| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| PINE RIDGE HEALTH AND REHABILITATION CENTER | 706 PINEYWOOD ROAD THOMASVILLE, NC 27360 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 04/09/24 through 04/13/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness, Event ID# RBPC11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 04/09/24 through 04/13/24. Event ID# RBPC11. The following intakes were investigated: NC00206216, NC00209109, NC00209496, NC00211442, NC00211694, NC00212544, NC00212597, NC00213893, NC00214014. 2 of the 19 complaint allegations resulted in deficiencies. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§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.<br><br>§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 | | 5/9/24 |

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

Electronically Signed | 05/08/2024

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| F 550 | Continued From page 1<br>practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident, staff interviews and student interviews, the facility failed to treat a resident in a dignified manner for 1 of 23 residents reviewed for dignity (Resident #17). Nurse #2 told Resident #17, in a loud and demeaning tone, to get back in her room and stop "stalking" her. Resident #17 stated Nurse #2's statement made her feel embarrassed and humiliated to be spoken to as if she were a child.<br><br>Findings included:<br><br>Resident #17 was admitted to the facility on 03/23/21 with the most recent readmission on 11/18/22. Her diagnoses included, in part, stroke, hemiplegia, diabetes mellitus and arthritis. | F 550 | (F550-Dignity)<br><br>Pine Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Pine Ridge Nursing and Rehabilitation Center's response to the Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any | |

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| F 550 | Continued From page 2<br>An annual Minimum Data Set assessment dated 01/30/24 revealed Resident #17 cognitively intact and she required substantial to maximal assistance with her activities of daily living. She was independent in her wheelchair for ambulation.<br><br>On 04/11/24 at 10:20 AM, while preparing to enter room acroos from Resident #17, this surveyor and Nurse #3 overheard Nurse #2 speak to Resident #17 in a demeaning manner. Nurse #2 told Resident #17 to get back in her room and to stop "stalking" her. Nurse #2 further told Resident #17 she would not attend to her any faster because she was sitting and watching her. Nurse #2 told Resident #17 her priority was the diabetics. The nurse was positioned a few rooms away on the same side of the hall as Resident #17. There was approximately 40 feet of distance between Nurse #2 and the Resident. Resident #17 blushed and backed her wheelchair back into her room.<br><br>An interview was conducted with Resident #17 on 04/11/24 at 10:50 AM and she stated when Nurse #2 yelled down the hall and told her to go to her room she felt embarrassed and humiliated. She said Nurse #2 spoke to her like a child and she was not a child. She said it was demeaning to be spoken to in that manner. She stated she was not stalking Nurse #17; she was just sitting in the hall waiting for her medications because she did not want to miss getting her as needed pain medication. She stated she had not asked the nurse for anything prior to the nurse telling her to get back in her room. Resident #17 stated she was just watching for Nurse #2 because she had chronic pain and had to stay ahead of her pain, or it was too hard to control. | F 550 | deficiency is accurate. Further, Pine Ridge Nursing and Rehabilitation center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.<br>F550 Residents Rights/Exercise of Rights<br>Resident # 17 is alert and oriented and was spoken to in a demeaning manner causing her to feel embarrassed and humiliated.<br>All residents have the potential to be affected by the alleged deficient practice. Residents are to be spoken to in a respectful manner to preserve their dignity.<br>On 4/11/2024 when the facility was made aware of the occurrence, Nurse #2 was given education regarding customer service, residents rights and dignity. Nurse #2 was removed from her duties.<br>On 4/11/2024 the Administrator went to interview Resident#17 and a formal written grievance was completed. The grievance was resolved to the resident's satisfaction.<br>On 4/11/2024 Resident Rights Audits were conducted with residents having a BIMS score of 13 and above to ensure that residents feel they are being treated with dignity and respect. Except for the occurrence with Resident #17, there were no adverse findings from the audits.<br>On 4/16/2024, The Administrator began in-servicing staff on residents' rights related to dignity and respect to include speaking to residents with professionalism | |

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| F 550 | Continued From page 3<br><br>On 04/11/24 at 11:12 AM an interview was conducted with Nurse #3, and she stated she heard Nurse #2 tell Resident #17 loudly, from between room 206 and 208, to go back in her room, "stop stalking me, I'm not coming to you yet". Nurse #3 stated Nurse #2 talked to Resident#17 in an unprofessional and harsh manner. Nurse #3 stated Nurse #2's tone was too loud and was demeaning. Nurse #3 stated Nurse #2 had been sent home immediately. Nurse #3 added it was not common practice for the facility staff to speak to the residents in that manner. She stated the facility did not tolerate bad customer service.<br><br>An interview was conducted with Nurse #2 on 04/11/24 at 1:00 PM and she stated she and Resident #17 always spoke to each other in that manner. Nurse #2 stated Resident #17 liked her and knew that was how she talked. She stated Resident #17 was a smoker and wanted her medications before she went to smoke. Nurse #2 stated she told Resident #17 that she had to administer medications to the diabetics and administer blood pressure medications first. She further stated she had to provide for residents going to dialysis and appointments and administer "important" medications before she could attend to Resident #17. Nurse #2 said Resident #17 "was rushing" her and she did not want to make a medication error. Nurse #2 stated Resident #17 sat and watched her from her bedroom door. Nurse #2 stated it was not about pain for Resident #17, it was about getting her medications prior to her smoke break. She stated she could not prioritize a cigarette break over diabetics and dialysis residents and other important matters. She further stated "That's just | F 550 | and providing good customer service skills. The in-service will be completed by 5/11/2024. No staff member will work until the in-service is completed.<br>Residents Rights is included in the new staff orientation for all facility and agency staff.<br>Management Staff to include the Administrator, Director of Nursing, Social Worker, Unit Manager, Quality Improvement Nurse, will conduct five dignity rounds each weekly for 4 weeks then 3 times a week for 1 month to ensure residents are treated with dignity and respect. The administrator is responsible for sustained compliance with the plan of correction.<br>The results of the dignity rounds audits will be reported to the QAPI committee by the Quality Improvement nurse times three months to ensure continued substantial compliance and/or make plan revisions. | |

