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	345266	A. BUILDING _____ B. WING _____	C 02/22/2024

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THE CARROLTON OF PLYMOUTH	1084 US 64 EAST PLYMOUTH, NC 27962

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/19/24 through 2/22/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # DHJA11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/19/24 through 2/22/24. Event ID# DHJA11. The following intakes were investigated NC00200948, NC00202738, NC00203099, NC00204039, NC00204174, NC00204241, NC00207687, NC00210498, NC00211873, and NC00213616. 3 of the 16 complaint allegations resulted in deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to maintain a pull cord within reach for the resident call system for 1 of 1 resident reviewed (Resident #64) for Resident Call System. Findings included: Resident #64 was admitted to the facility on 12/06/22 with a diagnosis that included debility,	F 558	Resident #64 had a clip placed on her call bell cord by the Maintenance Director on 2/22/2024. Call bell was determined to be in good working order and within reach of the resident. 100% audit of all resident call bells were audited by the Maintenance Director on 3/05/2024 to ensure proper functionality and being within reach of the resident.	3/29/24

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

Electronically Signed | 03/14/2024

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F 558	Continued From page 1 fibromyalgia, and chronic obstructive pulmonary disorder. Review of the quarterly Minimum Data Set (MDS) dated 12/11/23 revealed that Resident #64 was cognitively intact, independent with bed mobility, and required maximum assistance for transfers. Review of Resident #64's care plan revealed a problem of; At risk for falls with interventions that included to ensure the call light is within reach and to encourage Resident [#64] to use it for assistance, and to re-educate Resident [#64] on use of the call light. An observation of the resident call system for Resident #64 was conducted in conjunction with an interview with Resident #64 on 02/19/24 at 10:05 am. The observation revealed a thin string without a clip to attach it to the bed linens, the opposing end of the string was attached to a metal box attached to the wall. Observations of Resident #64 revealed she could not reach her call light pull cord. The pull cord was too short and did not reach the bed. During an interview with Resident #64 she indicated that she often could not reach her call light pull string. She stated that if she needed assistance that she just waited until someone came in to get her needs met or she yelled out for assistance. Resident #64 stated that she currently needed assistance and requested that the interviewer obtain assistance for her. In an interview with Nurse # 4 on 02/19/24 at 10:08 am at Resident #64's bedside she indicated that the string on the call light system for Resident #64 was not long enough and she would call maintenance to request to have an	F 558	In-service was initiated by ADON on 3/6/24 on ensure the call light system is functional and the call bell is in reach of the resident at all times for all staff to include Housekeeping, Therapy, Nursing, Maintenance, Activities, Dietary, and administrative staff. The in-service will be complete by 3/11/24. Maintenance Assistant will audit 10% of residents weekly x 4 weeks, then biweekly x 1 month utilizing a Call Bell Audit tool. The Director of Nursing/Designee will bring the results of the Call Bell Audit tool to the Executive QAPI Committee Meeting to evaluate the need for resolution or need for continued monitoring x 3 months.	

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extension string attached. She further stated that residents should be able to call for staff when they needed assistance.

In an observation of Resident #64's call light pull string, which was conducted in conjunction with an interview with Resident #64, on 02/20/24 at 8:57 am the call light pull string was noted longer in length than previous. The string for the call light was observed to have been wrapped around the lower rung of the bed rail and hung down beside the bed out of reach for Resident #64. In an interview with Resident # 64 she stated she could not reach her call light string and could not find it. She further indicated that this occurred about 5 times a day and she could not call for help when she could not reach the string. She stated the string could not be attached to the bed to keep it within her reach and it fell to the floor if it were placed on her bed. Resident #64 stated that if the call light string fell off the bed and she needed help that she "hollered" for help and staff would tell her she "could not be screaming and hollering because it disturbed other residents." She stated that it took up to 15 minutes before staff responded when she hollered.

In an interview with Nursing Assistant (NA) #1 on 02/21/24 at 6:20 am he stated he had worked at the facility for 1 year and worked night shift. He revealed that he tied Resident #64's the call light string to her bedrail. He stated that all the rooms on 600 hallway had the same call light system and had a pull string instead of a push button and the string did not have a clip to keep them in place. He further indicated that the call light strings were light in weight and sometimes fell to the floor if the resident moved in bed. He stated he never reported this to management because

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the system worked for most residents.

In a follow up interview with resident # 64 on 02/21/24 at 9:40 am she stated that she wanted to be able to reach her call light string to call for assistance all the time. Resident #64 indicated that when staff tied the string to her bedrail, it came loose and fell down out of her reach, and she could not call for assistance. She stated she had told the staff of her concern.
In an interview with the Administrator on 02/21/24 10:05 am she stated she thought the call light system on the 600 hall was effective and it concerned her if a resident could not use the call light system. She was not aware that Resident #64 could not use her call light system.

In an interview with the Director of Nursing (DON) on 02/21/24 10:06 am she stated that NAs were on the 600 hallway all night and if a call light string fell to the floor and a resident called out, they heard them and provided assistance.

In a follow-up interview with the DON 02/21/24 at 1:56 pm she stated that the call light system had not been a problem for Resident #64 or other residents on 600 hallway to get assistance. The DON indicated that staff tucked the string under the pillow, attached it to a trapeze bar, or tied it to a side rail. She further stated that if the string fell to the floor that Resident #64 could call out [verbally] and that an NA heard and came to assist, she further indicated that therapy was on that hall and could hear her too. The interview further revealed that staff made routine rounds to make sure residents' needs were met and if a call light string was too short staff reported it to maintenance and the string was extended.

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In an interview with the Maintenance Director on 02/21/24 at 11:28 am it was revealed that the call bell system on the 600 hallway worked the same as the push button call system but had a pull string instead of a push button. He stated that when a resident pulled the string it activated the call light on the hall. He stated that staff tied the string to the bed rail, to the bed frame, or laid it on the mattress. The interview further revealed that if staff laid the string on the mattress that the string was light weight and could slide off. The Maintenance Director further stated that most of the residents on 600 hallway could reach their call light string if it had an extended string attached, if the extended string didn't fall off, or if the string fell out of their reach. He stated that he received work orders and replaced strings when they were broken. He further stated that if the string was pulled on too hard that it pulled out of the box in the wall and would not work until he removed the face plate and rethreaded it. He indicated that this happened one or two times a month and if he was not at the facility that staff gave the residents a tap bell to use to call for assistance until he returned and repaired the call light system.

During an interview with the Maintenance Assistance on 02/21/24 at 12:15 pm it was revealed that the pull string call system was effective for residents that got up or reached over to access the pull string, but if the string was laid on the bed it fell to the floor because it was light weight. He further stated that it became an issue if a resident could not get up to reach the pull string, if they did not have the strength to pull the string, or if the string fell to the floor. He stated that staff sometimes tied the string to the bed, but the string still came loose and fell to the floor.

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F 558	Continued From page 5 In an interview with NA#2 02/22/24 11:38 am she indicated that she was assigned to Resident #64 often on day shift and she tied the call light string to the side rail of the bed, but the string broke if the side rail was put down when it was tied. She further indicated that Resident #64 would "holler" to the Nurse or NA to get help when her string broke or was out of reach. NA #2 stated that she was on the hallway the majority of her shift and she checked on Resident #64 every time she went down the hallway. She stated that Resident #64's call light string was found on the floor about 2 times a day on her shift. The interview further revealed that NA #2 reported this concern to maintenance, and they came and put another string on or tied a stuffed animal to the string, but the stuffed animal pulled off and some resident's liked the stuffed animal and removed it so they could play with it. In an interview on 02/22/24 11:28 am with Nurse #8 revealed that the call light system for Resident #64 had a pull string that was pulled for assistance. She stated the call light string did not have a clip and could not be attached to the bed and she had seen the string tied to the bed rail. She further stated that if the string fell out of reach that Resident #64 would call out "Nurse or can I get some assistance". Nurse #8 indicated that she recalled 2 occasions where Resident #64's call light string fell to the floor, and she could not reach it and had to call out for assistance.	F 558		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		3/29/24

