STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345532	A. BUILDING _____ B. WING _____	C 04/04/2024

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LIBERTY COMMONS NSG AND REHAB CTR OF LEE COUNTY	310 COMMERCE DRIVE SANFORD, NC 27332

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/1/24 through 4/4/24. The faciltiy was found out of compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 8E2C11.	E 000		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037		5/3/24

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

Electronically Signed | 04/22/2024

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E 037	Continued From page 1 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 037		

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E 037	Continued From page 2 (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 4 (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain an Emergency Preparedness program that met the requirements for annual staff training on the Emergency Preparedness (EP) Plan. The findings included: A review of the facility's EP manual, last reviewed on 2/26/24, revealed no documentation of the annual staff training in the past year. The Staff Development Coordinator was interviewed on 4/3/24 at 10:45 AM and reported she started at the facility in January 2024, had not provided any EP training to staff and was unsure who would provide that education. She was unable to locate the last time staff training had	E 037	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 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. E037 The Facility failed to maintain an Emergency Preparedness program that met the requirements for annual staff training on the Emergency Preparedness Plan. 1. Corrective action for affected	

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E 037	Continued From page 5 occurred regarding the EP Plan. The Administrator was interviewed on 4/3/24 at 12:04 PM and stated he started at the facility in January 2024. He was unable to locate the last time staff training had occurred regarding the EP Plan.	E 037	resident(s): No residents were listed in E037 deficiency. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On April 16, 2024, the maintenance director began conducting annual Emergency Plan Preparedness training. Training will be completed by May 3, 2024 3. Systemic changes The administrator will ensure that annual Emergency Preparedness training has been conducted by including that question on the annual Emergency Preparedness review and auditing compliance with the Emergency Preparedness Plan training for all staff. 4. Quality Assurance monitoring procedure. The Administrator and/or designee will monitor compliance utilizing the E097 Quality Assurance Tool weekly x 2 amd monthly x 3 and then annually in February of 2025. New hires will be audited for compliance as well as annual completed training by all staff. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the	

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E 037	Continued From page 6	E 037	Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: May 3, 2024	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/1/24 to 4/4/24. Event ID# 8E2C11. The following intakes were investigated NC00206984, NC00210549, NC00213251 and NC00214175. 4 of the 10 complaint allegations resulted in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		5/3/24

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F 550	Continued From page 7 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff interviews and record review, the facility failed to promote dignity by not assisting a resident who required staff assistance with activities of daily living (ADLs) with the removal of facial hair. This was for 1 (Resident #38) 3 residents reviewed for ADLs. The findings included: Resident #38 was admitted to the facility on 8/2/22 with a diagnosis of osteomyelitis. The quarterly Minimum Data Set dated 3/14/24 indicated Resident #38 was cognitively intact, exhibited no behaviors and she was dependent on staff for her personal hygiene. Review of Resident #38's revised care plan dated	F 550	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 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. F550 The facility failed to promote dignity by not assisting a resident who required staff assistance with removal of facial hair. (Resident #38).	

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F 550	Continued From page 8 2/14/24 read Resident #38 was resistant to Physician recommendations related to eating from the vending machine and not eating sugar free snacks, refusals of showers in the mornings and getting up out of the bed. Resident #38 was also care planned last revised on 3/15/24 for staff assistance with her personal hygiene. Review of Resident #38's electronic medical record and behaviors monitoring from 2/1/24 to present did not include any behaviors associated with refusal of personal hygiene. An observation and interview was completed with Resident #38 on 4/1/24 at 9:45 AM. She was sitting slightly upright in bed wearing a silk sleeping cap and a gown. Observed to her face was large amount of facial hair extending from in front of both ears downward to underneath her chin. When asked if the facial hair was her preference, she stated it was not. She stated staff last helped her remove the facial hair about two weeks ago. Another observation was completed on 4/2/24 at 9:20 AM. Resident #38's facial hair was unchanged. She stated staff came in earlier this morning and assisted her with her ADLs because she was going out for an eye appointment later this morning. An interview was completed on 4/3/24 at 10:05 AM with Nursing Assistant (NA) #1. He stated Resident #38 was always cooperative with him and was not known to refuse ADL assistance. He stated she preferred to sleep in each morning and would ask staff to return to complete ADLs later at times and on occasion, she would refuse to get out of the bed. NA #1 stated Resident #38	F 550	1. Corrective action for resident(s) affected by the alleged deficient practice: On 4/3/2024 resident #39 was assisted with the removal of facial hair by the Certified Nursing Assistant and it was documented as completed in ADL tasks in the medical record. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 4/5/2024 the Director of Nurses/Unit Manager/Staff Development Coordinator observed all resident's requiring assistance with removal of facial hair for the presence of unwanted facial hair. The results included: 1 resident was shaved by the Certified Nursing Assistant and it was documented as completed in ADL tasks in the medical record. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/18/24, the Director of Nurses and Staff Development Coordinator began education of all full time, part time, as needed, agency, nurses and Certified Nursing Assistants on facility policy on assuring that residents that require assistance with the removal of facial hair are assisted with the removal of the facial hair, along with applicable resident rights related to maintaining resident dignity. As well education on refusal of care/documentation and notification of the nurse was addressed. Education will be completed by 5/03/24 at which time all of	

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F 550	Continued From page 9 was not known to refuse assistance with her personal hygiene. An interview was completed on 4/3/24 at 10:50 AM with NA #2. She stated Resident #38 was always cooperative with her and she never refused any assistance with any of her ADLs with her. A wound care observation was completed on 4/3/24 at 11:55 AM with the Staff Development Coordinator (SDC) in Resident #38's Room positioning her for wound care. Resident #38 was observed with no changed in her facial hair. She motioned to her facial hair and stated, "I need to get on this and say something about it." This surveyor confirmed to the SDC who was present that Resident #38 was referring to her facial hair while the SDC shook her head in agreement. Another observation was completed on 4/3/2444 at 4:00 PM. Resident #38 was up in a wheelchair sitting in the hallway. She was clean shaven and stated after her wound care was completed earlier this morning, the staff came in and used something like Veet or Nair (hair removal cream) to remove her facial hair. An interview was completed on 4/4/24 at 10:05 AM with the Director of Nursing. She stated Resident #38's should be assisted with the removal of any unwanted facial hair to promote personal dignity.	F 550	the above must be in-serviced prior to working. 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 Director of Nurses or Designee will monitor compliance utilizing the F550 Resident Rights Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that resident dignity is being maintained as it relates to the removal of unwanted facial hair for residents requiring staff assistance. 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. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 5/03/2024	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must	F 561		5/3/24

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F 561	Continued From page 10 promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff and responsible party (RP) interviews and record review, the facility failed to honor a resident dependent of staff assistance with his shower preference. This was for 1 of 1 residents (Resident #33) reviewed for choices. The finding included: Resident #33 was admitted on 5/10/23 with diagnoses of a subdural hemorrhage and aphasia (unable to speak).	F 561	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 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	

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F 561	Continued From page 11 Review of Resident #33's admission Activity Review dated 5/10/23 completed with his RP read it was very important to Resident #33 to choose between a bed bath, sponge bath or a shower. The quarterly Minimum Data Set dated 2/5/24 indicated Resident #33 had severe cognitive impairment, exhibited no behaviors and he was dependent of staff for bathing. Review of Resident #33's comprehensive care plan included a care area for assistance with his activities of daily living (ADLs) last revised 2/6/24. Interventions included his preference of showers on the shower bed initiated 8/10/23. Review of Resident #33's undated electronic Aide Care Guide/Kardex include the direction under the bathing area that he preferred showers on the shower bed. An observation was completed on 4/1/24 at 10:10 AM of Resident #33 lying in bed wearing a hospital gown. His lips appeared dry with yellowish colored debris on his right lower lip that looked like dried skin. He had the body odor of sweat, but there was no evidence of him sweating. There were no odors of incontinence. A telephone interview was completed on 4/1/24 at 2:20 PM with Resident #3's RP. She stated he was not getting any showers and it was his preference before his injury. She stated she had made management aware on several occasions but it never did any good. She stated the facility always told her that he refused to take showers. An observation was completed on 4/3/24 at 9:00 AM of Resident #33. He appeared to have been	F 561	corrected by the dates indicated. F561 The facility failed to honor a resident dependent for staff assistance failed to honor his preference for a shower. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #33 was showered on 4/04/2023 by the assigned certified nursing assistant and the task was documented as completed on the resident shower sheet. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 04/18/2024 the Director of Nurses/ Staff Development Coordinator and Unit Manager audited all residents care plans for an identified bathing preference. The results included: 3 residents had an identified preference for a shower. On 4/18/2024 the Director of Nurses/Staff Development Coordinator/.Unit Manger audited the residents provided bathing method for the last 7 days to assure their bathing preference was being followed.. The results included: All 3 received showers on 4/18/2024 by the assigned certified nursing assistant. As of 4/18/2024 all residents bathing preferences were being honored and residents are receiving showers. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient	

