STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345319	A. BUILDING _____ B. WING _____	C 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERBERRY HEALTH CARE	**415 ELDERBERRY LANE MARSHALL, NC 28753**

(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 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		10/25/24

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

Electronically Signed | 09/19/2024

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) plan. The EP plan did not include a written policy and procedure for sewage and waste disposal in the event of an emergency. The plan did not have a system to track residents and staff in the event their EP plan was implemented. The EP Plan did not include names and contact information for staff and resident physicians. The facility failed to ensure all direct care staff were trained annually on the EP Plan. This had the potential to affect all residents and staff. The findings included: A review of the facilities supplied Emergency Preparedness (EP) plan revealed the Administrator had reviewed the material in October 2023. The following areas were not present in the supplied EP plan: A. The facilities EP plan did not have a written policy and procedure for sewage and waste disposal in the event of an emergency. B. The facilities EP plan did not contain a system to track the location of on-duty staff and sheltered residents during an emergency. C. The facilities EP plan did not contain a list of staff names and contact information or	E 001	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. No residents were affected by this deficient practice On 09/04/24, the Administrator and Maintenance Director reviewed the facility□s emergency preparedness plan and procedures and made the following updates: A. A written policy and procedure for sewage and waste disposal in the event of an emergency was developed on 09/04/24. B. A system to track the location of on-duty staff and sheltered residents during an emergency was added on 09/04/24.	

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E 001	Continued From page 2 names/contact information for the residents' physicians. During an interview on 8/28/24 at 3:55pm with the Administrator, she said they had a 50,000-gallon holding tank but verified there was not a written policy and procedure for sewage and waste disposal in the EP plan. The Administrator said the tracking sheet would be developed when an emergency arose and that they did not have a tracking form/sheet present and/or developed in their EP book. The Administrator verified there was no contact information for staff or resident physicians in the EP book. She stated, "if we put one in here then we have to keep it updated". The Administrator stated she was responsible for contact information being updated in the EP book.	E 001	C. A list of staff names and contact information was added on 08/30/24. The names and contact information for the residents□ physicians was added on 08/30/24. All residents have the potential to be affected. On 09/18/24, The Administrator reviewed the updated emergency preparedness plans with the quality assurance committee including the Director of Nursing, Assistant Director of Nursing, Business Office Manager, Social Worker, MDS Nurses, Medical Records, Activities Director, Dietary Manager, Maintenance Director, and Medical Director. The quality assurance committee will continue to review and update the emergency preparedness plans at least annually and as needed. On 09/25/24, the Administrator trained all direct care staff (full time, part time, and contract including agency staff) on the facility□s emergency preparedness plans. Any direct care staff that did not receive this education by 10/25/24 will not be allowed to work until they receive the education. Newly hired direct care staff and agency staff will receive the education the facility□s emergency preparedness plans during their orientation. The Administrator will direct the Quality	

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E 001	Continued From page 3	E 001	Assurance Committee to review the Emergency Preparedness Plan for updates and revisions during the monthly quality assurance and performance improvement meetings to ensure any necessary changes or updates have been incorporated/reviewed and signed as appropriate. Completion Date 10/25/2024	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 08/25/24 through 08/28/24. The following intakes were investigated: NC00217937, NC00209515, and NC00208341. One of the 4 complaint allegations resulted in deficiency. Event ID# NSHS11.	F 000		
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	F 575		10/25/24

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F 575	Continued From page 4 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 interviews, the facility failed to post 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, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. This observation occurred for 3 of the 4 days during the onsite recertification survey. The findings included: An observation of the facility's front hallway bulletin board was completed on 08/25/24 at 4:20 PM during end of day rounding. The observation revealed no signage or posting which included name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. All other hallways and common areas within the facility were observed which revealed no signage or posting which included name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the	F 575	No residents were affected by this deficient practice. On 09/04/24, the Administrator posted 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, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network on the bulletin board in front hallway of facility near the entrance to the lobby. All residents have the potential to be affected. On 09/18/24, The Administrator trained the the Director of Nursing, Assistant Director of Nursing, Business Office Manager, Front Office Manager, Social Worker, Activities Director and MDS Coordinator on the requirement to have 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,	

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F 575	Continued From page 5 protection and advocacy network. On 08/26/24 at 4:05 PM, an observation was completed, and the facility's front hallway bulletin board was observed to be in the same state. The front hallway bulletin board did not include name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. On 08/27/24 at 9:07 AM, an observation was completed of the front hallway bulletin board. The front hallway bulletin board continued to not include name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. During an interview with the Activities Director on 08/27/24 at 11:05 AM she stated there were Ombudsman posters with name/contact information posted throughout the facility. The Activities Director stated the other contact information inclusive of State Agency, State Long Term Care Ombudsman program, protection and advocacy group, and adult protective services, was posted at the front entrance as visitors leave the facility. An observation was completed with the Administrator and Activities Director on 08/27/24 at 11:07 AM of the posting board in the front hallway of the facility. The observation revealed no signage of the other required postings to	F 575	adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network posted in a form and manner accessible and understandable to residents and resident representatives. The training also included information about ensuring the facility□s postings are to be on the bulletin board at front entrance to facility and are not to be removed. The Administrator or designee will audit the required postings weekly for 4 weeks and then monthly for 2 months to ensure the required postings are still posted in the facility. Audit results will be documented on the audit tool titled Required Postings. The Administrator will present the audit results in the monthly Quality Assurance Performance improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 10/25/2024	