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comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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F 584	Continued From page 7 Based on observation, resident and staff interviews the facility failed to maintain and repair holes in the wall for 1 of 1 resident room (Room 610), maintain the walls around the Packaged Terminal Air Conditioner (PTAC) units (a commercial grade air conditioner that is installed directly through a wall) for 2 of 5 resident rooms (Rooms 610 and 617), failed to maintain room temperatures within regulatory requirements for 1 of 1 resident room (Room 412), and the facility also failed to repair flooring with exposed concrete at the central nursing station. This was for 3 of 3 resident rooms reviewed for a safe, clean, homelike environment. Findings included: a. Room 610 was observed on 02/19/24 at 3:40 pm. During the observation the wall behind and above the headboard of the resident's bed was noted to be white in color with a rough textured area of exposed dry wall compound (a white powder mixed with water to form a paste the consistency of cake frosting, which is spread onto drywall and sanded after dry to create a seamless base for paint on walls). This area was roughly the size of the headboard of the bed. The observation further revealed 3 grapefruit sized areas of the same unfinished color and texture on the wall directly beside the resident's bed. These areas were all unfinished, unsanded, and unpainted. Room 610 was observed on 02/19/24 at 3:40 pm. During the observation the PTAC unit was noted to have approximately 3 inch wide strips of white tape around all 4 sides of the PTAC unit that was wavy and separated from the wall at random intervals, the baseboard underneath the PTAC	F 584	1. Immediate action(s) taken for the resident(s) found to have been affected include: A PTAC was placed in room #412 on 3/08/2024 by the Maintenance Director to provide more warm air. The hole in the wall in room 610 was repaired on 3/14/2024 bu facility contractor. The walls around the Packaged Terminal Air Conditioner (PTAC) were repaired in room 610 and 617 on 3/14/2024 by facility contractor. New flooring is scheduled to be installed in the central corridor area by Carpet Design Center on March 18th-20th, 2024. 2. Identification of other residents having the potential to be affected was accomplished by: 100 % audit of the facility was completed on 3/01/2024 by the Administrator and/or her designee to identify holes, penetrations in resident care areas. The list of repairs needed was given to facility contractor for correction. The Maintenance Supervisor verified proper temperature levels in every room on 3/05/2024. 3. Actions taken/systems put in place to reduce the risk of future occurrence include: Activity Director/designee will audit 5 rooms per hall per week utilizing a Environmental Audit tool to include air temp monitoring x 4 weeks, then bi weekly x 4 weeks.	

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F 584	Continued From page 8 had detached from the wall, and a portion of a concrete block was observed underneath the center of the PTAC unit. In subsequent observations of Room 610 throughout the survey the unfinished wall areas and taped PTAC unit remained unchanged. There was no active repair noted to be in progress. During an interview with the Maintenance Director on 02/21/24 at 11:48 am it was revealed that he was unaware that the baseboard underneath the PTAC unit had detached from the wall. The interview further revealed that he was not sure when the repair work to the walls had begun but that he was away from work for an extended time in 2023 and that his assistant may have done the initial repair to the wall when he was gone. He further indicated that it was difficult to remember things. In a phone interview with the Maintenance Assistant on 02/21/24 at 12:06 pm it was revealed that he had been employed at the facility for 2 years and the PTAC tape was in place prior to his employment. He further indicated that the way the PTAC unit fit into the recess in the wall that it left an air crack around it and you could see light to the outside and that was why it was taped. The interview further revealed that he did not start the wall repairs in room 610 and he was unaware that the walls had not been completed. He indicated that he would have sanded and painted the wall the next day if he had done the repairs. During an interview with the resident in Room 610 on 02/21/24 at 1:13 pm revealed that the walls in her room had the "putty" on them for about a year. She further indicated that she did not like how the walls looked and it did not feel like home to her. An observation of the PTAC unit during the interview revealed that the previous tape had	F 584	4. How the corrective action(s) will be monitored to ensure the practice will not recur: Maintenance will forward the results of the Environmental Audit tool to the Executive QAPI committee for analysis and trending until the problem is deemed corrected.	

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been removed from the unit and an open crack was noted around the perimeter of the PTAC where the unit met the wall. Outside air could be felt flowing in and light could be seen when looking out through the cracks.

In an interview with Nurse Aide (NA) #6 on 02/21/24 at 01:15 pm it was revealed that she had worked at the facility for 3 years and that the walls in Room 610 wall had been unfinished for about a year.

In an observation of the PTAC in Room 610 on 2/22/24 at 9:30 am the unit was observed to have fresh tape reapplied around the perimeter of the PTAC to seal the space where the unit met the wall.

b. Room 617 was observed on 2/19/24 at 10:27 am. During the observation the PTAC unit was noted to have approximately 3-inch-wide strips of white tape around all 4 sides of the PTAC unit that was wavy and peeling and the tape was detached and pulled away on the rights side of the PTAC unit. A sticky rodent trap was observed underneath a chair on the right side of the PTAC unit and a rodent bait box was noted beneath the PTAC unit. The observation further revealed the baseboard beneath the PTAC was loose and the floor was littered with dark unidentifiable dirt and debris.

During an observation of Room 617 with the Maintenance Director on 02/20/24 at 12:55 pm The Maintenance Director pulled the tape further away from the right side of the PTAC and 2 holes were noted adjacent to the PTAC with one hole above the other that opened through to the inside of the wall. The PTAC was noted to be leaning

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slightly forward and he was observed to lift up on the unit and push it into the recess in the wall. During an interview with the Maintenance Director during the observation he indicated that he had worked at the facility for 6 years and the PTAC units had been taped around all 4 sides because the walls were uneven and jagged at the joints where the wall met the PTAC units. He stated that he could not do anything to repair the wall around the PTAC units and tape was the only solution. The interview further revealed that he did not know what caused the holes in wall in that room, but they had removed some pipes from an old heating system on that unit and had not sealed the holes but had just covered them with tape. He stated that the tape did not stick well and was falling off.

In a second interview with the Maintenance Director on 02/21/24 11:40 am it was revealed that he taped the PTAC units about 4 years ago because he had asked his previous supervisor how to fix the problem and nothing was recommended. He further stated that he reported the concern to his current supervisor who came and assessed the PTACs but nothing was recommended. He stated that if the PTAC unit was bumped with a bed or something that it dislodged from the recess in the wall, and you could see the outside light through the crack.

In an interview with the Maintenance Assistant on 02/21/24 at 12:06 pm it was revealed that he had been employed at the facility for 2 years and the PTAC's were already taped when he arrived. He further indicated that the way the PTAC unit fits in the recess in the wall that there was an "air crack" around it, and that light visible to the outside without the tape. He indicated that he had cut

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some pipes out of the wall and that is what caused the holes in the wall in Room 617.

In a follow up interview with the Maintenance Director on 02/22/24 at 8:03 am it was revealed that he had not reported the PTAC issue to his current supervisor as he had previously stated in an interview on 02/21/24 at 11:40 am, but that his current supervisor was at the facility a few weeks ago to observe the pipe removal work. He indicated that he had assumed that his supervisor had seen the tape and the condition of the PTAC units. He further stated that he did not make routine rounds to determine what repairs were needed to the building, but that staff reported issues in a computed based system that he checked daily. The interview further revealed that he did not report the condition of the PTAC units to his supervisor because he thought the tape on the units was sufficient.

In an interview with the resident in Room 617 A on 02/22/24 at 8:55 am he stated that he does not like how the PTAC unit looks taped up and ragged. He stated it does not feel like home to him like that and he further indicated that he thought the mice were coming in through the holes in the wall.

In an interview with the Administrator on 02/20/24 at 1:11 pm it was revealed that she was unaware that the PTAC units had been taped, and that Room 610 walls were not finished until last month when the facility received a Life Safety citation. She further indicated that all issues should have been addressed timely.

A review of a document entitled Inspection of Hospitals, Nursing Homes, Adult Care Homes,

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and Other Institutions it was revealed that the facility received a Life Safety inspection on 12/14/23 with the following observations and corrective actions that included to "maintain walls noted rooms with holes in the walls and tape around heat and air units".

In an interview with the Physical Therapy Manager on 02/21/24 at 9:48 am it was revealed that she had worked at the facility for 12 years. She did not recall how long the PTAC units had been taped and that maintenance came and retaped them if they saw a "crack" in the tape.

In a second interview with the Administrator on 02/21/24 at 9:59 am she stated that the PTAC units had been like that since she started work at the facility March of 2021 and should have been corrected. She further indicated that she had talked to the facility's corporate office yesterday to determine how it could be corrected. She stated the current condition of the PTAC units and holes in the wall concerned her because it was not aesthetically pleasing to the eye, it could be a portal of entry for vermin, and it was not heat efficient.