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F 561	Continued From page 12 recently bathed and dressed in a clean gown. An interview was completed on 4/3/24 at 10:00 AM with Nurse #1. She stated Resident #33 was known for his tensing up behaviors. She stated giving his medications thorough in his feeding tube could take an "a while" time due to his tensing up causing the medications not to drain into his stomach properly until he finally relaxed enough. An interview was completed on 4/3/24 at 10:05 AM with Nursing Assistant (NA) #1. He stated he completed a bed bath on Resident #33 earlier this morning. NA #1 stated Resident #33 can be combative at times and was known to tense his extremities whenever staff tried to bath, dress or change him. NA #1 stated he had never taken Resident #33 to the shower room because he would be hesitant to put him on the shower bed due to his behaviors. Review of shower schedule last updated 1/30/24 indicated Resident #33's was to receive his showers on Wednesdays and Saturdays on the evening shift. Review of Resident #33's electronic aide documentation for bathing from 1/1/24 to 4/2/24 did not include any documentation of a shower. The facility provided copies of Resident Shower Sheets that all read that bed baths were given instead of showers. The date of these sheets were 1/6, 1/10, 1/13, 1/17, 1/20, 1/24, 1/31, 2/7, 2/14, 2/21, 3/2, 3/16, 3/13, 3/26/243/30/24 and 4/3/24. An interview was completed on 4/3/24 at 4:00 PM	F 561	practice: On 4/18/2024 the Director of Nursing and Staff Development Coordinator began education to all full time, part time, PRN and agency Nurses and Certified Nursing Aide's on the following: following resident preferences for showers, refusal to be showered documentation, notification of the nurse of refusals, notification of the physician/responsible party and documentation of completion of care in Point Click Care tasks. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and Certified Nursing Aides who give residents care in the facility. As of 5/03/2024, any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 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 Director of Nursing and/or designee will monitor compliance utilizing the F561 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. The Director of Nursing/designee will monitor resident's	

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F 561	Continued From page 13 with NA #3. She stated she had no problems with Resident #33 in the shower room. She stated she was unable to recall the last time she gave Resident #33 a shower and she was uncertain what days and shift Resident #33 was scheduled to receive his showers. An interview was completed on 4/3/24 at 410pm with NA #4. She stated she had taken Resident #33 to the shower room in the past using the shower stretcher but he was known for tensing up and becoming combative. NA #4 stated she was uncertain the days and shift Resident #33 was scheduled for his showers. An interview was completed on 4/4/24 at 10:05 AM with the Director of Nursing (DON). She stated Resident #33 was known to refuse his ADLs and to become combative. The DON stated because he was known for those behaviors, it should be care planned and monitored. She stated she expected the staff to attempt to perform his showers and document his refusals then notify his RP of any refusals.	F 561	preference of shower's, shower compliance and satisfaction with showers. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 05/03/2024	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		5/3/24

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F 584	Continued From page 14 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with residents and staff, the facility failed to maintain bedside tables free from dried spills and debris for two rooms (Room 209 and 212), failed to repair a broken dresser drawer (Room 216) and failed to ensure a resident ' s bedpan was labeled and stored in a sanitary manner. This deficient practice affected 1 of 3 resident halls (200 Hall).	F 584	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 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	

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F 584	Continued From page 15 The findings included: 1. An observation of room 212 on 04/01/24 at 12:32 PM revealed bed A bedside table had a dried yellowish hardened substance on base of table measuring approximately 1 x 2 inches. Also bed A and B bedside tables with built up black substance on 2 separate 2.5 x 2 inch triangle areas on the base of each table. Room 212 was occupied with 2 residents at the time of the survey. Housekeeper #1 observed in room wiping the top of A bed bedside table. An observation of room 212 on 04/02/24 at 09:55 PM revealed a bedpan with a white powder like substance on the rim and the inside of the bedpan sitting in the seat of a wheelchair in the bathroom. The bedpan was not labeled nor was it in a plastic bag. An interview and observation were conducted on 04/02/24 at 11:55 AM with Nursing Assistant (NA) #3. She stated the bedpans should be kept in a plastic bag with the residents' name on it. She confirmed a bedpan with a white powder like substance was in a wheelchair in the bathroom of room 212. The bedpan was not in a bag. She stated she did not leave the bedpan like that, and she did not notice it this morning. She further stated she was assuming it was resident in bed-B ' s bedpan, but she was not positive. She further stated the resident in bed-A was incontinent of bowel and bladder and bed-B would request the bedpan at times. An observation of room 212 on 04/02/24 at 12:00 PM revealed the bedside tables remained in the same condition with yellowish hardened and black substances on the base of the tables. The	F 584	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F584 1. Corrective Action for Affected Residents: On 4/ 16/2024 both bedside tables in room 212 were cleaned, the bedpan in room 212 was discarded and a new bedpan was brought to the room and stored appropriately for resident's use and the drawer front in room 216 was repaired by the maintenance director. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 04/17/2024 the housekeeping director completed an audit of all bedside tables to ensure each was clean, dressers to ensure all did not have any broken drawers and that all bedpans were stored appropriately. 3. Systemic changes On 4/18/20204 the Director of Nurses/Staff Coordinator began In-service education to all full time, part time, and as needed nursing staff and agency, maintenance staff, housekeeping staff. Topics included: • All staff to ensure they complete a work order and submit to maintenance for any repairs they find in the facility. • All housekeeping staff to include all	

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F 584	Continued From page 16	F 584		

bedpan remained in the wheelchair in the bathroom with a white powder like substance on the rim and the inside of the bedpan.

An observation of room 212 on 04/03/24 at 8:55 AM revealed the bedside tables remained in the same condition with yellowish hardened and black substances on the base of the tables. The bedpan remained in the wheelchair in the bathroom with a white powder like substance on the rim and the inside of the bedpan.

An interview was conducted on 04/03/24 at 11:28 AM with the housekeeping supervisor. She stated housekeeping staff are to clean the entire bedside tables daily. The task is included on the daily checkoff sheet for the housekeepers to follow.

Review of housekeeping checkoff list revealed the area that read "wipe bedside table," as being completed for 04/1/24 through 04/04/24.

An interview was conducted on 04/03/24 at 1:19 PM with Housekeeper #1. She stated she was responsible for cleaning the 200 hall the week of 4/1/24. She stated she did use the check list while performing her duties. She further stated the task on the check list read "wipe bedside table," and she was under the impression that just meant the top of the bedside table, not the legs and base. She did not recall that task being elaborated or explained in detail during orientation.

Review of housekeeping checkoff list for room 209 and 212 revealed the area that read "wipe bedside table," as being completed for 04/3/24.

areas of equipment when cleaning, including legs.
- Nursing staff to properly clean and store bedpans.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 5/03/2024, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed.

4. Quality Assurance monitoring procedure.

The Housekeeping Director will audit bedside tables, dress drawers and bedpans In five rooms to ensure compliance weekly x 2 weeks then monthly x 3 month or until resolved. Auditing will be conducted to ensure all areas of bedside tables are clean, no dresser drawers are broken and bedpans are cleaned and stored appropriately. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance(QA)Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager

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F 584	Continued From page 17 An observation of room 212 on 04/03/24 at 3:35 PM revealed the bedpan remained in the wheelchair in the bathroom with a white powder like substance on the rim and the inside of the bedpan. An interview was conducted on 04/03/24 at 4:16 PM with Nursing Assistant (NA) #4. She stated all personal items such as bedpans, shampoo, body wash, and bath basins should have the residents ' room #, bed and stored in a plastic bag. She verified she was assigned room 212 on 04/02/24 and 04/03/24 but she was unaware that it was not stored in a plastic bag. An interview was conducted on 04/04/24 at 10:25 AM with the Director of Nursing (DON). She stated nursing staff should clean bedpans if they are dirty and keep them stored in a plastic bag with their room number. An interview was conducted on 04/04/24 at 10:28 AM with the Administrator. He stated the bedside tables were to be cleaned daily by housekeeping. 2. An observation of room 209 on 04/01/24 at 12:36 PM revealed Room 209 A and B bedside tables revealed 209-A bedside table had dried tan/brownish hardened substance on the base of table and 209-B bedside table had dried black splatters which appeared dirt like on the base of table. An observation of room 212 on 04/02/24 at 12:10 PM revealed the bedside tables remained in the same condition with dried tan/brownish hardened substance and black splatters which appeared dirt like on the base of the tables.	F 584	Date of Compliance: May 3, 2024	

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An observation of room 212 on 04/03/24 at 9:02 AM revealed the bedside tables remained in the same condition with dried tan/brownish hardened substance and black splatters which appeared dirt like on the base of the tables.

An interview was conducted on 04/03/24 at 11:28 AM with the housekeeping supervisor. She stated housekeeping staff are to clean the entire bedside tables daily. The task was included on the daily checkoff sheet for the housekeepers to follow. This task had been signed as being completed by Housekeeper #1. She indicated this task was thoroughly explained in orientation. She verified the 2 bedside tables in room 209 needed to be cleaned.

An interview was conducted on 04/03/24 at 1:19 PM with Housekeeper #1. She stated she was responsible for cleaning the 200 hall the week of 4/1/24. She stated she did use the check list while performing her duties. She further stated the task on the check list read "wipe bedside table," and she was under the impression that just meant the top of the bedside table, not the legs and base. She did not recall that task being elaborated or explained in detail during orientation.

