAs worked the day shift, and no RN was working the night shift. q. The nursing schedule for 7/8/24 indicated that 5 LPNs were scheduled to work the day shift and 6 NAs were scheduled to work the night shift. The daily posted nurse staffing sheet for 7/8/24 documented that 4 LPNs worked the day shift, and 5 NAs worked the night shift. r. The nursing schedule for 7/9/24 indicated that 11 NAs were scheduled to work the day shift and 7 NAs were scheduled to work the night shift. The daily posted nurse staffing sheet for 7/9/24 documented that 10 NAs worked the day shift, and 5 NAs were working the night shift. s. The nursing schedule for 7/12/24 indicated that 2 RNs were scheduled to work the day shift. The daily posted nurse staffing sheet for 7/12/24 documented that 1 RN worked the day shift. t. The nursing schedule for 7/13/24 indicated that 2 RNs were scheduled to work the day shift, 10 NAs were scheduled to work the day shift, 10 NAs were scheduled to work the evening shift, 1 RN was scheduled to work the night shift and 6 NAs were scheduled to work the night shift. The daily posted nurse staffing sheet for 7/13/24 documented that 1 RN worked the day shift, 9 NAs were working the day shift, 9 NAs worked the evening shift, no RN worked the night shift, and 5 NAs were working the night shift.	F 732		

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u. The nursing schedule for 7/14/24 revealed that 5 LPNs were scheduled to work the day shift, 1 RN was scheduled to work night shift and 6 NAs were scheduled to work night shift. The daily posted nurse staffing sheet for 7/14/24 documented that 4 LPNs worked the day shift, no RN was working the night shift, and 5 NAs worked the night shift.

v. The nursing schedule for 7/15/24 revealed that 6 LPNs and 10 NAs were scheduled to work the day shift. The daily posted nurse staffing sheet for 7/15/24 documented that 3 LPNs, and 9 NAs worked the day shift.

w. The nursing schedule for 7/16/24 revealed that 5 LPNs and 11 NAs were scheduled to work the day shift. The daily posted nurse staffing sheet for 7/16/24 documented that 3 LPNs, and 9 NAs worked the day shift.

x. The nursing schedule for 7/17/24 revealed that 10 NAs were scheduled to work the day shift. The daily posted nurse staffing sheet for 7/17/24 documented that 9 NAs worked the day shift.

On 7/22/24 at 9:19 AM, an interview occurred with Receptionist #1 who worked Monday thru Friday. She stated the Staffing Scheduler gave her the daily posting and she looked at the staffing schedule and put the staff numbers in the blanks.

The Staffing Scheduler was interviewed on 7/24/24 at 9:38 AM. She was able to review the staffing schedule and daily postings and verified the numbers did not correlate. She explained the receptionist had been filling the daily postings out based on the staff schedule and was not correct

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for the staff that worked.

The Administrator was interviewed on 7/24/24 at 10:47 AM and stated she expected the daily staff posting to be an accurate reflection of the staff that worked.

2) On 7/21/24 at 11:00 AM, the daily nurse staff sheet that was observed at the front desk of the facility was dated 7/17/24.

An interview occurred on 7/21/24 at 11:15 AM with the Weekend Supervisor. She stated she didn't manage the daily nurse staffing sheet that was located at the front desk of the facility.

On 7/22/24 at 9:10 AM, an interview occurred with the Staffing Scheduler who stated she gave the daily nurse staffing sheet to the receptionist to post daily at the front desk. She explained she was on vacation last week and was unable to state why 7/17/24 was still showing on 7/21/24.

An interview was completed with Receptionist #1 on 7/22/24 at 9:19 AM. She indicated she worked Monday through Friday and posted the daily nurse staffing sheet at the front desk when it was handed to her by the Staffing Scheduler. She was unable to state why the daily posting was still showing for 7/17/24 on 7/21/24.

A phone interview was conducted with Receptionist #2 on 7/23/24 at 1:31 PM. She indicated she worked Saturday and Sunday but was unfamiliar with a daily nurse staffing sheet.

