STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562	A. BUILDING _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 7/11/23 through 7/13/23. Event ID #UK0311. The following intakes were investigated: NC00203566, NC00200582 and NC00200676. 5 of the 11 complaint allegations resulted in a deficiency.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		8/10/23

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

Electronically Signed | 08/02/2023

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews, the facility failed to maintain a resident's dignity by not providing incontinence care. Resident #3 stated she felt frustrated and mad. This occurred for 1 of 3 residents reviewed for dignity (Resident #3). The findings included: Resident #3 was admitted to the facility on 9/20/21. Resident #3's quarterly Minimum Data Set dated 4/28/23 revealed she was cognitively intact with refusal of care occurring 1 to 3 days during the assessment period. She required extensive assistance with bed mobility, transfers, and toilet use. She was always incontinent of bowel and bladder. During a continuous observation on 7/11/23 from 11:38 am to 12:51 pm, an interview was conducted with Resident #3 who was sitting up in a wheelchair in her room. Resident #3 requested the surveyor to turn her call light on because she stated that she was wet and needed her brief	F 550	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. F550 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #3 stated it makes her frustrated when she is left to sit in wet brief for so long without help as staff are aware she can not clean herself. Resident #3 was provided incontinence care on	

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F 550	Continued From page 2	F 550		

changed. Resident #3 looked at the clock on the wall, discussing how long it would take staff to answer the call light. At 11:51 am, Resident #3's call light remained on while Nurse Aide (NA) #1 and NA #3 were observed passing by the room without answering the call light. At 11:49 am, Therapist #1 walked past the call light without answering it. At 11:54 am, another nurse aide was observed walking past the call light twice while delivering water to other rooms in the hall. At 12:37 pm, NA #1 walked into Resident #3's room and asked the resident what she needed. Resident #3 stated, "I'm wet and I need to be changed." NA #1 turned off the call light and stated to Resident #3 that she had to get linen and would be back to clean up the resident. At 12:45 pm, Therapist #2 entered Resident #3's room and asked Resident #3 how she was doing and if she needed anything. Resident #3 stated she was wet and needed to be cleaned up. Therapist #2 turned on the call light and left the room. At 12:51 pm, NA #2 and NA #3 entered Resident #3's room. At this time, there was a strong odor of urine which could be smelled from the hallway. Resident #3 stated to NA #2 and NA #3 that she was wet and needed to be changed. NA #2 assisted the resident to the bathroom by wheelchair. They placed a clean brief and pants on Resident #3. Resident #3 was assisted back to her wheelchair. NA #2 stated she was making rounds and NA #3 was assisting her. NA #3 stated Resident #3 had refused a shower at 11:00 am and he had agreed to help with her care but was not aware Resident #3 had turned on her call light.

A follow-up interview on 7/11/23 at 1:00 pm with Resident #3 revealed she had refused to take a shower at 11:00 am but she did not refuse

7/11/2023. Resident #3 remains in the facility and is provided timely incontinence care.

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:

Current residents will be interviewed by Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Social Worker (SW), Minimal Data Set (MDS) and/or Nurse(s) regarding dignity and respect using resident questionnaire by 8/10/2023. Residents not able to complete the questionnaire will have the clinical nursing management team physically check the resident brief to ensure the resident is clean and dry. If the resident is not, assistance will be provided immediately. This will be completed by 8/10/23.

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

" Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM) will provide education to current contract agency/ facility nursing staff regarding resident rights and dignity and what constitutes dignity with examples including being in soiled brief for an extended period of time by 8/10/2023. After 8/10/2023, all contracted agency/facility staff that has not worked and received the education will complete