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F 575	Continued From page 6 include the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. During an interview with the Administrator on 08/27/24 at 11:13 AM she stated the information should be posted with Regional, State, Local Ombudsman contact information and telephone number. The Administrator also stated the State Agency and other advocacy groups contact information and telephone numbers should be posted as well. The Administrator explained she updated the board as needed and verbalized there was signage in place with the State Agency contact information and telephone number as well as other advocacy group information. She continued to explain someone must have taken down the signage but was uncertain when the signage was removed and by whom from the front hallway bulletin board.	F 575		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or	F 600		10/25/24

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F 600	Continued From page 7 physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to protect a resident's right to be free from resident-to-resident abuse when Resident #74 struck Resident #73 on the left side of the head with a statue after Resident #74 believed Resident #73 was going to enter her room. Resident #73 sustained a laceration to the left side of his head requiring steri strips (an alternative to sutures). This affected 1 of 3 residents (Resident #73) reviewed for abuse. The findings included: Resident #74 was admitted to the facility on 08/16/2023 with diagnosis that included Unspecified dementia, unspecified severity, without behavioral disturbance (milder or mixed dementia with milder or nonaggressive behaviors), psychotic disturbance, mood disturbance, and anxiety. A review of Resident #74's Minimum Data Set (MDS) dated 05/22/2024 indicated her cognition was intact. She was not documented as having any behavioral issues. A review of Resident #74's care plan dated 6-3-24 did not indicate any goals set for behaviors or any interventions for behavioral issues. The record review for Resident #73 revealed, on 06/04/2024 at 7:59pm there was a resident-to-resident altercation involving Resident #73 and Resident #74. Resident #73 was standing outside Resident #74's room and	F 600	Resident #74 was assessed on 6/4/24, no injuries were noted. Resident #73 was assessed for injuries on 6/4/24 and noted to have the laceration to the left side of his head. The residents were immediately separated by the nurse with increased staff monitoring to prevent further altercations. This incident was investigated and reported to the North Carolina Healthcare Personnel Registry on 06/04/24. The local police department was also notified of the incident on 06/04/24. Resident #74 was discharged from the facility on 06/11/2024. On 06/05/24 the Director of Nursing, Assistant Director of Nursing & Social Worker interviewed all alert and oriented residents asking if they are treated with dignity and respect, if they feel safe, and if they knew who to report any concerns to. No other concerns or issues of abuse were identified during interviews. residents voiced that they knew to report any abuse allegations to Director of Nursing, Administrator or any Nurse or Staff Member. On 09/18/24 all current residents who are unable to cognitively report abuse had a skin assessment completed by the Director of Nursing, Assistant Director of Nursing, Charge Nurse and/or her designee on 06/05/24. No suspicious bruising or other issues were identified-	

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F 600	Continued From page 8 Resident #74 was yelling at Resident # 73 to move away from her room. Resided #73 was standing in the hallway near Resident #74's room looking outside the door end of the hall. Resident #73 did not leave when requested by Resident #74, she struck him with a wooden statue on the left side of his head. This caused Resident #73 to have an approximately one-inch laceration on his left temple. Nurse Aide (NA) #3 witnessed this incident and immediately requested assistance from a nurse and took Resident #73 back to his room where Resident #73's wound was cleaned and treated with steri strips and a bandage. Resident #74 was behaving his normal self and no infection was noted. On 08/28/2024 at 1:24pm a telephone interview was conducted with NA #3. NA #3 recalled the incident from 06/04/2024. She stated she was on her way to the laundry room when she heard Resident #74 yelling, and she observed Resident # 74 hit Resident # 73 on his head. She added that she ran towards Resident #73 and moved him away from Resident # 74. She stated she got the attention of a nurse (name unknown). She stated that Resident #74 informed her Resident #73 was trespassing in her room, and he should not have been there. NA #3 added Resident #73 was only in front of Resident #74's room and not inside her room. NA #3 stated she explained to Resident #74, that Resident #73 did not know what he was doing. She further stated she along with the nurse brought Resident #73 to his room. She stated she left the Resident's room when the NA (name unknown) from that hall entered the room. She stated she did not know Resident #74 as she worked in the Rehab Hall. She further added, she had known Resident #73 in passing, to be always smiling, and a happy person.	F 600	may need to change if concerns are noted. On 08/27/24, the Administrator met with the quality assurance committee including the Director of Nursing, Assistant Director of Nursing, Business Office Manager, Social Worker, MDS Nurses, Medical Records, Activities Director, Dietary Manager, Maintenance Director, and Medical Director to review regulation F600: Free from Abuse and Neglect and the facilities abuse and neglect policy to ensure adequate procedures are in place for preventing abuse and neglect including resident to resident altercations, and reporting and investigating any case of abuse or neglect. Abuse policy was reviewed and updated 08/27/24 to ensure timeline for reporting allgiations of abuse requiements were identified in the policy. On 9/9/24 and 9/26/24, the Administrator, Director of Nursing or Designee trained all staff (full time, part time, and contract including agency staff) on the regulation F600: Free from Abuse and Neglect and the facility□s abuse policy including procedures to prevent abuse including resident to resident altercations, and the requirement to report and investigate any case abuse or neglect. Any staff that did not receive the abuse education by 10/25/24 will not be allowed to work until they receive the education. Newly hired staff and agency staff will receive the abuse education during their	

