STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 02/29/2024

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LIBERTY COMMONS N&R CTR OF COLUMBUS CTY	1402 PINCKNEY STREET WHITEVILLE, NC 28472

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F 000	INITIAL COMMENTS The survey team entered the facility on 2/20/2024 to conduct a complaint survey and exited on 2/22/2024. The survey team returned to the facility on 2/26/2024 to obtain additional information and exited 2/29/2024. Therefore, the exit date was changed to 2/29/2024. Event ID# M3Y011. The following intakes were investigated NC00214002, NC00213887, NC00213720, NC00213481, NC00213407, NC00213189, NC00212656, NC00212486, NC00212179, NC00211755, NC00211798, NC00211731, NC00209686. 4 of the 30 complaint allegations resulted in deficiency. Past noncompliance was identified at: CFR 483.25 at F689 at a scope and severity G CFR 483.25 at F686 at a scope and severity G	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and Nurse Practitioner (NP) interviews, the facility failed to assess, monitor, document progress, and provide treatment for an open wound (skin tear) on the top of Resident #11's right foot for 1	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state	3/4/24

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

Electronically Signed | 03/19/2024

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F 684	Continued From page 1 of 5 residents reviewed for skin concerns. Weekly skin checks did not include the existence of a dressing to the right foot from the end of November 2023 through the end of February 2024. Observation on 2/27/24 revealed a dressing dated 11/17 on the top of the right foot. Once the dressing was removed from the top of the right foot, a wound with a dark hard perimeter and a soft yellow center was noted. Findings included: Resident #11 was admitted to the facility on 12/11/20 with diagnoses which included Alzheimer's dementia, colostomy, and peripheral vascular disease. Review of Resident #11's care plan indicated a 4/27/23 focus of at risk for pressure ulcer development with interventions which indicated to report to the nurse immediately redness, open areas, or irritation on the skin and to complete weekly full body skin assessments. Review of Resident #11's electronic health record revealed a 10/9/23 Nurse Practitioner progress note which indicated resident had an open wound to unspecified foot. The note indicated the goal of care was to prevent infection and promote healing. The note further indicated the wound had no signs of infection and status was reviewed with nursing. Record review indicated a physician order dated 10/10/23 for mupirocin 2% ointment apply to right foot topically every 72 hours for infection prevention. Order was discontinued on 11/17/23. Review of Resident #11's care plan revealed a	F 684	regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F684 Quality of Care: The Facility failed to assess, monitor, document progress and provide treatment for ano open wound (skin tear) on the top of resident #11's right foot. Corrective action for resident(s) affected by the alleged deficient practice: On 2/27/24, Resident #11 skin was assessed by Director of Nursing with notification to the Liberty Advantage Nurse Practitioner and Responsible Party of non-pressure area that has re-occurred. On 2/27/24 new orders received and initiated to include 2 view x-ray of right foot related to re-opening of the wound and physician order indicated apply betadine to area surrounding the wound to the top of the right foot, cleanse the wound and apply triple antibiotic ointment to the re-opened wound. Appropriate wound documentation completed by the Director of Nursing on 2/27/24. Corrective action for residents with the potential to be affected by the deficient practice: All residents who have current skin breakdown and are at risk for skin breakdown have potential to be affected by the alleged deficient practice. Beginning on 2/27/24 to 3/4/24 the Director of Nursing and Nurse managers completed full body skin assessment of all current residents for review to ensure no	

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F 684	Continued From page 2 10/12/23 focus of skin tear to top of right foot with a goal of the area will be healed by next review date. Interventions indicated: If a skin tear occurs, treat per facility protocol, and notify physician and family. Keep skin clean and dry. Monitor/document location, size, and treatment of skin tear. Report abnormalities, failure to heal, signs or symptoms of infection, or maceration to the physician. Perform skin tear treatments as ordered by the physician. Review of Resident #11's November physician orders revealed there was no order for a dressing to resident's right foot. Review of Resident #11's electronic health record revealed an 11/10/23 Nurse Practitioner progress note which indicated resident had an open wound of the foot. The note indicated to continue daily monitoring of the wound and the status was reviewed with nursing. Review of Resident #11's electronic health record revealed no progress note on or around 11/17/23 regarding the condition of a skin tear to resident's foot. Review of Resident #11's electronic health record revealed weekly skin checks were completed on the following dates with no new skin area concerns identified: 11/27/23, 12/3/23, 12/10/23, 12/17/23, 12/24/23, 12/31/23, and 1/4/24. Review of Resident #11's December 2023 physician orders revealed there was no order for a dressing to resident's right foot. Review of Resident #11's January 2024 physician orders revealed there was no order for a dressing	F 684	unidentified skin breakdown and ensure wound care being provided as ordered. This was completed on 3/1/24. Results included: 17 out of 86 residents with concerns noted. On 2/29/24 thru 3/4/24 the Director of Nursing implemented corrective action to include: Appropriate wound assessment completed, notification to MD/RP, implementation of treatment order, implementation of appropriate care plan with interventions. On 2/27/24 to 3/4/24, the Director of Nursing and nurse managers reviewed all resident with current skin breakdown for appropriate treatment orders, appropriate wound assessment and care planned interventions. The results included: 27 of 41 residents with concerns. On 2/29/24 thru 3/4/24 the Director of Nursing and Nurse management implemented corrective action to include: initiation of appropriate treatment, completion of correct wound assessment and care plan update with appropriate interventions. Systemic Changes: On 2/27/24, the Staff Development Coordinator began in-servicing all Full time, Part time, as needed Nurses staff (including agency) on Skin and Wound assessment and treatment policy. This training will include all current staff including agency. This training included: • Why are Skin and Wound UDA's important • What UDAs should be completed and when • Completing assessments accurately and thoroughly	

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F 684	Continued From page 3 to resident's right foot. Review of Resident #11's 1/10/24 quarterly Minimum Data Set (MDS) assessment revealed resident had severe cognitive impairment with no behaviors and did not resist care. Resident #11 was at increased risk of developing pressure ulcers or injuries, had no unhealed pressure ulcers and no lesions on the foot. The MDS assessment indicated Resident #11 had no dressings and no ointment or medication applied to the feet. Resident #11 required extensive assistance with bed mobility and transfers, and total assistance with dressing and toileting. Review of Resident #11's electronic health record revealed weekly skin check assessments were completed on the following dates with no skin area concerns identified: 1/19/24, 1/25/24, 2/2/24, 2/9/24, 2/16/24 and 2/23/24. Attempts were made to interview Nurse #3, the nurse that completed Resident #11's weekly skin check assessment on 2/23/24. Message was left for Nurse #3 with no return call received. An observation of a skin assessment was completed with MDS Nurse #2 and Unit Manager #1 on 2/27/24 at 10:20 AM. Observation indicated Resident #11 had a gauze dressing with a clear dressing covering it to the top of her right foot. There was dried dark drainage visible on the gauze dressing and it appeared to be dated 11-17. Unit Manager #1 attempted to remove the dressing but was unable to do so. Unit Manager #1 applied spray wound cleanser to the dressing and was able to remove it. Underneath the dressing an open area with a dark hard perimeter and a soft yellow center was observed.	F 684	• Risk assessment • What should I do if a new wound or skin condition is identified? • How to complete a weekly skin assessment • When to complete On 2/27/2024, the Staff Development Coordinator began in-servicing all Full time, part time, as needed Nurses, Nurse aides, Med tech (including agency) on Pressure Ulcer Prevention. This training will include all current staff including agency. This training included: • What is a Pressure Ulcer? • How do they occur? • Where do they occur? • Skin Assessment • General Care and Prevention • Prevention for High Risk Residents • Chair Positioning • Support Surfaces • What to do when I notice a change of skin condition? • Proper positioning and Pressure points Any clinical staff Registered Nurse, Licensed Practical Nurse, medication aide or Certified Nurse Assistant for full time, part time, As needed, and agency who did not receive in-service training by 3/1/24 will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has	

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F 684	Continued From page 4 Interview on 2/27/24 at 10:20 AM with MDS Nurse #2 indicated a date written on the dressing appeared to be 11/17 and she did not know why the dressing was there. Interview on 2/27/24 at 10:30 AM with Unit Manager #1 revealed she was unaware Resident #11 had an open area on her skin and could not explain why the dressing was left in place with a date that appeared to indicate it was placed on 11/17/23. Review of Resident #11's electronic health record revealed a non-pressure weekly wound review assessment dated 2/27/24 completed by the Wound Care Nurse. The assessment indicated Resident #11 had a wound to the top of the right foot with peri wound raised scabbing and an opened area of 1.5 x 2 centimeters with light yellow tissue present. The assessment indicated no drainage or induration. Interview on 2/27/24 at 1:10 PM with Nurse #4 revealed she worked at the facility for 4 years and was frequently assigned to Resident #11. Nurse #4 stated she completed a head-to-toe assessment of the resident's skin when the weekly scheduled skin check assessment came up. The assessment consisted of observations for skin breakdown or any new areas of concern. Nurse #4 stated anything not documented in the medical record with a current active treatment required documentation, notification of the physician and new orders. Nurse #4 indicated if she observed a dressing on a resident she would check for a physician order for the treatment. Nurse #4 further indicated she was unsure if she would remove the dressing and assess the area	F 684	been sustained. Any clinical staff Registered Nurse, Licensed Practical Nurse, medication aide or Certified Nurse Assistant for full time, part time, As needed, and agency will receive this education during orientation. Quality Assurance: Beginning the week of 3/4/24, The Director of Nurses or designee will monitor Compliance using the Quality Assurance Tool for skin and wound process. Monitoring will include observation of 5 residents to ensure weekly skin assessment and wound care is being completed as ordered. This is to be completed weekly x 2 weeks, then monthly x 3 months or until resolved. Reports will be presented by the Director of Nursing to the Monthly Quality of Life-Quality Assurance committee and corrective action initiated as appropriate. The weekly Quality assurance Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/4/2024	

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F 684	Continued From page 5	F 684		

or inform the physician or NP to assess the area and order treatment. Nurse #4 stated she recalled Resident #11 had an ostomy and a foot cradle to keep pressure off the top of her feet. Nurse #4 could not recall if Resident #11 had any wounds, if she observed a dressing or assessed resident's feet when she completed the recent skin check.