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| F 550 | Continued From page 4<br>how I sound, I don't speak like a Southerner, and I think everyone thinks I am talking harshly and nasty. Nobody is culturally competent in the south about my accent. People don't understand Northerners and now I look like the bad guy".<br><br>On 04/11/24 at 1:35 PM an interview was conducted with the Director of Nursing (DON) and she stated Nurse #2 received a final written warning due to her unprofessional language with Resident #17. The DON stated Nurse #2 had not had any disciplinary action prior, but the unprofessional behavior necessitated a final level of disciplinary action. She stated the facility did not tolerate staff speaking to residents in such a manner.<br><br>An interview was conducted with the Administrator on 04/11/24 at 1:49 PM and she stated she wrote the incident between Nurse #2 and Resident #17 up as a grievance and followed up with the Resident. She stated she expected staff to provide good customer service and to treat residents with dignity and respect. | F 550 | | |
| F 553 SS=D | Right to Participate in Planning Care<br>CFR(s): 483.10(c)(2)(3)<br><br>§483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, | F 553 | | 5/9/24 |

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| F 553 | Continued From page 5<br>amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br>(iii) The right to be informed, in advance, of changes to the plan of care.<br>(iv) The right to receive the services and/or items included in the plan of care.<br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-<br>(i) Facilitate the inclusion of the resident and/or resident representative.<br>(ii) Include an assessment of the resident's strengths and needs.<br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, residents, family and staff interviews the facility failed to offer 2 residents (Resident #47 and Resident #49) and 1 family member (Resident #80) the opportunity to participate in care plan meetings. This was discovered for 3 of 5 sampled residents reviewed for care planning<br><br>Findings included:<br><br>1. Resident #47 was admitted to the facility on 9/24/21 with diagnoses which included: hemiplegia affecting her left nondominant side.<br><br>The quarterly minimum data set (MDS) dated | F 553 | All residents have the potential to be affected by the alleged deficient practice.<br>On 4/9/2024 the social worker completed an audit of care plan participation. Residents who did not have evidence of a care conference during this time will have a schedule care conference in May 2024.<br>On 4/13/2024 the Social Worker and IDT team met with residents #47 and #49 and conducted a care plan meeting with the residents. Residents #47 and #49 are alert and oriented and their own responsible party.<br>On 5/1/2024, the Social Worker attempted to contact the responsible party for resident #80 to schedule a care plan | |

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| F 553 | Continued From page 6<br>1/10/24 indicated Resident #47 was cognitively intact.<br><br>There was no documentation in the medical record or provided by the social worker indicating Resident #47 attended or refused to attend her care plan meetings.<br><br>During an interview on 4/9/24 at 1:13 p.m., Resident #47 revealed she was not invited to, or participated in any of her care plan meetings in over a year.<br><br>On 4/11/24 at 10:05 a.m., during a telephone interview, Resident #47's family member (the resident is her own responsible party) expressed concern that the resident had not had a care plan meeting with the facility in over a year.<br><br>During an interview on 4/13/24 at 10:16 a.m., the Social Worker (SW) stated she began working at the facility on August 1, 2023, and her responsibilities included scheduling the care plan meetings for all the facility residents. The SW revealed she scheduled the care plan meetings with the residents and/or their Responsible Party (RP) 2-3 days in advance, in person and/or via telephone. When a resident and/or the resident's RP preferred not to attend the upcoming care plan meeting, she would document the refusal in the resident's medical record. The SW also revealed she was responsible for maintaining each resident's care plan meeting participation sign in sheets but was unable to locate any participation sheets for Resident #47. After reviewing her files and the resident's medical records, the SW stated the most recent documentation of Resident #47's participation in her care plan meeting was on 9/14/22. The SW | F 553 | meeting with the IDT team. The voice mail was full, so the care plan invitation was mailed out to the resident representative.<br>On 5/1/2024, the Social Worker prepared a care plan calendar for May 2024 to capture all upcoming care plan meeting dates. Residents and /or Resident Representatives will be notified of upcoming care plan meetings through mailed invitations, and verbal notification to the resident.<br>During the care plan meeting, there is a care plan meeting sign-in sheet for meeting attendees to sign. Copies of care plans will be given to the resident and/or resident representative if requested.<br>Once the care plan meeting is complete, documentation of the care meeting will be put into the resident's electronic health record and the sign in sheet will be maintained.<br>On 4/13/2024, the Administrator in serviced the Social Worker on residents' rights to be invited to care plan meetings.<br>The facility will audit 5 care plans a week x 1 month then 3 care plans a week x 1 month to ensure residents and/or representatives are invited to participate, and the care plan is appropriately documented in the electronic health record, and the care plan calendar is being followed as well as sign in sheet being maintained.<br>The Social Worker will bring the audits to the QAPI committee times 2 months. The QAPI committee will review the results of the audits for identification and trends, and action taken to determine the need | |