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F 550	Continued From page 3 incontinence care. At 11:00 am, she was already wet and needed to be changed. Resident #3 stated she looked at the clock on the wall which was how she kept up with the time. Resident #3 stated it made her frustrated when the staff let her sit in a wet brief. She stated, "It makes me frustrated when they leave me sitting so long without helping me, they know I can't do it myself." An interview with NA #2 on 7/11/23 at 1:10 pm revealed she was assigned to care for Resident #3. NA #2 stated that NA #3 had assisted her with rounds so they could get finished quicker. NA #2 stated she had offered a shower at 11:00 am to Resident #3 who refused so she left the room. She stated that she was not aware the resident needed incontinence care at that time, and she did not ask Resident #3 if she needed to be changed. An interview on 7/11/23 at 2:40 pm with Nurse #2 revealed she had asked NA #2 to make sure she completed care rounds with Resident #3 since she had refused care at 11:00 am. Nurse #2 stated she did not know Resident #3 did not receive incontinence care at 11:00 am. An interview on 7/11/23 at 1:46 pm with NA #1 revealed when she went in to answer Resident #3's call light, she couldn't remember what Resident #3 had wanted but she thought Resident #3 had asked for some water. NA #1 stated she got tied up giving the other residents water and she didn't come back to Resident #3's room. NA #1 stated she wasn't assigned to Resident #3 and only answered her call light, but she couldn't remember Resident #3 requesting to be changed.	F 550	upon their next scheduled shift. " Staff Development Coordinator (SDC) will include education regarding resident rights and dignity and what constitutes dignity with examples including being in a soiled brief for an extended period of time in general orientation for contract agency/facility nursing staff. " Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Social Worker (SW), Minimal Data Set (MDS), Nurse(s) will interview 10% of residents using questionnaire 2 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. Additionally, 10% of residents will be audited by the clinical nursing management team by physically checking the resident brief to ensure the resident is clean and dry. If the resident is not, assistance will be provided immediately, to ensure residents are receiving incontinence care timely 2 times a week x 4 weeks, weekly x 4 weeks, and then monthly x 1 month. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring audits and interview responses. The results of the audits and interviews will be reviewed weekly x4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits and	

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F 550	Continued From page 4 A follow-up interview on 7/11/23 at 2:55 pm with Resident #3 revealed when NA #1 came to her room to answer her call light, she had asked to be changed because she was "soaking wet" and that she never asked for some water from NA #1. Resident #3 demonstrated increased anger during the interview by wringing her hands, her face turned red, and she began to stutter. She said, "I have trouble getting my words out when I get mad." She added, "They knew I was wet." An interview was conducted on 7/12/23 at 11:05 am with the Director of Nursing (DON). The DON stated that anyone could answer the call lights. The DON stated Resident #3 should not have waited more than an hour before she was provided incontinence care. She also stated that whoever answered Resident #3's call light should have provided incontinence care to her or should have gotten another staff member to do it if they were doing another task at that time.	F 550	interview responses to determine trends and/or further problem resolution if needed. Date of compliance: 8/10/2023.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		8/10/23

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F 561	Continued From page 5 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, family member and staff interviews, the facility failed to provide the preferred type of bathing for 2 of 3 residents (Resident #4 and Resident #2) reviewed for choices. The findings included: 1. Resident #4 was admitted to the facility on 6/7/22 with diagnoses that included chronic ulcer of right lower leg and peripheral vascular disease. The quarterly Minimum Data Set (MDS) assessment dated 7/5/23 indicated Resident #4 had intact cognition, did not exhibit rejection of care behaviors, was totally dependent on two persons for bathing and had impairment to one side of both upper and lower extremities. A review of Resident #4's care plan reviewed on 7/5/23 indicated that Resident #4 had potential for actual mental and psychosocial adjustment	F 561	F561 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #2 was provided with their preferred type of bathing (shower) on 7/13/23. Resident #2 currently remains in the facility and is receiving preferred type of bath as scheduled. Resident #4 was provided with their preferred type of bath (shower) on 7/17/23. Resident #4 currently remains in the facility and is receiving preferred type of bath as scheduled. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:	

