STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345529	A. BUILDING _____ B. WING _____	R-C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

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{F 000}	INITIAL COMMENTS The survey team entered the facility on 7/31/24 to conduct a complaint survey and exited on 8/2/24. Additional information was obtained through 8/6/24 and therefore the exit date was changed to 8/6/24. Repeat tags F 646; F 692; and F 842 were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance.	{F 000}		
{F 686} SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident, family, staff, and physicians the facility failed to1) ensure orders were entered into the electronic medical record upon admission and after treatment order changes were made by a weekly visiting Wound Physician in order that nurses would know and provide the correct treatment on correct days 2) clarify which Wound Physician was to be	{F 686}	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated.	8/27/24

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

Electronically Signed | 08/19/2024

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{F 686}	Continued From page 1 overseeing the care of a resident's pressure sores when the facility became aware the resident had an appointment with an outside wound clinic who provided orders and while the resident was simultaneously being followed in house by the facility's Wound Physician who was giving orders 3) provide an air mattress per order 4) follow up on the Registered Dietician's recommendations for nutritional support to heal his pressure sores. This was for one (Resident # 1) of three sampled residents with pressure sores. The findings included: 1a. Record review revealed Resident # 1 was admitted to the facility on 7/3/24. Resident # 1's hospital discharge summary, dated 7/3/24, included the following information. The resident had a history of stroke, prostate cancer, lumbar stenosis, chronic pain and lymphedema, and wounds. Vascular surgery was consulted during the hospitalization, and the vascular physician did not think the resident had peripheral vascular disease. One of Resident # 1's wounds was located on the right ankle and a MRI had shown right "lateral ankle with underlying osteomyelitis of the distal fibula." (Osteomyelitis is a bone infection and the fibula is the leg bone which extends into the ankle joint). In addition to the right ankle, the discharge summary noted there were wounds to the resident's sacrum, right ischium, right and left heel and left ankle. Instructions for the care of the wounds included the following. The ankle wounds, heels, and right ischium were to cleansed with saline, dried, and an application of Aquacel Ag (a type of dressing that contains silver and absorbs wound fluid and bacteria) applied to the wound bed. The wound	{F 686}	F686 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 no longer in the facility, no other actions taken for resident #1 Identification of other residents having the potential to be affected by the same deficient practice: 100% of skin inspection for all current residents in the facility conducted on 08/19/2024, by Director of Nursing, Unit coordinator #1, and./or Unit manager #2, to identify any other resident with an open area and validate the proper assessment, orders, and plan of care is initiated and implemented. Findings of this audit are documented on a skin inspection tool located in the facility compliance binder. 100% of all new admission to the facility for the last 30 days were audited on 8/19/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other resident with the order for wound care, and/or air mattress was not transcribed/implemented correctly in the facility. Findings of this audit are documented on the new admission order audit tool located in the facility compliance binder. 100% audit of all orders written initiated within the last 30 days was completed by the DON, ADON, and unit coordinator (#1	

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{F 686}	Continued From page 2 beds were then to be covered with a silicone foam dressing and changed every three days. The sacral wound was to be cleansed with normal saline, dried, and silicone foam applied every three days and as needed if soiled. Also the discharge summary included information the plan was for Resident # 1 to receive IV antibiotics for the underlying osteomyelitis of the distal fibula at the skilled nursing facility and noted, "Might need BKA (below knee amputation) ultimately if infection does not improve on medical management wound clinic f/u (follow up)." "Wound clinic f/u at d/c (discharge) from SNF." Review of Resident # 1's admission MDS (Minimum Data Set) assessment, dated 7/8/24, coded the resident as cognitively intact and as having multiple pressure sores upon admission. Review of a skin assessment, documented as completed on Resident # 1's admission date of 7/3/24 by Nurse # 9, revealed the following measurements for pressure sores: Right outer ankle- 4 cm (centimeters) X 3 cm X 0/2 cm -Stage II Right inner ankle- 4 cm X 3 cm X 0.2 cm- Stage II Left outer ankle 1 cm x 1 cm X 0. 1 cm- Stage II Right heel 10 cm X 10 cm X 0.1 cm-unstageable Left heel 2 cm X 2 cm X 0.1 cm-Stage II Nurse # 9 was not available during the survey to interview about the difference between her assessment of where Resident # 1's pressure sores were located versus where the hospital discharge summary noted they were located. Review of the facility's physician orders and July 2024 TAR (Treatment Administration Record) revealed no orders were entered into the	{F 686}	or #2) to ensure any ordered air mattress is per physician orders. The audit was completed on 08/19/2024. Findings of this audit are documented on the air mattress order audit tool located in the facility compliance binder. 100% audit of all current residents with open area completed by the DON, ADON, and unit coordinator (#1 or #2) to identify which wound physician follows each resident. The audit was completed on 08/19/2024. Findings of this audit are documented on the air mattress order audit tool located in the facility compliance binder. 100% of all registered dietician recommendation for current residents given in the last 30 days were audited on 8/19/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other recommendations that were not transcribed/implemented correctly in the facility. Findings of this audit are documented on the new admission order audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 8/19/2024, an admitting licensed nurse on duty will review hospital discharge summary and transcribe all orders to resident□s medical records to include treatment orders. Effective 8/19/2024, a designated licensed nurse will complete wound round with the	

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{F 686}	Continued From page 3 resident's electronic medical record for Resident # 1's pressure sore care until 7/10/24. The TAR did not indicate any pressure sore care was rendered between the dates of 7/3/24 through 7/12/24 to any pressure sores. On 7/10/24 the following orders were entered for the bilateral heels, right ischium, and sacrum and documented as performed on the following dates on the July TAR. Also, the following orders remained as active orders through 8/1/24 on the TAR. For the resident's bilateral heels and right ischium, the staff were to cleanse the areas with saline, pat dry, and apply AquaCell Ag Advantage to the wound bed, and cover with a silicone foam dressing every three days and PRN (as needed). This was signed as completed five times between the date of the order (7/10/24) and 8/1/24 (when the order was discontinued.) These five dates were 7/13/24 (Saturday); 7/19/24 (Friday); 7/22/24 (Monday); 7/25/24 (Thursday); and 7/28/24 (Sunday). For the resident's Sacrum the staff were to cleanse the area with saline, pat dry and apply a silicone foam dressing every three days. This order was signed as completed five times between the dates of the order (7/10/24) and 8/1/24 (the date when it was discontinued.). These five dates were 7/15/24 (Monday), 7/20/24 (Saturday), 7/25/24 (Thursday), 7/28/24 (Sunday), and 7/30/24 (Tuesday). There were no orders or treatments documented as done for the right outer ankle (the wound with the underlying osteomyelitis) or the left outer ankle during the month of July 2024.	{F 686}	wound physician and transcribe all treatment orders to each resident□s medical records for proper implementation. Effective 8/19/2024, the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), and/or Unit coordinators (#1, #2, resumed the process for reviewing new admissions/readmission to ensure that the treatment orders, and other orders, including air mattress on the discharge summary, match the orders that are entered into the facility Electronic Health Records (EHR), and validate those orders have been implemented. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. Effective 8/19/2024 the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), and/or Unit coordinators (#1, #2, resumed the process for reviewing Registered dietician recommendations written in the last 24 hours or from the last held clinical meeting to ensure such recommendations are transcribed correctly and implemented. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily	