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| F 553 | Continued From page 7<br>acknowledged Resident #47's most recent MDS was in January 2024, and the resident should have been invited to the care plan meeting.<br><br>2. Resident #49 was admitted to the facility on 6/21/23 with diagnoses which included secondary Parkinsonism.<br><br>The quarterly minimum data set (MDS) dated 3/14/24 indicated Resident #49 was cognitively intact.<br><br>There was no documentation in the medical record or provided by the social worker indicating Resident #49 attended or refused to attend her care plan meetings.<br><br>On 4/10/24 at 12:02 p.m., during an interview Resident #49 revealed she had not been invited to or attended her care plan meetings.<br><br>During an interview on 4/13/24 at 10:16 a.m., the Social Worker (SW) stated she began working at the facility on August 1, 2023, and her responsibilities included scheduling the care plan meetings for all the facility residents. The SW revealed she scheduled the care plan meetings with the residents and/or their responsible party (RP) 2-3 days in advance, in person and/or via telephone. When a resident and/or the resident's RP preferred not to attend the upcoming care plan meeting, she would document the refusal in the resident's medical record. The SW also revealed she was responsible for maintaining each resident's care plan meeting participation sign in sheets. The SW confirmed there was a care plan meeting for Resident #49 in March 2024 but she there was no available | F 553 | for and/or frequency of continued monitoring and make recommendations for monitoring to ensure continued compliance.<br>The social worker is responsible for the plan of correction and the administrator for sustained compliance. | |

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| F 553 | Continued From page 8 | F 553 | | |

documentation indicating the resident was invited to or participated in any care plan meetings since her admission to the facility in June 2023.
3. Resident #80 was admitted to the facility on 10/28/2022. Her cumulative diagnoses included respiratory disease and dementia.

A quarterly Minimum Data Set Assessment dated 2/23/2024 indicated Resident #80 was severely cognitively impaired.

During an interview with the Family Member on 4/9/2024 at 1:13 pm she stated she had not been invited to a care plan meeting.

During an interview with the Social Worker on 4/11/2024 at 1:19 pm she stated she had worked at the facility for the past 8 months. She stated Resident #80 did not have a care plan meeting since 2/2023. She stated she met with Resident #80's Family Members informally but had not scheduled a formal care plan meeting where other members of the interdisciplinary team met with them. She stated she normally sets a care plan meeting and therapy, dietary, nursing, and activities departments were invited to the care plan for each resident. The Social Worker stated she sends out a mailed invitation to the Family Member and the resident is notified of a scheduled care plan meeting. The Social Worker stated since she meets with Resident #80's Family Member frequently she failed to schedule a formal care plan meeting with other disciplines available.

The Administrator was interviewed on 4/11/2024 at 6:37 pm and she stated Resident #80 should have a scheduled care plan meeting every 3 months and the resident and the resident

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| F 553 | Continued From page 9<br>representatives should be invited to the care plan meeting. The Administrator stated the Social Worker was responsible for scheduling the care plan meeting. | F 553 | | |
| F 584 SS=B | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>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.<br><br>The facility must provide-<br>§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.<br>(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.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas; | F 584 | | 5/9/24 |

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| F 584 | Continued From page 10<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to maintain walls (Rooms 111 B, 114 B, and 115 A) and a door (Room 111B) in good repair for 3 of 15 rooms (Rooms 111, 114, and 115) on the 100-hall reviewed for environment.<br><br>Findings included:<br><br>1a. Observations of room 111 B on 04/09/24 at 12:32 PM and on 04/10/24 at 12:34 PM revealed areas of gouged drywall to the left of the bathroom door. A 3-to-4-inch triangular section of the bottom corner of the bathroom door was broken completely off from the hinge side of the door.<br><br>1b. Observations of room 114 B's bathroom on 04/09/24 at 11:30 AM, and on 04/10/24 at 12:30 PM revealed the vinyl baseboard molding had separated from the wall on the right side from the commode in the bathroom. The 12-inch section of baseboard molding was attached to the bottom of the wall but hung loose from the wall at the top.<br><br>1c. Observations of room 115 A on 04/09/24 at 4:35 PM and on 04/12/24 at 5:20 PM revealed a section of gouged drywall behind the head of the bed. The section of gouged drywall was 3 feet wide and 3 feet long with multiple vertical gouges | F 584 | (F584 Safe/Clean Environment)<br><br>On 4/12/2024 the Maintenance Director corrected the areas for identified Rooms 114, and 115.<br><br>On 05/01/2024 the Maintenance Director replaced the bathroom door in Room 111. The hole in the wall was repaired and the baseboard around the toilet was glued back to the wall.<br><br>On 5/6/2024 the maintenance director initiated a 100% audit of the facility to ensure that walls, doors, and baseboards are not scuffed, peeling or have holes in them. Audit completed on 5/9/2024.<br><br>On 5/3/2024 the administrator in-serviced the maintenance director and assistant on expectations regarding painting, patching to include walls and doors in good repair.<br><br>The administrator, maintenance director and assistant as well as other management team members will observe 5 rooms weekly x 4 weeks then 3 rooms weekly x 1 month for any newly identified repair needs. This will be documented on | |