Interview with the Director of Nursing (DON) on 2/27/24 at 2:00 PM revealed weekly skin observations were scheduled through the computer. The DON stated she expected the nurses to complete head-to-toe assessments of each resident's skin on the weekly scheduled skin observation. The DON stated she expected socks to be removed prior to skin assessment of the feet. The physician and family were to be notified of any identified concerns. The DON stated she expected if a dressing was observed the nurse was to check for a physician order for treatment of the area. If there was no order in the electronic medical record, the nurse was to remove the dressing, assess the area and notify the physician and family. The DON indicated she did not know how the dressing was in place without a physician order.

Review of Resident #11's physician orders revealed a 2/27/24 order for 2 view x ray of right foot related to re-opening of the wound. A 2/27/24 physician order indicated apply betadine to area surrounding the wound to the top of the right foot, cleanse the wound and apply triple antibiotic ointment to the re-opened wound.

A 2/28/24 Nurse Practitioner progress note indicated Resident #11 had a reopening of a wound to the dorsum of the right foot. A foot x-ray

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F 684	Continued From page 6	F 684		

was ordered as the wound was full thickness and the goal was to assess the bone for baseline condition and any erosion associated with infection. There was no evidence of any changes in the bone near the wound area. The progress note further indicated Resident #11 had decreased pulse in the right foot with no tenderness, redness or swelling. The right foot had a wound with a dry loosely attached ring on the perimeter and a full thickness small area with a pink moist smooth bed in the center. Resident #11 remains at risk for poor healing due to peripheral arterial disease.

Interview with the Nurse Practitioner (NP) on 2/28/24 at 11:50 AM revealed there should be an order for dressings. The NP stated she did not document Resident #11's skin condition in her January assessment, so she did not know if a dressing was in place. The NP stated she evaluated Resident #11 in November, but the resident had socks on, so she did not assess her feet. The NP stated she expected the nurses to inform her of any concerns, assess open areas regularly and inform her of any changes. The NP stated she ordered an x ray due to possible bone involvement and to have a baseline of the area. The NP stated the x ray revealed no changes to the bone surrounding Resident #11's wound. The NP stated she observed the wound on 2/28/24 and it required treatment for an active wound with an open area.
Interview with the Administrator on 2/28/24 at 12:35 PM revealed she did not understand how Resident #11 had a dressing on with no order. The Administrator stated she had no explanation for why a dressing was on the resident with no order or documentation. The Administrator stated the nurses were to assess and document all

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F 684	Continued From page 7 wounds and complete weekly head to toe skin assessments.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff and the Senior Director of Compliance for the Orthopedic Office/Registered Nurse (RN) and Physician interviews, the facility failed to contact the Orthopedic office for clarification and instructions for removal of the orthopedic pneumatic (air pressure) boot, dressing changes and skin assessments on a resident's left ankle (Resident #7) after her follow-up appointment with the physician's assistant on 12/21/2023. Resident #7 developed deep tissue injuries (DTI) to the bottom of her left great toe, left lateral foot and left heel. This was for 1 of 3 residents reviewed for pressure ulcers. The findings included:	F 686	Past noncompliance: no plan of correction required.	

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The hospital discharge instructions for Resident #7 dated 12/14/2023 by the hospital Physician read in part that Resident #7 was admitted to the hospital with a displaced bimalleolar fracture (ankle fracture) of left lower extremity (LLE) and underwent a surgical repair on 12/5/2023 with a splint, with large bulky dressing and ace wrap applied postoperatively. She was scheduled for a post operative follow up visit on 12/21/2023.

Resident #7 was admitted to the facility on 12/14/2023. Her current diagnosis was fracture of the left displaced bimalleolar (type of ankle fracture that involve both the distal ends of the tibia and fibula) with an open reduction internal fixation surgical repair (ORIF) on 12/5/2023. She was discharged home on 1/22/2024.

There was not an Admission Skin Assessment completed on 12/14/2023.

The Care Plan for Resident #7 dated 12/14/2023 revealed a plan of care problem for alteration in musculoskeletal status related to fracture of the left lower extremity, and pain with a goal of the wound will heal and progress without complications through the review date. Interventions included anticipating and meeting needs and following physician orders for weight bearing status. There was a plan of care for pressure ulcer development risk related to decreased ability to assist with repositioning with a goal to minimize the risk for development of pressure ulcers through current interventions for the next 90 days. Interventions included to apply moisture barrier with each brief change and prn (as needed), encourage resident to shift weight frequently when sitting up in chair, and weekly full body assessments.

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The Weekly Skin Checks Assessment dated 12/17/2023 revealed no skin issues or risk factors were identified. The left foot dressing was not addressed.

The admission Minimum Data Set assessment for Resident #7 dated 12/18/2023 revealed she was moderately cognitively impaired, had a surgical dressing on left lower extremity, and was receiving routine pain medications. She was coded for receiving therapy and a planned discharge back to the community. She was coded as not having any pressure ulcers or skin issues.

A one-page handwritten document written by the Orthopedic Physician Assistant was provided to the facility after the 12/21/2023 post operative appointment. The document read in part that the staples were out, tall boot to LLE, TDWB (touch down weight bearing -when the ball of the foot can touch the ground, but no weight supported on it) LLE, and to follow up in 3 weeks in the office. There were no orders to remove the boot or for dressing changes on that note.

An interview with the DON was completed on 2/20/2024 at 3:18 PM. The DON explained the large bulky dressing Resident #7 was wearing on her left foot when she was admitted to the facility was not to be removed until the postoperative visit on 12/21/2023. She stated that Resident #7 was transported by the Facility Transporter to her follow up orthopedic appointment on 12/21/2023 and that the RP had met her at the appointment. The DON indicated that when Resident #7 had returned she had provided the facility with a one-page document handwritten by the

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Physician's Assistant (PA). The DON stated the only documentation the facility received following the Orthopedic Physician Assistant appointment on 12/21/2023 was a hand written document that read in part that the staples were out, tall boot to LLE, TDWB (touch down weight bearing -when the ball of the foot can touch the ground, but no weight supported on it) LLE, and to follow up in 3 weeks in the office. She stated there were no instructions for removing the tall boot and performing skin assessments on the sheet.

The Weekly Skin Checks Assessment dated 12/24/2023 revealed no skin issues or risk factors were identified. The left foot dressing was not addressed in the skin assessment.

An interview was completed with the Wound Nurse on 2/21/2024 at 12:38 PM. The Wound Nurse stated that Resident #7 was admitted to the facility on 12/14/2023 with a splint and a large bulky dressing wrapped in an ace wrap to her left foot. The Wound Nurse indicated that the Responsible Party (RP) had approached her on 12/22/2023 about Resident #7's right heel was getting "soft" (sign of tissue injury) and that she wanted her to wear heel protectors while in bed. She further stated that the RP had mentioned removing the tall boot on the LLE and she had told her they did not have a physician's order to remove the boot. She stated that she had checked Resident #7's right heel and it felt like it could be getting soft, so she had spoken to the Physician, and he had ordered Sure prep (a skin protectant) applied daily and covered with the heel protector. The Wound Nurse further stated the Orthopedic Office faxed an order to the facility on 12/27/2023 at 11:23 AM by the Physician Assistant that was dated 12/21/2023 at 8:42 AM

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to "remove boot from left lower extremity daily /cleanse area/ assess for wounds/ apply dry 4x4 gauze dressing to area as needed, Status post ORIF of fracture of ankle." She further stated that she had initiated the treatment to Resident #7's left ankle on 12/282023, but that she had not completely removed the boot. The Wound Nurse indicated that she had opened the boot and checked for drainage, the circulation status, and then she had cleansed the foot and applied dry gauze and closed the boot. She stated that the wounds were not visible because the boot was on the leg. The Wound Nurse further stated that when the DON had removed the boot on 12/29/2023, they had identified 3 suspected deep tissue injuries (SDTI) on the left foot. She stated there was one SDTI to the left heel, the left lateral side, and the bottom of the left great toe. The Wound Nurse indicated the wound assessments had been completed by the DON on 12/29/2023.