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{F 686}	Continued From page 4 On 7/11/24 the facility's Wound Physician documented she evaluated and treated the resident for the fist time. The Wound Physician noted the following. The right lateral ankle was a full thickness wound measuring 3.2 cm X 2.8 cm X0.2 cm with 30 % slough (nonviable tissue), 40 % granulation tissue (healthy tissue), and 30 % viable tissue (fascia). The Wound Physician documented "This wound has osteomyelitis, so that is now the main etiology that will affect wound healing. Additionally, while the arterial Doppler did show some peripheral vascular disease, vascular surgery did not believe that it was severe enough to inhibit wound healing." For the right ankle the Wound Physician noted the treatment plan should be Santyl and Calcium Alginate to be applied every day. The left lateral ankle was documented as resolved. The right heel pressure sore was documented as 5.5 cm X 8.9 cm with no measurable depth and had 100% black necrotic tissue. The Wound Physician noted the treatment plan for the right heel should be an application of betadine daily. The resident's right ischium was noted to be due to shearing and measured 1.6 cm X 3.3 cm X a non measurable depth. It was also noted to be 100 % necrotic. The Wound Physician noted the treatment plan for the ischium wound would be an application of Santyl and calcium Alginate every day. The Wound Physician noted the left heel pressure sore measured 2.4 cm X 2.4 cm X 0.1 cm and was 70 % granulation tissue and 30 % skin. The Wound Physician noted the treatment plan for the left heel wound was an application of calcium alginate with silver every day. The Wound Physician noted the Sacrum pressure sore measured 5.8 cm X 9.0 cm X 0.1 cm and was a	{F 686}	clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. Effective 08/19/2024, the facility attending physician will write a referral order to wound physician when deemed medically necessary. Each resident will be referred to only one wound physician as ordered by the attending physician. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of ensuring treatment and other orders (including air mattress) in discharge summaries, or as recommended by a wound physician are transcribed and implemented per order for each resident. The education also emphasized the importance of referring a resident to only one wound care physician per attending physician order and the importance of following registered dietician recommendation timely. This education will be completed by 8/27/2024. Any licensed nurses not educated by 8/27/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:	

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{F 686}	Continued From page 5 "cluster wound with exposed dermis." The treatment plan for the sacral wound was for an application of a hydrocolloid sheet to be applied three times per week. Review of Resident # 1's July 2024 electronic medical record revealed the 7/11/24 Wound Physician orders were not entered and did not appear on the treatment administration record in order that nurses carry them out. On 7/18/24 the Wound Physician noted she saw Resident # 1 again and documented the following information. The resident's right lateral ankle measured 3.5 cm X 3.7 cm X 0.2 cm and the wound bed contained 20 % slough, 60 % granulation tissue, and 20 % fascia. The Wound Physician's treatment plan was to clean the wound with an acid solution and apply calcium alginate silver daily. Resident # 1's right heel measured 5.0 cm X 7.0 cm X a non measureable depth and was 100% black necrotic tissue. The Wound Physician's treatment plan was to apply betadine daily to the pressure sore. Resident # 1's right ischium pressure sore measured 1.9 cm X 3.0 cm X a not measurable depth. The area was 50 % necrotic and 50 % viable tissue. The Wound Physician's treatment plan was to clean the wound bed with an acid solution and apply Santyl and calcium alginate every day. Resident # 1's left heel was documented to be 1.9 cm X 4.5 cm X 0.1 cm with 50 % granulation tissue and 50 % skin. The Wound Physician's treatment plan was to apply calcium alginate with silver every day. Resident # 1's sacrum measured 9.0 cm X 6.3 cm X not measureable depth and was 40 % necrotic, 20 % granulation tissue, and 40 % skin. The Wound Physician's treatment plan for the sacrum was to daily apply Santyl and calcium	{F 686}	Effective 8/27/2024, DON and/or ADON will monitor compliance with order transcription to include treatment and/or air mattress orders by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team cross referenced discharge summary orders with orders entered into the facility EHR for accuracy. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Results of the audit will be presented in QAPI for review and recommendation. Effective 08/27/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all incident reports for the last 24 hours or from last clinical meeting to ensure any identified skin alteration has had proper follow through to include treatment order and assessment entered in electronic medical records. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Effective 08/27/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all registered dietician recommendations during weekly meetings to ensure the recommendations were	

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{F 686}	Continued From page 6 alginate after cleaning with a acid solution. The Wound Physician noted her clinical documentation had been available to the referring physician, and also made available for access to the appropriate personnel and placement in the medical record. Review of Resident # 1's July 2024 electronic medical record revealed the 7/18/24 orders were not entered and did not appear on the treatment administration record in order that nurses carry them out. On 7/25/24 the Wound Physician noted she saw Resident # 1 again and documented the following information. The resident's right lateral ankle measured 3.4 cm X 2.6 cm X 0.2 cm and measured 20 % slough, 60 % granulation tissue, and 20 % fascia. Resident # 1's right heel measured 4.5 cm X 7. 5 cm X 0.1 cm and was 90 % necrotic tissue and 10 % granulation tissue. The resident's right ischium measured 2.0 cm X 1.8 cm X 1.1 cm and was 20 % necrotic tissue, 10 % slough, 20 % granulation tissue, and 50 % viable tissue. Resident # 1's left heel measured 2.8 cm X 3.0 cm X 0.1 cm and included 70 % granulation tissue with 30 % skin. The resident's sacrum measured 7.2 cm X 7.2 cm X a not measureable depth and included 20 % necrotic tissue, 20 % slough, 20 % granulation tissue, 20 % skin, and 20 % dermis. The Wound Physician's treatment plans for the wounds were the same as she noted on 7/18/24. Review of Resident # 1's orders revealed the Wound Physician's treatment plans were again not carried out after the resident was seen on 7/25/24.	{F 686}	carried out. Any negative findings will be corrected promptly. This monitoring process will be completed weekly for four weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the RD recommendation monitoring tool for new residents located in the facility compliance binder. Effective 08/27/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 08/27/2024.	