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| F 584 | Continued From page 11<br>from top to bottom.<br><br>During an interview and room observations with the Maintenance Director on 4/12/24 at 3:32 PM he stated he had been the Maintenance Director for a short time. He further stated facility staff notified him of repairs that were needed in residents' rooms. The Maintenance Director shared he was aware that there were many areas in the facility that needed repairs, and they were prioritizing the areas as they identified concerns. He explained he prioritized repairs by working on those which impacted resident safety first. He stated he used a web-based software to manage building tasks and work orders.<br><br>On 04/13/24 at 3:25 PM an interview was conducted with the Administrator, and she stated she expected the Maintenance Director to complete repairs that impacted patient safety first and then attend to cosmetic repairs. | F 584 | the Physical Plant/Environmental Rounds tool. Any identified areas will be given to the maintenance director to correct or placed on as a work order in the TELS system.<br><br>The maintenance director will report to the QAPI committee monthly x 2 months any identified concerns and corrections made. The QAPI committee will review the results of the audit tool for identification of trends, actions taken, and determine the need for and/or frequency of continued monitoring and make recommendations for monitoring for continued compliance.<br><br>The maintenance director is responsible for the plan of correction and the administrator for sustained compliance. | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as | F 656 | | 5/9/24 |

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| F 656 | Continued From page 12<br>required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to develop a comprehensive care plan which included an area of focus related to nutrition for 2 of 5 residents (Resident #90 and Resident #75) reviewed for nutrition.<br><br>The findings included: | F 656 | (F656 Develop/Implement Comp Care Plan)<br><br>On 4/10/2024 Nutrition Care plans were implemented for Resident #90 and Resident #75. | |

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| F 656 | Continued From page 13<br><br>1. Resident #90 was admitted to the facility on 1/30/24 with cumulative diagnoses which included cancer, dementia, and Type 2 diabetes. His admission orders included a diet order for a Cardiac, Consistent Carbohydrate Diet with regular textures.<br><br>The resident's weight history was reported to include a weight of 151.5 pounds (#) on 2/2/24 and 149.0# on 2/14/24.<br><br>A progress note authored by the facility's consultant Registered Dietitian (RD) was dated 2/14/24. The RD note reported the resident's meal intake was 50-100 percent (%) meals. She indicated the cardiac dietary restriction was not appropriate at that time and recommended Resident #90's diet be liberalized to a Consistent Carbohydrate Diet with regular textures. A physician's diet order was received in accordance with this recommendation to provide Consistent Carbohydrate Diet with regular textures (initiated 2/14/24) for Resident #90.<br><br>Further review of the resident's weight history included the following:<br>--On 2/28/24, the resident weighed 146.5#;<br>--His weight was reported to be 141.0# on 3/12/24, which was indicative of a significant weight loss of 5.37% in one month (from 2/14/24 to 3/12/24).<br><br>An RD progress note dated 3/13/24 reported Resident #90 experienced a significant weight loss of 5% over the previous 30 days. He was noted to have increased nutritional needs related to this significant weight loss. A recommendation was made to initiate 120 milliliters (ml) of Med | F 656 | All residents have the potential to be affected by the alleged deficient practice.<br><br>On 4/12/2024 the Regional Registered Dietician in-serviced the Dietary Manager worker(s), on developing and implementing a comprehensive person-centered nutrition care plan for each resident as indicated.<br><br>On 4/10/2024 the Regional Registered Dietician began auditing and updating resident care plans to ensure each resident has a care plan for nutrition as indicated. The audit will be completed by 4/11/2024. Corrections to the audit will be made by 4/11/2024.<br><br>Beginning 4/15/2024 the Regional Registered Dietician and/or Registered Dietician, and MDS nurse(s), and/or IDT will audit 10 resident care plans per week for nutritional care plans as indicated it include all new admissions. The weekly audit will be completed for one month to ensure nutrition care plans are in place, then five residents monthly times two months.<br><br>The Regional Registered Dietician and/or Registered Dietician and MDS nurse will monitor the results of the weekly audits for performance and to ensure that solutions are sustained and report weekly to the IDT and results of the audits will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee for review, trending, and need for continued monitoring. | |