An interview was conducted on 04/04/24 at 10:28 AM with the Administrator. He stated the bedside tables are to be kept clean by housekeeping.

3. An observation of room 216 on 04/01/24 at 12:42 PM revealed the dresser drawer remained in the same condition with the front panel attached on one side and the right side hanging down overlapping the bottom drawer.

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An observation of room 216 on 04/02/24 at 12:14 PM revealed the dresser drawer remained in the same condition with the front panel attached on one side and the right side hanging down overlapping the bottom drawer. There was exposed rough wood on the edge of the drawer where it broke away from the side panel.

An observation of room 216 on 04/03/24 at 9:05 AM revealed the dresser drawer remained in the same condition with the front panel attached on one side and the right side hanging down overlapping the bottom drawer. There was exposed rough wood on the edge of the drawer where it broke away from the side panel.

An interview was conducted on 04/03/24 at 11:00 AM with the Maintenance Assistant. He stated he was not aware of the dresser drawer being broken in room 216 and he did not have a work order for it. He verified the drawer was broken and removed the drawer to repair.

An interview was conducted on 04/03/24 at 11:05 AM with the Maintenance Manager. He stated he was not aware of the dresser drawer being broken and he did not have a work order for it. He verified the drawer was broken and would have expected staff to complete a work order so it could be repaired.

An interview was conducted on 04/03/24 at 11:08 AM with a cognitively intact resident in room 216. He stated the drawer had been broken since he had been in room 216. He was moved to room 216 on 7/14/2023. He thought they were aware it was broken.

An interview was conducted on 04/03/24 at 12:02

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F 584	Continued From page 20 PM with Nurse #3. She stated if something needed repair in the facility, she would let the unit supervisor know or she would fill out a work order request for maintenance making them aware of the situation. She stated that she had not noticed the broken drawer. An interview was conducted on 04/04/24 at 10:28 AM with the Administrator. He stated all furniture and equipment was to be in good repair and if it was broken staff were to report it to maintenance for repairs by completing a work order and putting it in the maintenance box.	F 584		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		5/3/24

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resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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F 623	Continued From page 22 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the resident and/or the responsible party (RP) in writing of the reason for hospital transfer/discharge for 4 of 4 residents reviewed for hospitalizations (Residents #40, #17, #15 and #2).	F 623	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 regulations the facility has taken	

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F 623	Continued From page 23 The findings included: 1. Resident #40 was admitted to the facility on 12/07/22. A significant change in status Minimum Data Set (MDS) assessment dated 01/11/24 indicated Resident #40 ' s cognition was severely impaired. A review of Resident #40's nurses notes revealed he was transferred to the hospital on 12/27/23 for lethargy. There was no documentation in the resident ' s medical record that written notice of transfer was provided to the resident and/or Responsible Party (RP) regarding the transfer. Resident #40 returned to the facility on 01/04/24. Attempted to interview the RP without success. An interview was conducted on 04/02/24 at 3:34 PM with the Administrator. He verified that the Social Worker (SW) failed to complete the form for Resident #40 and therefore, the responsible party (RP) was not notified in writing when the resident was discharged to the hospital on 12/27/23. An interview was conducted on 04/02/24 at 3:59 PM with the Director of Nursing (DON). She stated normally nursing notified the responsible party (RP) by phone and sends the notice of discharge/transfer with the resident to the hospital. The facility had not been mailing the notice of transfer to the responsible party (RP). Multiple attempts were made to contact the Social Worker (SW) from 2020, without success.	F 623	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. F623 Corrective action for resident(s) affected by the alleged deficient practice. The facility failed to notify the resident and or responsible party (RP) in writing of the transfer/discharge to the hospital. (Residents # 40, # 17, #15 and #2). Corrective action for residents with the potential to be affected by the deficient practice On 4/18/2024, the Director of Nurses audited the last 30 days of transfers/discharges to the hospital to ensure that there were no hospital transfers/discharges that did not have a written notification sent to the resident and/or responsible party. The results included: 7 of 7 transfer notices were sent with the resident to the hospital but not mailed. On 4/22/2024 a written notice of transfer/discharge to the hospital was completed by the Director of Nurses and sent to the responsible party or hand delivered to the resident for the above identified residents. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/15 /24, the Regional Nurse Consultant provided education to the Administrator, Director of Nurses Unit Manager and the Social Services Director on the transfer notification process for	

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F 623	Continued From page 24 2. Resident #17 was admitted to the facility on 10/26/23. A review of Resident #17's nurses notes, and transfer form revealed he was transferred to the hospital on 03/04/24 for lethargy. There was no documentation in the resident ' s medical record that written notice of transfer was provided to the resident and/or Responsible Party (RP) regarding the transfer. Resident #17 returned to the facility on 03/07/24. A quarterly Minimum Data Set (MDS) assessment dated 03/14/24 indicated Resident #17 was cognitively intact. An interview was conducted on 04/02/24 at 3:34 PM with the Administrator. He verified that the Social Worker (SW) failed to complete the transfer form for Resident #17 and therefore, the responsible party (RP) was not notified in writing when the resident was discharged to the hospital on 03/04/24. An interview was conducted on 04/02/24 at 3:59 PM with the Director of Nursing (DON). She stated normally nursing notified the responsible party (RP) by phone and sends the notice of discharge/transfer with the resident to the hospital. The facility had not been mailing the notice of transfer to the responsible party (RP). Multiple attempts were made to contact the Social Worker (SW), without success. 3. Resident #15 was admitted on 10/11/23 with diagnoses of adult failure to thrive, dysphagia and cerebral vascular accident (CVA).	F 623	residents being transferred or discharged to the hospital. All training was completed by 4/15/2024. 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 Director of Nurses will monitor compliance utilizing the F-tag 623 Transfer Notice Process monitoring quality assurance tool. Monitoring will include review of all transfer/discharges to the hospital weekly x 4, and then monthly x 3. The ongoing auditing program will be reviewed at the monthly Quality Assurance Meeting until deemed as no longer necessary for compliance with reporting abuse and neglect. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. DOC: 5/03/2024	

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The most recent re-admission Minimum Data Set dated 3/14/24 indicated she had moderate cognitive impairment.

Review of Resident #15's medical record included a nursing note dated 10/19/23 at 3:30 AM, she was transferred to the hospital for large amount of emesis. There was no documentation that a written notice of transfer was provided to the resident and/RP for the reason of the transfer.

Review of Resident #15's medical record included a nursing note dated 11/2/23 at 4:20 PM, she briefly lost consciousness during therapy and she was transferred to the hospital. There was no documentation that a written notice of transfer was provided to the resident and/RP for the reason of the transfer.

Review of Resident #15's medical record included a nursing note dated 11/22/23 at 8:52 AM, she was transferred to the hospital for small bowel series and possible gastric tube placement. There was no documentation that a written notice of transfer was provided to the resident and/RP for the reason of the transfer.

Review of Resident #15's medical record included a nursing note dated 1/11/24 at 2:35 PM, she was experiencing nausea and vomiting and was transferred to the hospital again for an evaluation. There was no documentation that a written notice of transfer was provided to the resident and/RP for the reason of the transfer.

Review of Resident #15's medical record included a nursing note dated 1/23/24 7:25 PM, she was transferred to the hospital for not being able to follow commands, She was alert but

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unresponsive and sent to the hospital for an evaluation. There was no documentation that a written notice of transfer was provided to the resident and/RP for the reason of the transfer.

Review of Resident #15's medical record did not include a nursing note explaining why she was sent back out to the hospital on 3/27/24. There was no documentation that a written notice of transfer was provided to the resident and/RP for the reason of the transfer.

On 4/2/24 at 4:01 PM an interview occurred with the Director of Nursing (DON) who stated that a copy of the transfer notice was sent with the resident to the hospital. The DON explained that the RP was notified by phone when a resident was sent to the hospital but she was unaware a written notice of transfer with the reason was required. The DON stated the facility had not been mailing or providing residents or RP's anything in writing regarding the reasons for hospital transfers.

An interview was conducted with Nurse #2 on 4/3/24 at 1:50 PM and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information, medication list, transfer form, and any other pertinent documents were sent with the resident when they were transferred to the hospital. The RP was notified by phone for the reason of the transfer.

The Administrator was interviewed on 4/4/24 at 10:13 AM and stated he would expect the resident and/or RP be provided with the written reason for hospital transfer per the regulation.

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4. Resident #2 was originally admitted to the facility on 5/12/21 with diagnoses that included end stage renal disease, congestive heart failure and chronic obstructive pulmonary disease (COPD).

A medical record review revealed Resident #2 was transferred to the hospital and readmitted to the facility for respiratory issues on 11/9/23 to 11/14/23, 11/23/23 to 11/28/23 and 1/4/24 to 1/11/24. There was no documentation that written notices of transfers were provided to the resident and/or responsible party (RP) for the reasons of the transfers.

A quarterly Minimum Data Set (MDS) assessment dated 1/18/24 indicated Resident #2 was cognitively intact.