In an interview with the Director of Nursing (DON) on 02/21/24 at 2:02 pm it was revealed that she was unaware of the taped PTAC units. She stated she let maintenance do maintenance.

In an interview with the Corporate Vice President of Property Management on 02/22/24 at 8:30 am it was revealed that he worked with maintenance to help them gain knowledge or obtain supplies or equipment that was needed, and he worked with contractors for anything outside of the scope of the Maintenance Director. He indicated that he

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visited the facility in October of 2023. He stated that he walked with the Maintenance Director and identified things like lights that were out and toilets that leaked, but he did not recall that the PTAC units were discussed. He further indicated that the Maintenance Director called him yesterday and made him aware of the PTAC unit concerns and holes in the wall. The interview further revealed that he was concerned that if the PTAC units were not sealed good that vermin could enter the building and that there could be heat loss or gain depending on the season. He stated that he was unaware that the PTAC units dislodge easily and that the units need to be slightly tilted toward the rear for condensate to run out and that is probably the reason for the cinder blocks under the PTAC units. He stated that he thought that the current repairs were appropriate for a short term, but should not be a long term solution. He further stated that he would have recommended that door casing be used to frame up the PTAC units but that he had not been made aware of the issue until yesterday.
2. Resident in room 412 A was admitted to the facility on 3/23/23 with diagnoses which included congestive heart failure and hypertension.

The resident in room 412 A's quarterly Minimum Data Set dated 12/09/23 revealed she was cognitively intact.

An interview with the resident in room 412 A on 2/19/24 at 10:53 AM revealed that she felt her room was too cold. She stated that she had told multiple staff members that she was cold. She stated she had told some staff members she was cold but did not remember who she had told. The resident in room 412 A was lying in bed wearing a flannel gown with a sheet and a double layer of

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thick faux sheepskin and fleece blanket over her.

An interview with Nurse #10 on 2/20/24 at 1:00 PM revealed that the resident in room 412 A had previously told her she was cold and she had previously told the Maintenance Director.

An observation and interview with the Maintenance Director on 2/20/24 at 11:50 AM revealed that the hand-held temperature monitor read 63.3 degrees in room 412. He stated he was unaware of any previously reported concerns about room 412 being cold. A check of the heating system revealed that the ceiling vent was partially closed. He stated that he was unaware of any concerns related to the room temperature. The Maintenance Director further stated that he checked the room temperatures of three resident rooms per hall daily. He stated that the room temperature should be between 71 degrees and 81 degrees. He stated would check the duct work in the attic and turn the heat up on the resident's hall.

Per the Weather channel the current outside temperature was 52 degrees on 2/20/24 at 12:00 noon.

An additional interview with the Maintenance Director on 2/20/24 at 2:21 PM revealed the temperature maintenance logs were for three areas of each hallway. He did not have maintenance logs for resident room temperature checks and clarified that he checked the resident hallways.

An observation and interview with the Maintenance Director on 2/21/24 at 8:09 AM revealed that the hand-held temperature monitor

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read 66 degrees in room 412. He stated that he would inform the Administrator for further guidance.

Per the Weather channel the current outside temperature was 41 degrees on 2/21/24 at 9:16 AM.

An observation and interview with the Maintenance Director on 2/22/24 at 10:17 AM revealed that the hand-held temperature monitor read 67 degrees in room 412. During this observation, the resident in room 412 A stated that she was warm enough and the room temperature was comfortable for her. He stated he had adjusted the heat on that resident's hall.

An interview with the Administrator on 2/21/24 at 1:03 PM revealed that she was previously unaware of the low room temperature. She stated that she had asked the Maintenance Director to adjust the heat on the resident's hall. She stated that the room temperature should be between 71 degrees and 81 degrees. She stated that the Director of Nursing (DON) had talked with the resident in room 412 A, and she did not want to be moved from that room. The DON had provided the resident with another blanket.

3. An observation on 2/19/24 at 9:30 AM revealed that the main entrance hallway, the central nurses' station, and the hallway from the central nurses' station to the main dining room had missing floor tiles and the concrete was visible.

An observation and interview on 2/21/24 at 11:45 AM with the Maintenance Director revealed the area where the flooring had been removed measured approximately 2 ½ feet wide and 52

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F 584	Continued From page 16 feet long. The concrete was approximately ¼ - ½ inch lower than the flooring on each side of the 2 ½ foot wide section. Parts of two types of flooring were visible on each side of the concrete area in places. The Maintenance Director stated that the old flooring was visible about 6 inches on each side of the concrete in some places with the newer flooring on top. The Maintenance Director stated that about March or April 2023 the facility had sewage problems. He stated that the sewage pipe ran under the facility and had to be dug up and repaired. Due to the sewage pipe being dug up, the flooring had to be removed and had not been replaced. He stated that corporate had received an estimate for the flooring on 12/20/23 but it had not been scheduled. An interview with the Administrator on 2/21/24 at 1:03 PM revealed that there was no date scheduled for the flooring to be repaired. An interview with the Corporate Vice President of Property Management on 2/22/24 at 8:41 AM revealed that he was aware of the missing flooring. He stated there was no scheduled date for it to be repaired. He stated that he had received a quote for the replacement flooring cost but it was a slow process.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		3/29/24

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medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 18 Based on observations, record review and staff interviews the facility failed to develop a person-centered comprehensive care. This was for 1 of 3 residents (Resident #225) reviewed for accidents. Findings included: Resident #225 was admitted to the facility on 1/30/24 with a diagnosis of sub-arachnoid hemorrhage (bleeding in the brain). A review of the Fall Risk Assessment for Resident #225 dated 1/30/24 revealed he was at moderate risk for falls. A review of Resident #225's admission Minimum Data Set (MDS) assessment dated 2/6/24 revealed he was moderately cognitively impaired. He had functional limitation in range of motion of both upper and lower extremities on both sides. He required substantial assistance to roll from left to right. Resident #225 was dependent going from sitting to lying. His ability to stand and transfer was not assessed. He had no falls prior to admission or since admission to the facility. The Care Area Assessment (CAA) for falls was not triggered. A review of a nursing progress note for Resident #225 written by Nurse #5 dated 2/8/24 at 6:00 PM revealed in part Resident #225 was lying on the mat beside his bed. Resident #225 stated, "I was trying to lay down on the mat". Review of Resident #225's care plan dated 1/30/24 last revised on 2/19/24 revealed no care plan focus area for falls. There was no fall mat intervention on Resident #225's care plan.	F 656	Resident # 225 care plan was updated by the MDS (Minimum Data Set) nurse on 2/21/2024 to reflect proper and accurate coding for the cited resident. Director of Nursing audited all assessments from 12/01/2022 to present to ensure care plans are in place for every CAA (Care Area Assessment) triggered on 3/11/2024. Administrator educated the MDS (Minimum Data Set) nurse that all residents should have a comprehensive and accurate care plan based on the needs of the resident identified in the Comprehensive Assessment. The education was completed on 2/21/2024 and included: the function of the care plan, care plans must be individualized and resident centered, care plans are a working tool and must be updated as needed to reflect the care provided to the resident. The Assistant Director of Nursing will educate all Certified Nursing Assistants (CNAs) and Licensed Nursing Staff on the importance of following the care plan for each resident, where to find the care plan in the electronic record and how and who to report changes needed on 3/11/2024. Newly hired CNAs will be educated during orientation by the Assistant Director of Nursing. An Audit tool was created to monitor the accuracy of care plans. Director of Nursing will audit 20% of care plans to ensure care plans are comprehensive, accurate and person-centered weekly x 4	

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F 656	Continued From page 19 On 2/19/24 at 10:42 AM an observation of Resident #225 revealed he was in bed. His bed was in a low position. Resident #225 was observed to have a fall mat in place along the right side of his bed. An interview with Resident #225 at that time indicated he did not remember having any falls. He stated he could get up and go to the bathroom by himself. On 2/21/24 at 10:10 AM an interview with Nurse #1 indicated she was the Unit Manager. Nurse #1 stated when a nurse implemented a fall intervention like a fall mat, the nurse should pass it along to her and to the Nurse #2 who was the MDS Coordinator so it could be care planned. She went on to say she felt this must have been done on a night shift. On 2/21/24 at 10:22 an interview with the Director of Nursing (DON) indicated all fall incident reports were discussed in morning meeting to determine what interventions needed to be put into place. She further indicated whoever had put the fall mat in place for Resident #225 needed to pass that information along. The DON stated she felt this must have been done on a night shift. She went on to say if she had been aware of the implementation of a fall mat and Resident #225's fall on 2/8/24, these things would have been incorporated into his care plan. On 2/21/24 at 1:25 PM an interview with Nurse #2 indicated she was the MDS Coordinator. She stated if she had been made aware of Resident #225's fall mat intervention and his fall on 2/8/24 she would have incorporated these things into his comprehensive care plan.	F 656	weeks, then biweekly x 4 weeks. The results of the Care Plan Audit Tool will be brought to QAPI by Director of Nursing for review and recommendations monthly x 3 months.	