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F 600	Continued From page 9 The Administrator was interviewed on 08/28/2024 at 2:33pm. She explained the facility policy or process to deal with abuse situation. She stated they had physically assessed Resident #73 and Resident #74. She added, they would bring the doctor in the facility to assess the Residents involved or would send the residents to the hospital on doctor's order. She stated they would investigate the situation and interview staff and other residents that may have witnessed the abuse. She further stated that they would separate the residents, so they were not close to each other to prevent future altercations. She stated they monitored the residents after the incident. An attempt to interview the Director of Nursing on 08/28/2024 at 3:00pm was unsuccessful.	F 600	orientation. The Administrator, Social Worker or designee will interview 5 residents weekly for 4 weeks and then 5 residents monthly for 2 months to ensure there are no concerns regarding abuse including resident to resident altercations. Audit results will be documented on the audit tool titled Resident Interviews- Free from Abuse and Neglect. The Director of Nursing, Assistant Director of Nursing or Designee will observe 5 residents to resident interactions weekly for 4 weeks then monthly for 2 months to ensure there are no concerns with abuse including resident to resident altercations. Audit results will be documented on the audit tool titled Resident Interactions Observations. The Social Worker and Director of Nursing will present the audit results in the monthly Quality Assurance Performance Improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 10/25/2024	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		10/25/24

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F 695	Continued From page 10 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to apply signage indicating the use of oxygen outside residents' rooms with supplemental oxygen for 2 of 2 residents reviewed for oxygen use (Resident # 69 and Resident # 273). The findings included: 1.Resident # 69 was admitted on 08/02/2024 with diagnoses of Chronic Obstructive Pulmonary Disease and Emphysema. A physician's order for Resident # 69 dated 08/03/2024 read may use and titrate oxygen (O2) to maintain oxygen levels between 88-92% every shift. Review of the admission Minimum Data Set (MDS) dated 8/09/2024 indicated Resident # 69 was cognitively intact and coded for the use of oxygen intermittently. During an observation on 08/25/24 at 1:11pm of Resident #69's room, there was no signage for oxygen use found anywhere near Resident # 69's room entrance. Resident # 69 was observed wearing oxygen via nasal cannula at 3.5 liters per minute (LPM). The oxygen concentrator was observed on the left side of the bed when facing the bed in Resident # 69's room.	F 695	An oxygen in use sign was placed outside resident #69□s room by Assistant Director of Nursing on 08/30/24. An oxygen in use sign was placed outside resident #273□s room by Assistant Director of Nursing on 08/30/24. The Director of Nursing and Assistant Director of Nursing completed an audit of all current residents with oxygen orders on 09/04/24 to ensure there was an oxygen in use sign outside of each resident□s room. There were no other rooms identified without oxygen signs. On 09/04/24, the Director of Nursing and Assistant Director of Nursing reviewed the process for ensuring the oxygen in use signs were placed outside of each resident with oxygen□s room. It was determined that when a new order was written for oxygen use, the staff nurse would be responsible for making the Ward Clerk aware of the new oxygen orders and the ward clerk would place the oxygen in use sign on the resident□s door. If the oxygen is implemented during hours the ward clerk is not working, the staff nurse on duty will be responsible for posting the oxygen in use sign outside the resident□s	

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ELDERBERRY HEALTH CARE	415 ELDERBERRY LANE MARSHALL, NC 28753

(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 695	Continued From page 11 During an observation on 08/25/24 at 04:22 PM there was no signage for oxygen use found anywhere near entrance of Resident # 69's room. During an observation on 08/26/24 at 11:24 am there was no signage for oxygen use found anywhere near entrance of Resident # 69's room. An interview with Nursing Assistant (NA)#4 occurred on 08/27/24 at 08:32 AM. The NA said he was responsible for making sure a concentrator was in the room and changing the resident's oxygen tubing from the oxygen tank to the concentrator when the resident arrived. During an interview with Nurse #2 on 08/27/24 at 08:36 AM she stated she would make sure there was an order for oxygen, make sure to have an oxygen tank, and tubing, ready to go prior to a resident being admitted. Nurse #2 stated she would make sure the resident's oxygen was at a good level when they were admitted, she would make sure oxygen was applied to the resident and make sure they were monitored. She stated the nurse on the hall was responsible to put up signage for oxygen use. She did not know how it was missed on admission for Resident #69. She stated she should have caught it yesterday (8/26/24) but was busy. An interview occurred on 08/27/24 at 08:41 with the Director of Nursing (DON). She stated it was the nurse's responsibility to put up the oxygen in use sign on the resident's door, but if it was not done then the Ward Clerk would check during weekly rounds. The DON discussed the Ward Clerk was still in training and she had forgot to tell her about that responsibility. The DON stated the	F 695	room door. The oxygen in use signs will be kept available in the clean utility room across from Nurses Station. On 09/18/24, the Director of Nursing and Assistant Director of Nursing provided traininf for the Ward Clerk and all licensed staff nurses (full time, part time, and contract including agency nurses) on the requirement to post an oxygen in use sign outside of each resident□s room where oxygen is in use. The training also reviewed the process for the nurses to make the ward clerk aware of any new oxygen orders so the ward clerk could place the oxygen in use sign outside of the resident□s room. If the oxygen is implemented during hours the ward clerk is not working, the staff nurse on duty will be responsible for posting the oxygen in use sign outside the resident□s room door. The oxygen in use signs will be kept available in the clean utility room across from Nurses Station. Maintenance has placed permanant No Smoking sign on all resident rooms. Any Licensed Nurses or Ward Clerks that did not receive the education by 10/25/24 will not be allowed to work until they receive the education. Newly hired Licensed Nurses and Ward Clerks and agency Nurses will be educated on the requirements and process for posting the oxygen in use sign outside of residents room when oxygen is in use during their orientation.	