On 7/24/24 at 10:47 AM, an interview occurred with the Administrator. She stated the Staffing

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F 732	Continued From page 50 Scheduler was on vacation last week and she had provided the daily nurse staffing sheet to Receptionist #1 to complete and post at the front desk. She was unable to state why the daily nurse staffing sheet for 7/17/24 was still showing on 7/21/24, but stated it was her expectation for the daily nurse staffing sheets to be completed and posted 7 days a week.	F 732		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews, Medical Director and staff interviews, the facility failed to hold blood pressure medications as ordered by the physician	F 757	On 7/25/24 the physician was notified that resident #19 was given blood pressure medication outside of the	8/15/24

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for 1 of 5 residents reviewed for unnecessary medications (Resident #19).

The findings included:

Resident #19 was admitted to the facility on 7/29/21 with a diagnosis of hypertension.

Review of Resident #19's physician orders included an order dated 3/29/24 for Metoprolol (a medication used to treat hypertension) 50 mg (milligrams) one tablet by mouth twice a day. Hold if heart rate is less than 60.

A quarterly Minimum Data Set (MDS) assessment dated 5/2/24 indicated Resident #19 was cognitively intact.

The July 2024 Medication Administration Record (MAR) was reviewed and revealed Resident #19 had received Metoprolol, despite the heart rate below 60 on the following dates:
* 7/6/24 evening dose- heart rate was 52.
* 7/10/24 morning dose- heart rate was 59.
* 7/14/24 evening dose- heart rate was 58.
* 7/16/24 evening dose- heart rate was 55.

An interview occurred with Medication Aide (MA) #1 on 7/24/24 at 1:42 PM, who was assigned to Resident #19 on 7/10/24. MA #1 indicated she was aware the resident had parameters to hold the Metoprolol. She reported she took the heart rate and recorded on the MAR. MA #1 reviewed the July 2024 MAR, verified the Metoprolol was administered despite the heart rate being below 60 when it should have been held and responded it was an oversight.

Multiple attempts were made to contact Nurse #2

ordered parameters. Resident #19 was reviewed by the provider and no negative outcomes were observed.

On 7/29/24, to protect residents in similar situations, the Director of Nursing or designee completed an audit of all other residents in the facility with parameters for their blood pressure medication to ensure their medication was given per provider orders. Two other residents in the facility were identified as receiving blood pressure medications outside of parameters. The physician was notified, both residents remain at baseline and have no negative outcomes from receiving their medications out side of prescribed parameters.

By 8/4/24 all licensed nurses and medication aides were educated by the Director of Nursing or designee on administering blood pressure medications within the prescribed parameters. Any new licensed nurse or agency nurse that has not received this education by 8/4/24 will receive this education prior to their next scheduled shift.

Beginning 8/11/24 the Director of Nursing or designee will audit 5 resident records per week to ensure that blood pressure medications are given with in prescribed parameters. The Director of Nursing and/or designee will observe 3 med passes per week to assure blood pressure medication are given within the prescribed parameters. Audits will continue for 12 weeks. Results of the

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F 757	Continued From page 52 who was assigned to Resident #19 on 7/6/24 and 7/14/24 as well as Nurse #3 who was assigned to Resident #19 on 7/16/24. On 7/25/24 at 9:00 AM, the Administrator was interviewed and stated she expected the nursing staff to follow doctor's orders included blood pressure medication with parameters to hold. The Medical Director (MD) was interviewed on 7/25/24 at 9:14 AM and stated if Resident #19 had received a few dosages of Metoprolol outside the parameters it would not have caused any serious harm. The MD added he would have expected the nursing staff to follow the orders for Metoprolol parameters as written.	F 757	audits will be reviewed by the QAPI committee and the plan of correction will be revised as needed.	
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).	F 802		8/15/24

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff, resident and Responsible Party (RP) interviews and record review, the facility failed to have sufficient dietary staff to prepare resident meals resulting in nursing staff preparing resident's breakfast on 7/20/24 and on 7/21/24, the resident's lunch meal not being prepared and delivered to the dining room and onto the halls as scheduled resulting in late meals. This was for 2 of 5 days of the state survey and affected residents receiving meal trays from the kitchen.