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F 656	Continued From page 20 On 2/22/24 at 10:21 AM an interview with the Administrator indicated if a fall mat had already been in place for Resident #225 at the time of his fall on 2/8/24, he would have needed an additional intervention put in place. The Administrator stated a fall mat intervention and Resident #225's fall on 2/8/24 fall were things that should have been addressed on his care plan.	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and	F 661		3/29/24

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F 661	Continued From page 21 non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a discharge summary and recapitulation of stay for 1 of 1 resident reviewed for hospitalization (Resident #74). Findings included: Resident #74 was admitted to the facility on 12/12/23. A review of the Discharge Planning Review dated 12/15/23 for Resident #74 revealed in part her expected length of stay with the facility would be short-term. Resident #74 expected to be discharged to the community. A review of Resident #74's discharge Minimum Data Set (MDS) assessment dated 12/25/23 revealed her return to the facility was not anticipated. Her discharge was planned. A review of a nursing progress note dated 12/25/23 at 11:12 AM written by Nurse #7 revealed in part Resident #74's family member was present. Instructions were provided regarding Resident #74's medications. Resident #74 was discharged home with her medications. Further review of Resident #74's medical record revealed no discharge summary or a recapitulation of her stay. On 2/20/24 at 10:43 AM an interview with Nurse #1 indicated she was the unit manager. She stated she would have been responsible for completing Resident #74's discharge summary	F 661	Resident # 74 no longer resides in the facility. The Director of Nursing completed an audit of all discharges for the past 60 days 2/27/2024. This audit was to ensure a recapitulation of resident stay was completed to include but not limited to diagnoses, course of illness/treatment/therapy, pertinent lab/radiology, consultation results, medications and post discharge plan of care. The Director of Nursing did address all concerns identified during the audit to include completion of recapitulation when indicated. Assistant Director of Nursing in-serviced with all nurses, social worker, Therapy Director, Dietary Manager and Activities in regards to Discharge Summary with emphasis on completing a recapitulation of resident stay with a completion date of 3/11/2024. The IDT team to include Director of Nursing, Social Worker, Dietary Manager and MDS nurse will review all discharges weekly x4 weeks then biweekly x 4 weeks utilizing the Discharge Summary Audit Tool. This audit is to ensure a recapitulation of stay is completed to include but not limited to diagnoses, course of illness/treatment/therapy, pertinent lab/radiology, consultation results, medications and post discharge plan of care. The Interdisciplianary Team will address all concerns identified during	

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F 661	Continued From page 22 and recapitulation of stay when Resident #74 discharged home on 12/25/23. She stated she had not done this. She went on to say she did not know why she had not. On 2/22/24 at 10:21 AM an interview with the Administrator indicated a discharge summary and recapitulation of stay needed to be completed for Resident #74 when she went home on 12/25/23. She stated this was to provide continuity of care and ensure Resident #74 understood her discharge plan.	F 661	the audit. The Administrator will review and initial the Discharge Summary Audit Tool weekly x 4 weeks then biweekly x 4 weeks to ensure all concerns were addressed. The Administrator will forward the results of the Discharge Summary Audit Tool to the Executive QAPI Committee monthly x 3 months. The Executive QA Committee will meet monthly x 2 months and review the Discharge Summary Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, dialysis nurse and physician interviews the facility failed to ensure a resident receiving dialysis had a physician's order for dialysis and failed to communicate with the dialysis provider to determine whether the implementation of a fluid restriction was required. This was for 1 of 1 resident (Resident #33) reviewed for dialysis. Findings included:	F 698	Resident # 33 diet order was verified and order obtained for dialysis to include a 1200cc fluid restriction on 2/22/2024 by Assistant Director of Nursing. Resident was assessed for signs and symptoms of fluid overload on 2/23/2024 by Floor Nurse. Assistant Director of Nursing initiated a review of active resident diets from 12/01/2023 until 2/27/2024. This audit was	3/29/24

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F 698	Continued From page 23 Resident #33 was admitted to the facility on 6/20/23 with diagnoses including end-stage renal disease and dependence on renal dialysis. A review of Resident #33's care plan revealed in part a focus area initiated on 3/3/23 of hemodialysis required due to end stage renal disease. The goal, last revised on 12/18/23, was for Resident #33 to have no signs and symptoms of complication from dialysis through the next review. An intervention was dialysis Monday, Wednesday, and Friday. Resident #33's care plan did not address the need for a fluid restriction. A review of the hospital discharge summary for Resident #33 dated 12/28/23 revealed a recommendation to resume Resident #33's diet as prior to admission to the hospital. A review of Resident #33's quarterly Minimum Data Set (MDS) assessment dated 1/4/24 revealed he was severely cognitively impaired. He received dialysis while a resident. A review of Resident #33's medical record revealed no physician's order for dialysis, no diet order, and no physician's order for a fluid restriction. On 2/20/24 at 8:32 AM an interview with Resident #33 indicated he went to dialysis on Mondays, Wednesdays, and Fridays. He was not observed to have a water pitcher at his bedside. On 2/22/24 at 8:00 AM an observation of Resident #33's breakfast tray ticket revealed was receiving a controlled carbohydrate (CCD), renal diet with an 840 ml fluid restriction per day.	F 698	to identify any resident with orders for fluid restriction to ensure appropriate interventions were initiated to include proper fluid volume needs based on disease processes. The Dietary Manager and Assistant Director of Nursing will address all areas of concern identified during the audit to include assessment of the resident, notification of the physician and RR, initiation of appropriate interventions with documentation in the electronic record and monitoring per facility protocol completed on 2/27/2024. 100% in-service was initiated by Assistant Director of Nursing with all nurses in regards to obtaining an order for dialysis, correct diet orders are reflected to include fluid restrictions and notification of the physician and resident representative. In-service will be completed by 3/11/2024. All newly hired nurses will be in-serviced by the Assistant Director of Nursing during orientation in regard to Dialysis orders and fluid restrictions. The Assistant Director of Nursing will audit 10% of resident charts weekly x 4 weeks then biweekly x 4 weeks. This audit is to ensure presence of physician's order for dialysis, correct diet order and fluid restriction needs. All areas of concern identified during the audit with be addressed immediately. The Director of Nursing will review and initial the Dialysis Audit Tool weekly x 4 weeks then biweekly x 4 weeks to ensure all areas of concern were addressed. The Director of Nursing will forward the	

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F 698	Continued From page 24 On 2/22/24 at 8:15 AM an interview with the Dietary Manager (DM) indicated she received a paper diet order slip from nursing when a resident was admitted or readmitted. She stated this information was entered into the food service system and printed out on the resident's diet ticket. She went on to say nursing was responsible for entering the information into the resident's medical record. A review of Resident #33's paper diet order revealed 2-gram sodium, renal diet with regular liquids. This was dated 12/28/23 and signed by the Assistant Director of Nursing. The DM discussed the fluid restriction printed on Resident #33's 2/22/24 breakfast tray ticket. She stated Resident #33 had previously been on this fluid restriction. She went on to say although it wasn't on the paper diet order dated 12/28/24 she received from nursing, she had a previous paper order from October 2023 for the fluid restriction, so she continued it. The DM stated the 840 ml per day fluid restriction that printed on Resident #33's breakfast ticket on 2/22/24 was the amount of fluids dietary provided on Resident #33's meal trays. On 2/22/24 at 8:17 AM an interview with the District Dietary Manager indicated a renal diet was more sodium restrictive than a 2-gram sodium diet. She went on to say this was why Resident #33's meal tray ticket did not indicate the 2-gram sodium. On 2/22/24 at 8:34 AM an interview with the Assistant Director of Nursing (ADON) indicated she did not see an order for dialysis or a fluid restriction in Resident #33's medical record. She stated Resident #33 had been hospitalized and come back to the facility. She went on to say when Resident #33 returned from the hospital,	F 698	results of the Dialysis Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

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Nurse #9 should have re-entered the order for dialysis into his record. The ADON stated Resident #33 had been on a fluid restriction prior to his hospitalization and should still be on one. She further indicated this was not something that would be on Resident #33's care plan but would show up on Resident #33's Medication Administration Record (MAR) for the nurse to check off each shift. She went on to say she herself would have entered the fluid restriction into Resident #33's medical record when she got the order for it by calling the dialysis center. She went on to say she had not called the dialysis center to follow-up regarding Resident 33's fluid restriction when he returned from the hospital. The ADON stated she probably provided the paper diet order to the dietary department for the 2-gram sodium, renal diet with regular liquids, and didn't enter the diet order into Resident #33's medical record.