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{F 686}	Continued From page 7	{F 686}		

On 8/1/24 at 2:00 PM Unit Manager # 1 was interviewed. Unit Manager # 1 was again interviewed on 8/2/24 at 2:15 PM with the facility Nurse Consultant, who had just starting consulting at the facility on 7/30/24. During this time records for Resident# 1 were reviewed with these staff members. Unit Manager # 1 reported the following information. She was not Resident # 1's Unit Manager. On his day of admission (7/3/24), she had been asked to help an orienting nurse (Nurse # 9) do a skin assessment for the resident. She did not know why she was the one to be asked. She measured Resident # 1's pressure sore wounds and wrote them on a piece of paper. She could tell from unwrapping the pressure sore wounds what the treatment application had been, and therefore she replaced what had been on the resident's wounds on 7/3/24. While she was doing all of this, the orienting nurse (Nurse # 9) just left the room, leaving her with Resident # 1. She (Unit Manger # 1) helped answer the resident's questions and left the room. She (the Unit Manager) did not enter any orders into the computer for the resident's treatments. Later Nurse # 9 left employment and did not complete orientation. On 7/8/24 she had been making rounds on Resident # 1's hall and spoke to Resident # 1 who told her his dressings needed to be changed. There were some protocols the facility utilized and therefore she used established protocols and changed his dressings that day. She had not been responsible for his admission paperwork and did not know that orders had been included on his discharge summary. On 7/8/24 she did not put the discharge orders into the computer so they would populate on the TAR. She (Unit Manager # 1) put Resident # 1's name on the Wound Physician's list so the Wound Physician would see the

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{F 686}	Continued From page 8	{F 686}		

resident when the physician next visited. On 7/11/24 Resident # 1 was seen by the Wound Physician and she (Unit Manager # 1) thought that she had put the Wound Physician's new orders in correctly into the new electronic computer system. The facility was starting to use a new electronic medical system in July 2024. During the interview the Unit Manager and the Nurse Consultant looked and validated the orders (which had indicated some of the wounds needed daily care) had not been put into the computer on 7/11/24 as the Unit Manager thought had occurred. Unit Manager # 1 and the Nurse Consultant were interviewed regarding what had transpired between the dates of 7/3/24 and 7/8/24. The Nurse Consultant called in Nurse # 10 during the 8/2/24 interview to speak to the surveyor. Nurse # 10 reported she had cared for Resident # 1 on 7/5/24 and changed his dressings. She followed orders in the discharge paperwork but did not put any orders into the computer so they would populate on the TAR. During the interview on 8/2/24 the Nurse Consultant reported the process should be that the resident is seen by the Wound Physician, orders placed in the computer and on the TAR, and carried out.

During an interview with Resident # 1 and his family member on 8/1/24 at 4:45 PM Resident # 1 reported he had not had dressing changes on 7/3/24 through 7/7/24 and had continued to have problems with consistent dressing changes. The resident's family member reported the resident had been seen at a hospital wound clinic recently on 7/30/24 where one of his dressings had been dated 7/25/24 before it was removed by clinic staff on 7/30/24. (The hospital wound clinic was part of the hospital which had been treating

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{F 686}	Continued From page 9	{F 686}		

Resident # 1 for his osteomyelitis). The resident and his family member also reported the current day (8/1/24) the facility Wound Physician had started to look at his wounds and evaluated only his left foot wound. When the facility Wound Physicians learned while evaluating his left foot that he had been seen at the hospital wound clinic earlier in the week, she reported that only one wound physician could oversee his wound care. Therefore, nothing had been done for his other pressure sore wounds that day and he was still waiting for care of his wounds.

On 8/1/24 a review of orders revealed there had been no clarification on 7/30/24 and 7/31/24 of which wound physician orders should be followed after Resident # 1 returned from the hospital clinic on 7/30/24.

On 8/1/24 orders were placed into the computer for the hospital wound clinic's wound care orders. On 8/1/24 Unit Manager # 1 and Nurse # 11 provided care for Resident # 1's pressure sore wounds (excluding the left heel wound which had been reportedly dressed earlier that day prior to the Wound Physician realizing the hospital clinic was managing his care.) Resident # 1 was observed to have a red open pressure sore to his sacrum, a red open area to his right ischium with visible depth, a red open wound to his ankle. He was also observed to have a black area to his inner heel which was approximately the size of a jar lid. His left foot was dressed and remained dressed.

The facility Wound Physician was interviewed on 8/5/24 at 5:14 PM and reported the following information. She was in the facility once per week. Routinely residents' dressings were already

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{F 686}	Continued From page 10	{F 686}		

taken off before she entered the room, and therefore she had no way of knowing what the dates were on the dressings which had been removed on the days when she saw a resident. It had varied which facility staff member made rounds with her. At times the facility had a sister facility which would send a wound care nurse to make rounds with her. At other times Unit Manager # 1 had rounded with her. She would give them the orders and see that they wrote them down. She then hoped they would carry through and put the orders in. Medicare did not pay for a resident to be seen by two different Wound Physicians and in Resident # 1's case, he might want to "stick" with the wound physician at the hospital. While hospitalized Resident # 1 had consulted with a surgeon about his wounds. It would be ideal to know which Wound Physician was going to oversee his care once the facility was aware two physicians were involved. Prior to the visit on 8/1/24 she had looked at the discharge summary and not seen an appointment and no one had mentioned to her that he had been to the hospital clinic earlier in the week. While she had been seeing him in July 2024, there had been no purulent drainage from the wounds and no bone showing. In general, a resident may not be at goal during the first part of treatment. She had seen him only three times and therefore just because he had missed her recommended treatment plan, she could not say that his wounds had suffered because of it.