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| F 656 | Continued From page 14<br>Pass 2.0 (a high calorie, high protein liquid nutritional supplement) to be given to Resident #90 twice daily. A physician's order was received on 3/13/24 for initiation of 120 ml of Med Pass 2.0 given twice daily in accordance with the RD's recommendation.<br><br>Review of Resident #90's electronic medical record (EMR) revealed his most recent Minimum Data Set (MDS) was a quarterly assessment dated 3/20/24. The MDS indicated the resident had moderately impaired cognition. He was assessed as being independent with eating. Resident #90 was reported to be 72 inches tall and weighed 141 pounds (#). He received a therapeutic diet. The MDS assessment indicated the resident had a significant weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months but was not on a physician-prescribed weight-loss regimen.<br><br>Resident #90's current Care Plan (last revised on 2/12/24) was reviewed. The care plan did not include a Nutrition area of focus with dietary orders, goals, and/or interventions to provide for Resident #90's nutritional care.<br><br>The facility's Dietary Manager was not available for an interview.<br><br>A telephone interview was conducted on 4/11/24 at 11:55 AM with the facility's consultant RD. During the interview, the RD reported it was the Dietary Manager's responsibility to initiate and revise the nutrition care plans. When asked if she would expect a nutrition care plan to be completed for Resident #90, she stated, "Any nutrition intervention should be care planned." | F 656 | The Dietary Manager is responsible for the plan of correction and the administrator for sustained compliance. | |

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| F 656 | Continued From page 15 | F 656 | | |

An interview was conducted on 4/11/24 at 3:19 PM with the facility's MDS Nurse. Upon inquiry as to who was responsible to complete a Nutrition care plan for a resident with a significant weight loss, she stated, "someone from dietary." During a follow-up interview conducted on 4/11/24 at 3:40 PM with the MDS Nurse, the nurse reported the Nutrition care plan had apparently been missed for Resident #90 prior to 4/11/24.

An interview was conducted on 4/11/24 at 3:49 PM with the facility's Regional Dietary Consultant. During the interview, the Consultant was informed there wasn't a Nutrition area of focus for Resident #90, who had experienced a significant weight loss. She stated the Dietary Manager was responsible for completing the Nutrition area of focus in the residents' care plans. When asked if she would expect a Nutrition area of focus to be included in a care plan for a resident with a significant weight loss, she nodded her head to indicate she would expect it.

An interview was conducted on 4/13/24 at 9:26 AM with the facility's Director of Nursing (DON). During the interview, the DON stated the Dietary Manager may not have been aware that it was her responsibility to complete the Nutrition care plan.

2. Resident #75 was admitted to the facility on 1/3/2024 with diagnoses of a progressive neurological disease, seizure disorder, and dementia.

A Significant Change Minimum Data Set assessment was completed 3/21/2024 and

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| F 656 | Continued From page 16<br>indicated Resident #75 was severely cognitively impaired, required extensive assistance with eating, and had a significant weight loss.<br><br>During a review of Resident #75's Care Plan dated 3/26/2024 no care plan for nutrition was found.<br><br>Resident #75 had a Dietician's Progress Note dated 3/26/2024 that indicated he had a significant weight loss, received a medication to stimulate his appetite, and had increased nutritional needs related to the weight loss.<br><br>Nurse #5 was interviewed on 4/9/2024 at 5:39 pm and she stated Resident #75 will only eat a few bites of a meal but will eat snacks. She stated she was not aware he did not have a care plan for nutrition and dietary would be responsible for developing a nutrition care plan.<br>The facility's Dietary Manager was not available for an interview.<br><br>On 4/11/2024 at 11:48 am the Consultant Registered Dietician was interviewed by phone, and she stated she saw Resident #75 on 3/25/2024 and he presented with significant weight loss. She stated the Dietary Manager is responsible for the nutritional care plans.<br><br>The Administrator was interviewed by phone on 4/11/2024 at 6:38 pm and she stated Resident #75 should have a care plan for significant weight loss and she thought it must have been overlooked by the Dietary Manager. | F 656 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5) | F 758 | | 5/9/24 |

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| F 758 | Continued From page 17<br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their | F 758 | | |

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| F 758 | Continued From page 18<br>rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff and consultant pharmacist interviews and record reviews, the facility failed to limit the duration of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) ordered on an as needed (PRN) basis to 14 days and/or indicate the duration and rationale for the PRN order to be extended beyond 14 days, when appropriate. This occurred for 2 of 7 residents whose medications were reviewed (Resident #71 and Resident #73).<br><br>The findings included:<br><br>1. Resident #71 was admitted to the facility on 7/9/21 with re-entry from a hospital on 7/2023. His cumulative diagnoses included a history of a stroke and anxiety disorder.<br><br>A review of the resident's electronic medical record (EMR) revealed a physician's order dated 2/27/23 was received for 0.5 milligram (mg) lorazepam (an antianxiety medication) to be given as one tablet by mouth three times daily for anxiousness. Lorazepam is a psychotropic medication and a controlled substance medication.<br><br>Further review of Resident #71's EMR revealed a | F 758 | F758 Drug Regimen is Free from Unnecessary Drugs<br><br>Physician addressed pharmacist recommendations on 4/11/2024 and a stop date was obtained for the prn medication of resident #73. Resident #71 physician gave order to discontinue the prn medication.<br><br>The Director of Nursing initiated an audit on 5/2/2024 for all residents with orders for prn psychotropic. The audit will ensure prn psychotropic medications have a stop date. The audit will be completed by the unit manager and/or QI nurse. The DON will follow up with the physician for any areas of concern identified.<br><br>In-servicing will be conducted by the Director of Nursing for the Medical Director, Nurse Practitioner, Unit Manager and Licensed nursing staff to include agency and contracted nurses when ordering/receiving an order for psychotropic medications, to ensure the medication has a stop date. The in-servicing was initiated on 5/1/2024 and completed by 5/9/2024. After 5/9/2024 | |