On 2/22/24 at 8:51 AM a telephone interview with Nurse #9 indicated she did not enter resident's orders for dialysis. She stated the ADON, or other administrative nurse did this. She went on to say she did not know if Resident #33 had an order for a fluid restriction. Nurse #9 stated most residents who received dialysis were. She further indicated she knew Resident #33 was on a fluid restriction in the past, and she knew he was supposed to get 240 milliliters (ml) on her 3PM-11PM shift. She went on to say usually there was a place on resident's MAR that let the nurse know how much fluid the resident was to get on each shift.

A review of Resident #33's February 2024 MAR did not reveal a fluid restriction.

On 2/22/24 at 9:21 AM a telephone interview with

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the Dialysis Nurse indicated Resident #33 received his dialysis on Monday, Wednesday, and Friday. She stated all residents receiving dialysis needed to be on a fluid restriction. She went on to say the recommended fluid restriction for Resident #33 was 40 ounces (1182 ml) daily. She further indicated someone from the facility should have reached out to the dialysis center to determine what the recommended fluid restriction was for Resident #33 to ensure this was carried out. The Dialysis Nurse stated she was not aware of any issues of fluid overload with Resident #33, or the dialysis center would have immediately contacted the facility to see what was going on.

On 2/22/24 at 9:35 AM an interview with the Director of Nursing (DON) indicated the ADON, Unit Manager, or if it was on the weekend, the weekend manager should be entering residents orders on admission or readmission. She went on to say Resident #33 probably should have an order for dialysis in his medical record. She stated the facility know which residents were receiving dialysis. The DON went on to say the Dietician should have caught that Resident #33 needed to be on a fluid restriction. She stated a fluid restriction was something that showed up on a resident's MAR so the nurses would be aware.

On 2/22/24 at 9:46 AM an interview with Nurse #8 indicated she was caring for Resident #33 that day and was familiar with him. She stated he had been on a fluid restriction in the past. She went on to say nurses became aware a resident required a fluid restriction because it showed up on the MAR with the amount of fluid allowed per shift. She further indicated she did not see this on Resident #33's MAR.

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F 698	Continued From page 27 On 2/22/24 t 9:55 AM an interview with Nurse Aide (NA) #5 indicated she was caring for Resident #33 that shift. She went on to say she was made aware a resident was on a fluid restriction by the nurse telling her. She stated Resident #33 was not on a fluid restriction. She further indicated resident's who were on a fluid restriction did not get a water pitcher at their bedside. On 2/22/24 at 10:17 AM a telephone order with Resident #33's Physician indicated Resident #33 should have an order for his dialysis in his medical record. He went on to say he really did not give orders for fluid restrictions because he had so much trouble with dehydration in residents. The Physician stated this was something that should have come from dialysis. On 2/22/24 at 10:21 AM an interview with the Administrator indicated normally the ADON or another administrative nurse entered resident's orders on admission or readmission. She stated there should have been clarification regarding Resident #33's need for a fluid restriction. She went on to say she did not know whether there needed to be a physician's order for dialysis.	F 698		
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:	F 867		3/29/24

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F 867	Continued From page 28 §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 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.	F 867		

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§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.

§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

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F 867	Continued From page 30 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: Based on observations, record review and staff interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint surveys of 7/28/21 and 2/16/23. This was for 4 recited deficiencies in the areas of Accuracy of Assessments (F641), Develop/Implement Comprehensive Care Plans (F656), Discharge Summary (F661), and Infection Control (F880). The continued failure during 2 or more federal surveys of record showed a pattern of the facility's inability to	F 867	WHAT WE DID FOR RESIDENT INVOLVED: Facility held an Ad-HOC QAPI on 2/27/2024. OTHERS THAT HAVE THE POTENTIAL TO BE AFFECTED All residents have the potential to be affected by the alleged deficient practice. SYSTEMIC CHANGES: The Administrator/designee will review the last 3 months of facility QAPI meetings for signs of Program feedback, data systems	

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F 867	Continued From page 31 sustain an effective Quality Assurance Program. The findings included: The tag is cross-referenced to: F641 - Based on record review and staff interviews the facility failed to accurately complete the discharge Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for hospitalization (Resident #74). During the recertification and complaint survey of 2/16/23 the facility was cited for failing to code the MDS accurately for Pre-Admission Screening and Resident Review (PASRR). F656 - Based on observations, record review and staff interviews, the facility failed to develop a person-centered comprehensive care. This was for 1 of 3 residents (Resident #225) reviewed for accidents. During the recertification and complaint survey of 7/28/21 the facility was cited for failing to address pain in a resident's care plan. During the recertification and complaint survey of 2/16/23 the facility was cited for failing to care plan a resident's falls. F661 - Based on record review and staff interviews the facility failed to complete a discharge summary and recapitulation of stay for 1 of 1 resident reviewed for hospitalization (Resident #74). During the recertification and complaint survey of 2/16/23 the facility was cited for failing to	F 867	and monitoring per state regulation/guidelines by 3/15/2024. Corporate Compliance Officer provided education to the Administrator and Director of Nursing on the QAPI/QAA system on 3/14/2024. The DON/designee will educate all staff through by 3/21/2024 on QAPI/QAA and what the performance improvement plans that the facility currently has in place. MONITORING: The Cheif Nursing Officer/designee will review the monthly QAPI/QAA meeting minutes monthly x 3 months to ensure ongoing compliance with state regulations for an effective QAPI system. MONITORING/SUSTAIN COMPLIANCE The results of the audit will be brought through the facilities monthly QAPI meeting monthly x 3 months to evaluate the need for resolution or need for continued monitoring.	

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F 867	Continued From page 32 complete a recapitulation of stay for a discharged resident. F880 - Based on observation and staff interviews the facility failed to maintain infection control for 6 of 6 residents (Resident #54, Resident #56, Resident #61, Resident #26, Resident # 70, and Resident #125) reviewed for Coronavirus disease 2019 (COVID-19) testing. The facility further failed to use a N-95 respirator (N-95) (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) for 1 of 1 resident (Resident #69) reviewed for contact isolation. During the recertification and complaint survey of 2/16/23 the facility was cited for failing to perform hand hygiene after removing soiled gloves and before putting on clean gloves during wound care. During an interview on 2/22/24 at 11:57 the Administrator stated the focuses of the deficiencies from the current survey when compared to the previous deficiencies within the same category were different. For example, the infection control concern from the previous deficiencies related to hand washing while the current survey concerns were related to donning and doffing of personal protective equipment and isolation precautions. This was why there were repeated deficiencies within the three years of survey. She stated while they monitored the previous deficiencies and corrective action, it did not cover the current concerns of the survey. She concluded this was why she felt the deficiencies were repeated.	F 867		
F 880 SS=E	Infection Prevention & Control	F 880		3/29/24

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F 880	Continued From page 33 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 34 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain infection control for 6 of 6 residents (Resident #54, Resident #56, Resident #61, Resident #26, Resident # 70, and Resident #125) reviewed for Coronavirus disease 2019 (COVID-19) testing. The facility further failed to use a N-95 respirator (N-95) (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) for 1 of 1 resident (Resident	F 880	1. Immediate action(s) taken for the resident(s) found to have been affected include: Director of Nursing re-educated Nurse # 11 on 2/19/24, regarding proper procedure for COVID-19 testing, PPE requirements and contact isolation. The Assistant Director of Nursing re-educated Nurse #10 on PPE requirements on 3/12/2024.	