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F 561	Continued From page 6 difficulties related to change in resident's usual and customary routines. Interventions included to allow resident input into daily care and schedules. Resident #4 did not have a care plan for refusal of care. The facility's shower schedule indicated Resident #4 preferred to have showers two times a week on Wednesday and Saturday on the evening shift from 7:00 PM to 7:00 AM. The Documentation Survey Reports for May, June and July 2023 indicated the following information regarding the type of bath Resident #4 received: May 2023 - Resident #4 was documented to have received no showers, partial bed baths on 5/6/23, 5/10/23, 5/13/23 and 5/24/23 and a full bed bath on 5/31/23. Resident #4 refused a shower on 5/10/23. June 2023 - Resident #4 was documented to have received no showers and a full bed bath on 6/7/23 and 6/28/23. Resident #4 refused a shower on 6/19/23. July 2023 - Resident #4 was documented to have received no showers, a full bed bath on 7/1/23 and a partial bed bath on 7/5/23 and 7/12/23. On 7/11/23 at 10:25 AM, an interview with Resident #4 revealed she got a bed bath every day, but she preferred to take a shower instead. Resident #4 stated she was supposed to receive a shower twice a week. She stated that she had asked the staff if she could have a shower and they often told her the next shift would give it to her. Resident #4 stated when the evening shift came in, they would often tell her that they were	F 561	Current residents and/or responsible parties will be interviewed by Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Social Worker (SW), Minimal Data Set (MDS) Nurse(s), Activities Director to determine the resident's/responsible party's preferred type of bath for the resident. This information will be added to the resident care guide in the care plan. 3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: • Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM) will provide education to current contract agency/ facility nursing staff and therapy staff regarding residents being offered and receiving their preferred type of bath. If resident refuses their preferred type of bath, the resident's assigned nurse will document the refusal of the preferred type of bath in the electronic health record. Education will be completed by 8/6/2023. After 8/6/2023, all contracted agency/facility staff that has not worked and received the education will complete upon their next scheduled shift. • Staff Development Coordinator (SDC) will include education residents being offered and receiving their preferred type of bath and requirements for documentation of refusals in general orientation for contract agency/facility nursing staff. • Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager	

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too busy to give her a shower. During the interview, Resident #4 looked clean, did not have greasy hair, and did not have any body odor.

A phone interview with Nurse Aide (NA) #6 on 7/13/23 at 1:30 PM revealed she worked with Resident #4 in June on the night shift. NA #6 stated she did not give Resident #4 a shower on her scheduled shower day because no one had ever told her to do so, and she wasn't familiar with the shower schedule.

A phone interview with NA #5 on 7/13/23 at 9:10 AM revealed she worked with Resident #4 on 7/5/23 on the night shift. NA #5 stated she did not give Resident #4 showers on her scheduled shower days because no one had ever told her that she was supposed to do so. NA #5 stated she did not receive any information about showers during orientation when she started. NA #5 stated she was told by the staff to give the residents a bed bath so that's what she had been doing.

A phone interview with NA #7 on 7/13/23 at 10:19 AM revealed she had worked with Resident #4 on 7/12/23 on the night shift. NA # 7 stated she did not give Resident #4 showers on her scheduled shower days because Resident #4 always refused her showers. NA #7 stated that Resident #4 was afraid to get on the shower bed. NA #7 stated Resident #4 refused to take a shower on 7/12/23 so she gave her a bed bath instead.

A follow-up interview with Resident #4 on 7/13/23 at 10:30AM revealed Resident #4 did not get offered a shower on 7/12/23. Resident #4 stated they just went into her room and gave her a bed bath. Resident #4 stated she had never refused a

(UM), will complete audits of documentation in the electronic health record to identify any resident not receiving their preferred type of bath. Documentation audits will be conducted 3 times per week x 4 weeks, 1 time a week x 4 weeks, then monthly x1. Additional, 5 residents with BIMS of 12 or higher will be interviewed weekly to ensure they are being offered their preferred type of bath.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:

The Administrator is responsible for the plan of correction and monitoring audits and interview responses. The results of the audits and interviews will be reviewed weekly x4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits and interview responses to determine trends and/or further problem resolution if needed.

Date of compliance: 8/10/2023.

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shower and had never told anyone that she was afraid to use the shower bed. Resident #4 stated that she liked the shower bed and that staff had used the mechanical lift to get her from the bed to the shower bed. Resident #4 stated since she had been at the facility, she had only received a shower twice.

On 7/13/23 at 1:50 PM, an interview with the Director of Nursing (DON) revealed she was aware that Resident #4 did not receive her scheduled showers. The DON stated staff had told her that Resident #4 always refused her showers so the staff would go and take care of another resident and then come back to Resident #4 and see if she changed her mind. If Resident #4 still refused the shower, then the staff would offer her a bed bath. The DON stated that Resident #4 should receive her scheduled showers based on her preferences.

2. Resident #2 was admitted to the facility on 7/15/22 with diagnoses that included dementia.

The significant change in status Minimum Data Set (MDS) assessment dated 5/15/23 indicated Resident #2 had moderately impaired cognition, exhibited no rejection of care behaviors, and was totally dependent on staff with personal hygiene and bathing.