The Medical Director, who was also Resident # 1's facility physician, was interviewed on 8/5/24 at 12:14 PM and reported the following information. He knew the facility had been undergoing a change in their electronic medical system provider and it had been hard for them. He did

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not recall anyone mentioning a problem with wound care orders not being in place for Resident #1. The facility's Wound Physician was a specialist in wound care, and he would defer to her for treatment. The Wound Physician relied on other people to put in the orders, and the facility needed to figure that part out. He also thought Resident # 1's family was making appointments for him at outside clinics.

It was confirmed with the DON (Director of Nursing) on 8/6/24 at 2:04 PM that the facility had been the one who made transport arrangements for Resident # 1 to be seen at the hospital wound clinic on 7/30/24, and therefore realized he had gone on 7/30/24 to another wound physician after already being seen by the facility's wound physician.

An attempt was made to talk to the hospital wound clinic during the survey and a return call was not received.

1b. Review of Resident # 1's orders revealed a 7/24/24 order for an air mattress. Resident # 1 was observed on 7/31/24 at 11:31 AM and 2:40 PM with no air mattress in place. Resident # 1 was again observed on 8/1/24 at 4:45 PM with no air mattress. On 8/2/24 at 8:45 AM Resident # 1 was observed on no air mattress.

During a follow up interview with the Nurse Consultant on 8/6/24 at 2:38 PM, the Nurse Consultant reported the facility did have air mattresses and there should have been a corroboration between central supply, maintenance, and the nursing staff in getting the air mattress to the resident's room and on the bed.

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{F 686}	Continued From page 12 1c. Review of Resident # 1's Registered Dietician (RD) notes revealed the RD noted on 7/13/24 at 12:53 PM Resident # 1 had multiple wounds and a low albumin level. For wound healing support the RD recommended the resident receive a multivitamin daily, Vitamin C 500 mg (milligrams twice per day, zinc sulfate 220 milligrams daily for 14 days; and prostat 30 ml (milliliters) twice per day. (Prostat is a protein supplement which supplies 15 grams of protein per 30 ml of Prostat. Protein is important in the wound healing process). Review of Resident # 1's orders revealed on 7/24/24 the resident was ordered to receive Vitamin C but not the amount recommended by the RD for wound healing. The order was for 250 mg one time per day. There had been no zinc ordered for the resident as of 7/31/24. The resident was ordered on 7/24/24 to receive prostat one time per day on 7/24/24 with no specific amount entered as to be given. There was no order for the twice per day Prostat as recommended by the RD. Interview with the facility Nurse Consultant on 8/2/24 at 2:15 PM revealed there had been no follow up to all of the RD's specific recommendations for wound healing which were made on 7/13/24.	{F 686}		
{F 692} SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	{F 692}		8/27/24

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{F 692}	Continued From page 13 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to 1) follow up on the registered dietician's nutritional recommendations for residents who had nutritional risks such as protein calorie malnutrition, wounds, and/or weight loss (Residents # 1 and # 12) and 2) ensure a process where the RD was aware while evaluating a resident's nutritional needs that the resident was concerned about weight loss which had occurred prior to admission and the extent of the weight loss the resident had experienced (Resident # 1). This was for two out of three sampled residents reviewed for nutritional needs. The findings included: 1. Record review revealed Resident # 1 was admitted to the facility on 7/3/24. Resident # 1's hospital discharge summary, dated 7/3/24, included the following information. The resident	{F 692}	F692 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 no longer in the facility, no other actions taken for resident #1 Resident #12 registered dietician recommendation for 240ml of nutritional supplement implemented on 8/6/2024. Identification of other residents having the potential to be affected by the same deficient practice: 100% of interviews for current residents admitted in the last 30 days, who are alert and oriented, and phone interviews for resident□s responsible party for those who were not interviewed conducted on 08/22/2024, by Director of Social Services #1 and/or #2 to identify any other resident with concern about weight loss before	

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{F 692}	Continued From page 14 had a history of stroke, prostate cancer, lumbar stenosis, chronic pain, lymphedema, and wounds. One of Resident # 1's wounds was located on the right ankle and a MRI had shown right "lateral ankle with underlying osteomyelitis of the distal fibula." (Osteomyelitis is a bone infection and the fibula is the leg bone which extends into the ankle joint). In addition to the right ankle, the discharge summary noted there were wounds to the resident's sacrum, right ischium, right and left heel and left ankle. The discharge summary also noted Resident # 1 had severe protein calorie nutrition. Review of Resident # 1's admission MDS (Minimum Data Set) assessment, dated 7/8/24, coded the resident as cognitively intact and as having multiple pressure sores upon admission. He was also assessed to be 79 inches tall (6 feet and 7 inches tall) and as weighing 195 pounds. Resident # 1's care plan, dated 7/13/24, included the information the resident was at risk for weight loss or malnutrition related to a past medical history of protein calorie malnutrition, a history of weight loss, a history of low albumin levels, skin integrity issues, lymphedema and diuretic use. Some of the interventions included for a RD consult and to provide supplements as ordered. Resident # 1 was interviewed on 7/31/24 at 2:40 PM and reported prior to being hospitalized he had resided at another facility. Since February 2024 he had lost approximately 40 pounds, and the weight loss was such that his dentures were now loose. He had pressure sores and he wanted nutritional foods to help heal his wounds. He was very interested in doing whatever could be done to heal his wounds. He thought he was to be	{F 692}	admission. Findings of this audit are documented on a weight changes interview tool located in the facility compliance binder. 100% of all registered dietician recommendation for current residents given in the last 30 days were audited on 8/19/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other recommendations that were not transcribed/implemented correctly in the facility. Findings of this audit are documented on the new admission order audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 8/19/2024, the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), and/or Unit coordinators (#1, #2), resumed the process for reviewing new admissions/readmission to ensure that any resident with significant weight loss before admission is communicated to the physician and/or registered dietician for recommendations. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder.	