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F 880	Continued From page 35 #69) reviewed for contact isolation. Findings included: Review of facility policy entitled Infection Prevention and Control Program dated 10/01/20 and revised 10/01/23 revealed that the facility followed accepted national standards and guidelines for the prevention and transmission of communicable diseases and infections. During an interview and observation of outbreak COVID-19 testing for residents on the 200 hallway on 02/19/24 at 2:30 pm Nurse #11 revealed that she was a PRN nurse and did not work at the facility on a routine basis. She tested Residents #56, Resident #61, Resident #26, Resident #70 Resident #125, and Resident #54. One resident (Resident # 54) was tested in a common hallway (hallway 200). Nurse #11 performed hand hygiene using a alcohol-based hand rub and prepared her testing supplies. Nurse #11 further performed hand hygiene using an alcohol-based hand rub before donning gloves and after doffing gloves in-between each resident. She wore a procedure face mask (breathable disposable masks designed for one-time use in medical environments, including patient procedures. Procedure masks are traditionally characterized by an ear loop) and gloves during sample collection. After she collected each sample with a swab, she returned to the medication cart where she performed the test by laying the specimen swab on a test card and applied a clear solution. She then folded the test card over the specimen swab and laid the test cards side by side, and when she ran out of space, she laid them on top of one another while she waited for the test results. She did not wear a gown or use eye protection during the collection of the specimens. The interview further revealed	F 880	2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that 100% of residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of occurrence include: 100% In-service education was provided to all licensed nurses by Assistant Director of Nursing on proper testing procedures for COVID-19 by 3/11/2024. 100% In-service education was provided to all staff to include Administration, Dietary, Therapy, Housekeeping, Maintenance, Activities, Social Work and Laundry by the Assistant Director of Nursing on transmission-based precautions with a focus on proper personal protective equipment completed on 3/11/2024. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Assistant Director of Nursing/Designee will observe 5 employees weekly x 4 weeks, then biweekly x 4 weeks for proper COVID-19 testing procedures, transmission-based precautions and donning and doffing PPE utilizing an Infection Control Audit tool.	

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F 880	Continued From page 36 that she had not received training on COVID-19 testing at the facility because she did it at other facilities and knew how to do the testing. An interview with the Infection Preventionist (IP) on 02/20/24 at 11:13 am revealed that the facility was currently in outbreak testing because the facility had COVID-19 positive residents. It was further revealed that the IP trained the nurses on how to COVID-19 test residents and this training consisted of a demonstration only. She stated that the facility did not have a policy on PPE used for COIVD-19 testing and it was their practice to follow current CDC guidelines. She stated the process that was taught to the Nurses was they gathered supplies, took a cart or a table to set up with hand sanitizer and a place to dispose of used items after they tested and they tested in the residents' room, and should not be tested in the hallway or any common area. She stated that the nurse that tested residents she would wear a mask and gloves unless the residents were symptomatic or were suspected to be positive for COVID-19 and then they wore an N-95 mask. She stated that she followed CDC guidelines on COVID-19 testing and PPE. She stated that the protocol for outbreak testing was to remove and dispose of gloves and perform hand hygiene in-between each resident and that for outbreak testing that the Nurse did not need to wear eye protection, N95 or a gown. In a second interview with the IP on 02/20/24 at 12:01 pm she stated that the facility was in outbreak testing because there are COVID-19 positive residents in the building. She stated that anybody could be positive and that is why everyone is tested because all residents and staff are potentially positive.	F 880	The Infection Control Audits will be forwarded to the Executive QAPI Committee monthly x 3 months by the Director of Nursing to evaluate trends and determine need for further monitoring.	

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In an interview with the DON on 02/21/24 at 2:07 pm it was revealed that Nurses were trained by the Infection Preventionist on how to do COVID-19 testing for residents. She stated that residents are tested in their rooms. She did not know if the Nurse that tested the residents needed to use full personal protective equipment (PPE) or not, she had not heard. She indicated that the nurses had not been wearing gowns when they tested and she did not know if a N-95 was required or not for testing, but that they should wear a mask when they tested because COVID-19 was airborne. She stated that residents were tested because everyone would potentially be infected, and you would not know if a resident had been positive or negative. She further indicated that the facility followed CDC recommendations on COVID-19 testing and PPE.

2. The facility Personal Protective Equipment policy last revised 10/1/23 read in part for respiratory protection to wear a NIOSH-approved N95 or higher-level respirator to prevent inhalation of pathogens transmitted by the airborne route.

An interview with Resident #69 on 2/19/24 at 10:37 AM revealed that he was Covid positive and that it was day 5 of his isolation.

An observation on 2/20/24 at 10:07 AM with Nurse #10 revealed she donned an isolation gown, gloves, eye protection to enter Resident #69's room to administer his medications. She was not observed to place an N-95 mask on. Nurse #10 was observed already have on a surgical mask prior to entering Resident #69's

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F 880	Continued From page 38 room. Nurse #10 removed her gown and gloves prior to exiting room. She was observed to walk back to the medication cart in the hall by the resident's room, removed the eye protection and disposed of it in the medication cart trashcan. An interview with the Infection Preventionist and Corporate Nurse Consultant on 2/20/24 at 10:23 AM revealed that the staff had been in-serviced on the need to follow transmission-based precautions. An interview with the Administrator and the Director of Nursing (DON) on 2/21/24 at 1:18 PM revealed that staff are supposed to wear the correct personal protective equipment when in an isolation room and they did not know why Nurse #10 had not done so.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		3/29/24

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F 883	Continued From page 39 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and Physician, resident and staff interviews the facility failed to assess	F 883	Resident #38, 21, 20 and 55 was assessed and offered the pneumococcal	

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and offer a recommended Pneumococcal vaccine to residents on admission for 4 of 5 residents reviewed for vaccine status (Resident #38, Resident #21, Resident #20, and Resident #55).

Findings included:

Review of the facility's policy titled Pneumococcal Vaccine (Series) dated 10/01/20 and revised 09/14/2022 indicated "It is our policy to offer our residents, staff, and volunteers' immunizations against pneumococcal disease in accordance with the current CDC guidelines and recommendations". The policy further indicated that each resident would be assessed for and offered a pneumococcal immunization upon admission, and the type of immunization offered depended upon the recipient's age and susceptibility to pneumonia, in accordance with CDC guidelines and recommendations. The policy delineated pneumococcal vaccine recommended for ages 65 years and older and ages 19 to 64 years and further delineated the recommendation based on prior vaccine received, chronic medical conditions and risk factors that would indicate a higher need for vaccination such as diabetes mellitus, heart disease, and chronic lung disease.

a. Resident #38 was admitted to the facility on 8/26/20. He was 56 years old on admission. His active diagnoses included peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel, stroke, and Diabetes Mellitus.

Resident #38's minimum data set assessment (MDS) dated 12/22/23 revealed he was assessed

vaccine on 3/5/24 by Assistant Director of Nursing. The pneumococcal vaccine was administered on 3/7/24 by Assistant Director of Nursing to resident #21 and resident #55 . Resident #38 and #20 refused consent for the vaccine

In-service education was provided to the Assistant Director of Nursing by DON on 3/6/24 on facility immunization policy and procedures relating to vaccinations. All residents who have not been offered the pneumococcal vaccine has the potential to be affected by the alleged deficient practice. A 100% audit of all current residents was conducted on 3/5/24 by Administrator to identify consent and administration of all residents who elect to have the pneumococcal vaccine and documentation in the medical record. All identified residents who elected for administration will receive vaccination by 3/20/2024 by Assistant Director of Nursing and documented in the medical record. 100% in-service of all licensed nurses was initiated on 3/6/24 by Assistant Director of Nursing on providing education to the resident or resident□s representative of benefits and side effects of vaccinations, obtaining consent for administration, documentation of the vaccinations in medical record. The in-service will be completed by 3/11/24. The in-service will be incorporated into the new employee orientation.

The Director of Nursing/Designee will monitor the pneumococcal immunizations for all new residents weekly x4 weeks,

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F 883	Continued From page 41 as not cognitively intact. The immunization record of Resident #38 revealed that he had not received a pneumococcal vaccine while a resident at the facility. Review of vaccine consent forms for Resident #38 revealed that he had no pneumococcal vaccine consent forms and no documentation of being offered or given a pneumococcal vaccine. Interview with Resident #38 on 02/22/24 at 10:32 am revealed that he recalled that he was offered and received the flu and COVID-19 vaccines when admitted but he did not recall being offered a pneumococcal vaccine. He stated he would want a pneumococcal vaccine if it were offered to him. b. Resident #21 was admitted to the facility on 9/21/22. She was 81 years old on admission. Her active diagnoses included coronary artery disease (a narrowing or blockage of your coronary arteries, which supply oxygen-rich blood to your heart), hypertension (high blood pressure), and Diabetes Mellitus. Resident #21's minimum data set assessment (MDS) dated 01/18/24 revealed she was assessed as cognitively intact. Review of vaccine consent forms for Resident #21 revealed that she had no pneumococcal vaccine consent forms and no documentation of being offered or given a pneumococcal vaccine. The immunization record of Resident #21 revealed that she had not received a	F 883	then bi weekly x 4 weeks then monthly using a Pneumococcal Monitoring Audit Tool. Results of the Pneumococcal Audit Tool will be taken to the Executive QAPI Committee monthly by the Director of Nursing to ensure corrective action as appropriate.	