The following order written by the Orthopedic Physician Assistant dated 12/21/23 was faxed to the facility on 12/27/23: Remove boot from left lower extremity daily/cleanse area/assess wounds/apply dry dressing to area as needed. Status post ORIF of fracture ankle.

The Physician's orders revealed an order written on 12/22/2023 for Sure prep to right heel and cover with heel protector one time a day for skin protection.

The December 2023 Treatment Administration Record for Resident #7 revealed there were no treatments ordered for her left foot until 12/27/2023. The treatment order read in part to remove to remove boot from left lower extremity daily, cleanse area, assess for wounds and apply

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dry dressing to areas as needed one time a day and was documented as completed by the Wound Nurse on 12/28/2023 and 12/29/2023. There was a treatment order dated 12/22/2023 for Sure prep to right heel. Cover with heel protector once a day. The treatment was signed off as completed by a nurse every day from 12/22/2023-12/31/2023 except 12/24/2023 which was blank.

There was a grievance filed on 12/29/2023 by the Responsible Party (RP) regarding the physician orders not being followed and that causing her to get behind in her therapy from 12/21/2023 until 12/29/2023. The following response was given by the Director of Nursing (DON) on 12/29/2023, "Have been in close communication with the family regarding discharge status and weight bearing status, order clarification and current condition.

An interview was completed with the DON on 2/22/2024 at 11:28 AM. The DON stated that she was unaware there were any problems with Resident #7's care until Resident #7's RP had filed a grievance on 12/29/2023. She further stated the allegation was that the facility was not following physician's orders by not removing the pneumatic tall boot and performing skin assessments on the left ankle. The DON stated an investigation was immediately started. The DON indicated the RP had called the Orthopedic Office on 12/26/2023 regarding clarification orders for the left tall boot but the office was closed, due to the holidays and she had left a message. She stated that the Orthopedic Office had faxed an order to the facility on 12/27/2023 at 11:23 AM by the Physician Assistant that was dated 12/21/2023 at 8:42 AM to "remove boot

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from left lower extremity daily /cleanse area/ assess for wounds/ apply dry 4x4 gauze dressing to area as needed, Status post ORIF of fracture of ankle." The DON stated the Orthopedic Office had not faxed any other paperwork to the facility on 12/27/2023.

The Weekly Skin Checks assessment completed by the Director of Nursing (DON) on 12/29/2023 read, in part, that new skin conditions were identified, the type of skin condition was listed as bruising to the left foot and top of toes, and SDTI (suspected deep tissue injury) to bottom of left great toe, left lateral foot and left heel. The type of treatment started: betadine (skin protectant) to all areas. No new risk factors were identified.

The Weekly Pressure Ulcer Review for Resident #7 was completed by the DON on 12/29/2023. There were 3 suspected deep tissue injuries (SDTI) (bruising) noted on Resident #7's left foot. Wound #1 was a SDTI on the left heel that was 1.1 centimeter (cm) long and 0.5 cm wide and no depth. Wound #2 was a SDTI on the bottom of the left great toe that was 1.2 cm long and 1.2 cm wide with no depth. Wound #3 was documented as a SDTI to the left lateral foot that was 2.9 cm long x 2.1 cm wide and no depth. The skin around the area was intact with no odor or drainage.

The Physician's orders revealed an order dated 12/29/2023 to remove boot from left lower extremity daily. Cleanse area, assess and treat wounds and apply dry dressing to surgical areas as needed. There was also a physician's order dated 12/29/2023 to apply betadine to left great toe (bottom), left heel, and left lateral foot every shift for treatment.

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An interview was completed with the DON on 2/22/2024 at 11:28AM. The DON stated Resident #7's pneumatic tall boot on the left foot was removed on 12/29/2023 and she had performed the skin assessments with the family present. She further stated when she removed the boot on 12/29/2023 to assess the foot there was bruising to the top of the foot and 3 SDTI were noted. There was one on her left great toe, left heel, and the left lateral aspect of the foot. The DON indicated she had performed the wound treatment prdered by the Physician with the Wound Nurse on 12/29/2023. The DON stated that she had immediately reached out to the Orthopedic Office on 1/2/2024 regarding their routine orders following orthopedic surgery and had received clarification on not to remove the large bulky surgical dressing until after the first post op visit, and instructions for boots and immobilizers. She further stated that if a resident returned from a physician's office or was admitted with a dressing or orthopedic device and does not have orders for care the nurses were to call the office immediately for instructions. The DON indicated the facility received the Orthopedic Office Clinic Note and Office Plan when the RP picked it up from the Orthopedic Office and brought them to the facility 12/29/2023.

During the interview the DON confirmed the following reports were brought to the facility by the RP on 12/29/23:

1. The Office Clinic Note/Physician Progress note written by the PA at the Orthopedic Office for Resident #7's appointment on 12/21/2023 read in part, "She has been non-weightbearing to the left lower extremity. Her left ankle shows well-healed

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surgical incision with no sign of infection. Surgical staples in place. No surrounding erythema or drainage noted. Moderate tenderness to palpation noted medial lateral malleolus (ankle), Achilles tendon is intact (thick tendon in the back of the ankle)."

2. The Orthopedic Office Plan note written by the PA on 12/21/2023 read in part that the staples were removed and steri-strips (strips of adhesive that secure the incision together) were applied. The Patient was placed in a tall walking boot to the left lower extremity. The patient was fitted with a pneumatic walking boot to stabilize and support the ankle/foot. She was instructed on the use of the device and how and when to wear it, and weightbearing status. The patient was to be touchdown weightbearing to the left lower extremity using a walker for assistance with ambulation and she will follow-up in the office in 3 weeks.

A telephone interview was completed with the Senior Director of Compliance, Risk, and Quality/Registered Nurse for the Orthopedic Office on 2/21/2024 at 2:37 PM. She stated that Resident #7 was admitted on to the hospital with left ankle fracture and the Orthopedic Physician had performed an ORIF on 12/5/2023 and she was discharged to the facility on 12/14/2023. The Senior Director of Compliance, Risk, and Quality Assurance/RN indicated the Physician Assistant had provided handwritten instructions and he had documented that he provided verbal instructions for donning and doffing, proper use of the device and weight bearing status to the patient and RP. She further stated that the PA had documented in the in the physical exam on 12/21/2023 that the left ankle surgical incision was well healed without

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signs of infection and there were no wounds on her left foot. The Senior Director of Compliance, Risk, and Quality Assurance/RN stated that there was an order sheet written by the Orthopedic Physician dated 12/21/20 at 08:42 AM that read in part to remove the boot from left lower extremity daily/cleanse area/assess for wounds/apply dry dressing to area as needed. Status post ORIF of fracture of ankle that was provided at the 12/21/2023 visit. She further stated that she did not know why the facility had not received the order on 12/21/2023, but the Orthopedic Office had faxed the order to the facility on 12/27/2023 after the RP had called the office and left a message on 12/26/2023.

An interview was conducted with the Physician on 2/22/2024 at 1:00 PM. The Physician stated that anytime a resident has a brace or other orthopedic device that it puts them at risk for skin breakdown and especially if they were not very mobile like Resident #7. He further stated that the facility had initiated treatment as soon as the wounds were discovered, and they had improved while at the facility.

An interview was completed with the Administrator on 2/22/2024 at 4:21 PM. The Administrator stated that when families go with the residents to doctor's appointments, they usually will bring the paperwork back to the facility and if they go by facility transportation the Transporter will bring the paperwork back. She further stated that Resident #7 was alert and therefore the facility had not sent anyone with her to the Orthopedic Office visit on 12/21/2023. The Administrator indicated that she did not expect residents to develop wounds while wearing an orthopedic device and the breakdown in the

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system was the nurses not calling the physician's office for care orders for Resident #7 when she returned from the appointment.

An interview was completed with the DON on 2/22/2024 at 1:53 PM. The DON stated that the root cause analyses of Resident #7's wounds were determined to be that the nursing staff had not contacted the Orthopedic office for clarification and instructions for removal of Resident #7's left ankle tall boot, and dressing changes; and skin assessments were not completed with the boot off after her follow-up appointment with the physician's assistant on 12/21/2023. She further stated the nursing staff and admission staff were provided education regarding splints, boots, and immobilizers, and the importance of making sure orders were in place for care and maintenance, that the skin checks were completed, and the care plan was updated.

The facility provided the following Corrective Action Plan with a completion date of 1/8/2024.

Root cause analysis: Treatment orders were not clarified on admission and after postoperative visit, no admission wound assessment was completed, and the device was not removed for skin assessments.