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F 695	Continued From page 12 only admission check list they have was in the electronic record. During an interview on 08/27/24 at 08:46 AM with NA#5 who was the new Ward Clerk, she stated she tried to check on 8/26/24 for oxygen signs, and that she thought she had most of them. NA #5 stated if a resident did not have an oxygen use sign, she would let the DON know and DON would get a sign made. An interview on 08/27/24 at 10:51 AM occurred with the Administrator. The Administrator stated the Ward Clerk was responsible for placing the oxygen use sign on the resident's door. She stated NA #5 had not fully taken over that position and had not completed the full orientation. 2. Resident # 273 was admitted 08/15/2024 with diagnoses of Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure with Hypercapnia, Obstructive Sleep Apnea, Chronic Respiratory failure with Hypoxia. Review of the Admission documentation dated 8/15/2024 revealed Resident # 273 was Cognitively intact. A physician's order for Resident # 273 dated 08/15/2024 read Baseline oxygen (O2) at 4 liters. May titrate O2 via nasal canula to keep oxygen level above 90%. Notify provider for increased O2 demand. During an observation on 08/25/24 at 01:21 PM of Resident # 273's room, there was no signage for oxygen use found anywhere near Resident #273's room entrance. Resident # 273 was observed wearing oxygen via nasal cannula at	F 695	The Director of Nursing, Assistant Director of Nursing or designee will audit 5 residents with oxygen weekly for 4 weeks and then monthly for 2 months to ensure the required oxygen in use sign is posted outside their room. Audit results will be documented on the audit tool titled Oxygen in Use Signage. The Director of Nursing will present the audit results in the monthly Quality Assurance Performance Improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 10/25/2024	

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F 695	Continued From page 13	F 695		

2.5 liters per minute (LPM). The oxygen concentrator was observed on the left side when facing the bed in Resident # 273's room.

During an observation on 08/25/24 at 04:23 PM there was no signage for oxygen use found anywhere near Resident 273's room entrance.

During an observation on 08/26/24 at 11:25 am there was no signage for oxygen use found anywhere near Resident 273's room entrance.

An interview with Nursing Assistant (NA)#4 occurred on 08/27/24 at 08:32 AM. The NA said he was responsible for making sure a concentrator was in the room and changing the resident's oxygen tubing from the oxygen tank to the concentrator when the resident arrived.

During an interview with Nurse #2 on 08/27/24 at 08:36 AM she stated she would make sure there was an order for oxygen, make sure to have an oxygen tank, and tubing, ready to go prior to a resident being admitted. Nurse #2 stated she would make sure the resident's oxygen was at a good level when they were admitted, she would make sure oxygen was applied to the resident and make sure they were monitored. She stated the nurse on the hall was responsible to put up signage for oxygen use. She did not know how it was missed on admission for Resident #69. She stated she should have caught it yesterday (8/26/24) but was busy.

An interview occurred on 08/27/24 at 08:41 with the Director of Nursing (DON). She stated it was the nurse's responsibility to put up the oxygen use sign on the resident's door, but if it was not done then the Ward Clerk would check during weekly

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F 695	Continued From page 14 rounds. The DON discussed the Ward Clerk was still in training and she had forgot to tell her about that responsibility. The DON stated the only admission check list they have was in the electronic record. During an interview on 08/27/24 at 08:46 AM with NA#5 who was the new Ward Clerk, she stated she tried to check on 8/26/24 for oxygen signs, and that she thought she had most of them. NA #5 stated if a resident did not have an oxygen use sign, she would let the DON know and DON would get a sign made. An interview on 08/27/24 at 10:51 AM occurred with the Administrator. The Administrator stated the Ward Clerk was responsible for placing the oxygen use sign on the resident's door. She stated NA #5 had not fully taken over that position and had not completed the full orientation.	F 695		
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.	F 732		10/25/24

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F 732	Continued From page 15 §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. (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 staff interview and record review, the facility failed to ensure daily nurse staffing sheets were completed daily for 18 of the 59 days (07/05/2024, 07/06/2024, 07/07/2024, 07/13/2024, 07/14/2024, 07/20/2024, 07/21/2024, 07/28/2024, 07/29/2024, 08/01/2024, 08 /02/2024, 08/03/2024,08/04/2024, 08/10/2024, 08/11/2024, 08/17/2024, 08/18/2024, and 08/24/2024) reviewed for nurse staffing information. The findings included: Observation on 08/25/2024 at 11:00am revealed the daily nurse staffing sheet posted at the nurses' station was dated 8/23/24. There were no	F 732	No residents were affected by this deficient practice. The daily posting of nurse staffing information for 8/25/24 was posted on 08/25/24 at 2:30pm by Charge Nurse. All residents and visitors have the potential to be affected. The Administrator and Medical Records audited the daily postings for nurse staffing from 8/29/24 - 9/15/24 on 09/18/24 to ensure daily staffing information sheets were posted daily and maintained. There were no dates identified during audit without daily posting of nursing staff.	