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| F 758 | Continued From page 19<br>physician's order was received on 9/8/23 for 2 mg / milliliter (ml) lorazepam to be given as 1 mg intramuscularly (IM) every 12 hours as needed (PRN) for agitation until oral lorazepam arrived, then discontinue.<br><br>The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 2/7/24. Resident #71 was reported to have severely impaired cognition with no behaviors nor rejection of care. He was dependent on staff for all of his Activities of Daily Living (ADLs), except for requiring only supervision or touching assistance for eating. The Medication section of the MDS revealed Resident #71 received an antianxiety medication during the 7-day look back period.<br><br>Resident #71's EMR indicated the physician's orders for both the scheduled lorazepam (initially ordered on 2/27/23) and the PRN injectable lorazepam (initially ordered on 9/8/23) continued as active orders up through the date of the review on 4/10/24. A review of Resident #71's Medication Administration Records (MARs) revealed no doses of PRN lorazepam were documented as having been administered to the resident from 9/8/23 through 4/10/24.<br><br>A telephone interview was conducted on 4/12/24 at 1:47 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported she was addressing the use of PRN psychotropic medications with the facility. Most recently, the pharmacist reported a statement included in the Executive Summary Comments from her April 2024 Consultant Report indicated there were still some psychotropic medications ordered PRN with no "stop date." The consultant pharmacist stated she requested the facility | F 758 | any licensed nurses who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, to include agency or contracted nurses will be in-serviced during orientation regarding psychotropic medication orders and notification to the DON.<br><br>Monitoring will be completed through the Interdisciplinary Team Meeting 5x's weekly x 4 weeks. All orders for psychotropic medication will be monitored for appropriate length of therapy with a stop date. The DON will present the findings of the audit to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months.<br><br>The Quality Assurance Performance Improvement Committee will meet monthly for 2 months and review the Antibiotic Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.<br><br>The Director of Nursing is responsible for the plan of correction and the administrator for sustained compliance. | |

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| F 758 | Continued From page 20 | F 758 | | |

please make sure that this was observed for all residents, including Hospice.

An interview was conducted on 4/13/24 at 9:26 AM with the facility's Director of Nursing (DON). Upon inquiry, the DON reported nursing staff was aware that PRN psychotropic medications must have a stop date. The DON stated she thought Resident #71's order for the PRN lorazepam had inadvertently been left on the resident's current orders.

2. Resident #73 was admitted to the facility on 2/8/23. Her cumulative diagnoses included Alzheimer's disease. She was admitted to Hospice on 3/12/24.

A review of the resident's electronic medical record (EMR) revealed a physician's order dated 3/21/24 was received for 1 milligram (mg) lorazepam (an antianxiety medication) to be given as one tablet under the tongue (sublingually) every 4 hours as needed (PRN) for end of life care / anxiety / agitation. The end date for the PRN lorazepam order in Resident #73's EMR was "Indefinite." Lorazepam is a psychotropic medication and a controlled substance medication.

Resident #73's most recent Minimum Data Set (MDS) was a Significant Change assessment dated 3/25/24. The resident was reported to have severely impaired cognition with no behaviors nor rejection of care. She was dependent on staff for all of her Activities of Daily Living (ADLs). The Medication section of the MDS revealed Resident #73 did not receive an antianxiety medication during the 7-day look back period.

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| F 758 | Continued From page 21<br><br>A review of the controlled substance declining inventory sheets for Resident #73 was conducted on 4/12/24 at 3:00 PM. This review revealed 12 tablets of 1 mg lorazepam were dispensed from the pharmacy on 3/21/24 and stored on the medication cart for this resident. None of the lorazepam tablets were documented as having been removed from the inventory.<br><br>Documentation on Resident #73's March 2024 and April 2024 Medication Administration Records (MARs) revealed no doses of PRN lorazepam were administered to the resident through the date of the review.<br><br>A telephone interview was conducted on 4/12/24 at 1:47 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported she was addressing the use of PRN psychotropic medications with the facility. Most recently, the pharmacist reported a statement included in the Executive Summary Comments from her April 2024 Consultant Report indicated there were still some psychotropic medications ordered PRN with no "stop date." The consultant pharmacist stated she requested the facility please make sure that this was observed for all residents, including Hospice.<br><br>An interview was conducted on 4/13/24 at 9:26 AM with the facility's Director of Nursing (DON). Upon inquiry, the DON reported nursing staff was aware that PRN psychotropic medications must have a stop date. She stated these medications were typically limited to 14 days or extended up to 90 days with a stop date designated in the order. | F 758 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals | F 761 | | 5/9/24 |

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| F 761 | Continued From page 22<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to: 1) Discard expired medications stored on 1 of 2 medication (med) carts (200 Hall Med Cart) and in 1 of 1 Med Storeroom (100/200/300 Hall Medication Storeroom); 2) Date injectable medications as to when they were opened to allow for the determination of its shortened expiration date for medications stored on 1 of 2 med carts (200 Hall Med Cart) and in 1 of 1 Med Storeroom (100/200/300 Hall | F 761 | F761 Label/Store Drugs and Biologicals<br><br>On 4/9/2024 the Director of Nursing removed and destroyed all medications and supplies that were not labeled with an open date and/or expired from the refrigerators in medication rooms and medication storage cabinets. Medication that was found on the cart that should have been refrigerated was discarded and | |