On 4/2/24 at 4:01 PM an interview occurred with the Director of Nursing (DON) who stated that a copy of the transfer notice was sent with the resident to the hospital. The DON explained that the RP was notified by phone when a resident was sent to the hospital and was unaware a written notice of transfer with the reason was required.

An interview was conducted with Nurse #2 on 4/3/24 at 1:50 PM and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information, medication list, transfer form, and any other pertinent documents were sent with the

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F 623	Continued From page 28 resident when they were transferred to the hospital. She added that when a resident was discharged to the hospital a phone call was made to the RP for the reason of the transfer. The Administrator was interviewed on 4/4/24 at 10:13 AM and stated he would expect the resident and/or RP to be provided with the written reason for hospital transfer per the regulation.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) accurately in the areas of dental status and range of motion for 2 of 21 residents reviewed for MDS accuracy (Resident #49 and Resident #53). The findings included: 1. Resident #49 was admitted on 12/21/23 with cumulative diagnoses of cerebral vascular accident, hemiplegia, and acute gingivitis. Review of Resident #49 hospital discharge summary dated 12/21/23 read he had poor dentition and bleeding gums. There was no recommended intervention except the use of an antiseptic mouthwash four times daily. Review of Resident #49's admission Minimum Data Set (MDS) dated 12/28/23 indicated he had severe cognitive impairment, exhibited no	F 641	F-641 Accuracy of Assessments Corrective actions Resident #49 Minimum data set Admission assessment with Assessment Reference date of 12/28/2023 was modified and corrected by MDS floater nurse on 4/4/2024 to reflect accuracy at the time of the assessment reference date look back timeframe of the assessment. Resident #53 Minimum data set Admission assessment with Assessment reference date of 3/4/2024 was modified and corrected by the facility MDS Nurse on 4/4/2024 to reflect accuracy at the time of the Assessment reference date look back timeframe of the assessment. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice.	5/3/24

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F 641	Continued From page 29 behaviors, was dependent on staff for all of his activities of daily living (ADLs). He was not coded for missing broken natural teeth, cavities, bleeding or inflamed gums. An observation completed on 4/1/124 at 12:47 PM revealed multiple missing teeth in Resident #49's mouth both upper and lower gums. There was no evidence of bleeding gums at the times of the observations and he denied oral pain. A telephone interview was complete on 4/4/24 at 9:42 AM with the Corporate MDS Nurse #1. She stated she completed all the MDS coding remotely and relied on some of the observation information emailed to her regarding Resident #49's current dental status. She stated clearly, the information she was provided was incorrect. An interview was completed on 4/4/24 at 10:05 AM with the Director of Nursing (DON). She stated the facility did not have any in-house MDS Nurses and that Corporate Nurses had been completing the MDS assessments remotely with the assistance of emailed observations. The DON stated it must have been an oversight. 2. Resident #53 was admitted to the facility on 2/26/24 with diagnoses that included a stroke resulting in hemiplegia (weakness to one side of the body) and hemiparesis (paralysis to one side of the body) of the right dominant side. Resident #53's baseline care plan included a focus area initiated on 2/27/24 for Activities of Daily Living (ADL) self-care performance deficit related to intracranial hemorrhage with right hemiparesis. A review of the Occupational Therapy Evaluation	F 641	A 100 % audit of the most recent completed Minimum data set assessment in the past 30 days of all current residents who have functional limitation in range of motion of the upper extremities or inflamed/bleeding gums/loose natural teeth will be completed in order to identify if the following questions were coded accurately in the section of GG0115A and L0200D on the Minimum data set assessment: GG0115A Upper extremity: (shoulder, elbow, wrist, hand) L0200E Inflamed or bleeding gums or loose natural teeth This audit will be completed by regional Minimum data set consultant no later than 04/22/2024. Any resident who is identified as having inaccurate coding of any one or more of the above questions will have a correction of that assessment completed immediately by the regional minimum data set consultant. Any necessary Minimum data set corrections will be completed no later than 04/22/2024. Systemic Changes By 4/19/2024, the regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Nurse and the MDS floater nurse that includes the importance of thoroughly reviewing each resident's medical record in order ensure that the assessment is coded accurately. Special emphasis will be placed on the following areas of the Minimum Data Set assessment: GG0115A: Functional Limitation in Range	

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F 641	Continued From page 30 dated 2/27/24 indicated Resident #53's right upper extremity had impaired range of motion. A review of Resident #53's admission Minimum Data Set (MDS) assessment dated 3/4/24 revealed Resident #53 had moderately impaired cognition and required assistance from staff for ADLs. She was not coded with any range of motion deficits to the upper body. On 4/1/24 at 10:45 AM, an interview and observation were conducted with Resident #53. She was unable to lift or use her right arm or hand and used her left hand to gesture and write on the erasable white board. Resident #53 was observed on 4/2/24 at 11:48 AM propelling herself in the hallway. A sling was present to the right arm, and she was using her left hand to pull herself on the handrails in the hallway. An interview occurred with the Occupational Therapist on 4/3/24 at 2:57 PM. She verified that Resident #53 was unable to use the right arm or hand due to paralysis. A telephone interview was completed with the Corporate MDS Nurse #1 on 4/4/24 at 9:42 AM. She explained that she completed all MDS coding remotely and received the information from "record reviews and emailing different staff members". She reviewed Resident #53's 3/4/24 MDS and verified that range of motion was not coded as impaired for one of the upper extremities but should have been. The Corporate MDS Nurse #1 stated she felt it was an oversight. On 4/4/24 at 10:13 AM, the Administrator and	F 641	of Motion upper extremity: shoulder, elbow, wrist, hand. If the resident is noted to have limitation of upper extremity. It must be determined whether the limited ROM has an impact on functional ability or places the resident at risk for injury. L0200E: inflamed or bleeding gums or loose natural teeth: if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip The MDS needs to be thoroughly reviewed for accuracy prior to closing and locking the assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin auditing 5 random recently completed minimum data set assessments for accuracy in coding on the Minimum data set assessment for functional limitation in range of motion upper extremity (GG0115A), and inflamed/bleeding gums or loose natural teeth (L0200) to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This audit will be done weekly x 4 weeks and then monthly x 2 months using the audit tool titled	

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F 641	Continued From page 31 Director of Nursing were interviewed and stated it was their expectation for the MDS to be coded accurately.	F 641	"Accurate Coding of MDS Audit Tool". Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 05/03/2024	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon	F 644		5/3/24

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F 644	Continued From page 32 a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed to refer a resident (Residents #25) for a level II Preadmission Screening and Resident Review (PASRR) for a newly diagnosed serious mental illness for 1 of 2 residents reviewed for PASRR. The findings included: Resident #25 was admitted to the facility on 02/02/21 with diagnosis that included Bipolar Disease, Dementia, Parkinson's Disease, and seizure disorder. She was admitted with a level 1 PASRR as of 04/15/19 and no further screening was required unless a significant change occurred to suggest a diagnosis of mental illness. Record review revealed Resident #25 was diagnosed on 08/04/22 with bipolar disorder. There was no evidence a referral for a level II PASRR screening was completed following the identification of this new serious mental health diagnosis. Resident #25's annual Minimum Data Set dated 12/16/23 indicated she was not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. An interview was conducted on 04/02/24 at 3:34 PM with the Administrator. He stated the Social Worker (SW) was responsible for ensuring residents with a newly evident diagnosis of a serious mental illness was referred for a level II PASRR evaluation. He also stated a PASRR level	F 644	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 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. F644 The facility failed to refer a resident for a level II Preadmission Screening and Resident Review (PASRR) upon a significant change in status assessment. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 04/02/2024, the Social Worker submitted through NCMUST a Preadmission Screening and Resident Review (PASRR) for resident # 25. It was submitted and accepted on 4/ 02 /20224. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility have the potential to be affected. On 4/18/2024, the Social Worker completed 100 % audit of all residents who have had a new diagnosis assigned to them from January 1, 2024 to date, in order to validate that the State Mental Health Authority was notified and a new resident review request was sent through the NCMUST system for any resident who received a new	

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F 644	Continued From page 33 II screening request should have been sent at the time Resident #25 was newly diagnosed with bipolar disorder. He verified Resident #25 had not been referred for level II evaluation at any point after the new diagnosis through present day. He indicated there was not a system in place to monitor for PASRR completion. He further stated they had not had a SW for a while but recently hired one who was being trained for the position.	F 644	diagnosis of Severe Mental Illness or Intellectual Disability/Mental Retardation Audit results are: No residents were identified as having been assigned a new diagnosis of Severe Mental Illness and/or Intellectual Disability from January 1 2024 to 4/18/2024. 14 residents already have been screened and assigned Level II PASRR. 59 residents have PASRR screenings that are up to date. As of 4/18/2024 all residents are in compliance with the PASRR process. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 4/18/2024, the Nurse Consultant completed education with the facility Social Worker/Admission Coordinator and Health Information Manager which included the PASARR assessment process and requirements for when a level II PASARR is to be completed. The Health Information Manager will notify the Social Worker when a new diagnosis has been added that would potentially qualify for a level II PASARR. On 4/18/2024 the Nurse Consultant made the Health Information Manager aware of the responsibility of notifying the Social Worker of when a new diagnosis has been added that would potentially qualify a resident for a level II PASARR and made Social Worker aware of responsibility of requesting Level II PASRR reviews when indicated. Any	