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F 732	Continued From page 16 daily nurse staffing sheets for 8/24/24. Review of the daily nurse staffing sheets from 07/01/2024 to 08/28/2024 indicated there were no daily nurse staffing sheets for the following days 07/05/2024, 07/06/2024, 07/07/2024, 07/13/2024, 07/14/2024, 07/20/2024, 07/21/2024, 07/28/2024, 07/29/2024, 08/01/2024, 08 /02/2024, 08/03/2024,08/04/2024, 08/10/2024, 08/11/2024, 08/17/2024, 08/18/2024, and 08/24/2024. An interview occurred on 08/28/24 at 4.43PM with the Medical Record Staff responsible for posting staff information. The Medical Record staff stated that he was responsible for posting the daily nurse staffing sheets every morning on weekdays. He further added on weekends and on his days off the charge nurse was responsible for posting the daily nurse staffing sheet. He specified the following days 07/05/2024, 07/06/2024, 07/07/2024, 07/13/2024, 07/14/2024, 07/20/2024, 07/21/2024, 07/28/2024, 07/29/2024, 08/01/2024, 08/02/2024, 08/03/2024,08/04/2024, 08/10/2024, 08/11/2024, 08/17/2024, 08/18/2024, and 08/24/2024, were either weekends or his days off. He indicated on these days; the charge nurses would have had to post the nurse staffing on the board. An interview with the Administrator on 08/28/24 at 05:15 PM was completed. The Administrator indicated medical records staff was responsible to post the daily nurse staffing information on the board near the nurse's station. When he was out on leave and/or on weekends the charge nurse for the day was responsible to post this information. She stated she was not aware that in the absence of the Medical Record staff the charge nurse was not posting the daily nurse	F 732	The Administrator, Director of Nursing, and Medical Records reviewed the process for ensuring the nurse staffing information is posted daily and maintained for a minimum of 18 months. Charge Nurse will be responsible for posting the nurse staffing information daily. The Director of Nursing will serve as a backup to post the nurse staffing information if both medical records and the charge nurse are not on duty. Medical Records will be responsible for collecting and maintaining a file with the daily nurse staffing information postings for a minimum of 18 months. On 09/18/24, The Administrator trained the Director of Nursing, Medical Records, Assistant Director of Nursing and the Charge Nurses on the requirement to post the following information on a daily basis at the beginning of each shift in a clear and readable format in a prominent place accessible to residents and visitors: (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.	

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F 732	Continued From page 17 staffing sheet on the board. She did not specify if anyone checked the postings to ensure they were being completed.	F 732	The training also included information on the facility□s process for which disciplines are responsible for posting the nurse staffing information and the requirement for maintaining the posted daily nurse staffing data for a minimum of 18 months, or as required by state law, whichever is greater. Newly hired Charge Nurses, Medical Records personnel and/or Director of Nursing will be educated on the requirement and procedure for posting the nurse staffing information and maintaining the posted nurse staffing data for a minimum of 18 months, or as required by state law, whichever is greater. The Administrator or designee will observe the required daily nurse staffing information postings daily for 4 weeks and weekly for 2 months to ensure the required postings are posted in the facility. Audit results will be documented on the audit tool titled Nurse Staffing Posting. The Administrator will present the audit results in the monthly Quality Assurance Performance Improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 10/25/2024	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		10/25/24

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F 812	Continued From page 18 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure ready to use dishware was clean and not stacked wet, label and date leftover perishable foods in the walk-in cooler. This occurred for 1 of 2 kitchen observations. The findings included: 1. The initial tour of the kitchen occurred on 8/25/24 at 11:55am with Cook #1. The initial observation of the serving line and dishware area revealed the following: a. Dishware that was ready for use was put away and stacked wet. -7 out of 10 divided plates -11 out of 20 domed lids and bottoms -6 out of 20 trays	F 812	a. The wet dishware in storage including the 7 divided plates, 11 domed lids and bottoms, and 6 trays were rewashed and dried by the Dietary Aide on 08/25/24. b. The dishware with debris on them including the 7 divided plates, 1 red plate, 1 tray, and 6 domed lids and bottoms were rewashed and dried by the Dietary Aide on 08/25/24. c. The 3 large plastic bags of cheese that were not dated were discarded on 08/25/24 by the Cook. All residents have the potential to be affected. On 08/30/24 the Dietitian Consultant completed an audit of all food	

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F 812	Continued From page 19 b. Dishware that was ready for use was put away and/or stacked with white and yellow debris on them. -7 out of 10 divided plates had white and yellow dried debris. -1 out of 2 red plates had black and yellow dried debris. -1 out of 20 trays had a clear sticky substance present, substance was shiny when observed and was sticky when touched. -6 out of 20 domed lids and bottoms had dry white and yellow debris c. 3 large plastic bags that were not dated contained opened and partially used packages of yellow sliced cheese not individually wrapped in the walk-in cooler. During an interview with Cook #1 on 8/25/24 at 12:16pm Cook #1 said the open bagged cheese in the walk-in cooler should have been dated and did not know why it was not. During an interview with Dietary Manager on 08/26/24 at 08:57 am, Dietary manager stated divided plates, plates, trays and domed lids and bottoms should stay in the rack until dry. The Dietary Manager stated opened bagged items in the walk-in fridge should be dated. During an Interview On 08/28/24 at 05:24 PM the Administrator stated she expected open food to be labeled and dishes to be properly washed, dried and clean.	F 812	in storage to ensure all open food items were labeled and dated and of all dishware in storage to ensure all dishes were clean, free of debris, and dry. Dietitian did not identify any open food items that were unlatched or undated and all dishware storage were dry, clean and free of debris. All Dietary staff (full time, part time, and contract) were re-educated by the Dietary Consultant 08/30/24 on the following topics: " Labeling and dating all open food items in storage. " Washing dishware, ensuring all debris is removed from the dishware, dishes are clean and dry before placing the dishware back in storage. Any Dietary staff that did not receive the education by 10/25/24 will not be allowed to work until they receive the education. Newly hired Dietary staff will be educated on all topics listed above during their orientation. The Dietary Manager or designee will complete an audit weekly to ensure all dishware is stored clean, free of debris, and dry weekly for 4 weeks and then monthly for 2 months. Audit results will be documented on the audit tool titled Clean and Dry Dishware Audit. The Dietary Manager or designee will complete an audit weekly to ensure all open food items in storage are labeled and dated for 4 weeks and then monthly for 2 months. Audit results will be documented on the	