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{F 692}	Continued From page 15 getting a supplement drink, but he had not been getting it consistently. A review of weights on 8/1/24 revealed one weight had been completed. This was on 7/7/24 and registered 195 pounds. Review of the facility RD's (registered dieticians) notes revealed the RD had evaluated the resident twice. The first time was on 7/13/24 when the RD noted the following information in her note. Resident # 1's current weight was 195 pounds, and he was 79 inches tall. His hospital weight had ranged from 200 to 216 pounds. His current BMI (body mass index) was normal. His intake was generally greater than 75%. He had multiple wounds. His hospital albumin level was low at 2.3 on 6/15/24. He had increased nutritional needs due to his wounds and low albumin. For wound healing, the RD recommended the resident start receiving a multivitamin daily, Vitamin C 500 mg (milligrams) twice per day, zinc sulfate 220 milligrams daily for 14 days; and prostat 30 ml (milliliters) twice per day. (Prostat is a protein supplement which supplies 15 grams of protein per 30 ml of Prostat. Protein is important in the wound healing process). The RD also noted the resident had an intolerance to dairy and recommended the resident receive Ensure clear twice per day. Review of Resident # 1's orders revealed on 7/16/24 Resident # 1 was ordered to receive a mighty shake once per day. On 7/18/24 the resident was ordered to receive a multivitamin daily. On 7/24/24 the resident was ordered to receive Vitamin C but not the amount recommended by the RD for wound healing. The order was for 250 mg one time per day. There	{F 692}	Effective 8/19/2024, the registered dietician will interview the new admission as part of the new admission nutritional assessment to identify if a resident has any concern about weight loss before admission. The registered dietician will address any findings promptly and document them in resident□s clinical records. Effective 8/19/2024 the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), and/or Unit coordinators (#1, #2), resumed the process for reviewing Registered dietician recommendations written in the last 24 hours or from the last held clinical meeting to ensure such recommendations are transcribed correctly and implemented. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of reviewing discharge summaries for any significant weight losses and communicating findings to the attending physician. The education also emphasized the importance of following registered dietician recommendation	

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{F 692}	Continued From page 16 had been no zinc ordered for the resident as of 7/31/24. The resident was ordered on 7/24/24 to receive prostat one time per day on 7/24/24 with no specific amount entered as to be given. There were no orders for the twice per day Prostat as recommended by the RD as of the date of 7/31/24. The RD next documented she reviewed the resident on 7/31/24 at 6:56 PM and noted the resident's weight was still documented to be 195 pounds. She requested a current body weight. She noted the resident had been placed on a multivitamin, vitamin C, prostat, and a house shake daily. She did not note that there had been no clear order about the amount of prostat the resident was receiving nor that it was ordered to be given once per day rather than twice per day per her recommendation. She did not note anything about the difference in the resident getting one mighty shake daily compared to her prior recommendation of Ensure clear twice per day. She did not note anything about the resident not getting zinc to facilitate nutrition to heal his wounds per her prior recommendation. Interview with the facility Nurse Consultant on 8/2/24 at 2:15 PM revealed there had been no follow up to all of the RD's specific recommendations made on 7/18/24 and this should have been done. The Nurse Consultant also reported the resident had not been weighed prior to 8/2/24. On 8/2/24 the Nurse Consultant reported facility staff weighed the resident and the resident weighed 195.8 pounds. The Nurse Consultant reported the RD was not coming into the facility to talk to residents and view them as she evaluated them.	{F 692}	timely. This education will be completed by 8/27/2024. Any licensed nurses not educated by 8/27/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 08/27/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all registered dietician recommendations during weekly meetings to ensure the recommendations were carried out. Any negative findings will be corrected promptly. This monitoring process will be completed weekly for four weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the RD recommendation monitoring tool for new residents located in the facility compliance binder. Effective 08/27/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.	

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{F 692}	Continued From page 17 The RD was interviewed on 8/5/24 at 9:40 AM and reported the following information. She was part of a contracting agency the facility utilized and had been filling in during the month of July, 2024. She worked remotely. She did not see Resident # 1 in person when she evaluated him in order to talk to him and realize he was reporting that he had lost so much weight that his dentures were loose and that the weight loss was approximately 40 pounds since February, 2024. If she had known he was reporting that he had lost weight to the point of his dentures being loose, then she would have worked on that as well. His record indicated he did have a history of diuretic use and lymphedema which could contribute to weight fluctuations. His meal intake was documented to be greater than 75 %. She had made the recommendations on 7/13/24 which she noted on 7/31/24 had not all been implemented. She thought the facility was doing something since he was getting some of the things she had recommended and therefore she had not called it to their attention again. Typically, other facilities had a system where they had a resident weighed at routine intervals after admission so that it could be determined if a resident was losing weight. She had only seen one weight and therefore she had requested on 7/31/24 the resident be reweighed to see how he was doing. During an observation on 8/1/24 at 6:15 PM of Resident # 1's wound care, the resident was observed to have a pressure sore on his sacrum, his ischium, his right ankle, and his right heel. Additionally, the resident and staff reported he still had a pressure sore to his left heel that had already been dressed for the day.	{F 692}	Compliance date: 08/27/2024.	

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2. Resident #12 was admitted to the facility on 10/4/2023 with cumulative diagnoses some of which included vascular dementia, Parkinson's disease, and Type 2 Diabetes Mellitus. Resident #12 started receiving Hospice services on 6/30/2024.

Documentation on a quarterly Minimum Data Set assessment dated 5/15/2024 revealed Resident #12 had lost weight and was not on a prescribed weight loss plan.

Documentation on a care plan initiated on 10/6/2023 for Resident #12 revealed a care plan description of a nutritional risk with some of the interventions being for the Registered Dietitian to monitor and the provision of nutritional interventions as/if ordered.

Documentation in a Nutrition/Dietary Note dated 7/23/2024 written by the Registered Dietitian (RD #1) revealed Resident #12 continued to have a weight loss despite interventions and food/fluid intake varied. RD #1 made the recommendation in the nutrition note for Resident #12 to receive 240 milliliters of a nutritional supplement three times a day between meals.

An interview was conducted with the facility Administrator on 8/2/2024 at 10:55 AM. The facility Administrator stated both she and the Assistant Director of Nursing (ADON) had received the nutrition recommendation from RD #1 on 7/23/2024. The Administrator stated she expected the ADON to address the nutrition recommendations made on 7/23/2024 for Resident #12.