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| F 761 | Continued From page 23<br>Medication Storeroom); and 3) Store medications in accordance with the manufacturer's storage instructions on 1 of 2 med carts (200 Hall Med Cart).<br><br>The findings included:<br><br>1. An observation was conducted on 4/9/24 at 3:15 PM of the 200 Hall Medication (Med) Cart in the presence of Nurse #1. The observation revealed the following medications were stored on the med cart:<br><br>a. According to the manufacturer, in-use vials of Lantus insulin should be stored under refrigeration or at room temperature and used within 28 days.<br><br>An opened vial of Lantus insulin (100 units/ml) dispensed from the pharmacy on 2/10/24 for Resident #19 was dated as opened on 3/1/24 (39 days prior to the date of the observation). A pharmacy auxiliary sticker placed on the medication vial containing the insulin read in part, "Expires 28 days after opening."<br><br>b. According to the manufacturer, in-use vials of Lantus insulin should be stored under refrigeration or at room temperature and used within 28 days.<br><br>An opened vial of Lantus insulin (100 units/ml) dispensed from the pharmacy on 3/1/24 for Resident #30 was dated as opened on 3/1/24 (39 days prior to the date of the observation). A pharmacy auxiliary sticker placed on the medication vial containing the insulin read in part, "Expires 28 days after opening." | F 761 | reordered.<br><br>On 4/9/2024 an audit of medication rooms and med carts to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed and/or returned to the pharmacy timely for destruction. (Director of Nursing and Staff Development Coordinator)<br><br>The Director of Nursing will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol, returning expired or discontinued medications to the pharmacy for destruction when indicated and locking medication cart.<br><br>On 4/10/2024 the Director of Nursing initiated an in-service with all nurses and medication aides regarding Medication Storage with emphasis on labeling medications with an open date/expiration date and discarding expired medications per pharmacy policy. In-services will continue and be completed on 4/12/2024 by the Staff Development Coordinator. After 4/12/2024 any nurse or medication aide who has not worked or received the in-service will complete in-service prior to the next scheduled work shift. All newly hired nurses or medication aides will be in-serviced during orientation regarding Medication Storage. | |

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| F 761 | Continued From page 24<br>c. According to the manufacturer, in-use vials of Novolog insulin should be stored under refrigeration or at room temperature and used within 28 days.<br><br>An opened vial of Novolog insulin (100 units/ml) dispensed from the pharmacy on 3/1/24 for Resident #30 was dated as opened on 3/2/24 (38 days prior to the date of the observation).<br><br>d. According to the manufacturer, in-use vials of Lantus insulin should be stored under refrigeration or at room temperature and used within 28 days.<br><br>An opened vial of Lantus insulin (100 units/ml) dispensed from the pharmacy on 2/13/24 for Resident #18 was dated as opened on 3/4/24 (36 days prior to the date of the observation).<br><br>e. According to the manufacturer, in-use vials of Humalog insulin should be stored under refrigeration or at room temperature and used within 28 days.<br><br>An opened vial of Humalog insulin (100 units/ml) dispensed from the pharmacy on 3/1/24 for Resident #18 was dated as opened on 3/6/24 (34 days prior to the date of the observation).<br><br>f. According to the manufacturer, in-use vials of Lantus insulin should be stored under refrigeration or at room temperature and used within 28 days.<br><br>An opened vial of Lantus insulin (100 units/ml) dispensed from the pharmacy on 3/9/24 for Resident #5 was not dated as to when it had been opened to allow for the determination of its | F 761 | The Director of Nursing will initiate an audit on 4/15/2024 of all medication rooms and med carts weekly x 4 weeks then monthly x 1 month utilizing the Medication Storage Audit Tool. This audit is to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed. The Director of Nursing will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol.<br><br>The Director of Nursing will present the findings of the Medication Cart Audit Tool and Medication Storage Room Audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Quality Assurance Performance Improvement (QAPI) Committee will meet monthly for 2 months and review the Medication Cart Audit Tool and Room Audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.<br><br>The Director of Nursing is responsible for the plan of correction and the administrator for sustained compliance. | |

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shortened expiration date. The insulin vial was dispensed 31 days prior to the date of the observation.

g. The Center for Disease Control and Prevention (CDC) Injection Safety Guidelines include information on when multi-dose vials (MDVs) should be discarded. The Guidelines state, "Medication vials should always be discarded whenever sterility is compromised or cannot be confirmed. In addition, the United States Pharmacopeia (USP) General Chapter 797 recommends the following for multi-dose vials of sterile pharmaceuticals: If a multi-dose [vial] has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial."

An opened 20 milliliter (ml) multi-dose vial of 1% lidocaine solution was stored on the med cart. The vial of 1% lidocaine was not dated as to when it had been opened to allow for the determination of its shortened expiration date.

h. The Center for Disease Control and Prevention (CDC) Injection Safety Guidelines include information on when single-dose vials (SDVs) should be discarded. The Guidelines state, "Vials that are labeled as single-dose or single-use should be used for only a single patient as part of a single case, procedure, injection ... Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient."