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F 812	Continued From page 20	F 812	audit tool titled Food Storage Audit. The Dietary Manager will present the audit results in the monthly Quality Assurance Performance Improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 10/25/2024	
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to contain trash when the dumpster doors were not closed and failed to keep the area around the dumpsters free of accumulated trash and debris for 2 of 2 dumpsters observed. The findings included: An observation was completed on 08/25/24 12:24 PM. The observation revealed two dumpsters, the 1st dumpster door was three quarters open, and the 2nd dumpster door was completely open with bags of trash that were viewable inside the dumpster. Trash and debris were noted around both dumpsters. The trash around both dumpsters included used plastic gloves, tissues, plastic cup, and a plastic food container with light brown food debris inside the lid of the container. The 2nd dumpster had sign reminding staff to close the dumpster doors due to bears in the area.	F 814	No residents were affected by this deficient practice. On 08/26/24, Maintenance cleaned up the trash and debris including the used plastic gloves, tissues, plastic cup, and a plastic food container with light brown food debris inside the lid of the container around both dumpsters and ensured the doors on the dumpsters were closed. All residents have the potential to be affected. All staff (full time, part time, and contract) were re-educated by the Administrator or Dietary Manager on 09/08/24 on the following topics: a)ensuring the dumpster doors stay closed, b) no trash is left outside the dumpsters, and c) the area around the dumpsters remains the clean.	10/25/24

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F 814	Continued From page 21 Cook #1 was interviewed on 08/25/24 at12:27 PM because the Dietary Manager was not available. Cook #1 verified the dumpster doors were open, and there was trash/debris around the dumpsters. Cook #1 closed the dumpster doors. He stated that he checked the dumpsters and made sure the doors were closed at the end of his shift and that all shifts were supposed to check the doors to ensure they were closed and check for any trash around the dumpster. An interview was completed on 8/26/2024 at 9:01am with the Dietary Manager. Dietary Manager was informed of observations made on 8/25/2024 with Cook #1. The Dietary Manager stated he had placed the sign on the dumpster because they had previously had an issue with bears in the dumpster and stated the dumpster doors should remain closed and there should not be trash and debris around the dumpsters. He also stated all staff were responsible for ensuring the dumpster doors remained closed and no trash was left on the ground. An interview was completed on 08/28/24 at 05:24 PM with the Administrator. The Administrator stated she would expect dumpster doors to be closed and for no trash to be around dumpsters.	F 814	Any staff that did not receive the education by 10/25/24 will not be allowed to work until they receive the education. Newly hired staff will be educated on ensuring the dumpster doors stay closed, no trash is left outside the dumpsters, and area around the dumpsters remains the clean during their orientation. The Dietary Manager or designee will audit the dumpsters to ensure the area around the dumpsters is clean, free of debris, and the dumpster doors are closed weekly for 4 weeks and then monthly for 2 months. Audit results will be documented on the audit tool titled Dispose Garbage Audit. The Dietary Manager will present the audit results in the monthly Quality Assurance Performance Improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 10/25/2024	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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	F 842		10/25/24

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agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained

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F 842	Continued From page 23 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain a complete and accurate medical record when 1) staff documented that they provided suctioning to a resident twice a day when suctioning had not been provided and 2) staff failed to document treatment provided to resident after they sustained a laceration to the left lower leg. This occurred for 2 of 2 residents (Resident #4 and Resident #75) reviewed for accurate medical record. The findings included: 1. Resident #4 was admitted on 03/02/2017 with diagnosis including acute and chronic respiratory failure with hypoxia and tracheostomy status. A physician's order dated 1/14/2024 read	F 842	On 08/28/24, the Director of Nursing made the Physician aware that resident #4 was not receiving routine tracheostomy suctioning as ordered. The current suctioning order was reviewed with the Physician and the order was changed to suctioning as needed or when resident allowed. Resident #75 is not a current resident in the facility. The Director of Nursing and Assistant Director of Nursing completed an audit of all residents with suctioning orders on 09/10/24 to ensure the Staff Nurses have been accurately documenting that suctioning was performed and/or refusals	