An interview with the ADON on 8/2/2024 at 12:45

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{F 692}	Continued From page 19 PM revealed she located the Nutrition/Dietary Note dated 7/23/2024 for Resident #12 but had not found where the recommendations had been acted upon. An interview with RD #1 was conducted on 8/5/2024 at 9:13 AM. RD #1 explained she was working remotely twice a week for the facility since the second week in July 2024. RD #1 further explained several recommendations she made for Resident #12 were sent to the Administrator, Interim Director of Nursing (ADON), and the Dietary Manager on 7/23/2024. RD #1 stated she had the expectation her recommendations would be addressed or acted upon within 3 days. RD #1 stated she had communicated to the facility she expected documentation to be put in the electronic record if her recommendations were not approved by the family or the physician. RD #1 stated she would have no way of knowing if her recommendations were acknowledged unless Resident #12 triggered for another weight loss the week after the recommendations were made, for which the resident had not.	{F 692}		
F 842 SS=E	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.	F 842		8/27/24

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F 842	Continued From page 20 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, 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	F 842		

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UNIVERSAL HEALTH CARE/NORTH RALEIGH	5201 CLARKS FORK DRIVE NW RALEIGH, NC 27616

(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 842	Continued From page 21 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure the medical records were accurate and complete regarding administration of medication and treatments. This was for four (Residents # 1, 3, #10, and # 13) of six sampled residents whose medical records were reviewed for documentation related to medications and treatments being documented correctly in the medical record. The findings included: 1a. Resident # 1 was admitted to the facility on 7/3/24. A review of Resident # 1's July MAR (Medication Administration Record) and TAR (treatment administration record) revealed multiple blanks and/or inaccurate information. Although not all inclusive some examples are as follows: Resident # 1's MAR included the order for intravenous Ceftriaxone 2 grams to be administered every 24 hours. The MAR included	F 842	F842 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #1 no longer in the facility, no other actions taken for resident #1 On 08/19/2024 Resident #3 medical records were reviewed by the Administrator for completion and accuracy including documentation of administration morphine as prescribed in the last seven days, identified omission were communicated to the attending physician. No negative signs or symptoms identified following missing documentation of morphine. On 08/19/2024 Resident #10 medical records were reviewed by the Administrator for completion and accuracy including documentation of medication administration as prescribed in the last seven days, identified omission were	

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F 842	Continued From page 22 two different areas where nurses could sign for the administration of this daily medication. There were 30 check marks between the dates of 7/8/24 to 7/31/24 indicating it had been given 30 times. On 8/2/24 at 10:50 AM the MAR was clarified as inaccurate when the Nurse Consultant, DON (Director of Nursing) and ADON (Assistant Director of Nursing) reconciled the amount of antibiotics remaining from the pharmacy with the number that had been delivered. The conclusion was that it had been administered 20 times from 7/8/24 through 8/1/24. 1b. Resident # 1's July MAR did not include an order for PICC line flushes which originated on 7/7/24. The nurses were to flush the PICC line with saline before IV antibiotic administration and saline and heparin following the IV antibiotic. The MAR did not indicate this was being done and was incomplete regarding the flushes. According to orders placed on the MAR on 7/7/24 Resident # 1's external portion of the PICC line was to be measured weekly with weekly dressing changes. There was a blank on 7/17/24 when this was scheduled to be completed. 1c. Resident # 1's MAR reflected he was to receive Prostat one time per day. This 7/24/24 order was incomplete. There was no amount entered to be given. 1d. Resident #1's 7/3/24 hospital discharge summary included information the resident had wounds to his right ankle, sacrum, ischium, and bilateral heels. During an interview with Nurse # 10 on 8/2/24 at 2:15 PM the nurse reported she changed all of Resident # 1's dressings on	F 842	communicated to the attending physician. No negative signs or symptoms identified following missing documentation of morphine. Resident #13 no longer in the facility, no other actions taken for resident #13 Identification of other residents having the potential to be affected by the same deficient practice: 100% of all new admission to the facility for the last 30 days were audited on 8/19/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other resident with the order for antibiotics that was not transcribed correctly in the facility medical records. Findings of this audit are documented on the new admission order audit tool located in the facility compliance binder. 100% audit of all new antibiotic orders-initiated within the last 30 days was completed by the DON, ADON, and unit coordinator (#1 or #2) to ensure ordered medication were transcribed correctly in resident□s medical records and administered per physician orders. The audit was completed on 08/19/2024. Findings of this audit is documented on the new antibiotic order audit tool located in the facility compliance binder. 100% of all current residents with an intravenous (IV), PICC, Central lines, or any other venous access line were audited on 08/19/2024 by the Director of Nursing, Assistant Director of Nursing, and/or unit coordinator (#1 or #2) to identify any other resident with no orders to flushes. Findings of this audit are	

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F 842	Continued From page 23 7/5/24. There was no documentation regarding this in the resident's facility record. Interview with Unit Manager # 1 on 8/2/24 at 2:15 PM revealed she had changed Resident # 1's dressings by using established protocols the facility had on the date of 7/8/24. There was no documentation of these 7/8/24 dressing changes and what dressings were applied. During an interview with the Nurse Consultant on 8/2/24 at 12:05 PM the nurse consultant reported the documentation on the administration records related to medications could not be trusted as accurate because the facility had undergone a change- over in their provider of their electronic medical records starting on 7/3/24 and 7/4/24. 2. Resident # 3 was readmitted on 7/3/24 with orders for morphine sulfate oral solution 100 mg/5 ml give 0.25 mg via gastrostomy tube four times a day for pain or shortness of breath. This order was transcribed on the July 2024 MAR (medication administration record) to be scheduled at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Resident # 3's MAR was reviewed with the ADON on 8/2/24 at 9:25 AM and confirmed to be inaccurate. The MAR included the ADON's initials on multiple dates and times signifying that she had administered the morphine. According to the ADON during the change over to the facility's new electronic medical system, she had allowed other nurses to log into the electronic medical system under her name. Therefore, her initials appeared as completing administration of medications which she had not actually given. According to the ADON the facility staff had done their best with the change over to a new electronic medical	F 842	documented on the venous access line audit tool located in the facility compliance binder. 100% audit of current residents with orders for pain narcotic medication to include morphine, other medication including Lexapro and Gabapentin completed by Director of Nursing, Assistant Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 on 09/19/2024 to identify any other resident who did not receive pain medication per physician orders in the last two weeks. Findings of this audit are documented on a pain medication audit tool located in the facility compliance binder. 100% audit of the controlled drug receipt/record/disposition form for current residents with orders for controlled medication completed by Director of Nursing, Assistant Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 on 08/19/2024 to identify if medication were removed from the card per physician order. Findings of this audit are documented on Narcotic count audit tool located in the facility compliance binder. 100% inspection of all current resident medication ordered completed by comparing ordered medication in EHR and the available medication on each cart to assure all ordered medication including Lexapro are available to be used. The audit was completed on 08/19/2024 by Unit Coordinator #1 and/or #2. all missing medication was re-ordered from the contracted pharmacy per physician order.	