The facility's shower schedule indicated Resident #2 was scheduled to have showers two times a week on Wednesday and Saturday on the evening shift from 7:00 PM to 7:00 AM.

The Documentation Survey Reports for May, June and July 2023 indicated the following information regarding the type of bath Resident

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#2 received:
May 2023 - Resident #2 was documented to have received a full bed bath on 5/5/23, 5/8/23, 5/9/23, 5/11/23, 5/12/23, 5/13/23, 5/15/23, 5/18/23 and 5/25/23. No showers were documented.

June 2023 - Resident #2 was documented to have received a full bed bath on 6/5/23, 6/6/23, 6/7/23, 6/8/23, 6/15/23, 6/19/23, 6/20/23, 6/21/23, 6/22/23 and 6/26/23. No showers were documented.

July 2023 - Resident #2 was documented to have received a shower on 7/13/23 and a full bed bath on 7/3/23, 7/6/23, 7/7/23, 7/8/23 and 7/12/23.

An interview was attempted with Resident #2 on 7/11/23 at 10:00 AM but she only stared at the surveyor and did not answer any questions.

During an observation of care on Resident #2 on 7/12/23 at 8:25 AM, Nurse Aide (NA) #4 was observed checking Resident #2's brief to see if she was soiled. She pulled back the cover to check the brief and when NA #4 opened Resident #2's brief, Resident #2's brief was dry. NA #4 closed Resident #2's brief and stated that she would give Resident #2 a bed bath after she ate breakfast. NA #4 washed Resident #2's face and hands before breakfast.

An observation of care on Resident #2 on 7/12/23 at 9:55 AM revealed NA #4 provided a bed bath to Resident #2. NA #4 explained to Resident #2 what she was doing during the procedure. Resident #4's brief was not wet prior to the procedure but she continued to smell of urine. After washing Resident #2's face, arms, upper torso, legs and feet, NA #4 refreshed the basin

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F 561	Continued From page 10	F 561		

with fresh water and proceeded to soap and wash Resident #2's perineal area. No body odor or foot odor was noted after the bed bath was completed.

An interview was conducted with Resident #2's family member on 7/13/23 at 9:17 AM. The family member stated that the staff would not shower her unless she told them to and as far as knew, they gave her a shower whenever she asked them to. The family member stated she had told the Director of Nursing (DON) who told her that the night shift nurse aides and not the day shift nurse aides were responsible for giving Resident #2 a shower. The family member stated that Resident #2 needed to get her showers because she had always had problems with her feet giving off an odor.

A phone interview with Nurse Aide (NA) #5 on 7/13/23 at 9:10 AM revealed she had worked with Resident #2 on the night shift but did not recall what date. NA #5 stated she did not give Resident #2 showers on her scheduled shower days because no one had ever told her to do so. NA #5 stated she had not received any information about showers during orientation when she started, and she was told by the staff to give the residents a bed bath so that's what she had been doing. NA #5 stated she didn't know about the shower schedule and had not received education about this from the Director of Nursing (DON). She further stated that she had never given any resident a shower on the night shift from 7:00 PM to 7:00 AM and that she had only been giving bed baths.

A phone interview with Nurse Aide (NA) #6 on 7/13/23 at 1:30 PM revealed she worked with

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	345562	A. BUILDING _____ B. WING _____	C 07/13/2023

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F 561	Continued From page 11 Resident #2 on the night shift in June and July 2023. NA #6 had given Resident #2 a partial bed bath and a full bed bath but not a shower. NA #6 stated she did not give Resident #2 showers on her scheduled shower days because no one had ever told her that she was supposed to do so. NA #6 stated that no one had ever told her to even get Resident #2 up out of the bed until 7/12/23. NA #6 stated she was not familiar with the shower schedule and had not been educated by the DON about it. NA #6 stated she had not given any resident a shower on the night shift from 7:00 Pm to 7:00 AM. An interview with the Director of Nursing (DON) on 7/13/23 at 1:50 PM revealed she was aware that Resident #2's family member had been concerned about her not receiving showers. The DON stated that she was currently doing audits on the showers and was aware that Resident #2 continued to not receive any of her scheduled showers. The DON stated she had provided a verbal in-service to the night shift staff whenever showers were not completed but could not remember if she had talked to NA #5 or NA #6. The DON stated Resident #2 sometimes would cry and staff would treat this as a refusal, but they were supposed to follow the shower schedule and give her a shower on her scheduled shower days. She confirmed that Resident #2 was scheduled for showers on the 7:00 PM to 7:00 AM shift. The DON stated they had scheduled Resident #2 for night shift showers based on the facility's schedule and not because it was preferred by Resident #2 or her family member.	F 561		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		8/10/23