1. Corrective action for the Resident involved, Resident #7:

On 12/27/2023 the facility received and initiated clarification orders from the Physician for Orthopedic boot and skin care that were initiated. On 12/29/2023 the Director of Nursing (DON)

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completed a follow-up assessment with removal of the orthopedic boot per order and completed skin assessment. Areas of suspected deep tissue injury (SDTI) were identified with notification to Physician for treatment and monitoring. Orders initiated on 12/29/2023. The Responsible Party (RP) was made aware of treatment orders. On 1/8/2024 the DON went with Resident #7 to the orthopedic appointment to discuss current treatment plan for this resident. The family was also in attendance. Resident #7 was admitted to the facility with a bulky dressing that remained in place until the return visit on 12/21/2023. On 12/21/2023 Resident #7, then had another device that remained until the clarification for removal on 1/29/2023, then that is when the skin issues monitoring, and treatment plan was initiated with the DON involvement.

2. Corrective action for potentially impacted residents:

On 12/29/2023 the Nurse Management team completed an audit of all new and readmissions for the last 7 days to ensure treatments were entered according to the new admission orders per Discharge Summary and or orders were clarified for continuing care for residents such as but not limited to: post op surgical site care, orders for care of orthopedic boots/immobilizers/braces to include skin and wound assessments, and weight bearing status. This audit was completed by nurse management on 1/7/2024. The results included: 1 out of 15 residents without treatment orders and orders for splint. On 1/7/2024 the DON implemented corrective action for those residents which included: clarification of orders, implementation of orders, and notification of the RP.

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On 1/7/2024 the DON reviewed the past 7 days of new admissions/readmissions to include bedside validation assessment to ensure appropriate assessment was completed to include but not limited to: Weekly skin assessment, pressure ulcer assessment and/or non-pressure wound assessment. This was completed on 1/7/2024. The results included: 1 out of 13 without all assessments. On 1/8/2024 the nursing staff implemented corrective actions for those residents which included: Completion of assessments.

On 1/5/2024 the Assistant Director of Nursing (ADON) reviewed all residents that have had a follow-up appointment or out of facility consultation in the past 7 days to ensure post visit summary reports were received and that all new/changed orders were implemented or clarification orders were received for continued plan of care and implemented to include orders for but not limited to: orthopedic boots/braces/immobilizers, surgical care, and weight bearing status. This was completed on 1/8/2024. The results included: 4 of 11 without post appointment visit notes. On 1/8/2024 the ADON implemented corrective action for those residents which included: Post visit summary obtained and verified that there were no follow-up notes. No missed orders were found.

3. Education:

On 12/29/2023 the DON began in-servicing all full time, part time and as needed registered nurses (RN), licensed practical nurses (LPN) to include agency on Admission/Readmission and Consultation Order process. The training

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included:
Admission/readmission order entry.
Preventing transcription errors during admission/readmission process.
Reviewing admission paperwork to identify all necessary orders/treatments.
Obtaining clarification orders for treatments and medications.
Assessments/UDA (user defined assessment-eliminates paper assessments and puts them in the electronic record)
/Documentation/Report
Utilizing batch orders.
Assessing documents after consultations/appointments/ER visits/and hospital visits.

On 12/29/2023 the Director of Nursing began in-servicing all full time, part time and as needed RN, LPN, Medication Aide, and Nurse Aide staff including agency on Brace/Immobilizer/Ortho boot process. This training included all current staff including agency staff. This training included:
Various reasons Splints/Braces/Ortho boots are used.
Nurse Aide role with management of splints/immobilizers/braces/ortho boots.
Nurses role in management of splints/immobilizers/braces/ortho boots.
Potential complications that may occur related to splints/immobilizers/braces/ortho boots.
The education was completed on 1/8/2024.

4. Quality Assurance:

The DON or designee will monitor to ensure orders are in place for splints/braces/immobilizers/ortho boots, and admission/readmission/consultation orders and

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F 686	Continued From page 21 office notes, and the skin and wound process assessments weekly for 2 weeks and monthly for 3 months or until resolved. Reports will be presented to the weekly QA meeting by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored, and the ongoing auditing program will be reviewed at the weekly QA meeting and the quarterly QA meeting. The weekly QA meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, Health Information Management, and the Dietary Manager. 5. Allegation of Compliance Date: 1/8/2024 The Corrective Action Plan was validated on 2/22/2024 and concluded the facility had implemented an acceptable action plan on 1/8/2024. Interviews with nursing staff, including agency staff revealed the facility had provided education and training on clarification of orders for new admissions and readmissions and after out of facility consultations and doctors' appointments, the importance of completing skin assessments, and managing braces/immobilizers/splints/and ortho boots.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		

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F 689	Continued From page 22 by: Based on record review, observations, staff and Physician interviews, the facility failed to provide incontinence care safely for a resident who was dependent on staff assistance for 1 of 4 residents reviewed for falls (Resident #1). On 1/2/24 Nurse Aide (NA) #6 was attempting to pull the brief out from under Resident #1 by turning him onto his side and pressing on his back for him to roll over resulting in the resident rolling off the side of the bed and landing on the floor on his left shoulder and neck. Resident #1 experienced pain on the left side of his neck at a level of 8 out of 10 (with 10 being the worst pain possible), cervicogenic headaches (a pain that develops in the neck and is felt in the head), and sustained a cervical neck strain of the left trapezius muscle (injury to the large muscle in the back that supports the head and neck caused from overstretching or trauma). The findings included: Resident #1 was admitted to the facility on 7/13/2023. His diagnoses included chronic combined systolic and diastolic congestive heart failure, dementia, atrial fibrillation (abnormally fast pulse rate) and anemia. He was discharged from the facility on 11/26/2023 and was readmitted from the hospital to the facility on 12/16/2023. The quarterly Minimum Data Set (MDS) assessment dated 12/16/2023 revealed Resident #1 was moderately cognitively impaired, with no behaviors. He was coded as being incontinent of bowel and bladder, receiving anticoagulant therapy, weighing 239 pounds and was 68 inches tall, with 2 or more falls. He was coded as receiving physical therapy (PT) and occupational therapy (OT). Resident #1 was not coded for	F 689	Past noncompliance: no plan of correction required.	

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frequent complaints of pain or for taking routine or as needed pain medications. Resident #1's functional ability for toileting was coded as "Dependent - Helper does ALL of the effort..."

The Care Plan for Resident #1 initiated 7/13/2023 and reviewed 12/16/2023 revealed a plan of care for actual falls with risk for further falls related to unsteady gait with a goal of minimizing fall risk for 90 days. Interventions included: anticipate my needs as much as possible; encourage to wear nonslip socks when not wearing shoes; ensure bilateral wedges in place when resident is in bed to establish parameters; ensure call light is within reach; keep bed locked in low position at all times; keep frequently used objects within reach; low bed mattress on floor to left side bed when resident's bed in position; and staff to perform hourly rounding on resident. A plan of care for activities of daily living (ADL) self-care deficit r/t dementia, unsteady gait, and frequent falls with a goal of his needs would be met for next 90 days. Interventions included: to anticipate resident's needs as much as possible; limited assistance of 1staff person for bed mobility, transfers, and toilet use; encourage resident to use call light and to wait for assistance before transferring.

A physician's order dated 12/31/2023 revealed Resident #1 was receiving Eliquis (Apixaban) Tablet (a blood thinner) 2.5 milligrams (mg), give 1 tablet two times a day for atrial fibrillation; lower dosage because of anemia.
Resident #1's active physician's orders as of 1/1/24 included an order initiated on 12/28/2023 for Acetaminophen tablet 325 mg, give 2 tablets by mouth every 4 hours as needed (PRN) for general discomfort and Resident #1 had not received any prior to 1/2/2024.

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F 689	Continued From page 24 A Fall Report completed by Nurse #6 on 1/2/2024 at 1:15 AM revealed the following information: " Nursing Description: Resident noted on the floor between his bed and the wall. " Resident Description: He rolled over. " Immediate Action taken: Resident assessed, vital signs taken, 2 persons assist transfer with mechanical lift back to bed. " Resident taken to hospital: No " Injuries observed at time of incident: No injuries observed at the time of the incident. " Level of consciousness: Alert " Mobility: Ambulatory with assistance " Mental Status: Oriented to person, place, situation " Injuries Reported Post Incident: No injuries observed post incident " Level of Pain: there was not a pain level documented " Predisposing physiological factors: Confused, incontinent, impaired memory. " Witnesses: Nurse Aide (NA) #6 " The physician notification was documented in the chart. A telephone interview was completed with NA #6 on 2/21/2024 at 11:00 AM. NA #6 stated that when she was changing Resident #1's brief in bed on 1/2/24 at approximately 1:00 AM, she had moved the bed away from the wall to get the covers off the bed and had only raised it to about knee high level. She further stated that residents generally required more assistance with bed mobility at night because they were drowsy from being woken up for care. NA #6 stated that when she had attempted to pull the brief out from under his body that she had gently pressed on his back for him to roll over just a little more and his leg	F 689		

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rolled off the bed and he fell onto the floor. NA #6 stated that she had reported the fall immediately to Nurse #6. She further stated that the nurse had assessed Resident #1 and they had transferred him back to bed with the mechanical lift. NA # 6 stated it was just an accident and that she had not intentionally pushed Resident #1 out of the bed. She further stated that he did not complain of pain at the time.