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F 842	Continued From page 24 system, but nurses needed to sign in and the IT (information technology) department could not provide sign in access quickly enough. 3. Resident # 10 was admitted to the facility on 12/5/23. A review of Resident # 10's MAR (Medication Administration Record) revealed multiple blanks on the resident's MAR. Although not inclusive some of these included the morning administration of the resident's calcium carbonate, cholecalciferol, diltiazem, escitalopram, spironolactone, metoprolol, acetaminophen, and gabapentin on the dates of 7/4/24 and 7/10/24. Nurse # 10, who per administrative staff had been assigned to Resident # 10 on these dates, was interviewed on 8/2/24 at 2:50 PM and reported she had given the resident her medications on 7/4/24 and 7/10/24. 4. Resident #13 was admitted to the facility on 7/4/2024 with cumulative diagnoses some of which included Type 2 Diabetes Mellitus and idiopathic peripheral autonomic neuropathy. Documentation in a physician order initiated on 7/4/2024 at 6:16 AM revealed Resident #13 had an order for 300 milligrams Gabapentin to be administered as one oral capsule by mouth three times a day for nerve pain. Documentation on the July Medication Administration Record (MAR) revealed Resident #13 received the first dose of Gabapentin at 9:00 PM from the Assistant Director of Nursing on 7/5/2024. The Assistant Director of Nursing (ADON) was	F 842	Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 8/19/2024, an admitting licensed nurse on duty will review hospital discharge summary and transcribe/document all orders to resident□s medical records to include orders for antibiotic therapy, and venous access line flushing. Any documented need for antibiotic therapy or other medication/treatment noted in the discharge summary without an order will be communicated to the discharging entity and/or facility attending physician immediately for clarification. Effective 8/19/2024, the Clinical leadership team, which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, resumed the process for reviewing new admissions/readmission to ensure that the medication orders and other orders on the discharge summary, match the orders that are entered into the facility Electronic Health Records (EHR). Additionally, if there are recommendations on the discharge summary that are not reflected in the discharge orders, the clinical team will ensure the clarification is obtained from the discharging facility and/or resident□s attending physician. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be	

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F 842	Continued From page 25 interviewed on 8/2/2024 at 9:20 AM. The ADON revealed she was not in the building to give Gabapentin to Resident #13 on 7/5/2023 at 9:00 PM and she would not have any way of knowing which nurse it was she gave her login information to. The ADON confirmed it was inaccurate documentation that she administered Gabapentin to Resident #13 on 7/5/2024. An interview was conducted with the facility Nurse Consultant on 8/2/2024 at 12:05 PM. The facility Nurse Consultant stated the MAR documentation could not be trusted in the facility and was not a true reflection of the medication administered or who gave the medication to the resident.	F 842	documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. Effective 8/19/2024 the Clinical team, which consists of the DON, ADON, Minimum Data set (MDS), Unit coordinators (#1, #2), and/or wound nurse, resumed the process for reviewing physician orders written in the last 24 hours or from the last held clinical meeting to ensure such orders are transcribed correctly and administered per physician order. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any findings will be documented on the daily clinical meeting form and maintained in the daily clinical meeting binder. Effective 08/19/2024, facility employees will document the administration of medication based on physician orders to treat a specific condition as diagnosed, and document the administration of such medication in each resident□s clinical record. Effective 08/19/2024, the facility clinical team to include the Director of Nursing, assistant director of Nursing, Unit coordinator #1 or #2 revised the shift change process to provision for validating the accuracy of controlled drug to including morphine. This process will ensure medication is removed from the card based on the physician orders and, if	

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otherwise, proper documentation will be included on the disposition of any medication removed/not removed from the card. Finding of this systemic change is documented on the narcotic count sheets located in the narcotic count binders on each medication cart.
DON, ADON, and/or Staff development coordinator will complete 100% of education for all licensed nurses to include full time, part time, and as needed employees (PRN). The emphasis of this education will be the importance of ensuring medication and other orders in discharge summaries are transcribed and administered per physician order for each admitted/readmitted resident.

The education also emphasized on proper ways to enter medication in facility electronic medical records, and proper steps to be taken (including contacting the discharging entity and/or facility attending physician for clarification) when the need to continue a certain medication or treatment is documented in discharge summary without a physician order. This education will be completed by 8/27/2024. Any licensed nurses not educated by 8/27/2024 will be taken off the schedule until educated. This education will also be implemented in new hire orientation for licensed nurses.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 8/27/2024, DON and/or ADON

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F 842	Continued From page 27	F 842	will monitor compliance with order transcription to include antibiotic therapy by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team cross referenced discharge summary orders with orders entered into the facility EHR for accuracy. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Results of the audit will be presented in QAPI for review and recommendation. Effective 8/27/2024, DON and/or ADON will monitor compliance with venous line flushes by reviewing daily clinical meeting reports to ensure completion and validate that residents with venous line have corresponding orders to flush the line entered in the facility EHR for accuracy. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication monitoring process. This monitoring process will be accomplished by reviewing medication administration records for all residents with orders for pain medication, and other medication to include Lexapro to ensure Licensed nurses and medication aides are administering such medication per physician orders. This monitoring process will be completed daily (Monday through	

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F 842	Continued From page 28	F 842	Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a medication review monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the controlled medication monitoring process. This monitoring process will be accomplished by reviewing the controlled drug receipt/record/disposition form for all residents with orders for narcotic medication orders to ensure medication was removed from the card per physician order. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Narcotic count review monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete medication availability monitoring process. This monitoring process will be accomplished by reviewing five randomly selected residents orders and validating the availability of	

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F 842	Continued From page 29	F 842	medication in the medication cart. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Medication availability monitoring tool located in the facility compliance binder. Effective 08/19/2024, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will complete the medication administration monitoring process. This monitoring process will be accomplished by reviewing medication administration audit report ensure no resident is listed with missing medication administration. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a Medication administration monitoring tool located in the facility compliance binder. Effective 08/27/2024, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure	

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F 842	Continued From page 30	F 842	the facility remains in substantial compliance. Compliance date: 08/27/2024.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	F 867		8/27/24

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systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

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

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

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

§483.75(e) Program activities.