The findings included:

An initial tour was completed on 7/21/24 at 11:40 AM of the facility kitchen. On entry, there was one employee observed holding a large tray of raw chicken drumsticks. She stated she was the Dietary Manager and that she was the only staff member in the kitchen working but a dietary aide had just arrived and would be assisting her. The DM stated that one scheduled staff member was a no show no call, one called out, one person came in clocked in and then clocked back out and left. She stated this was a very recent issue this weekend. She stated she notified her supervisor and that assistance was on the way. The DM stated her supervisor was working to hire new staff. The problem was that as soon as new staff were hired, they would turn around and quit.

Review of the Daily Meal schedule revealed that the main dining room was to be served lunch at 12:00 PM. Random interviews were completed with residents waiting the in the dining room on 7/21/24. The residents stated yesterday the aides had to make breakfast because nobody showed

During the week of survey the Food Service Manager and other department heads assisted the kitchen due to insufficient dietary staff so meals could be served on time to serve lunch and all meals at the posted time for the main dining room for halls 100, 200, and 300.

On 7/26/24, to protect residents in similar situation, the new Food Service Manager reviewed the dietary schedule with the administrator and Regional Dietician. Arrangements were made to fill in empty shifts with dietary staff from sister facilities so there would be enough staff to serve meals on time. Advertisements for new dietary staff have been placed in Apploi and Indeed. A corporate recruiter is also assisting with new hires.

Beginning 8/2/24, to protect residents in similar situations, the Administrator and the new Food Service Manager will monitor the schedule for the dietary department to ensure adequate staffing is scheduled. If there are call offs, other departments and other staff will be called or reassigned to assist with meal service.

On 8/1/24 the new Food Service Manager educated all dietary staff on adhering to the attendance policy to ensure meals are provided safely and timely. All new dietary staff will receive this same education prior to working in the kitchen.

Beginning 8/11/24 the new Food Service

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F 802	Continued From page 54 up in the kitchen and that their lunch was late yesterday too. Staff were observed passing lunch trays to residents in the dining room at 1:30 PM. On 7/21/24, review of the Dietary Cart Schedule revealed the lunch trays were scheduled to arrive on the 100 hall at 12:15 PM but arrived at 2:15 PM, the 200 hall lunch trays were scheduled to arrive at 12:30 PM but arrived at 2:15 PM and the 300 hall trays were scheduled to arrive at 12:40 PM but arrived at 2:30 PM. An interview was completed on 7/22/24 at 12:05 PM with the Regional Dietary Manager (DM). She stated she had a conversation with the current DM who stepped down as DM to a cook position effective immediately. She stated the new DM from a sistering facility has helped out at the facility in the past and has taken over effective today. She stated at no time on 7/20/24 or 7/21/24 did she receive any messages or call notifying anyone of the situation at the facility until the Administrator notified her on 7/21/24. The Regional DM stated that this was an emergent problem that required her and the Administrator to be notified immediately but that didn't happen. She stated she terminated 5 employees today and was interviewing 7 applicants. The Regional DM stated she was now working closely with the Administrator to ensure the facility dietary staffing needs were met. During a telephone interview on 7/22/24 at 4:00 PM with Resident #7's RP, she stated there were no dietary staff to prepare breakfast for the residents on 7/20/24 so 3 of the nursing assistants had to do it. She stated she heard about what happened on 7/21/24 but nothing that bad had ever happened before. She stated she's	F 802	Manager and/or administrator will audit 3 meals per week for sufficient dietary staff and adherence to facility scheduled meal times. Audits will continue for 12 weeks. Results of the audits will be reviewed by the QAPI committee and the plan of correction will be revised as needed.	

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known the kitchen to be short staffed but for no staff to show was unacceptable.

During a resident council meeting on 7/24/24 at 3:00 PM, Resident #21, Resident #88 and Resident #84 voiced recent problems with staffing in the kitchen and that the nursing assistants had to prepare food so that the residents would have something to eat on Saturday.

An interview was completed on 7/25/24 at 10:11 AM with Nursing Assistant (NA) #1 and NA #9. They stated they worked first shift on 7/20/24 along with NA #10 who was not working the day of the interview. Both stated when they arrived to work that morning, the Weekend Supervisor informed them that there was not staff in the kitchen and that they needed to prepare resident's their breakfast prior to beginning their assignments. She stated they were told there was dietary staff on their way to come in and assist. NA #9 stated because the dietary staff do breakfast preparation the night before, a lot of the work was started but it was still overwhelming. NA #1 and NA #9 stated some of the dietary staff showed up during the preparation of breakfast on 7/20/24 and took over.