A nurse's note for Resident #1 revealed the following secure conversation text message (text message from the nurse to the provider that is uploaded into the progress notes) from Nurse #6 to the Physician on 1/2/2024 at 2:31 AM which read in part, "Resident had a witnessed fall. Resident assessed, no injury noted, VSWNL [vital signs within normal limits], 2 persons assist with transfer using the [mechanical] lift back to bed. Currently resting in bed, call light within reach, bed in lowest position."

Nurse #6 sent another secure conversation text message to the Physician on 1/2/2024 at 6:49 AM, which read in part, "Resident is now complaining of left sided neck pain, he is able to turn his head and move his head up and down, nontender to touch, please advise." The Physician responded back to Nurse #6 on 1/2/2024 at 7:19 AM with the following response, "Follow".

A telephone interview was conducted with Nurse #6 on 2/22/2024 at 1:00 PM. Nurse #6 stated that the first thing she did when a resident fell was to ask them if they were in pain anywhere. She further stated that she checked their vital signs and completed neurological checks if they hit their head. Nurse #6 indicated that if the resident

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was not having any pain, and their vitals were stable she would use the mechanical lift to put them back to bed. Nurse #6 stated that she was an agency nurse and traveled to many different facilities and she could not recall the details of Resident #1's fall. Nurse #6 indicated she was unable to recall if Resident #1 was provided with any pharmacological or non-pharmacological interventions for pain management on 1/2/24.

A nurse's note for Resident #1 revealed a secure conversation text message dated 1/4/2024 at 9:49 AM from Unit Manager #1 to the physician. The note read in part, "I know you have already been made aware of resident's neck pain, however resident is still complaining and stating that it is getting worse, and he wants to go to the ER [emergency room] or see a specialist. Please advise.
The Physician responded back on 1/4/2024 with the following response, "ER does not have a specialist. He would be wasting his time and our time. I will see him today,"

An order for a 2-view cervical spine x-ray for neck pain was ordered on 1/5/2024 by the Physician.

The mobile x-ray report dated 1/5/2024 for a 2-view cervical spine x-ray revealed in part, "1. Mild degenerative changes of the cervical spine are present. 2. No acute fracture is identified. However, the lower cervical spine is excluded from examination by the patient's shoulder. Follow-up examination may yield additional information."

A nurse's note written by Nurse #10 on 1/5/2024 at 8:12 PM, read in part, "Pt [patient] observed on the floor of room at his bedside after unwitnessed

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fall. Pt states he fell asleep in wheelchair. Pt fully physically assessed. No injuries found."
The Physician responded back on 1/5/2024 at 11:15 PM with the following response, "follow".

A Fall Report completed by Nurse #10 on 1/5/2024 at 8:12 PM revealed the following information:
" Nursing Description: Patient observed on the floor of room at his bedside. Patient stated he fell asleep. Patient fully physically assessed. No injuries found.
" Resident Description: Patient stated he fell asleep.
" Immediate Action Taken: Patient was fully assessed. No injuries found.
" Resident taken to hospital? No
" Injury Type: No injuries observed at time of incident
" Level of Consciousness: Alert
" Mobility: Ambulatory with assistance.
" Mental Status: Oriented to Person, Place, Situation
" Injuries Report Post Fall: No injuries post incident.
" Predisposing Factors: Drowsy
" Predisposing Situation Factors: Other/asleep in wheelchair.
" No witnesses
" The Physician was notified on 1/5/2024 at 8:25 PM.

The January 2024 Medication Administration Record (MAR) for Resident #1 revealed he was administered acetaminophen 325 mg 2 tablets on 1/6/2024 at 7:55 AM for neck pain level of 6 out 10 pain scale (0= no pain and 10= worst pain you have ever felt) and it was effective.

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The January 2024 MAR revealed Resident #1 was administered acetaminophen 325 mg 2 tablets by mouth on 1/7/2024 at 1:57 PM for complaint of neck pain 6 out of 10 on the pain scale and it was effective.

A nurse's note written by Nurse #6 on 1/7/2024 at 2:00 PM indicated it was reported that resident had a fall recently and had been complaining of neck pain. He was administered acetaminophen 325 tablet 2 tablets for complaint of neck pain.

The January 2024 MAR revealed Resident #1 was administered acetaminophen 325 mg 2 tablets by mouth on 1/9/2024 at 6:41 AM for complaint of neck pain 6 out 10 on the pain scale and it was effective.

A nurse's note written by Nurse #10 on 1/9/2024 at 7:40 AM indicated acetaminophen tablet 325 milligrams (mg), give 2 tablets by mouth every 4 hours as needed was administered for complaints of neck pain.

Unit Manager #1 wrote in a secure conversation text message with the Physician on 1/9/2024 at 10:32 AM, " ...resident continues to complain of neck pain and wants to know if he can go to a specialist or have something to help with the pain such as a cream/ointment. Please advise. Thanks."

The Physician responded back to Unit Manager #1 on 1/9/2024 at 2:04 PM with the following response, "[Resident #1] needs to get PT [physical therapy]; specialist won't do anything for his neck; He has dementia/PT [physical therapy] needs to be done for ROM [range of motion] exercises and his neck will get better."

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The physician's orders did not reveal an order for physical therapy for his neck.

The January 2024 MAR for Resident #1 revealed he was administered acetaminophen 325 mg tablet 2 tablets by mouth on 1/9/2024 at 1:44 PM for complaint of neck pain 8 out of 10.

A written statement by Unit Manager #1 was provided by the facility on 2/22/2024 regarding the secure conversation text messages between her and the Physician regarding Resident #1's neck pain and physical therapy order. The statement dated 2/21/2024 read in part, "On 1/9/2024, MD [Physician] was notified that Resident #'s x-ray was completed and uploaded for him to review. MD was made aware that he continued to complain of pain, and he requested to see a specialist. The MD responded back and gave an order for PT consult for ROM [range-of-motion] exercises. spoke with the resident about his pain and the MD's response and he told me that he just came off of therapy and I also verified he was on restorative [therapy]. He kept stating that he wanted to go somewhere and see somebody about his neck. I asked him if thought PT would help with his pain and he stated the computer had to work before the body would work. Therapy was not notified at this time because the resident was not interested in therapy due to his wanting to go out of this facility and see another doctor. On 2/11/2024, Resident #1 requested to go to the ER to be evaluated. A CT of the neck and head was done at that time. MD reviewed the results with no added follow-up ...I asked him if he took anything for pain and he stated that he takes 2 [acetaminophen] tablets. I asked him if it helped and he stated that it does ease the pain off."

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An interview was completed with Unit Manager #1 and the DON on 2/22/2024 at 10:17 AM. The DON stated the secure conversation text message from Unit Manager #1 to the Physician on 1/9/2024 at 2:02 PM regarding Resident #1 needing to get PT done for ROM (range of motion) exercises and his neck will get better, was a physician's order and should have been entered into his record as an order. She further stated that when the Unit Manager spoke to Resident #1 on 1/9/2024 he had stated that he did not want therapy, he had wanted to see a specialist and he still did. Unit Manager #1 indicated Resident #1 would not take anything stronger than acetaminophen for the pain."

An interview completed with the Certified Occupational Therapy Assistant (COTA) was completed on 2/21/2024 at 3:39 PM. The COTA explained that Resident #1 was discharged from skilled therapy on 12/28/2023 and he was currently working with the restorative nursing program. She stated that the therapy department had not received an order for physical therapy for neck pain in January 2024.

A secure text message written on 1/11/2024 at 9:53 AM by Nurse #8 indicated, "He and family are adamant on him going to the ER [emergency room] because of his ongoing head and neck pain. He is leaving now."

The Physician responded back to Nurse #8 on 1/11/2024 at 10:03 AM with the following response, "It is not a prison so he can do what he wants."

An interview was completed with Nurse #8 on 2/22/2024 at 2:26 PM. Nurse #8 stated that she

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was the nurse assigned to care for Resident #1 on 1/11/2024 on the 7am to 7pm shift. She further stated that Resident #1 was complaining of neck pain and he and his family insisted that he be sent to the Emergency Room for evaluation. Nurse #8 indicated that Resident #1 had a CT (computed tomography scan-medical imaging technique that is used to obtain detailed internal images of the body) in the ER and was sent back to the facility.

The ER Triage notes written by the ER physician revealed Resident #1's chief complaint was that he fell off the bed one week ago now with neck pain, headache, dizziness. The plan was to obtain a CT (computed tomography scan is a medical imaging technique used to obtain detailed internal images of the body) of the head and cervical spine. The CT of the head and cervical spine report for Resident #1 dated 1/11/2024 at 1:38 PM revealed there were no acute intracranial (inside the skull) abnormalities or cervical spine fractures.