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F 644	Continued From page 34	F 644	Social Worker, Health Information Manager or Admissions Coordinator who did not receive in-service training by 5/03/2024 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 been sustained. Any newly hired full-time or agency staff will receive this education during orientation. 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 Social Worker or designee will monitor compliance utilizing the F644 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The Social Worker or designee will monitor for compliance with audit of new resident records for the need of a Level II PASARR screening. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	

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F 644	Continued From page 35	F 644		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide nail care to a resident dependent of staff assistance with his activities of daily living (ALDs). This was for 1 (Resident #49) of 4 residents reviewed for ADLs. The findings included: Resident #49 was admitted on 12/21/23 with cumulative diagnoses of cerebral vascular accident, right hemiplegia and prediabetes. The quarterly Minimum Data Set dated 1/22/24 indicated severe cognitive impairment, he exhibited no behaviors and he was dependent on staff for all of his ADLs. Resident #49 was care planned on 12/22/23 and last revised 1/23/24 for an ADL self-care performance deficit related to an intercranial hemorrhage. Interventions included to check his nail length, trim and clean as necessary. Report any changes to the nurse. Review of Resident #49's March 2024 Physician orders included an order dated 12/22/23 for blood glucose checks twice daily for nutrition monitoring. This order was discontinued on	F 677	Date of Compliance: 05/04/2024 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 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. F677 The facility failed to provide finger nail care for a resident dependent on staff assistance with activities of daily living. For Resident #49. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #49, on 04/05/2024 nail care was provided by the unit manager and documented as completed. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	5/3/24

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F 677	Continued From page 36 3/22/24 due to the discontinuation of his tube feedings. Review of Resident #49's April 2024 Physician orders included an order dated 1/30/24 for a right hand/wrist splint for 4-6 hours on day shift. Monitor resident's tolerance and skin integrity while the splint is in place/at removal one time a day to prevent contracture. Review of Resident #49's March 2024 and April 2024 medication administration records (MARs) included documented evidence that the floor nurses were initialing off ensuring the right hand splint was on correctly and there was no skin integrity concerns. An observation was completed on 4/1/24 at 12:47 PM of Resident #49. He was lying in bed wearing his right hand splint. The fingernails to his left hand were grown out over his fingertips approximately ½ inch, appeared jagged with a dark black substance underneath the nails. Observation of the fingernails to his splinted right hand revealed his nails extended approximately ¾ of an inch past his fingertips. The nails were jagged and appeared to have a less black colored substance underneath the nails. An observation was completed on 4/2/24 at 11:45 AM of Resident #49. He was again wearing his right hand splint and his fingernails were unchanged. Another observation was completed on 4/2/24 at 4:00 PM of Resident #49. He was sitting in a reclining chair in the lounge watching television. His right hand splint had been removed and his fingernails were unchanged. When asked to allow	F 677	On 4/05/2024, the Unit Manager/Staff Development Coordinator audited all current residents for the need of nail care. Nail care was provided to 16 of 58 residents. As of 4/05/2024 all residents were in compliance. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/18/2024 the Director of Nurses/Staff Development Coordinator began education of all full time, part time, and PRN Nurses and CNA's on the following: • Nail care should be performed daily with baths/showers and as needed • Refusal of any care by the resident is to be documented and the nurse notified. • Completion of nail care is to be documented in the medical record. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA's who give residents care in the facility. As of 5/03/2024 any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that	

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F 677	Continued From page 37 observation of his right palm, Resident #49 presented his right hand. Observed were four fingers curled over into his palm that he was unable lift so the fingernails to the right hand were not visible. An observation was completed on 4/3/24 at 9:53 AM of Resident #49. He was lying in bed. He left hand fingernails were unchanged. Resident #49's right hand splint had not been applied yet so his fingernails to his right hand were not visible due to his right hand contracture. An interview was completed on 4/3/24 at 10:00 AM with Nurse #1. She stated Resident #49's splint application order populated on the MAR for 9:00 AM. She stated she just had not had time to go and apply the splint yet this morning. Nurse #1 stated it was the nurses who were responsible for applying and removing Resident #49's right hand splint. When asked if she noticed the condition of Resident #49's fingernails when she applied his hand splint yesterday, she stated she thought it was already on him when she came in at 7:00 AM yesterday. Nurse #1 was unable to say who may have applied the splint. Review of the MAR with Nurse #1 for 4/2/24 revealed it was initiated by an orientee Nurse #1 worked with yesterday. Nurse #1 confirmed she did remove Resident #49's right hand splint yesterday but she did not notice the condition of his fingernails. She stated she would cut and clean his fingernails today after the aide completed his bath. When questioned if the aides were allowed to provide his nail care, Nurse #1 stated she was unsure since at one time they were performing blood glucose checks on him but that stopped when his tube feeding stopped last month.	F 677	the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F677 Quality Assurance Tool weekly for 2 weeks then monthly x 3 months or until resolved. Monitoring of 5 random residents will be done for nail care compliance. 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 or until deemed not necessary for compliance with ADL Care. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: May 03, 2024	

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F 677	Continued From page 38 An interview was completed on 4/3/24 at 10:05 AM with Nursing Assistant (NA) #1. He stated nobody in particular was responsible for cutting Resident #49's fingernails and whoever noticed the need was responsible for cutting his fingernails. NA #1 stated he had not noticed the condition of Resident #49's fingernails. A telephone interview was completed on 4/4/24 at 9:30 AM with Nurse #4. She confirmed she worked first shift Monday 4/1/24 with Resident #49 and that she initialed off that she applied his right hand splint and noted the skin integrity to his hand. When questioned about if she noticed the condition of Resident #49's fingernails on 4/1/24, she stated she thought his splint may have already been on his hand when she first saw him around 9:00 AM. Nurse #4 stated the aides were also trained on the application and removal of his right hand splint and it was added to the MAR for the nurses to just ensure that it was being done. Nurse #4 stated she did not recall removing Resident #49's right hand splint either. She stated NA #1 was instructed to complete nail care and shave all the male residents on 4/1/24 but apparently, he did not do it as instructed. Nurse #4 stated anyone could do Resident #49's nail care because he was not diabetic. An interview was completed on 4/4/24 at 10:05 AM with the DON. She stated Resident #49 was not ever considered a diabetic and that anyone who noticed that his fingernails were dirty, long and jagged should immediately clean and trim them when identified.	F 677		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5)	F 791		5/3/24

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F 791	Continued From page 39 §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are	F 791		

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F 791	Continued From page 40 eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observations, staff, Nurse Practitioner (NP) #1 interviews and record review, the facility failed to follow dental consult Physician order dated 2/28/24 for 1 (Resident #49) of 1 resident reviewed for dental services. The findings included: Resident #49 was admitted on 12/21/23 with cumulative diagnoses of cerebral vascular accident, hemiplegia, and acute gingivitis. Review of Resident #49's hospital discharge summary dated 12/21/23 read he had poor dentition and bleeding gums. There was no recommended intervention except the use of an antiseptic mouthwash four times daily. Review of Resident #49's admission Physician orders dated 12/21/23 included an order for First-Mouthwash BLM Mouth/Throat Suspension (mouth rinse made of different medications used to relieve pain from mouth and throat sores) four times a day for gingivitis. Review of Resident #49's admission Minimum Data Set (MDS) dated 12/28/23 indicated he had severe cognitive impairment, exhibited no behaviors, was dependent on staff for all of his activities of daily living (ADLs). Review of a nursing note dated 2/28/24 at 12:37 PM documented by Nurse #1 read a small amount of blood was noted in Resident #49's mouth. His mouth was cleaned with a swab	F 791	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 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. F791 The facility failed to follow dental consult physician orders dated 2/28/2024 for resident #49. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 4/3/2024 resident #49 was made an appointment for 4/11/2024. The appointment was cancelled by the dental office due to the resident's inability to be transferred into the dental chair. On 4/10/2024 an appointment was made for resident #49 to be seen on 4/25/2025 by Access Dental at the facility. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 4/18/2024 the Director of Nurses/Unit Manager/Staff Development Coordinator audited orders for March 1-	