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

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F 867	Continued From page 32 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 867		

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	345529	A. BUILDING _____ B. WING _____	R-C 08/06/2024

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F 867	Continued From page 33 Based on observations, record review, resident, staff, nurse practitioners, and physician interview the facility Quality Assessment Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the complaint survey completed 6/6/2024. This was for three repeat deficiencies in the areas of pressure sore care, nutritional status, and resident record documentation that were originally cited on 6/6/2024. The continued failure of the facility showed a pattern of the facility's inability to sustain an effective QAPI committee. The findings included: This citation is cross referred to: F686: During the complaint survey of 8/6/2024 the facility failed to 1) ensure orders were entered into the electronic medical record upon admission and after treatment order changes were made by a weekly visiting Wound Physician in order that nurses would know and provide the correct treatment on correct days 2) clarify which Wound Physician was to be overseeing the care of a resident's pressure sores when the facility became aware the resident had an appointment with an outside wound clinic who provided orders and while the resident was simultaneously being followed in house by the facility's Wound Physician who was giving orders 3) provide an air mattress per order 4) follow up on the Registered Dietician's recommendations for nutritional support to heal his pressure sores. This was for one of three sampled residents with pressure sores. During the complaint survey of 6/6/2024 the facility failed to have a system in place to	F 867	F867 Corrective actions accomplished for those residents found to be affected by the deficient practice: As of 08/19/2024 facility Quality Assurance Performance Improvement (QAPI) process has put in place measures to address the repeated deficient practice for F686, F692, and F842. The plan implemented was approved by the QAPI committee on 08/19/2024 to be effective to attain and maintain compliance and hence prevent repeat citation. Identification of other residents having the potential to be affected by the same deficient practice: On 8/19/2024, the facility Administrator conducted a review annual and complaint surveys for the prior 3 years to review all areas of repeat deficient practice. The review focuses on the action plans implemented to identify whether the repat citation resulted from the same component of regulatory requirements and implement sustainable plan to attain and maintain compliance. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 08/19/2024, the facility Administrator will discuss all cited deficiencies from the last annual inspection survey and/or from complaint investigation sited in the previous 12 months to ensure the areas remains in regulatory compliance.	

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F 867	Continued From page 34 accurately evaluate the extent nutrition was contributing to the development and non-healing of the wounds and develop a plan to address any nutritional deficit for one of three sampled residents reviewed for pressure sores. F692: During the complaint survey of 8/6/2024 the facility failed to 1) follow up on the registered dietician's nutritional recommendations for residents who had nutritional risks problems such as protein calorie malnutrition, wounds, and/or weight loss and 2) ensure a process where the RD was aware while evaluating a resident's nutritional needs that the resident was concerned about weight loss which had occurred prior to admission and the extent of the weight loss the resident had experienced. This was for two out of three sampled residents reviewed for nutritional needs. During the complaint survey of 6/6/2024 the facility failed to ensure a system was in place for the registered dietitian to become aware of accurate weights and develop a plan of care to address weigh loss for one of two residents reviewed for nutritional status. F842: During the complaint survey of 8/6/2024 the facility failed to ensure the medical records were accurate and complete regarding administration of medication and treatments. This was for four of six sampled residents whose medical records were reviewed for documentation related to medications and treatments being documented correctly in the medical record. During the complaint survey of 6/6/2024 the facility failed to ensure the medical record was	F 867	100% education of all active/current facility members of QAPI committee to includes Director of nursing Assistant Director of nursing (ADON), business office manager, activities director, housekeeping manager, maintenance director, admissions director, social workers, staff development coordinator, medical records, Rehab Director, MDS Coordinators, and Central Supply Person), were completed by the facility Administrator. The emphasis of this education includes but is not limited to the contents of QAPI committee and the importance of developing and maintaining appropriate plans to correct identified quality deficiencies to prevent re-occurrences. This education will be completed by 08/27/2024, any department leader not educated by 08/27/2024, will not be allowed to work until educated. This education will be provided annually and will be added on new hire orientation for all new Department leaders effective 05/08/2023. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 08/27/2024 Facility Administrator will review the Plan of Corrections for F686, F692, and F842 during weekly ad hoc QAPI meeting to ensure the monitoring process is effective to attain and maintain compliance and prevent no future repeat citation. This monitoring process will be completed weekly for eight weeks, then monthly for three months or until the pattern of compliance is	

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F 867	Continued From page 35 complete and accurate regarding administration of treatments, administration of medications, administration of enteral feedings, and weights for one of one sampled resident reviewed for accuracy of medical records. An interview was conducted with the facility Administrator on 8/2/2024 at 10:55 AM. The Administrator stated she had trusted the Assistant Director of Nursing (ADON) to work with the Registered Dietitian to make sure the facility was compliant with monitoring weights and nutritional requirements for the residents with pressure sores and/or at nutritional risk. The Administrator confirmed the facility had QAPI meetings on 6/25/2024 and 7/30/2024 during which the ADON was trusted to monitor and present actual information regarding residents with pressure sores and residents at nutritional risk to make sure the facility was compliant with citations F686 and F692. The Administrator also confirmed the ADON was trusted to monitor the resident Medication Administration records (MARs) and Treatment Administration records (TARs) so the information could be accurately presented to the Interdisciplinary team at the QAPI meeting. The Administrator revealed she really did think the monitoring of the records was being completed despite a lack of any evidence of any monitoring of the records for accuracy or completeness. The Administrator indicated she really did think the communication in the QAPI meetings indicated the facility plan of correction was working and was being monitored. An interview was conducted with the ADON on 8/2/2024 at 12:15 PM. The ADON was unable to explain why sampled residents for the current survey were not a part of the facility QAPI	F 867	maintained. Findings of this monitoring process will be documented on Quality Assurance monitoring tool located in the facility compliance binder. Effective 08/27/2024, the facility administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for six months, or until the pattern of compliance is achieved established Compliance date: 08/27/2024.	

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F 867	Continued From page 36	F 867		

monitoring process for residents with pressure sores and residents requiring nutritional interventions. The ADON stated she thought the monitoring process for QAPI was complete. The ADON was also unable to provide any evidence the facility had QAPI monitoring tools of the resident MARs and TARs for accuracy and completeness of the record. The ADON stated she was aware in the 7/30/2024 QAPI meeting with the interdisciplinary team that the MARs and TARs had a lot of blanks. The ADON stated the QAPI team decided to implement further measures of education, disciplinary action, intercom announcements, and signs posted throughout the building to try to improve the consistency of documentation by the nursing staff.