A telephone interview was attempted with the Weekend Supervisor on 7/24/24 at 12:17 PM and a message was left. At the time of exit there was no return call.

An interview was completed on 7/24/24 at 4:00 PM with the Administrator. She stated the Weekend Supervisor did not notify her about there being no dietary staff in the kitchen on 7/20/24. She stated she was uncertain if the Weekend Supervisor notified the Director of

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F 802	Continued From page 56 Nursing (DON) and unable to ask her because DON just resigned and left the facility. She stated the Weekend Supervisor called about the situation in the kitchen on Sunday 7/21/24 when the survey team entered the facility and she immediately contacted the Regional DM that day. She stated she and the Regional DM had since discussed the problems in the dietary department and the issues would be handled between the two of them to assure things were addressed.	F 802		
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, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, test tray tasting, and interviews with staff, residents, and the Regional Registered Dietician (RD), the facility failed to serve food that was palatable in taste and appealing in appearance to 4 of 4 residents reviewed for food (Resident #84, Resident #23 Resident #13 and Resident #17). The findings included: 1a. Resident #84 was admitted on 9/20/23. The quarterly Minimum Data Set dated 6/13/24 indicated Resident #84 was cognitively intact and	F 804	On 7/21/24 and 7/22/24,the residents who were identified in the deficient practice were served an alternate meal with no negative. On 7/31/24, to protect residents in similar situations, residents were interviewed in Food Committee meeting(new Food Service Manager and Activities Director) . Suggestions by the residents were reviewed and implemented by the CDM. Recommendations sent to facility RD for approval.	8/15/24

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F 804

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required only staff set up assistance with her meals.

Review of Resident #84's July 2024 Physician orders indicated she was prescribed a regular diet.

An observation was completed on 7/21/24 at 2:20 PM of Resident #84 eating her lunch. She stated she could hardly eat "that food." On her plate was a baked drumstick that appeared dry and over cooked, mashed potatoes with gravy, boiled or steamed yellow squash. Resident #84 stated the cook in the kitchen just did not know how to properly season food.

Another observation of Resident #84 eating her lunch was completed on 7/22/24 at 12:45 PM. She was served the items observed on the tray line. She stated the food was hot enough but the ham was dry and she didn't recognize what the brown mashed up stuff was on her plate but she wasn't going to eat it. Resident #84 stated only in the past week or so got this bad and she didn't know if they hired a cook that didn't know what they were doing.

1b. Resident #13 was admitted on 10/13/12.

The significant change Minimum Data Set dated 6/27/24 indicated she was cognitively intact and required only staff set up assistance with her meals.

Review of Resident #13's July 2024 Physician orders indicated she was prescribed a regular diet.

An interview was completed on 7/21/24 on 2:40

F 804

On 8/1/14 100% of food service cooks were in-serviced by the new Food Service Manager to cook meals according to the recipe approved by the registered dietician. Any new food service cook will receive this same training prior to cooking a meal.

Beginning on 8/11/24 the new Food Service Manger or designee will audit 5 meals per week for 12 weeks to ensure food is palatable. The new Food Service Manager or designee will interview 5 residents per week for 12 weeks. Results will be brought to Food Service Committee for review Results of the audits will be reviewed by the QAPI committee and the plan of correction will be revised as needed.

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PM with Resident #13. She stated she had recently received her tray. On her plate was a baked chicken drumstick, mashed potatoes with gravy, boiled or steamed yellow squash and apple cobbler. She stated the chicken was over baked and inedible and that she had requested a small salad that was on the way to her now.

An observation of Resident #13 was completed on 7/22/24 at 1:02 PM. On entry to her room, her tray was sitting on her bedside table. She had only ate a few bites of her meal. When questioned if she didn't like the flavor of the food, she stated "no, not really." She stated the kitchen was preparing her a salad and it would be there shortly. She stated she often ordered for the always available menu because she preferred the food items on that menu better.

1c. Resident #23 was admitted on 4/30/21.