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F 791	Continued From page 41 dipped in water and the bleeding was noted to be coming from his right lower gum. The Physician was notified. Review of Resident #49's February 2024 Physician orders included an order dated 2/28/24 for a dental consult due to a large cavity and red gums. Review of a Nursing Concern/Visit Request for the Physician form dated 2/28/24 completed by Nurse #1 read Resident #49 was bleeding from his lower right gum and a large cavity to his right lower back tooth. The note recommended a dental consult. The note was signed by NP #1 on 2/29/24 with agreement regarding the dental consult and another mouthwash was ordered. The form was last signed by the Unit Manager on 3/1/24. Review of a NP #1 progress note dated 2/29/24 read Resident #49's chief complaint was bleeding gums and a cavity. The note read Resident #49 had poor dental hygiene inflamed gums, red, bleeding gums and a number of civilities that needed to be seen by a dentist for treatment. Resident #49 acknowledged improvement in oral pain since admission to the facility. The progress note read the plan was to begin magic mouthwash (prescription mouthwash used to treat oral pain) three times daily and the facility was to make a dental appointment for Resident #49's cavities and severe gingivitis. Review of Resident #49's March 2024 Physician orders included an order dated 3/5/24 for Peridex (antiseptic mouthwash used to treat gingivitis in adults) mouthwash every morning and at bedtime for gingivitis for 30 days swish for 30 seconds	F 791	April 18, 2024 for any dental consult orders and to assure an appointment was made. The results included: 2 residents are to be seen for a nonemergent dental concern with appointments made on 5/10/2024 by Access Dental for both residents. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/18/2024 the Nurse Consultant educated the Director of Nurses/Staff development Coordinator and Unit Manager. On 4/ 19 /2024 the Director of Nursing/Staff Development Coordinator began in-service education to all full time, part time, and as needed licensed nurses, to include agency nurses. Topics included: • Following through of physician orders timely. • Assuring appointments are made timely and if concerns arise notification is done with the physician/resident and responsible party. • Assuring that the results of ordered consults are obtained timely. • Review of the consultation reports and notification of the physician. • Notification of the resident/ responsible party of any newly obtained orders or follow up appointments etc. • Uploading of the consultation report into the medical record timely. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed by	

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F 791	Continued From page 42 after toothbrushing then expectorate. Review of Resident #49's electronic medical record did not include any documentation of a dental consult since his admission on 12/21/23. An interview was completed on 4/2/24 at 9:36 AM with the Director of Nursing (DON). She stated the reason there was no dental consults in Resident #49's electronic medical record was because the appointment was never made until today and was scheduled for 4/11/24 at 8:00 AM. At this time, the DON was unable to offer any explanation as to why Resident #49's dental appointment was never obtained. An observation and attempted interview was completed on 4/2/24 at 11:45 AM with Resident #49. He was lying in bed and it appeared that he recently received oral care. When asked to open his mouth for observation he obliged. Observed were multiple missing teeth to upper and lower, irritation at his gum lines and at least one hole to one of his right lower back teeth. When questioned about pain in his mouth, he shook his head "no." An interview was completed on 4/3/24 at 8:45 AM with the Social Worker. She explained that it was the responsibility of the previous receptionist schedule consult appointments and transportation. An interview was completed on 4/3/24 at 10:05 AM with Nursing Assistant (NA) #1. He stated Resident #49's oral status has been the way it is now since he was admitted in late December 2023 and he thought the dentist was supposed to see him but apparently never did. NA #1 stated	F 791	the Quality Assurance process to verify that the change has been sustained. Any applicable staff who does not receive inservice education by 5/03/2023, will not be allowed to work until training been completed. 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 Director of Nurses or Designee will monitor compliance utilizing the F791 Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Physician orders will be monitored at Daily Clinical (Monday -Friday)and the appointment process monitored for compliance. 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. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 5/03/2024	

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F 791	Continued From page 43	F 791		

was Resident #49 on a purred diet and required assistance with his meals. He stated his appetite was good and he had not noticed that Resident #49's dental status impaired his hunger or eating ability.

Review of Resident #49's electronic medical record revealed no significant weight loss since his admission and no oral medications for pain were prescribed since admission.

An interview was completed on 4/3/24 at 10:00 AM with Nurse #1. She recalled an aide getting her to look at Resident #49's mouth because he observed blood in his mouth after oral care. She stated she went to assess Resident #49's mouth and noted that his gums were very red, appeared inflamed and he had a large cavity on one of his right back bottom teeth. She stated he denied pain but she wrote a Nursing Concern/Visit Request for the Physician form for NP #1 to assess his mouth the next morning. Nurse #1 stated she also made the Unit Manager aware and think she obtained an order for a dental consult on 2/28/24. Nurse #1 stated at no point since identifying the condition of his teeth and gums has he complained of pain as long as he uses his prescribed mouthwashes as ordered and he was complaint with that. Nurse #1 stated it was not until 4/2/24 that anyone mentioned anything about Resident #49's dental consult.

An interview was completed on 4/4/24 at 8:50 AM with the Unit Manager. She stated the previous receptionist was responsible to setting on consult appointments and she put the original order in electric computer for Resident #49's dental consult on 2/28/24 and gave a copy of the NP #1 signed Nursing Concern/Visit Request for the

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Physician form with the dental consult order for the previous receptionist to set up later that day. She was unable to explain why she signed the form on 3/1/24 but NP #1 signed the form on 2/29/24. The Unit Manager stated she would leave the signed referral forms on top of the previous receptionist's laptop keyboard or on top of her laptop if it was closed. She stated she would then follow up with the previous receptionist about a week later to make sure consult appointment had been made. The Unit Manager stated for Resident #49, she did follow up with the previous receptionist a week later and recalled her telling her that she was still working on it and mentioned something about his insurance. The Unit Manager stated the previous receptionist did not show up for work last week so she was not aware of the status of the dental appointment at present but she contacted NP #1 about the missed appointment on 4/2/24 and he now has a dental appointment for 4/11/24.

A telephone interview was completed on 4/3/24 at 2:10 PM with the previous receptionist. She stated she worked at the facility up until last week and was responsible for setting up consult appointments and transportation for the residents. She explained the Unit Manager or the nurse would fill out a referral form, get it signed by NP #1 or the Physician. She stated it was then given to her to set up consult appointment and transportation if needed. The previous receptionist recalled attempting to schedule a dental appointment for Resident #49 but there was a problem with his insurance. She stated she did not mention the insurance problem to anyone at the facility but the Unit Manager.
An interview was completed on 4/3/24 at 9:00 AM with NP #1. She stated she was aware that

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Resident #49's dental issues on his admission in December 2023. She recalled the pharmacy consultant recommending the discontinuation his mouthwash prescribed in the hospital. She stated she agreed with the recommendation and discontinued the mouthwash but it was not long before Resident #49 started complaining of oral pain so she restarted the mouthwash and ordered a dental consult. NP #1 stated sometime around the first of March 2024, she inquired about his dental appointment and the Unit Manager told her the previous receptionist was still working on it. NP #1 stated that was when she ordered the Perdex mouthwash for 30 days. She stated she was made aware on 4/2/24 that Resident #49's dental consult order dated 2/28/24 or 2/29/24 had never been acted on. NP #1 stated she wrote another order on 4/2/24 and the facility obtained a dental appointment that day for 4/11/24. She stated she assessed Resident #49 on 4/2/24 to ensure his mouthwashes were adequate pain control. He indicated he was not experiencing any oral pain. NP #1 stated she expected her orders to be acted on and if there a problem with reimbursement, the facility was to assist in finding the resources for him to see a dentist.

An interview was completed on 4/4/24 at 9:05 AM with the Administrator who confirmed that the previous receptionist made the consult appointments for the residents. He stated the previous receptionist did not show up for work last week and would not return calls from the facility. He stated until the new receptionist was trained, the Social Worker would assist with making the consult appointments. The Administrator stated a problem with Resident #49's insurance was not an acceptable reason not to schedule the dental appointment and had

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F 791	Continued From page 46 the previous receptionist made the Social Worker, the DON or himself aware, it could have been handled then because lack of insurance was not an excuse for not receiving dental care.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		5/3/24

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F 842	Continued From page 47 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain complete and accurate medical records in the areas of dental (Resident #30), urology (Residents #160 and #36) and podiatry (Resident #36). This was for 3 of 21	F 842	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	

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F 842	Continued From page 48 resident records reviewed. The findings included: 1. Resident #30 was admitted to the facility on 11/14/23. A review of Resident #30's physician orders included an order dated 1/4/24 for a dental consult on 1/5/24 at 10:00 AM. A review of Resident #30's electronic medical record (EMR) did not include any dental consult progress notes. On 4/2/24 at 9:35 AM, an interview occurred with the Director of Nursing (DON) who stated the dental consult from 1/5/24 was not located in the facility and she would reach out to the provider to get a copy faxed over. The DON further stated it was the receptionist's responsibility to upload consultations to the EMR, but she had recently departed the facility. The Administrator was interviewed on 4/2/24 at 3:46 PM and provided the dental consult note from 1/5/24 that was faxed to the facility on the day of the interview. He stated the reason Resident #30's consults were not in the EMR was because the receptionist was responsible to upload the consults after the nurses had reviewed them but she apparently "wasn't doing her part" and was no longer employed at the facility. He further indicated the medical records person from the sister facility was working a couple of days a week at his facility to assist in getting things caught up. A phone interview was conducted 4/3/24 at 2:10	F 842	and state 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. F842 1. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to maintain accurate medical records for dental records for resident #30, urology records for residents #160 and #36 and podiatry records #36. On 4/ 05/2024 the Director of Nurses obtained the dental consult record for resident # 30 and the consult was uploaded in to the medical record. On 4/05/2024 the Director of Nurses obtained the urology consultation record for resident # 160 and #36 and the consult was uploaded in to the medical record. On 4/05/2024 the Director of Nurses obtained the podiatry consultation record for resident #36 and the consult was uploaded in to the medical record. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with ordered dental, podiatry or urology consultations have the potential to be affected by the alleged deficient practice. On 4/ 05/2024 and 4/18/2024 the Director of Nursing/Staff Development Coordinator began auditing from March 1- 4/18/2024 of ordered dental, podiatry and urological consults for the presence of the consultation records in the residents'	