The hospital ER discharge instructions dated 1/11/2024 at 3:46 PM for Resident #1 listed the following diagnosis:
1. Strain of cervical portion of left trapezius muscle; 2. cervicogenic headache; 3. Osteoarthritis of shoulders bilateral; and 4. acute cystitis (bladder infection) with hematuria (blood in the urine). The discharge instructions included cervical strain and sprain rehab stretching and range-of-motion exercises.

An interview and observation were conducted with Resident #1 on 2/20/2024 at 11:28 AM. Resident #1 was observed in his room, and he was sitting up in his wheelchair propelling around

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the room with his feet. Resident #1's head of the bed was up against the far side of the wall near the window and the right side of the bed against another wall, there was a fall mat rolled up at the end of the bed, and the bed was in low position, and the call light within reach of the resident.
Resident #1 stated that he has had several falls while residing in the facility and most of them were his fault for trying to get to the bathroom by himself. He further stated that he was supposed to push the call light button and wait for a staff member to respond, but sometimes he just could not wait. Resident #1 indicated that on the night of 1/2/2024 at around 1:00 AM NA #6 was providing incontinence care and had raised the bed up to provide care and asked him to roll over facing the wall on his right side, and he had rolled over on his side. Resident #1 indicated he needed assistance with turning in bed at night because of the arthritis in his left shoulder and he was a "hard sleeper". He stated that when he felt NA #6 push on his back to roll him over a to get his brief out from under him, his left leg rolled off the bed, and he fell and hit the floor with his head and neck. Resident #1 stated that he did not want to get NA #6 in trouble and did not think she had pushed him out of bed on purpose. He further stated that he felt that it was an accident and that she had been trying to help him. Resident #1 indicated that he had told the nurses several times that his neck was hurting after the incident. He further stated that on 1/5/2024 he had fallen asleep in his wheelchair and slid out of his chair and landed on his buttocks but he was not injured.
A follow-up interview was conducted with Resident #1 on 2/21/2024 at 9:25 AM. Resident #1 stated that he just wanted to clarify that after NA #6 had raised the bed up to provide care and

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he had rolled over on his right side, that she had pushed him over a little further to get the brief out from underneath him and that's when he rolled out of the bed and hit his head and neck. He stated that the nurse on duty had come and assessed him and helped NA #6 assist him back to bed with the mechanical lift. Resident #1 further stated that the physician had determined that he did not need to be sent to the ER for evaluation. He indicated that his neck was not hurting very bad at the time of the 1/2/24 fall, but when he woke up a couple of hours later his neck was hurting. Resident #1 stated he had complained to the nurse and that she had given him acetaminophen for pain. He explained that the neck pain had kept getting worse to almost where he couldn't stand it anymore and it was affecting his neck movement. Resident #1 stated that he would only take acetaminophen for pain because he did not want to get addicted to drugs and they made him feel confused. He indicated acetaminophen was usually effective. He explained that he had kept asking to be sent to the ER and was told he could not go. Resident #1 stated that he had finally gotten so frustrated that he had told his family and they had demanded he be sent to the ER. Resident #1 stated that he had not been offered PT on his neck and had not received PT for his neck pain. He further stated that he was receiving restorative therapy and ambulated with his walker and the Restorative Therapy Aid at least 4 times a week and that it was not helping his neck. Resident #1 indicated that he continued to have neck pain and that he would be willing to try therapy if it would help his neck pain.

An interview was completed with the Restorative Aide/NA on 2/22/2024 at 09:01 AM. The

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Restorative Aide/NA stated that she had been providing ambulatory therapy with Resident #6 since December 2023. The Restorative Aide indicated that Resident #6 was complaining of pain in his neck frequently in January, but he was not complaining as much now. She explained that he had really progressed in therapy in the last few weeks.

An interview was completed with the Physician on 2/22/2024 at 12:48 PM. The Physician stated that when a resident that was receiving anticoagulant therapy and had a fall and hit their head, he would usually send them to the ER. He further stated that it depended on the situation of the fall and if the resident seemed appropriate then he might not send them to the ER. The Physician stated that for a low risk fall to the head or neck he usually ordered neurochecks and vital signs per the facility protocol and if they continued to complain of pain, he would send them to the ER. The Physician further stated that Resident #1 was certainly at risk for falls and had a lot of falls, and the facility followed their protocol. He indicated that Resident #1 had refused PT on 1/9/2024 and that a specialist (neurologist or neurosurgeon) would not see him unless he had tried therapy. The Physician stated that Resident #1's neck and shoulders had arthritic changes due to his age and his cognitive function was at baseline when he had assessed him on 2/20/2024.

An interview was completed with the Director of Nursing (DON) on 2/22/2024 at 1:10 PM. The DON stated that the facility had investigated the fall that occurred on 1/2/2024 involving Resident #1 falling out bed while receiving care from NA #6 and determined the root cause to be improper positioning during care. She further stated that

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Resident #1 was positioned too close to the edge of the bed when he rolled over causing his left leg to slide off the bed and his body fell on the floor. The DON indicated that Resident #1 required assistance from 1 staff member for incontinence care in bed, because he could follow commands and roll over by himself. She further stated that the facility had immediately suspended NA #6 pending the investigation.

The facility provided and implemented the following Corrective Action Plan with a completion date of 1/9/2024.

1. On 1/2/2024 while performing incontinence care, NA #6 asked Resident #1 to roll over so she could change his brief. When Resident #1 rolled over he was too close to the edge of the bed and when NA #6 attempted to pull the brief out she just lightly touched his back to roll over a little more and his left leg slid off the bed and he fell onto the floor. Nurse #6 assessed Resident #1 for injuries and performed neurochecks and obtained his vital signs and determined he was uninjured. NA #6 and Nurse #5 assisted Resident #1 back to bed with the mechanical lift.

2. On 1/2/2024 NA #6 was immediately suspended pending investigation and educated regarding appropriate bed positioning safety. NA #6 was brought in for return demonstration of how the incident occurred and the root cause analysis of the fall was determined to be that the resident had been positioned too close to the edge of the bed prior to rolling over. The DON met with NA #6 and education was provided on Preventing Falls from Bed and Bed Positioning Safety with return demonstration. On 1/4/2024 the DON and Support Nurse interviewed all alert and oriented

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residents on the assignment for any concerns related to falls and provision of care. The results included: There were no identified concerns. On 1/4/2024 the DON and assigned nurses completed head to toe assessments on all residents that were alert and oriented (BIMS above 12) for alterations in skin integrity and any s/s of injuries. The results included: There were no identified concerns. On 1/7/2024 the Nurse Consultant identified residents that were potentially impacted by this practice by auditing all current residents with falls in the last 7 days to ensure no similar events and to ensure there were appropriate interventions in place to prevent a reoccurrence. The results included: There were no identified concerns.

3. On 1/5/2024, the DON and the Staff Development Coordinator began in-servicing all full time, part time, and as needed registered nurses (RN), licensed practical nurses (LPN), Medication Aides, Medical Technicians staff (including agency) on Preventing Falls from Bed and Bed Positioning Safety. The education will be provided in the new hires orientation and the agency staff orientation. The training included:
a. How do I know how to best assist a resident while they are in the bed?
b. Preventing falls from bed during care.
c. Positioning reminders.
d. What are common causes of falls?
e. Identifying falls risk
f. General fall prevention strategies
g. How to access the Kardex from the IPAD.
h. Nursing immediate actions.

4. The Quality Assurance (QA) monitoring tool for bed positioning safety was implemented on 1/7/2024. The DON will review 4 residents

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F 689	Continued From page 37 positioning in bed during care weekly x 2 weeks and monthly times x 3 months for positioning safety or until resolved. Reports will be presented to the weekly Quality of Life-QA committee and the quarterly Quality Assurance and Performance Improvement committed meetings. 5. Allegation of Compliance Date 1/9/2024. The corrective action plan was validated on 2/22/2024 and concluded the facility had implemented an acceptable plan of correction on 1/9/2024. Interviews with nursing staff including agency staff, revealed the facility had provided education on preventing falls in bed and bed positioning safety and where to locate the information on resident bed mobility status in the Kardex. Staff interviewed all verbalized they were provided education on preventing falls in bed and bed positioning safety prior to working. Review of the monitoring tools for bed positioning safety that began on 1/7/2024 were completed weekly as outlined in the corrective action plan.	F 689		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility administration failed to provide effective leadership and oversight to ensure residents were protected from potential	F 835	Past noncompliance: no plan of correction required.	

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misappropriation of property by having no system in place to account for purchases made by staff for residents with resident funds, credit cards, debit cards or Electronic Benefit Transfer (EBT) card. This failure affected 1 of 3 residents reviewed for misappropriation of property and had the potential to affect other facility residents.

Findings included:
Resident #5 was admitted to the facility on 11/23/20 with diagnosis which included in part dementia and delusions.

Review of Resident #5's 1/15/24 Annual Minimum Data Set (MDS) revealed resident was cognitively intact with no behaviors exhibited.