The quarterly Minimum Data Set Dated 7/10/24 indicated Resident #23 was cognitively intact and required only staff set up assistance with her meals.

Review of Resident #23's July 2024 Physician orders indicated she was prescribed a low concentrated sweet, no added salt, regular texture diet.

An observation of Resident #23 was completed on 7/22/24 at 12:55 PM with her spouse in the room. She stated she didn't eat her lunch tray. She stated she looked at it, but she didn't want to eat any of it because it didn't look good. She stated the ham looked dry and she didn't recognize the brown mashed up vegetable on her plate but she wasn't going to eat it. She stated

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she was going to eat food her spouse purchased and brought to her.

1d. Resident #17 was admitted on 5/27/23.

The annual Minimum Data Set dated 6/7/24 indicated she was cognitively intact and independent with her meals.

Review of Resident 17 #'s July 2024 Physician orders indicated she was prescribed a regular diet.

An observation of Resident #17 was completed on 7/22/24 at 1:10 PM. Her family member was in the room and had brought in takeout food. Resident #17 stated she didn't eat her lunch today because she knew her family member was coming and bringing her take out but she did look at what they brought and stated it wasn't appealing or appetizing to her. She stated sometimes the food served tasted really good, but it was hit or miss recently. Resident #17 stated up until earlier in the week, what they were served was "pretty tasty, but something happened in that kitchen in the last few days."

On 7/22/24 at 1:17 PM, the Regional DM presented a sample tray to the surveyor. The baked ham appeared dry as if it had been sitting in a bath of juices for an extended period of time. She and the surveyor tasted the ham. It was dry to the point it flaked apart in one's mouth, otherwise, the flavor was palatable. The lima beans were palatable, the greens had a slight taste of lemon but were palatable. The whipped sweet potatoes appeared so dark in color it was difficult to discern them as sweet potatoes. The surveyor and the Regional DM tasted the sweet

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F 804	Continued From page 60 potatoes, and both determined they were unpalatable. The Regional DM stated she suspected the cook added too much cinnamon or some other spices and for some reason, she added a lot of lemon. She stated the sweet potatoes were unpalatable and the cook did not follow the corporate recipe. An interview was completed on 7/24/24 at 4:00 PM with the Administrator. She stated the Regional DM had informed her of the results of the test tray completed on 7/22/24 and since that day, the cook responsible for that meal was no longer employed at the facility. She stated this cook was the DM who was working this past weekend when the survey team entered to no dietary staff assisting her in the kitchen. The Administrator stated there had been no issues with the cook's meal preparation until 7/21/24.	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative	F 809		8/15/24

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F 809	Continued From page 61 meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility failed to serve the lunch meal at the posted time on 7/21/24 in the main dining room and on 3 of 3 halls (100 hall-Lillan's Way, 200 hall-Greene's Commons and 300 hall-Granny's Place). The findings included: An observation was completed on 7/21/24 at 11:50 AM of the area outside of the main dining room. There was a posting titled " Dietary Cart Schedule" which read the following regarding the lunch meal: - main dining room- 12:00 PM - 100 hall (Lillian's Way)- 12:15 PM - 200 hall (Greene's Commons)- 12:30 PM - 300 hall (Granny's Place)- 12:40 PM a. Resident #80 was admitted on 11/23/22. The quarterly Minimum Data Set dated 5/13/24 indicated she was cognitively intact and she was independent with her meals. A review of Resident #80's July 2024 Physician orders included an order dated 4/2/24 for a regular diet. An interview was completed with Resident #80 on 7/21/24 at 1:00 PM in the main dining room. She stated this was the longest she had ever had to wait for her lunch and that this morning was the	F 809	During the week of survey the Food Service Manager and other department heads assisted the kitchen due to insufficient dietary staff so meals could be served on time to serve lunch and all meals at the posted time for the main dining room for halls 100,200, and 300. On 7/26/24 the new Food Service Manager reviewed the dietary schedule with the administrator and Regional Dietician. Arrangements were made to fill in empty shifts with dietary staff from sister facilities so there would be enough staff to serve meals on time, until the facility is able to hire more staff. Advertisements for new dietary staff have been placed in Apploi and Indeed. A corporate recruiter is also assisting with new hires. Beginning 8/2/24, to protect residents in similar situations, the Administrator and the Food Service Manager will monitor the schedules for the dietary department to ensure adequate staffing is schedule. If there are call offs, other departments and other staff will be called or reassigned to assist with meal service. On 8/1/24 the Food Service Manager educated all dietary staff on facility meal times and adhering to the attendance	