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pneumococcal vaccine while a resident at the facility.

Interview with Resident #21 on 02/22/24 at 10:20 am revealed that she could not recall if she was offered or received a pneumococcal vaccine on admission. She stated she wasn't sure if she would want one or not if offered.

c. Resident #20 was admitted to the facility on 02/12/13. She was 50 years old on admission. Her active diagnoses included anemia (a condition of not having enough healthy red blood cells to carry oxygen to the body's tissues), coronary artery disease (a narrowing or blockage of your coronary arteries, which supply oxygen-rich blood to your heart), hypertension (high blood pressure), and Diabetes Mellitus.

Resident #20's minimum data set assessment (MDS) dated 12/07/23 revealed she was assessed as cognitively intact.

The immunization record of Resident #20 revealed that she had previously received dose 1 of the pneumovax vaccine on 6/18/13 prior to admission to the facility. She had not received a pneumococcal vaccine while a resident at the facility.

Review of vaccine consent forms for Resident #20 revealed that she had no pneumococcal vaccine consent forms and no documentation of being offered or given a pneumococcal vaccine while she resided at the facility.

Interview with Resident #20 on 02/22/24 at 10:40 am revealed that she was not offered and did not receive a pneumococcal vaccine while she

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resided at the facility. She stated she received flu and COVID shots but not a pneumococcal shot. She stated she would want a pneumococcal shot if offered one.

d. Resident #55 was admitted to the facility on 03/03/21. He was 73 years old on admission. His active diagnoses included peripheral vascular disease (a slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel, stroke, and Diabetes Mellitus.

Resident #55's minimum data set assessment (MDS) dated 02/08/24 revealed he was assessed as cognitively intact.

The immunization record of Resident #55 revealed that he had not received a pneumococcal vaccine while a resident at the facility.

Review of vaccine consent forms for Resident #55 revealed that he had no pneumococcal vaccine consent forms and no documentation of being offered or given a pneumococcal vaccine.

Interview with Resident #55 on 02/20/24 at 3:30 pm revealed that he was offered and received the flu and COVID-19 vaccines when admitted but he did not recall being offered a pneumoccocal vaccine. He stated he would want a pneumococcal vaccine if it were offered to him.

In an interview with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) on 02/20/24 at 03:19 pm revealed that Resident #55, Resident #20, Resident #38, and Resident #21 had not been offered and did not receive a

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pneumococcal vaccine while a resident at the facility. The interview further revealed that she reviewed the facility policy, and the residents should have been screened, offered and if they accepted they should have received a pneumococcal vaccine according to CDC recommendations. She further indicated that she did not think that the pneumococcal vaccine had to be offered to residents under 65 years old and was not aware of the qualifying diagnoses.

In an interview with the DON on 02/21/24 at 02:07 pm she indicated that she was not aware that a pneumococcal vaccine had not been offered to the residents and stated that they should have been screened and offered a pneumococcal vaccine on admission regardless of their age. She further indicated that the Admissions Director completed the vaccine consent forms with the new admissions and the Infection Preventionist would have followed up with the residents and determined if they wanted a vaccine. She stated that residents that had not received a pneumococcal vaccine were at higher risk according to CDC recommendations. She stated she did not know why residents were not screened and were not offered a vaccine, unless the Admission Director was out and someone unfamiliar with the process did the admissions.

During an interview with the Admissions Director on 02/21/24 at 02:19 pm it was revealed that she had been employed in her position since March of 2021. She stated that as part of her job duties that she offered the flu, pneumonia, and COVID-19 vaccine to new residents on admission. She stated that she completed consent forms with the residents, and they signed to indicate if they wanted to receive a vaccine or

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not. She then gave copies of the completed signed consent forms to the Infection Preventionist. The interview further revealed that she had not completed consent forms for the pneumococcal vaccine until about a year and a half ago because that form was missing from the admission paperwork packet. She stated this was because the facility changed ownership and some forms were not in the new admission packet, to include the pneumococcal consent form. She indicated the pneumococcal consent form was added back to the packet when someone (she could not recall who) realized that it was not in the packet, she did not recall the exact date. She stated she did not offer the pneumococcal vaccine consent form for most of 2021 to early 2022. She further indicated that it would not have been her responsibility to go back and determine who the omission affected.

In an interview with the Administrator on 02/21/24 at 02:28 pm it was revealed that she was told by the Infection Preventionist on 02/20/24 that residents had not been offered or received a pneumococcal vaccine, she stated that she was unaware prior to that. The Administrator stated that when residents were admitted that the Admissions Director gave them a consent form that they completed and signed to indicate if they wanted a vaccine, the Admissions Director then completed a vaccine history for each resident. She further indicated that the Admissions Director communicated that information to the IP. She recalled that some paperwork had been missing from the admissions packet and some forms were added to the packet but was not aware when or what was added to the packet. The interview further revealed that a new company took ownership of the building on 10/01/20 and

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F 883	Continued From page 46 she had started in her position 2 days prior to that changeover. She stated the new company brought their own admission packet with them. The Administrator indicated that residents who did not get a pneumococcal vaccine were at a higher risk for pneumonia and that the facility was working to get that corrected and would do 100% audits. She stated that consents for the pneumococcal vaccine should have been completed on admission and the vaccine should have offered to a resident that desired to be vaccinated. An interview with Physician #1 on 02/22/24 10:20 am revealed that the facility should have screened all newly admitted residents for pneumococcal vaccine status and should have offered a pneumococcal vaccine for those that consented. He stated that it was a standing order protocol that should have been followed. He further indicated that residents should have been screened periodically during their stay and offered a pneumococcal vaccine according to current CDC recommendations. Physician #1 stated that residents that wished to receive the vaccine should have received one and residents that had not received the vaccine were at higher risk for infection based on the seriousness of their diagnosis, and explained that residents with a less serious diagnosis had a lowered risk for infection, and residents with a more serious diagnosis had a higher the risk for infection that could result in death. He stated he would have expected the facility to have screened, obtained consents and administered the vaccine for those that consented.	F 883		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4)	F 925		3/29/24

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F 925	Continued From page 47 §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interviews, the facility failed to maintain an effective pest control program for 3 of 5 hallways (Hallways 400, 500, and 600). Findings included: During observations on the 600 hallway on 02/19/24 at 10:27 am a sticky rodent trap was observed underneath a chair beside the packaged terminal air conditioner, or PTAC (a commercial grade air conditioner that is installed directly through a wall), and a rodent bait box was observed beneath the PTAC. The PTAC was noted to have had 3-inch-wide tape around all 4 sides that was detached and pulled away on the right side. Two open holes (approximately 1 inch in diameter each) were noted above one another on the wall parallel to the right side of the PTAC. Review of Resident #60 Minimum Data Set (MDS) dated 11/28/23 revealed he was moderately cognitively intact. An interview with Resident #60 on 02/19/24 at 10:27 am revealed that he saw a mouse every night and that it came from the outside. Resident #60 stated that the PTAC had been taped around the edges, and he thought that was how the mouse got in. He stated there was a mouse trap beside the PTAC that the maintenance man provided but he did not think they caught the mouse because he still saw it at night. He	F 925	Resident #60 rodent bait box was removed on 2/21/2024 by the Maintenance Assistant. Area around resident's #60, #62, and #39 PTAC will repaired to ensure any penetrations were sealed and holes repaired on 3/28/2024 by the Facility Contractor. 100% audit was conducted by the Administrative team and completed on 3/01/2024 for wall penetrations, holes and sources of potential entry. The list of repairs needed submitted to the facility contractors for needed repairs. The Pest Control vender was contacted and arrived at the facility on 3/08/2024 to provide a monthly treatment and discuss the plan for pest control moving forward, where to send the reports and best way to communicate the needs of the building. Activity Director/designee will audit 5 residents per week x 4 weeks, then 5 residents per week biweekly x 2 utilizing a Pest Control Audit tool. Immediate action will be taken to correct problems identified. The Administrator will submit the results of Pest Control Audit tool will to the Executive QAPI committee for analysis and trending until the problem is deemed corrected.	