Review of the facility's initial 24-hour allegation report submitted to the Division of Health Service Regulation dated 2/12/24 revealed the facility became aware at 12:30 PM on 2/12/24 that Resident #5 was missing an Electronic Balance Transfer (EBT) card. Law enforcement was made aware. The EBT card was later found. Purchases on the card were made which the resident stated he did not make or authorize. The accused person, the Assistant Director of Nursing (ADON), was suspended pending the investigation. All cognitively intact residents were interviewed by the facility leadership team on 2/13/24 to inquire if they experienced misappropriation. All residents that were not cognitively intact had skin audits completed by staff nurses to identify any signs of abuse. Staff education was initiated on 2/13/24.

Review of the 5-day allegation report dated 2/19/24 revealed the Resident #5 reported to the Administrator on 2/12/24 that he was unable to

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locate his EBT card. An investigation was initiated. The missing card was located by the Assistant Director of Nursing (ADON). Resident #5 stated the last time he recalled using the EBT card was around Christmas and that he had not given the card to anyone to use. The ADON acknowledged she purchased items frequently for Resident #5 utilizing his United Health Care (UHC) card and EBT cards. The ADON indicated she made purchases for Resident #5 at several stores in the past week using his cards. The ADON acknowledged some of her personal items, frozen pizzas and onions, were accidentally billed to Resident #5's UHC card and she offered to make retribution. The ADON stated she typically returned receipts with purchases made on his cards however the receipts for the recent purchases were not located. On 2/15/24 and 2/16/24, the Administrator and Director of Nursing (DON) reviewed camera footage for dates of transactions made with Resident #5's cards. The camera footage was unable to visualize specific items brought into Resident #5's room on the dates that purchases were made. The allegation report concluded that technically the facility substantiated the allegation however the facility felt the staff member made a mistake in judgment using the resident's cards to make purchases.

Interview with Resident #5 on 2/21/24 at 3:20 PM revealed he kept valuables including his EBT and UHC cards in a locked drawer in his room. Resident #5 stated the (EBT) card had money on it, several hundred dollars the last he knew, and the United Healthcare (UHC) card had money on it to spend on healthcare items and food. Resident #5 stated he did not give the cards to the ADON to purchase items for him recently and

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he did not know the cards were used. Resident #5 stated he had the Social Worker (SW) check the balances on his cards and found the following transactions: 2/1/24 UHC $106.54, 2/4/24 UHC $74.42, 2/8/24 EBT $23.24, 2/8/24 EBT $7.58, 2/9/24 EBT 18.00, 2/9/24 UHC $21.45. Resident #5 stated he had not made or authorized someone else to make the transactions. Resident #5 stated he was upset and frustrated by this.

An interview was conducted on 2/21/24 at 4:15 PM with the Administrator. The Administrator revealed she technically substantiated the allegation of misappropriation but felt the investigation indicated the staff member made a mistake in judgment using the resident's cards to purchase items. The Administrator further revealed she had no reason to believe there was misappropriation in the facility until this incident occurred. The Administrator stated previously there was not a policy that indicated that employees were not to purchase items for residents with resident funds, credit cards, debit cards or EBT cards. Following this incident, the Administrator stated a new process was enacted to ensure a system was in place to account for purchases made, to designate specific staff allowed to make purchases and a tracking of funds used with receipts attached. The Administrator stated all staff were in-serviced on the new process.

An interview was conducted on 2/22/24 at 11:25 AM with the detective from the Whiteville Police Department. The detective stated he was notified of the missing cards and the transactions. The detective stated he was informed staff frequently made purchases for residents. The detective stated he presented the information to the District

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Attorney who determined no further investigation was required as it was considered a civil matter versus criminal.

An interview was conducted with the Social Worker (SW) on 2/22/24 at 1:25 PM. The SW indicated Resident #5 came to her office on 2/12/24 stating he could not find his EBT and UHC cards. The SW immediately went to Resident #5's room with another staff member as a witness and searched for the cards but were unable to locate them. SW stated she took Resident #5 back to her office to call the automated system for EBT and UHC cards to find out the balance on the cards. SW stated the ADON then came to her office and stated she found the cards. When the SW informed Resident #5 of the balances, Resident #5 became upset and stated he had not made or authorized the transactions. SW stated the UHC card can be used by scanning a bar code and did not require a PIN (personal identification number) or identification.

Attempts were made on 2/21/24 and 2/22/24 via phone to contact the ADON with no answer received and no return call. The ADON was no longer employed at the facility due to other reasons.

The facility provided and implemented the following Corrective Action Plan with a completion date of 2/19/24.

1. Immediate retribution to Resident #5 was made by the facility on 2/19/24 with funds placed in a trust account. The conclusion of the facility's investigation revealed the ADON admitted erroneously purchasing personal items with

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Resident #5's personal EBT card including frozen pizzas and onions. The ADON confirmed she utilized Resident #5's EBT and UHC cards for numerous transactions. The root cause analysis indicated there was not a process in place for use of resident credit, debit, EBT or UHC cards for purchases made by a staff member for a resident.

2. The ADON was immediately suspended pending investigation. At the conclusion of the investigation, the ADON was terminated for other reasons.
Resident #5 received retribution from the facility. Resident #5's EBT and UHC cards were placed in the safe in the office. On 2/13/24, the facility leadership team interviewed all cognitively intact residents if they experienced any misappropriation of funds, and the residents were informed of the new policy for designated staff only to purchase items for residents.

3. Education was completed by 2/19/24 by the Administrator and Staff Development Coordinator for all employees regarding what to do if a resident requested that a staff member purchase items utilizing personal cash, bank card, credit card, EBT, UHC or other personal funds the staff member should under no circumstances complete such transactions or take into their possession the items. The staff should immediately report this request to the Administrator or Director of Nursing for further guidance. The Administrator will contact the residents' family to make purchases for the resident. If a family member is unable to do so, the Administrator will designate the SW or other staff member to take resident funds, make the purchases and return the receipt for items

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purchased. The resident and staff member will sign for the funds received, funds returned, items purchased, and receipt provided. The documentation for this and receipts will be maintained in the business office. Education is ongoing for newly hired staff and agency staff.

4. Initial concerns regarding staff use of resident funds to purchase items for residents and the new policy were reviewed by the Quality Assurance and Performance Improvement (QAPI) committee on 2/16/24. The facility will no longer allow staff to take personal funds to purchase items for residents. A form was initiated for resident requests for the facility to make purchases for them. The Administrator will designate a leadership team member to purchase requested items for the resident, ensure that all funds are accounted for and receipts for purchases are maintained by the Business Office Manager.

Weekly audits will be completed with 5 staff members interviewed regarding misappropriation and the new policy regarding personal funds. Monitoring of the weekly audits will be completed by the Administrator or designee for a minimum of 3 months or until no longer deemed necessary by the QAPI committee.

Weekly audits will be completed by The Administrator and or the Director of Nursing (DON) by reviewing the facility form used for resident requests for personal purchases. The forms will be reviewed for the resident's name, date of purchase, amount of funds taken, amount of funds returned, items purchased, signatures of the resident and the staff member that made the purchases along with the receipt. The forms and

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F 835	Continued From page 44 receipts for purchases were to be retained in the business office. This will be monitored weekly for 3 months or until no longer deemed necessary by the QAPI committee. Weekly audits of 5 cognitively intact residents will be completed regarding concerns of misappropriation. The weekly audits will be monitored for 3 months or until no longer deemed necessary by the QAPI committee. 5. Allegation of Compliance Date: 02/19/24. The Corrective Action Plan was validated on 2/22/24 and concluded the facility had implemented an acceptable corrective action plan on 2/19/24. Interviews with staff revealed the facility had provided education on the new policy for purchasing items for residents with resident funds, EBT or debit cards. Review of the monitoring tool revealed it was started the week of 2/19/24 as outlined in the corrective action plan with no concerns identified.	F 835		
F 867 SS=G	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input	F 867		3/20/24

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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.