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F 842	Continued From page 49 PM with Receptionist #1, who had departed from the facility the week of 3/25/24. She verified the receptionist was responsible for scanning consultations into the EMR system but was unable to state why Resident #30's dental progress note was not present in her medical record. The DON was interviewed again on 4/3/24 at 3:22 PM and explained when a resident returned from a medical consultation appointment, the nurses reviewed the form and took off any necessary orders. The consultation progress note was then placed in the medical records box where the receptionist was responsible for scanning and uploading the document into the resident's medical record. On 4/4/24 at 10:13 AM, the Administrator indicated it was his expectation for consultation progress notes to be scanned and uploaded to the resident medical record in a timely manner. A telephone interview was conducted on 4/4/24 at 1:17 PM with the medical records person from the sister facility. She explained she was working at the facility one day a week and focused on coding, certifications, auditing of regulatory visits and attended the Medicare meeting for compliance. She stated it was the responsibility of the receptionist to scan consults into the EMR and she (the medical records person) was not scanning consults. 2. Resident #160 was admitted to the facility on 3/14/24 with diagnoses that included chronic hematuria (blood in urine) and presence of a urinary catheter.	F 842	charts. As of 4/18/2024 the results included:7 of 7 residents had ordered dental, podiatry or urology consultation reports done within the last 30 days and they are present in their chart. As of 4/ 18 /2024 all residents with ordered dental, urology or podiatry consults for the past 30 days were in compliance with the presence of the consultation report in their medical record. 3. Systemic changes: On 4/18 /2024 the Nurse Consultant provided in-service education to management to the Director of Nursing, Nursing Management and the Administrator and on 4/ 19 /2024 the Director of Nursing/Staff Development Coordinator began in-service education to all full time, part time, and as needed licensed nurses, to include agency nurses. Topics included: • Following through of physician orders timely. • Assuring that the results of ordered consults are obtained timely. • Review of the consultation reports and notification of the physician. • Notification of the resident/ responsible party of any newly obtained orders or follow up appointments etc. • Uploading of the consultation report into the medical record timely. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses and management nurses as identified above and will be reviewed by the Quality Assurance process to verify	

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F 842	Continued From page 50 Review of a nursing progress note dated 3/26/24 indicated Resident #160 was seen at the urology clinic with orders to start Avodart (a medication used to treat an enlarged prostate) 0.5 milligrams (mg) one capsule by mouth every day. A review of Resident #160's physician orders included Avodart 0.5 mg one capsule by mouth every day that was started on 3/26/24. A review of Resident #160's electronic medical record (EMR) did not include urology progress notes. On 4/2/24 at 9:35 AM, an interview occurred with the Director of Nursing (DON) who stated the urology consult from 3/26/24 was not located in the facility and she would reach out to the provider to get a copy faxed over. The DON further stated it was the receptionist's responsibility to upload consultations to the EMR, but she had recently departed the facility. The Administrator was interviewed on 4/2/24 at 3:46 PM and provided the dental consult note from 1/5/24 that was faxed to the facility on the day of the interview. He stated the reason Resident #30's consults were not in the EMR was because the receptionist was responsible to upload the consults after the nurses had reviewed them but she apparently "wasn't doing her part" and was no longer employed at the facility. He further indicated the medical records person from the sister facility was working a couple of days a week at his facility to assist in getting things caught up. A phone interview was conducted 4/3/24 at 2:10	F 842	that the change has been sustained. Any applicable staff who does not receive inservice education by 5/03/2023, will not be allowed to work until training been completed. 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 Director of Nursing or designee will monitor the Resident Record Process for compliance. The F 842 Quality Assurance tool will be completed weekly for 2 weeks then monthly for 3months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Date of compliance: 05/03/2024	

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PM with Receptionist #1, who had departed from the facility the week of 3/25/24. She verified the receptionist was responsible for scanning consultations into the EMR system but was unable to state why Resident #160s urology progress note was not present in his medical record.

The DON was interviewed again on 4/3/24 at 3:22 PM and explained when a resident returned from a medical consultation appointment, the nurses reviewed the form and took off any necessary orders. The consultation progress note was then placed in the medical records box where the receptionist was responsible for scanning and uploading the document into the resident's medical record.

On 4/4/24 at 10:13 AM, the Administrator indicated it was his expectation for consultation progress notes to be scanned and uploaded to the resident medical record in a timely manner.

A telephone interview was conducted on 4/4/24 at 1:17 PM with the medical records person from the sister facility. She explained she was working at the facility one day a week and focused on coding, certifications, auditing of regulatory visits and attended the Medicare meeting for compliance. She stated it was the responsibility of the receptionist to scan consults into the EMR and she (the medical records person) was not scanning consults.

3. Resident #36 was admitted on 10/17/23 with cumulative diagnoses of cerebral vascular accident (CVA), hemiplegia, obstructive and reflux uropathology.

The quarterly Minimum Data Set dated 2/6/24

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indicated he was cognitively intact, exhibited no behaviors, coded for a urinary catheter and not coded for any open areas to his feet.

Review of Resident #36's comprehensive care plan included a care area dated 10/23/23 and last revised on 2/7/24 for an indwelling catheter related to obstructive uropathy. Another care area was for actual impairment to his skin integrity to his left 1st and 2nd toes on 2/5/24 last revised 2/28/24.

An interview was completed on 4/1/24 at 1:23 PM with Resident #36. He stated his injuries to his toes were a result of the podiatrist visit and the facility had been doing wound care with the wound doctor since sometime in January 2024 when it first happened. Resident #36 stated he had a urology appointment back in late January 2024 and another follow up urology appointment later in the week to discuss the possibility of getting a suprapubic catheter.

Review of Resident #36's electronic medical record did not include any documentation regarding any urology consults or podiatry consults that he stated resulted in the injuries to his left foot.

The following documentation was requested 4/2/24 at 9:00 AM from the Administrator: copies al all podiatry consult notes and urology consults from 1/1/24 to present.

On 4/2/24 at 9:36 AM, the Director of Nursing (DON) stated she reached out to their podiatry provider to get copies of Resident #36's notes because they were not in the electronic medical record. She stated the previous medical records

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person was the receptionist and she walked out last week and things have not been uploaded. The DON was able to provide a recent podiatry note dated 3/22/24 but this note was not related to his original injuries to his left foot back in January 2024. She stated they faxed over the 3/22/24 podiatry note today at her request.

On 4/2/24 at 1:56 PM, the Administrator provided a copy of a podiatry note dated 1/4/24 and an incident report dated 1/9/24 related to Resident #36's toes injuries as a result of the 1/4/24 podiatry visit. The Administrator stated the 1/4/24 podiatry note was faxed to the facility today. At same time Administrator provided a urology consult note dated 1/31/24 with orders to follow up again in 1-2 months. He stated the urology note was also faxed to the facility today.

An interview was completed on 4/2/24 at 3:46 PM with the Administrator. He stated the reason Resident #36's consults were not in his electronic medical record was because the receptionist was responsible to upload the consults after the nurses have reviewed then but she apparently was not doing her part. He stated she was "let go last week" and the medical records person from the sister facility was coming a couple of days a week to assist in getting things caught up.

A telephone interview was completed on 4/4/24 at 1:17 PM with the medical record's person at the sister facility. She stated she came to the facility one day a week and focused on coding, certifications, auditing of regulatory visits and attended Medicare meetings for compliance. She stated it was the responsibility of the previous receptionist to scan consults into the electronic medical record.

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F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will 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.	F 867		5/3/24

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F 867	Continued From page 55 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §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	F 867		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 56 facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, responsible party (RP), resident and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	

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	345532	A. BUILDING _____ B. WING _____	C 04/04/2024

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F 867	Continued From page 57 monitor interventions the committee put into place following annual recertification and complaint survey on 2/17/22. This was for seven deficiencies that were cited in the areas of Resident Rights/Exercise of Rights, Self Determination, Notice Requirements Before Transfer/Discharge, Accuracy of Assessments, Care Plan Timing and Revision, Activities of Daily Living Care Provided for Dependent Residents and Resident Records-Identifiable Information. In addition, six deficiencies were cited during the annual recertification and complaint survey on 2/9/23 in the areas of Self Determination, Notice Requirements Before Transfer/Discharge, Accuracy of Assessments, Care Plan Timing and Revision, Activities of Daily Living Care Provided for Dependent Residents and Resident Records-Identifiable Information. The duplicate citations during three federal surveys of record show a pattern of the facility's inability to sustain an effective QAPI program. The findings included: The citations are cross referenced to: 1) F550- Based on observations, resident, staff interviews and record review, the facility failed to promote dignity by not assisting a resident who required staff assistance with activities of daily living (ADLs) with the removal of facial hair. This was for 1 (Resident #38) 3 residents reviewed for ADLs. During the facility's annual recertification and complaint survey dated 2/17/22, the facility failed to treat residents in a dignified manner by not responding to call lights resulting in feeling of anger and frustration. This was for 5 of 5	F 867	To remain in compliance with all federal and state 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. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: The facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation (CI) survey conducted on 2/17/22. This was for 7 deficiencies that were cited in the areas of resident rights (F 550), self-determination (F561), notice requirements before transfer/discharge (F623), accuracy of assessments (F641), develop/implement comprehensive care plan (F656), care plan timing and revision (F657), Activities of daily Living (ADL) care provided for dependent residents (F677) and resident records -identifiable information (842) and were recited on the current recertification and CI survey of 4/1/2024. The QAA committee additionally failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and CI survey conducted on 2/9/2023.	