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F 809	Continued From page 62 longest she had ever had to wait for her breakfast. She stated her breakfast arrived around 9:45 AM but that she had already eaten something she had in her room but the aides offered her a snack. Another observation was completed in the main dining room on 7/21/24 at 1:30 PM. The trays were being passed and set up for the residents. According to the Dietary Cart Schedule, the trays on the 100 hall were due to arrive at 12:15 PM. On 7/21/24, the lunch trays actually arrived on the hall at 2:15 PM According to the Dietary Cart Schedule, the trays on the 200 hall were due to arrive at 12:30 PM. On 7/21/24, the lunch trays actually arrived on the hall at 2:15 PM. b. Resident #84 was admitted on 9/20/23. The quarterly Minimum Data Set dated 6/13/24 indicated Resident #84 was cognitively intact and required only staff set up assistance with her meals. A review of Resident #84's July 2024 Physician orders included an order dated 4/2/24 for a regular diet. An observation was completed on 7/21/24 at 2:20 PM of Resident #84 who resided on the 200 hall. She stated she this weekend was the worst weekend since she was admitted to the facility when it came to getting her breakfast and lunch at a decent time. She stated she called her daughter today and she was coming to see the Administrator tomorrow.	F 809	policy. Beginning 8/11/24 the Administrator, new Food Service Manager or designee will audit 3 meals per week for adherence to the facility scheduled meal times and adequate staff. Audits will continue for 12 weeks. Results of the audits will be reviewed by the QAPI committee and the plan of correction will be revised as needed.	

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F 809	Continued From page 63 c. According the Dietary Cart Schedule, the trays on the 300 hall were due to arrive at 12:40 PM. On 7/21/24, the lunch trays actually arrived on the hall at 2:30 PM. An interview was completed on 7/22/24 at 12:05 PM with the Regional Dietary Manager (DM). She stated the reason for the late lunch trays was because of what happened yesterday when the surveyor walked in and saw that there was only the Dietary Manager (DM) in the kitchen and that the DM had not notified her or the Administrator. She stated the Administrator notified her once she was notified on 7/21/24 and she diverted staff from neighboring facilities to assist immediately. The Regional DM stated it was unacceptable for any meal to be served outside the posted schedule within reason. She stated things happen that might make the meal be around 15 minutes or so late. The Regional DM stated what occurred on 7/21/24 at lunch and what occurred on 7/20/24 at breakfast where the aides had to started preparation of breakfast until dietary staff arrived that resulting in late breakfast was unacceptable. An interview was completed on 7/24/24 at 4:00 PM with the Administrator. She stated it unacceptable for the residents to receive the meals more than 15-20 minutes outside schedule.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		8/15/24

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F 812	Continued From page 64 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 observation and staff interviews, the facility failed to date leftover food items in the walk-in refrigerator and also failed to store raw meat below fresh produce in the walk-in refrigerator. Raw and thawing meat should be stored below food items to prevent cross-contamination. This was for 1 of 2 observations completed of the walk-in refrigerator and had the potential to affect food served to residents. The findings included: On 7/21/24 at 11:40 AM an observation was completed of the walk-in refrigerator with the Dietary Manager (DM). Inside was observed an unlabeled and undated plastic containers covered with cellophane with what appeared to be left over ground meat, pureed corn bread and beef macaroni with noodles. The DM stated the items should have been labeled when they were placed in the walk-in refrigerator. She stated since they were not labeled, they must be discarded immediately. Also observed in the walk-in	F 812	On 7/21/24 the old Food Service Manager discarded the unlabeled and expired food that was brought to her attention by the survey team. The produce stored beneath thawing protein was immediately discarded. On 7/22/24,to protect residents in similar situations, the old Food Service Manager immediately performed an audit of refrigerators and stock rooms in the kitchen and nourishment rooms to ensure there were no expired, unlabeled, or inappropriately stored food items. No negative findings. On 8/1/2024 the Regional registered dietician and new Food Service Manager educated kitchen staff on policies and procedures for labeling opened food items, discarding expired food items, and storing items appropriately per food	