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F 677	Continued From page 12 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to ensure a dependent resident received incontinence care when requested for 1 of 4 residents reviewed for assistance with activities of daily living (Resident #3). The findings included: Resident #3 was admitted to the facility on 9/20/21 with diagnoses that included chronic obstructive pulmonary disease (COPD) and muscle weakness. Resident #3's care plan revised on 3/7/23 indicated she had an activities of daily living/personal care deficit related to COPD, weakness, and impaired mobility. Resident #3 was incontinent and wore briefs. She had a history of refusing incontinence care and showers, despite staff's continued encouragement and education on the risk factors associated with not having adequate incontinence care. Interventions included for Resident #3 to require one person assist with toileting and incontinence care after incontinent episodes. Resident #3's quarterly Minimum Data Set dated 4/28/23 revealed she was cognitively intact with refusal of care occurring 1 to 3 days during the assessment period. She required extensive assistance with bed mobility, transfers, and toilet use. She was always incontinent of bowel and	F 677	F677 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #3 was provided incontinence care on 7/11/2023. Resident #3 remains in the facility and is provided incontinence care when requested. 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current residents with BIMS greater than 12 will be interviewed by Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Social Worker (SW), Minimal Data Set (MDS), Nurses ensuring incontinence care is being provided when requested by 8/10/2023. Residents not able to be interviewed will have the clinical nursing management team physically check the resident brief to ensure the resident is clean and dry. If the resident is not, assistance will be provided immediately. This will be completed by 8/10/23. 3. Measures to be put in place or	

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F 677	Continued From page 13 bladder. During a continuous observation on 7/11/23 from 11:38 am to 12:51 pm, an interview was conducted with Resident #3 who was sitting up in a wheelchair in her room. Resident #3 requested the surveyor to turn her call light on because she stated that she was wet and needed her brief changed. At 11:51 am, Resident #3's call light remained on while Nurse Aide (NA) #1 and NA #3 were observed passing by the room without answering the call light. At 11:49 am, Therapist #1 walked past the call light without answering it. At 11:54 am, another nurse aide was observed walking past the call light twice while delivering water to other rooms in the hall. At 12:37 pm, NA #1 walked into Resident #3's room and asked the resident what she needed. Resident #3 stated, "I'm wet and I need to be changed." NA #1 turned off the call light and stated to Resident #3 that she had to get linen and would be back to clean up the resident. At 12:45 pm, Therapist #2 entered Resident #3's room and asked Resident #3 how she was doing and if she needed anything. Resident #3 stated she was wet and needed to be cleaned up. Therapist #2 turned on the call light and left the room. At 12:51 pm, NA #2 and NA #3 entered Resident #3's room. At this time, there was a strong odor of urine which could be smelled from the hallway. Resident #3 stated to NA #2 and NA #3 that she was wet and needed to be changed. NA #2 assisted the resident to the bathroom by wheelchair. Both nurse aides washed their hands and applied gloves. They assisted the resident to the corner railing where the resident held onto the railing, and she pulled herself to a standing position. The nurse aides removed her wet pants before removing her brief which was heavily soiled with	F 677	systemic changes made to ensure practice will not re-occur: • Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM) will provide education to current contract agency/ facility nursing staff noting residents should receive incontinence care when requested and be checked and changed several times per shift, if unable to communicate the need for incontinence care by 8/10/2023. After 8/10/2023, all contracted agency/facility staff that has not worked and received the education will complete upon their next scheduled shift. • Staff Development Coordinator (SDC) will include education noting residents should receive incontinence care when requested and be checked and changed several times per shift, if unable to communicate the need for incontinence care for contract agency/facility nursing staff in general orientation for contract agency/facility nursing staff. • Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), Social Worker (SW), Minimal Data Set (MDS), Nurse(s) will interview 10% of residents dependent for ADL care with a BIMS of 12 or higher to ensure incontinence care is being provided when requested and be checked and changed several times per shift, if unable to communicate the need for incontinence care 2 times a week x 4 weeks, weekly x4 weeks, and then monthly x1. Additionally, 10% of residents with BIMS less than 12 will be audited by the clinical nursing	