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F 867	Continued From page 58 residents reviewed for dignity. The Administrator and Director of Nursing (DON) were interviewed on 4/4/24 at 10:30 AM and felt the repeat citation was due to the use of agency staff in the facility. They stated that they have started tracking agency staff to keep consistency for the care of the residents. 2) F561- Based on observations, staff, and responsible party (RP) interviews and record review, the facility failed to honor a resident dependent of staff assistance with his shower preference. This was for 1 of 1 resident (Resident #33) reviewed for choices. During the facility's annual recertification and complaint survey dated 2/17/22, the facility failed to honor residents' choices related to showers and shampoos. This was for 3 of 4 residents reviewed for choices. During the facility's annual recertification and complaint survey dated 2/9/23, the facility failed to honor a resident's choice related to showers for 1 of 1 resident reviewed for choices. The Administrator and DON were interviewed on 4/4/24 at 10:30 AM and felt the repeat citation was due to the use of agency staff in the facility. They stated they have started tracking agency staff to keep consistency for the care of the residents. 3) F623- Based on record review and staff interviews, the facility failed to notify the resident and/or the responsible party (RP) in writing of the	F 867	2. Corrective action for residents with the potential to be affected by the alleged deficient practice: • Corrective action has been taken for the identified concerns in the areas of: self-determination (F561) • Corrective action has been taken for the identified concerns in the areas of: Safe/Clean/Comfortable /Homelike Environment (F584.) • Corrective action has been taken for the identified concerns in the areas of: notice requirements before transfer/discharge (F623) • Corrective action has been taken for the identified concerns in the areas of: accuracy of assessments (F641) • Corrective action has been taken for the identified concerns in the areas of: care plan timing and revision (F657) • Corrective action has been taken for the identified concerns in the areas of: Activities of daily Living (ADL) care provided for dependent residents (F677) • Corrective action has been taken for the identified concerns in the areas of: resident records -identifiable information (842) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 04/22/2024 to review the deficiencies from the April 1- April 4, 2024 annual recertification survey, CI survey, and reviewed the citations. On 04/22/2024, the Regional Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning	

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F 867	Continued From page 59 reason for hospital transfer/discharge for 4 of 4 residents reviewed for hospitalizations (Residents #40, #17, #15 and #2). During the facility's annual recertification and complaint survey dated 2/17/22, the facility failed to notify the responsible party in writing of the reason for the discharge to the hospital for 4 of 5 sampled residents reviewed for hospitalizations. During the facility's annual recertification and complaint survey dated 2/9/23, the facility failed to notify the resident and or responsible party (RP) in writing of the reason for the transfer/discharge to the hospital and failed to send a copy of the discharge notice to the Ombudsman for 3 of 3 sampled residents reviewed for hospitalization. The DON was interviewed on 4/4/24 at 10:30 AM and stated it was her responsibility to get the reason for hospital transfer form completed and was unaware of the regulation that it needed to be provided in writing. 4) F641- Based on observations, staff interviews and record review, the facility failed to code the Minimum Data Set (MDS) accurately in the areas of dental status and range of motion for 2 of 21 residents reviewed for MDS accuracy (Resident #49 and Resident #53). During the facility's annual recertification and complaint survey dated 2/17/22, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of nutrition, restraints, dental status, accidents, pressure ulcers, and pain management. This was for 7 of 22 residents reviewed.	F 867	of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 4.22.2024 the administrator completed in-servicing with the Quality Assurance Performance Improvement team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the 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. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 5/3/2024. 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 monthly x 6 months. The tool will monitor facility identified concerns that need to be	

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F 867	Continued From page 60 During the facility's annual recertification and complaint survey dated 2/9/23, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of bladder incontinence, pressure ulcer, & nutrition for 3 of 20 sampled residents whose MDS were reviewed. The Administrator and DON were interviewed on 4/4/24 at 10:30 AM and felt the reason for the repeat citation was not having an MDS coordinator in the facility in the past year. Currently the MDS assessments were being completed offsite by corporate MDS nurses. 5) F657- Based on record review and staff interviews, the facility failed to revise the comprehensive care plan for the discontinuation of an antipsychotic medication for 1 (Resident #33) of 5 residents reviewed for unnecessary medications. During the facility's annual recertification and complaint survey dated 2/17/22 , the facility failed to review and revise the care plan in the areas of medication and pressure ulcer. This was for 2 of 22 residents reviewed. During the facility's annual recertification and complaint survey dated 2/9/23, the facility failed to review and revise the care plan in the areas of code status and pressure ulcer for 2 of 20 sampled residents whose care plans were reviewed. The Administrator and DON were interviewed on 4/4/24 at 10:30 AM and felt the reason for the repeat citation was not having an MDS coordinator in the facility in the past year.	F 867	addressed by the Quality Assurance Committee. Reports will be presented to the 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 no longer deemed necessary for compliance with the missing laundry process. The Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager and Medical Director. Date of Compliance: 05/03/2024	

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F 867	Continued From page 61 Currently the MDS assessments were being completed offsite by corporate MDS nurses. 6) F677- Based on observations, staff interviews and record review, the facility failed to provide nail care to a resident dependent of staff assistance with his activities of daily living (ALDs). This was for 1 (Resident #49) of 4 residents reviewed for ADLs. During the facility's annual recertification and complaint survey dated 2/17/22, the facility failed to provide nail care to residents' dependent on staff assistance with activities of daily living (ADLs). This was for 5 of 8 reviewed for ADLs. During the facility's annual recertification and complaint survey dated 2/9/23, the facility failed to trim and clean dependent residents' nails and failed to provide incontinent care for 3 of 8 residents reviewed for Activities of Daily Living (ADL's). The Administrator and DON were interviewed on 4/4/24 at 10:30 AM and felt the repeat citation was due to the use of agency staff in the facility. They stated they have started tracking agency staff to keep consistency for the care of the residents. 7) F842- Based on record reviews and staff interviews, the facility failed to maintain complete and accurate medical records in the areas of dental (Resident #30), urology (Residents #160 and #36) and podiatry (Resident #36). This was for 3 of 21 resident records reviewed. During the facility's annual recertification and	F 867		

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F 867	Continued From page 62 complaint survey dated 2/17/22, the facility failed to have complete and accurate medical records in the areas of wound care, protective skin coverings, medications and topical treatments. This was for 3 of 22 residents reviewed. During the facility's annual recertification and complaint survey dated 2/9/23, the facility failed to maintain accurate medical records for 1 of 1 resident reviewed for diabetic wound care. The Administrator and DON were interviewed on 4/4/24 at 10:30 AM and felt the repeat citation was due to the turnover in receptionists in the past year.	F 867		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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F 657	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the comprehensive care plan for the discontinuation of an antipsychotic medication for 1 (Resident #33) of 5 residents reviewed for unnecessary medications. The findings included: Resident #33 was admitted on 1/11/22 with a diagnosis of schizoaffective disorder. The quarterly Minimum Data Set dated 1/6/24 indicated moderate cognitive impairment and she was not coded for any behaviors. She was coded for the use of an antipsychotic. Review of Resident #33's last revised care plan dated 1/8/24 read she was receiving an antipsychotic medication for schizoaffective disorder. Review of a psychiatry progress note dated 2/14/24 read a gradual dose reduction was appropriate to try and her antipsychotic medication (Zyprexa) was discontinued with orders for staff to monitor for re-emerging symptoms. Review of the Physician orders read the prescribed Zyprexa was discontinued on 2/14/24. An interview was completed on 4/3/24 at 10:00 AM with Nurse #1. She stated Resident #33 had been stable since the discontinuation of her antipsychotic. An interview was completed on 4/3/24 at 4:10 PM with Nurse #2, She stated Resident #33 had not exhibited

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

The above isolated deficiencies pose no actual harm to the residents

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F 657	Continued From Page 1 any symptoms of hallucinations or outburst since stopping the antipsychotic. A telephone interview was completed on 4/4/24 at 9:42 AM with the Corporate MDS Nurse #1. She stated herself and Corporate MDS Nurse #2 had completing the facility's MDS's remotely and that communication regarding new, changed or discontinued orders were emailed to her by the Director of Nursing (DON) and she revised the care plan accordingly. She stated Resident #33's discontinued antipsychotic medication should have been removed from her care plan and it was an oversight. An interview was completed on 4/4/24 at 10:05 AM with the DON. She stated Resident #33's antipsychotic medication should have been removed from her comprehensive care plan when it was discontinued.