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F 842	Continued From page 24 Tracheostomy Suctioning every 12 hours for secretions. A review of the quarterly Minimum Data Set (MDS) dated 08/14/2024 showed Resident #4 was moderately cognitively impaired and was documented for suctioning and tracheostomy care. A review of the Medication Administration Record (MAR) for the month of August 2024 revealed Resident #4 had suctioning completed 50 out of 51 times. During an interview on 08/26/24 at 9:18 AM with Nurse #1 stated Resident #4 was only suctioned in a dire emergency, that Resident #4 hated to be suctioned. During a phone interview on 08/27/24 at 10:02 AM Nurse #6 said Resident #4 was suctioned as needed. Nurse #6 said Resident #4 did not like to be suctioned but sometimes she did require it, but not that often. Nurse #6 said she had suctioned Resident #4 "maybe" 5 times. Nurse #6 had documented that she had suctioned Resident #4 11 times in August of 2024 by review of the MAR. Nurse # 6 said she was aware of an order that if the resident needed to be suctioned then do it. Nurse #6 stated "I have not suctioned Resident #4 11 times. I understood the order meant to assess for the need to be suctioned". Nurse #6 said maybe she misunderstood the prompt on the computer. During a telephone interview on 08/27/24 at 10:17 AM Nurse #7 said Resident #4 had not needed to be suctioned because she cleared her secretions out on her own. Nurse #7 stated she had not	F 842	or when administration of suctioning did not occur. All residents with suctioning orders had complete and accurate documentation during audit. The Director of Nursing and Assistant Director of Nursing completed an audit of all current residents with wounds on 09/18/24 to ensure there were documented assessments of each wound including a description of the wound in their medical record and treatment was performed as ordered. During audit of wound documentation, no othe residents were identified. The Administrator, Director of Nursing and Assistant Director of Nursing reviewed the current process for documentation for suctioning orders and how to input orders into the electronic medical record to allow the nurses to document when suctioning was not provided as ordered and the reason why. The licensed nurses will be required to document the reason the suctioning was not provided in the medical record and to notify the physician when the suctioning has not been provided for three consecutive orders. The order will be updated as needed. The Administrator, Director of Nursing and Assistant Director of Nursing reviewed the current process for assessing and documenting new wounds in the medical records. The Licensed Nurses will be required to document a wound assessment including a description of the wound and measurements in the medical	

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suctioned Resident #4 since the end of June 2024. Review of the August 2024 MAR revealed Nurse #7 signed she had suctioned Resident #4 12 times. Nurse #7 reviewed how the order was written and stated "yeah, I do see that I would need to chart no in the future."

During an interview on 08/27/24 at 10:32 with Nurse #1, the nurse said on average she had suctioned Resident #4 three times per month "if that much". Per review of Resident #4's MAR, Nurse #1 had signed off that she suctioned Resident #4 12 times in August 2024. Nurse #1 stated she had only suctioned Resident # 4 one time in August. The nurse stated she was unaware she could document that suctioning was not provided.

During an interview on 08/27/24 at 10:40 AM with the Director of Nursing (DON), the DON said spot checks on accuracy of the MAR's were completed by the DON, or Assistant Director of Nursing (ADON). The DON said the order should be changed to just be as needed and she stated she was unaware the nursing staff were mis-documenting.

During an interview on 08/27/24 at 10:45 AM the Administrator said the ADON and Nurse consultant monitor the MAR for accuracy, but the Administrator did not know the schedule of how often. The Administrator said the Nurse Consultant came in about every other month, otherwise the MARs were looked at randomly. The Administrator said the DON trained staff in the computer system. The Administrator said maybe Resident #4 was being suctioned daily at one time, but the order was never changed. The Administrator said it would need to be reviewed in

record when the wound is first identified. All wounds will then be assessed weekly with a documented wound assessment until the wound is healed. All wound care orders and treatments will be documented on the treatment administration record and signed off upon completion.

On 9/9/24 and 10/9/24, the Director of Nursing trained all licensed nurses (full time, part time, and contract including agency nurses) on the following:
" The process for putting suctioning orders in the electronic medical records to allow for documentation when the suctioning was not provided and the reason why. The licensed nurses were also trained on the requirement for documenting the reason the suctioning was not provided in the medical record and to notify of the physician when the suctioning has not been provided as ordered so the order can be updated as needed.
" The requirement to document a wound assessment including a description of the wound and measurements in the medical record when the wound is first identified. All wounds will then be assessed weekly with a documented wound assessment until the wound is healed. All wound care orders and treatments will be documented on the treatment administration record and signed off upon completion.

Any Licensed Nurses that did not receive the education by 10/25/24 will not be allowed to work until they receive the

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F 842	Continued From page 26 the QA Meeting. 2. Resident # 75 was admitted on 09/05/2023 with the diagnosis of laceration without foreign body left lower leg. A facility initiated initial investigation report dated 10/28/23 written by the Director of Nursing (DON) revealed Resident #75 sustained a 3.7 centimeter by 2.5-centimeter laceration to her left leg while transferring from her wheelchair to her bed. The summary of the investigation documented Resident #75's laceration was treated with steri strips by Nurse #3 initially and that the steri strips had come off on 10-29-23 causing the laceration to re-open and Nurse #2 had placed another type of dressing and ordered a dry multifunctional wound dressing for Resident #75. Review of resident record revealed there was no documentation about a change to Resident #75's orders or condition of her laceration on 10/29/23. Review of Resident #75's orders dated 10/29/23 and 10/31/23 revealed the resident was to have a multifunctional dressing applied. Review of Resident #75's October 2023 Treatment Administration Record (TAR) showed no documentation that steri-strips had been applied. During an interview on 08/27/24 at 4:29 PM with Nurse #2, the nurse remembered doing treatments on Resident #75's leg on 10/29/23. Nurse #2 said the injury would be documented in an incident report, weekly assessment would be completed on the wound. Steri strips would be documented on the Treatment Administration	F 842	education. Newly hired Licensed Nurses and agency Licensed Nurses will be educated on the requirements to document wound assessments in the medical record and wound care/treatment orders on the treatment administration record during orientation. The newly hired Licensed Nurses and agency Licensed Nurses will also be educated on entering suctioning orders in the electronic medical records, documenting refusals or the reason the suctioning did not occur, and to notify the Physician when the suctioning has not been provided for three consecutive orders as ordered during orientation. The Director of Nursing, Assistant Director of Nursing or designee will audit 2 residents with suctioning orders weekly for 4 weeks and then monthly for 2 months to ensure the suctioning is provided as ordered and documented correctly in the medical record Audit results will be documented on the audit tool titled Suctioning Audit. The Director of Nursing, Assistant Director of Nursing or designee will audit 2 residents with wounds weekly for 4 weeks and then 5 residents with wounds monthly for 2 months to ensure the wound assessment is documented in the medical record and wound care is signed off on the treatment administration record. Audit results will be documented on the audit tool titled Wound Assessments and Treatments.	