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F 677	Continued From page 14 urine and feces. An observation of Resident #3's bottom revealed no red or open areas after the nurse aides cleaned it. They placed a clean brief and pants on Resident #3. Resident #3 was assisted back to her wheelchair. NA #2 stated she was making rounds and NA #3 was assisting her. NA #3 stated Resident #3 had refused a shower at 11:00 am and he had agreed to help with her care but was not aware Resident #3 had turned on her call light. A follow-up interview on 7/11/23 at 1:00 pm with Resident #3 revealed she had refused to take a shower at 11:00 am but she did not refuse incontinence care. At 11:00 am, she was already wet and needed to be changed. Resident #3 stated she looked at the clock on the wall and this was how she kept up with the time. An interview with NA #2 on 7/11/23 at 1:10 pm revealed she was assigned to care for Resident #3. NA #2 stated that NA #3 had assisted her with rounds so they could get finished quicker. NA #2 stated she had offered a shower at 11:00 am to Resident #3 who refused so she left the room. She stated that she was not aware the resident needed incontinence care at that time, and she did not ask Resident #3 if she needed to be changed. An interview on 7/11/23 at 1:15 pm with NA #3 revealed the nurse had asked him to assist NA #2 with her care rounds and he was told that Resident #3 had refused care at 11:00 am. He stated Resident #3 was an easy resident to provide care for and if he knew her call light had been activated, he would have assisted the resident immediately.	F 677	management team by physically checking the resident brief to ensure the resident is clean and dry, 2 times a week x 4 weeks, weekly x 4 weeks, and then monthly x 1 month. If the resident is not, assistance will be provided immediately. 4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The Administrator is responsible for the plan of correction and monitoring audits and interview responses. The results of the audits and interviews will be reviewed weekly x4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the audits and interview responses to determine trends and/or further problem resolution if needed. Date of compliance: 8/10/2023.	

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An interview on 7/11/23 at 2:40 pm with Nurse #2 revealed she had asked NA #2 to make sure she completed care rounds with Resident #3 since she had refused care at 11:00 am. Nurse #2 stated she did not know Resident #3 did not receive incontinence care at 11:00 am.

An interview on 7/11/23 at 1:46 pm with NA #1 revealed when she went in to answer Resident #3's call light, she couldn't remember what Resident #3 had wanted but she thought Resident #3 had asked for some water. NA #1 stated she got tied up giving the other residents water and she didn't come back to Resident #3's room. NA #1 stated she wasn't assigned to Resident #3 and only answered her call light, but she couldn't remember Resident #3 requesting to be changed.

A follow-up interview on 7/11/23 at 2:55 pm with Resident #3 revealed when NA #1 came to her room to answer her call light, she had asked to be changed because she was "soaking wet" and that she never asked for some water from NA #1.

An interview on 7/12/23 at 8:37 am with Therapist #1 revealed she had walked by Resident #3's room while the call light was on but didn't answer it because she probably did not see it or pay attention to it. Therapist #1 reported she was task-oriented and was probably thinking of something else when she walked past Resident #3's call light.

An interview on 7/12/23 at 1:40 pm with Therapist #2 revealed she went into Resident #3's room to retrieve Resident #3's roommate's glasses. When she spoke with Resident #3, the resident told her that she needed to be changed.

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Therapist #2 turned on Resident #3's call light and spoke with a group of nurse aides and the nurse on the hall. Therapist #2 stated she could not remember who she talked to, but she told them that Resident #3 had requested to be changed. Therapist #2 further stated that the staff informed her that Resident #3 had refused to take a shower early that morning, but that staff was going back to check on her.

An interview was conducted on 7/12/23 at 11:05 am with the Director of Nursing (DON). The DON stated that anyone could answer the call lights. The DON stated Resident #3 should not have waited more than an hour before she was provided incontinence care. She also stated that whoever answered Resident #3's call light should have provided incontinence care to her or should have gotten another staff member to do it if they were doing another task at that time.