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	345266	A. BUILDING _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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indicated that he did not like mice in his room.

Review of Resident #62 MDS dated 01/05/24 revealed the resident was cognitively intact.

In an interview with Resident #62 (500 hallway) on 02/22/24 at 09:15 am revealed that she often saw mice and rats in her room during the night and she last saw one was about a week ago. She stated that she did not want mice in her room, and she was afraid they would get into her bed with her. She stated she let staff know and they all knew about the rodents.

Review of Resident #39 MDS dated 12/19/23 revealed the resident was cognitively intact.

In an interview with Resident #39 (400 hallway) on 02/22/24 at 09:29 am revealed that she saw a mouse in her room about a month ago. She stated that she did not want mice in her room, and she was afraid they would get into her bed with her. She stated she let staff know.

Review of Resident #46 MDS dated 12/09/23 revealed the resident was cognitively intact.

In an interview with Resident #46 (400 hallway) on 02/22/24 at 09:32 am revealed that she saw a mouse in her room about a month ago. She stated that she named the mouse "Mickey," and she was going to feed it, but her roommate was very afraid of the mouse, so she didn't. She stated the mouse left the room after thirty minutes. She stated she told staff, and they all knew about the mouse, and she was not sure what was done about it.

In an interview with the Maintenance Director on

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02/20/24 at 12:55 pm it was revealed that he was aware of mice in Resident #60's room and the facility had a pest control program with a professional exterminator company that came twice a month and "put down" sticky traps. The interview further revealed that he removed 2 mice from Resident #60's room in July of 2023. He stated that he worked for the facility for 6 years and he was not sure how the mice got in. The Maintenance Director further indicated that he placed a locked mouse bait box under the PTAC and a sticky rodent trap under the chair beside the PTAC to trap the mice. He indicated that he was not sure what the holes beside the PTAC were from, but they had been doing work to remove some pipes on the 600 unit and they did not seal the holes and mice could be coming in through the holes. He further stated that the facility did not keep pest control logs.

In a second interview with the Maintenance Director on 02/21/24 11:40 am it was revealed that if the PTAC units were bumped with a bed or something that it dislodged from the recess in the wall, and you could see to the outside light through the crack.

An interview with the Administrator on 02/20/24 01:11 pm revealed she had been aware the facility had mice at times, and she had seen them. She indicated that the facility had contracted with a pest control company, and they came to the facility monthly and as needed. The interview further revealed that the facility did not keep records or logs regarding pest control. She indicated that she was unaware of any holes in the wall, but if there were holes in the wall that would have been a portal of entry for mice.

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In an interview with the Maintenance Assistant on 02/21/24 12:06 pm it was revealed that he had worked for the facility for 2 years. He stated that the PTACs on 600 hall had been taped because there had been a crack around the units where they did not fit in the hole tightly and they saw light and felt the air flow from the outside around the units. The interview further revealed that he was aware of a mouse problem and that they had caught some mice with sticky traps in the past. He stated that mice could be coming in through the holes around the PTAC units.

During an interview with a contracted Pest Control Account Manager on 02/21/24 at 12:32 pm it was revealed that they provided pest control services to the facility and treated monthly. He stated that they sprayed inside the facility for bugs and placed rodent bait stations with poison outside of the building to help prevent mice from entering the building. He indicated mice could enter the building through small holes and that they most likely entered through the PTAC units. The interview further revealed that they had other interventions that controlled mice on the interior of the building, such as poison bait boxes in a locked container, or containment traps if the facility desired but they have not indicated that they had a mouse problem inside the building. The Pest Control Account Manager indicated that the condition of the building was "a little rough" and he thought the mice entered through the PTAC units. He further revealed that the pest control service had not provided rodent control for the interior of the building and had only treated the exterior of the building with rodent bait boxes. He stated a service technician treated the facility about a week ago and the facility had not mentioned a concern of mice inside the building.

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He stated they had not made recommendations since the facility had not reported a mouse problem inside. He indicated he would send the treatment records for the facility.

Review of pest control treatment records received from the pest control company for the months of July 2023 to February 2024 revealed the facility had received exterior (outside) treatment with a product that targeted roof rats, Norway rats, and mice for the months of December 2023, January 2024, and February 2024. This treatment was in the form of bait blocks placed on the exterior of the building. There was no treatment noted for the interior of the building. The facility did not receive treatment for rats or mice in the other months reviewed.

In a follow-up interview with the Maintenace Director 02/22/24 08:03 am it was revealed that the pest control service did not place the rodent bait box or sticky traps inside the building and that he got them from his office and placed them in Resident #60's room. He indicated that a previous pest control technician provided him with rodent bait boxes and sticky traps, and he kept them in his office to have on hand in case he needed them. He did not recall when or the name of the technician who provided the bait boxes and sticky traps. He stated he also bought sticky traps from the home improvement store. The interview further revealed that the Maintenance Director walked with the pest control technician when they came to service the building, but he had not done that for the past 2 months. He stated that the pest control service had not made any recommendations about keeping rodents out and that he looked for holes on the exterior of the building and if he found holes, he patched them

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to help keep mice out. The interview revealed that if the Maintenance Director received a report of a mouse in the building that he placed a bait box or sticky trap (that he kept in his office) in the reported area, but he did not remember the dates or where they were placed, and he did not keep a rodent control record with such information.

A review of maintenance work orders on 02/22/24 at 09:04 am revealed that residents reported mouse/rat sightings on 08/29/23 with a comment entered that the "both residents have seen and heard a mouse in their room the past 2 days". This work order was marked as completed on 8/29/23 with no noted intervention or treatment. Another work order submitted on 2/18/24 had a comment that the "resident has snack in her room all the time that family brings". This work order was marked as completed on 02/19/23 with no noted intervention or treatment. The work orders were submitted by staff.

In an interview on 02/22/24 at 09:36 am with Nurse #3 she stated that she saw mice here and there and told the maintenance man and she thought they put down glue traps to try to catch them. She stated some of the residents were afraid of the mice.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345266	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/22/2024

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 568	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to provide a quarterly statement for 1 of 2 residents reviewed for personal funds (Resident #9). Findings included: Review of Resident #9's Minimum Data Set assessment dated 12/22/23 revealed Resident #9 was assessed as cognitively intact. Review of Resident #9's statement printed 2/20/24 revealed Resident #9's account with the facility was opened 10/26/23. During an interview on 2/19/24 at 1:49 PM Resident #9 stated he had an account at the facility but did not know how much money he had in his account and did not believe he or his responsible party had received a statement. During an interview on 2/20/24 at 10:36 AM the Business Office Manager stated Resident #9 had an account at the facility since 10/26/23. Her cooperate office used to send the Business Office Manager a reminder for each resident that was due for a quarterly statement. At some point last year, this notice stopped being sent and she forgot to issue Resident #9 his quarterly statement and he should have received a quarterly statement prior to now. During an interview on 2/20/24 at 10:47 AM the Administrator stated resident statements should be sent out to the resident or financial representative quarterly.
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to accurately complete the discharge Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for hospitalization (Resident #74).

Findings included:

Resident #74 was admitted to the facility on 12/12/23.

A review of the Discharge Planning Review for Resident #74 dated 12/15/23 revealed in part her expected length of stay with the facility would be short-term. Resident #74 expected to be discharged to the community.

A review of a nursing progress note dated 12/25/23 at 11:12 AM revealed in part Resident #74 refused to take her walker and bedside commode with her. Her family member was present. Instructions were provided regarding Resident #74's medications. Resident #74 was discharged home with her medications.

A review of Resident #74's discharge MDS assessment dated 12/25/23 revealed her return to the facility was not anticipated. Her discharge was planned. She was discharged to a short-term general hospital. Resident #74 was cognitively intact.

On 2/20/24 at 10:41 AM an interview with Nurse #2 indicated she was the MDS Coordinator. She stated she completed the discharge status section of Resident #74's discharge MDS assessment dated 12/25/23. She went on to say Resident #74 had been discharged home to the community and not to a short-term general hospital. She further indicated she was human and had made an error. She stated she would correct this.

On 2/22/24 at 10:21 AM an interview with the Administrator indicated Resident #74's discharge MDS assessment should accurately reflect Resident #74's discharge destination.