§483.75(d)(2) The facility will develop and implement policies addressing:

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F 867	Continued From page 46 (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 assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or	F 867		

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F 867	Continued From page 47 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, resident and Physician interviews the facility's Quality Assurance and Performance Improvement (QAPI) Program failed to maintain implemented procedures and effective monitoring of interventions the committee put into place following the recertification and complaint investigation survey of 5/4/2023 and the complaint investigation survey of 9/15/23. This was for one recited deficiency in the area of supervision to prevent accidents (F689). During the 5/4/2023 recertification and complaint investigation survey, deficient practice was cited for failing to provide incontinence care safely to a dependent resident when the resident fell off the bed during care and fractured her right femur (thighbone) in two places. During the complaint	F 867	F867 1. Corrective action for resident(s) affected by the alleged deficient practice: Facility's Quality Assurance and Performance Improvement (QAPI) Program failed to maintain implemented procedures and effective monitoring of interventions the committee put into place following the recertification and complaint investigation survey of 5/4/2023 and the complaint investigation survey of 9/15/23. This was for one recited deficiency in the area of supervision to prevent accidents (F689). During the 5/4/2023 recertification and complaint investigation survey, deficient practice was cited for failing to	

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F 867	Continued From page 48 investigation survey of 9/15/2023, deficient practice was cited for failing to provide a bed bath safely to a dependent resident when the resident fell off the bed during care and fractured her left femur and tibia (shinbone). During the current complaint investigation survey of 2/29/2024, deficient practice was cited for failing to provide incontinence care safely to a dependent resident when the resident rolled off the bed resulting in Resident #1 experiencing pain on the left side of his neck at a level of 8 out of 10 (with 10 being the worst pain possible), cervicogenic headaches (a pain that develops in the neck and is felt in the head), and sustaining a cervical neck strain of the left trapezius muscle (injury to the large muscle in the back that supports the head and neck caused from overstretching or trauma). The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) program. This tag is cross referenced to: F689: Based on record review, observations, staff and Physician interviews, the facility failed to provide incontinence care safely for a resident who was dependent on staff assistance for 1 of 4 residents reviewed for falls (Resident #1). On 1/2/24 Nurse Aide (NA) #6 was attempting to pull the brief out from under Resident #1 by turning him onto his side and pressing on his back for him to roll over resulting in the resident rolling off the side of the bed and landing on the floor on his left shoulder and neck. Resident #1 experienced pain on the left side of his neck at a level of 8 out of 10 (with 10 being the worst pain possible), cervicogenic headaches (a pain that develops in the neck and is felt in the head), and sustained a cervical neck strain of the left trapezius muscle	F 867	provide incontinence care safely to a dependent resident when the resident fell off the bed during care and fractured her right femur (thighbone) in two places. During the complaint investigation survey of 9/15/2023, deficient practice was cited for failing to provide a bed bath safely to a dependent resident when the resident fell off the bed during care and fractured her left femur and tibia (shinbone). During the current complaint investigation survey of 2/29/2024, deficient practice was cited for failing to provide incontinence care safely to a dependent resident when the resident rolled off the bed resulting in Resident #1 experiencing pain on the left side of his neck at a level of 8 out of 10 (with 10 being the worst pain possible), cervicogenic headaches (a pain that develops in the neck and is felt in the head), and sustaining a cervical neck strain of the left trapezius muscle (injury to the large muscle in the back that supports the head and neck caused from overstretching or trauma). The continued failure during three federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) program. The facility Quality Assurance Performance Improvement Committee (QAPI) consisting of the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Social Worker, and Dietary Manager, implemented a plan of correction after the fall on 1/2/2024 to include root cause analysis (RCA) with education and monitoring to allege	

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	345207	A. BUILDING _____ B. WING _____	C 02/29/2024

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F 867	Continued From page 49 (injury to the large muscle in the back that supports the head and neck caused from overstretching or trauma). During the recertification and complaint survey on 5/4/2023 deficient practice was cited at F689 for failing to provide incontinence care safely to a dependent resident when the resident fell off the bed during care and fractured her right femur (thighbone) in two places. During the complaint investigation survey of 9/15/2023, deficient practice was cited at F689 for failing to provide a bed bath safely to a dependent resident when the resident fell off the bed during care and fractured her left femur and tibia (shinbone). An interview was completed with the Administrator on 2/22/2024 at 4:14 PM. The Administrator stated that the facility's Quality Assessment and Assurance (QAA) Committee was continuing to focus on preventing falls from bed and bed positioning safety. She further stated the QAA committee had met on 1/4/2024 to review the fall that occurred on 1/2/2024 involving Resident #1, and that they had developed a QA tool for bed positioning safety. The Administrator indicated that the QAA committee was conducting audits for QA weekly x 2 weeks and monthly x 3 or until resolved. A follow-up interview with the Administrator was completed on 2/27/2024 at 10:00 AM. The Administrator stated that the plan of corrective (POC) she provided to the State Survey Agency was the current plan because the QAPI team met on 1/9/2024 and updated the QA: Post Fall Process tool and the QA: Tool for Bed Positioning	F 867	compliance/past non-compliance of 1/9/202. This included ongoing Quality Assurance Monitoring weekly x 2 and monthly x 3 or until resolved. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: The QAPI committee held a meeting on 3/19/2024 to review the deficiencies from the 5/4/2023 annual recertification and complaint investigation survey as well as those from the complaint investigation surveys of 9/15/23 and 2/29/2024. The QAPI committee conducted a RCA with review of prior F689 tags for trends in occurrences identifying failure to follow resident care plans and/or identifying risk as trends. Based on the review of the RCA completed by the QAPI committee on 3/19/2024 the facility initiated an additional audit to review to assess 100% of residents' risk for falls to ensure adequate preventative measures and interventions care planned. This will be completed by 3/20/2024. The Quality Assurance team reviewed the Systemic Change related to F689 implemented on 1/5/2024 by Director of Nurses and Registered Nurse management began In-servicing all FT, PT, PRN RN's, LPN's, Nurse Aides, Med Aides, Med tech staff (including agency) on Preventing Falls from Bed. Initial training completed 1/9/24, and subject matter included:	

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F 867	Continued From page 50 Safety. She further stated that the QA tool for QAPI was different from the monitoring tool they had been using for the 9/15/2023 QAPI tag. The Administrator stated that due to Resident #1's fall from bed the QA committee had implemented the new monitoring tool extended the audit for QA x weeks and monthly x 3. She indicated that the POC had been reviewed in the Quarterly Assurance Committee meeting with all members present on 1/24/2024. The facility provided and implemented the following Corrective Action Plan with a compliance date of 2/9/2024. 1. Corrective Action for resident affected by the alleged deficient practice: The facility's Quality Assessment and Assurance (QAA) failed to maintain procedures and effective monitoring of interventions the committee put into place following the complaint investigation survey on 9/7/2023 in which the facility failed to provide a bed bath safely for a dependent resident as the resident fell off the bed during care with resultant fractures, and the recertification and complaint survey conducted on 5/4/2023 in which a resident fell during incontinent care from the bed resulting in femur fractures. On 1/2/2024 the facility failed to provide incontinence care safely for a dependent resident as the resident fell off the bed during care with resultant neck strain and pain. The root cause analysis to reduce the risk of harmful events was conducted on 1/4/2024 with QAA committee members to include the nurse consultant, and the director of clinical services and with corrective action plan. 2. Corrective action for residents with the potential to be affected by the alleged deficient	F 867	• How do I know how to best assist a resident while they are in the bed? • Preventing falls from bed during bed care • Positioning reminders • What are the common causes of falls? • Identifying Falls Risk • General Falls Prevention Strategies • How to access the Kardex from the IPAD: • Nursing immediate actions 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 1/9/2024, the Regional Clinical Consultant completed an in-service with the QAPI committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. On 1/9/2024 the Nurse consultant, the director of clinical services and the director of operations provided education to the QAPI team members on Root cause analysis process to include a way to identify breakdowns in processes and systems that contribute to an event and how to prevent future events. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then	

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F 867	Continued From page 51 practice: The Quality Assurance Performance committee held a meeting on 9/12/2023 to review the deficiencies from the May 1, 2023 to May 4, 2023 annual recertification survey, CI survey, and reviewed the citations. On 9/12/2023, Regional Clinical Consultant in-serviced the facility Administrator and The Quality Assessment and Assurance committee on the appropriate functioning of the QAPI committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to prevent occurrence of alleged deficient practice. Education: On 9/12/2023 the Administrator completed in-servicing with the QAPI team members that included the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and Dietary Manager on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. On 9/27/2023 the Nurse Consultant, the Director of Clinical Services and the Director of Operations provided education to the QAPI team members on root cause analysis process to include a way to identify breakdowns in processes and systems that contribute to an event and how to prevent future events. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor	F 867	monthly x 6 months. The Administrator or designee will present the F867 Quality Assurance Tool to the QAPI committee to ensure corrective action initiated as appropriate. The Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager attend the weekly QA Meeting. The Clinical Nurse Consultant will review the tool weekly x 4 weeks then monthly x 6 months to ensure root cause analysis and to monitor for any patterns of deficient practice. Date of Compliance: 03/20/2024	

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F 867	Continued From page 52	F 867		

compliance utilizing the F867 Quality Assurance Tool weekly x 2 weeks and monthly x3. The tool will monitor facility identified concerns that to be addressed by the QAA committee. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until deemed necessary for compliance.
The nurse consultant will review the tool weekly x 4 weeks then monthly x 6 months to ensure root cause analysis and to monitor for any patterns of deficient practice.

Date of Compliance: 1/9/2024

The above corrective action plan was not acceptable to the State Survey Agency. The facility did not develop components of an F867 corrective action plan that addressed how the facility would identify other residents having the potential to be affected and for measures but into place or systemic changes made to ensure the deficient practice would not recur following the 1/2/24 fall that resulted in a repeat deficiency at F689. The corrective action plan did not demonstrate sufficient evidence to ensure the QAPI Program would be effective and that compliance would be sustained.