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F 842	Continued From page 27 Record (TAR). Nurse #2 said she should have documented Resident #4's dressing came off and was replaced. During a telephone interview on 08/28/24 at 10:11 AM with Resident #75's Physician, the Physician said he would typically expect measurements, description of the wound and treatment to be in the order and progress note. The Physician stated he thought there was poor documentation. During an interview on 08/28/24 at 12:23 PM with the Director of Nursing (DON), the DON said she would expect to see measurement, drainage, pain, and order for treatment in the progress notes. She would expect to see how it was cleaned and what was used to clean and treat, what dressing was applied. The DON stated she was unaware there was a lack of documentation for Resident #75's laceration. During an interview on 08/28/24 at 1:37 PM with the Administrator, the Administrator said nurses should have assessed and notified family and the Doctor and document treatment for dressing if the Doctor felt it was needed. The Administrator would expect to see documentation of the dressing in the progress notes, that the exact dressing would be in the Treatment Administration Record (TAR). The Administrator stated she was unaware of the lack of documentation for Resident #75's laceration.	F 842	The Director of Nursing will present the audit results in the monthly Quality Assurance Performance improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 10/25/2024	
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for	F 847		10/25/24

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binding arbitration, the facility must comply with all of the requirements in this section.

§483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(m)(2) The facility must ensure that:
(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;
(ii) The resident or his or her representative acknowledges that he or she understands the agreement;

§483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with

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F 847	Continued From page 29 federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure their arbitration agreement explicitly stated: 1) the resident or legal representative has the right to rescind the arbitration agreement within a 30 day timeframe; and 2) that neither the resident nor his or her representative was required to sign an agreement as a condition of admission or as a requirement to continue to receive care in the facility. This deficient practice affected 1of 1 resident (Resident #60) reviewed for arbitration. The findings included: A review of the facility admission packet and arbitration agreement dated 06/21/23 titled "Terms" did not include statements of the following: 1) The resident or his or her representative has the right to rescind the agreement within 30 days after signing it. 2) The resident nor his or her representative was required to sign an agreement as a condition of admission or as a requirement to continue to receive care in the facility. Resident #60 was admitted to the facility on 06/21/23. Review of Resident #60's arbitration agreement revealed the resident's representative had signed the agreement on 06/21/23. Resident	F 847	On 08/30/24, the Administrator reviewed the admission packet and added the following language to the terms of the arbitration agreement: 1) The resident or his or her representative has the right to rescind the agreement within 30 days after signing it. 2) The resident nor his or her representative was required to sign an agreement as a condition of admission or as a requirement to continue to receive care in the facility. Resident #60's POA will be provided a revised arbitration agreement with the 30 day rescind option by 09/30/24. A revised arbitration agreement will be offered to all current residents or their POA's by 10/25/24. All current residents will be given the option to sign the new agreement by 10/25/24. All arbitration agreements signed before 8/28/24 will be invalid. All residents have the potential to be affected. Effective 09/04/24, all new admissions will receive the updated admission packet that includes the updated terms of the arbitration agreement.	

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F 847	Continued From page 30 #60's admission Minimum Data Set (MDS) assessment dated 07/04/23 revealed she was moderately cognitively impaired. An interview was conducted with the Social Worker on 08/28/24 at 11:00 AM which revealed she reviewed the Arbitration Agreement with residents and families upon admission to the facility. The Social Worker explained the residents have a choice whether they want to accept, decline, or rescind the arbitration agreement. The Social Worker stated that specific verbiage regarding the ability to rescind the agreement within a 30 day timeframe and not signing the arbitration agreement as a condition of admission or a requirement to receive care were not in the current Arbitration Agreement dated 06/21/23 that was being used. An interview was conducted with the Administrator on 08/28/24 at 11:10 PM which revealed the residents can rescind the Arbitration Agreement within a 30 day timeframe. The Administrator explained that resident's or their legal representative (if the resident was not cognitively intact) could rescind or decline the agreement and that signage of the Arbitration Agreement was not a condition of admission to the facility. The Administrator was surprised to see the Arbitration Agreement document currently being used did not have the required information in the agreement.	F 847	On 09/04/24, The Business Office Manager, Social Worker, and Admissions Director were trained by the Administrator on the updated language in the arbitration agreement that is included in the admissions packet. The Administrator or designee will audit 2 new admissions weekly for 4 weeks and then monthly for 2 months to ensure the resident and their representative received the updated admissions packet with the updated terms to the arbitration agreement. Audit results will be documented on the audit tool titled Arbitration Agreement Audit. The Administrator will present the audit results in the monthly Quality Assurance Performance improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 10/25/2024	