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F 812	Continued From page 65 refrigerator was a large pork loin inside of a cardboard box thawed out. Below the pork lion was observed a cardboard tray of fresh blueberries packaged in one pint plastic containers with holes to allow for air to circulate to the berries. The DM stated produce should not have been stored below meats and that the blueberries would need to be discarded immediately. The DM was observed removing the unlabeled food and the tray of blueberries from the walk-in refrigerator and discarded the items. She was unable to offer any explanation except to say she was short staff and overwhelmed. An interview and observation was completed on 7/22/24 at 12:10 PM with the Regional Dietary Manager (DM). She stated all leftover food items were to be labeled and discarded after 72 hours and that at no time should meat ever be stored above fruits or vegetables. A tour of the walk in refrigerator was completed. There were no observed concerns.	F 812	category. New hires will be educated upon hire. Beginning 8/11/24 The new Food Service Manager or designee will audit refrigerators and food storage areas 5 days per week for 12 weeks to ensure there are no unlabeled or expired food items and all food items are stored appropriately. Audits will continue for 12 weeks. Results of the audits will be reviewed by the QAPI committee and the plan of correction will be revised as needed.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		8/15/24

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F 842	Continued From page 66	F 842		

must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, 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.

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F 842	Continued From page 67 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to have complete and accurate medical records in the area of wound care. This was for 1 of 2 residents (Resident #40) reviewed for wound care. The findings included: Resident #40 was admitted to the facility on 8/14/19 with diagnoses that included peripheral vascular disease and diabetes. A review of Resident #40's active physician orders included an order dated 6/22/24 to cleanse wound to the right heel with normal saline, pat dry, apply calcium alginate to the wound bed and cover with foam dressing every three days. Review of a Wound Nurse Practitioner (NP) progress note dated 7/10/24 revealed the vascular wound to Resident #40's right heel was resolved. A new order to apply skin prep and leave open to air was indicated. The July 2024 Medication Administration Record	F 842	On 7/24/24 the medical record for resident #40 was corrected to reflect current treatment order and preventive skin care. On 8/1/24, to protect residents in similar situation, the Director of Nursing or designee completed an audit of all other wound orders to ensure the medical record was correct and the resident had the correct wound order was in place. No other issues were identified. On 8/4/24 the wound nurse was educated by the Regional Director of Clinical Services to have a second nurse verify all new orders written by the wound provider during wound rounds. All licensed nurses were educated by the Regional Director to have two nurses verify the wound orders that the provider completes weekly with wound rounds so medical records are correct. After 8/4/24 all new licensed nurses and agency nurses will receive this same education prior to their next shift.	

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F 842	Continued From page 68 (MAR) was reviewed and included an order to cleanse Resident #40's right heel with normal saline, pat dry, apply calcium alginate to the wound bed and cover with foam dressing every three days. There was no order to provide skin prep to Resident #40's right heel. Wound care with calcium alginate was signed off as completed 7/13/24 and 7/16/24. On 7/24/24 at 12:15 PM, an interview occurred with the Wound Care nurse who reviewed Resident #40's July 2024 MAR and wound care progress note dated 7/10/24. She acknowledged the vascular wound to Resident #40's right heel was resolved on 7/10/24 and the order for wound care should have been discontinued. In addition, the Wound Care nurse verified the order for skin prep to the right heel was not showing in Resident #40's active physician orders. She felt this was an oversight. An observation of wound care on Resident #40 occurred on 7/24/24 at 12:40 PM with the Wound Care nurse. An area of pink closed skin was present to the right heel. An interview occurred with the Administrator on 7/25/24 at 9:00 AM and stated that she would expect Resident #40's medical record to be accurate.	F 842	Beginning 8/11/24 the Director of Nursing or designee will audit 3 resident records per week to ensure that the correct order is in place for wound care. Audits will continue for 12 weeks. The results of the audits will be reviewed by QAPI Committee and change to the plan will be made as needed.	