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An opened 10 ml single-dose vial of sterile water for injection dispensed for Resident #26 was stored on the med cart. The vial of sterile water for injection was labeled for single use only.

i. According to the manufacturer, intact (unopened) bottles of latanoprost eye drops should be stored under refrigeration at 36 degrees Fahrenheit (o F) to 46 o F.

An unopened bottle of latanoprost eye drops dispensed from the pharmacy on 4/7/24 for Resident #19 was stored on the med cart. A blue pharmacy auxiliary sticker placed on the bottle read, "Refrigerate until opened."

An interview was conducted with Nurse #1 on 4/9/24 at 3:45 PM. During the interview, the nurse reviewed each vial of expired insulin and confirmed the dating of (or failure to date) each of the vials. Upon inquiry, the nurse reported she would need to contact the pharmacy to request replacement vials of insulin for those that were identified as expired. Additionally, the hall nurse reported the multi-dose vial of 1% lidocaine needed to be discarded since she could not determine when it had been opened and the single-dose vial of sterile water for injection should have been discarded after the first use. When asked, Nurse #1 acknowledged the latanoprost eye drops should have been stored in the refrigerator until opened.

An interview was conducted with the facility's Director of Nursing (DON) on 4/9/24 at 4:00 PM. At that time, the DON confirmed Nurse #1 had shown her the expired insulin vials and the vials of lidocaine and sterile water for injection. The

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DON reported she was surprised by the findings of the 200 Hall Med Cart observation because the med carts had been inspected the previous week to ensure proper storage of the medications.

A follow-up interview was conducted with the DON on 4/13/24 at 9:43 AM. During the interview, the DON reported she would have expected nursing staff to date the vials of insulin as to when they had been opened, remove any expired medications from the medication carts, and notify the pharmacy of the need to replace these medications so they were available when needed for the resident. Additionally, the DON stated a single-use vial of sterile water for injection should have been discarded immediately after it was used for the first time. She also noted the unopened bottle of latanoprost eye drops should have been refrigerated until needed.

2. Accompanied by Nurse #1, an observation was conducted on 4/9/24 at 3:46 PM of the 100/200/300 Hall Medication Storeroom. The observation revealed the following medications were stored in the Medication Storeroom:

a. A manufacturer's box of 650 milligrams (mg) acetaminophen suppositories with 9 suppositories remaining in the box were observed to be stored in the Med Storage Room. The manufacturer's expiration date for the suppositories was June of 2023.

b. According to the manufacturer labeling, a vial of PPD solution in use for more than 30 days should be discarded.

One (1) opened multi-dose vial of Tuberculin PPD injectable solution (used for skin testing in the

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| F 761 | Continued From page 28<br>diagnosis of tuberculosis) was stored in the med room refrigerator. The PPD solution was labeled as having been opened on 3/7/24 (33 days prior to the date of the observation).<br><br>c. Three (3) unopened bottles of 80 milligrams (mg) simethicone chew tablets (each containing 100 tablets) were expired with a manufacturer's expiration date of March 2024. Simethicone is an over-the-counter medication used to prevent or reduce excessive intestinal gas.<br><br>d. One (1) - 8 ounce, unopened bottle of Kaopectate medication was expired with a manufacturer expiration date of March 2024. Kaopectate is an over-the-counter medication used to treat occasional upset stomach, heartburn, and nausea.<br><br>An interview was conducted with the DON on 4/13/24 at 9:43 AM. During the interview, the DON reported she would expect the nursing staff to date everything as to when it was opened and to discard expired medications in accordance with the manufacturer's instructions. She stated the hall nurses were responsible to check the facility's stock medications in the Med Storeroom to ensure they were not expired. | F 761 | | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>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 | F 867 | | 5/9/24 |

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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.

§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

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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 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

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| F 867 | Continued From page 31<br>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.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§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:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint surveys completed on 6/17/21 and a complaint investigation completed on 2/24/22. This was for 4 deficiencies that were cited in the areas of: Resident Rights/Exercise of Rights (550) which was cited on 6/17/21, 2/24/22 and recited on the current recertification and complaint survey of 4/13/24; Right to Participate in Planning Care | F 867 | F867 QAPI Improvement Activities<br><br>On 5/9/2024 the facility QAA Committee held their meeting to review the purpose and function of the QAA committee and review on-going compliance. The Administrator, DON, MDS Nurse, QI Nurse, Unit Manager, Maintenance Director, Social Worker, Dietary Manager, Activity Director, and Housekeeping Supervisor will continue to attend QAPI Committee Meetings on an ongoing basis and additional team members will be | |

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| PINE RIDGE HEALTH AND REHABILITATION CENTER | 706 PINEYWOOD ROAD THOMASVILLE, NC 27360 |

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| F 867 | Continued From page 32<br>(553) which was cited on 6/17/21 and recited on the current recertification and complaint survey of 4/13/24; Develop/Implement Comprehensive Care Plan (656) which was cited on 6/17/21 and recited on the current recertification and complaint survey of 4/13/24; and Safe/Clean/Comfortable/Homelike Environment (584) which was cited on 2/24/22 and recited on the current recertification and complaint survey of 4/13/24. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program (QAA).<br><br>The findings included:<br><br>This citation is cross-referenced to:<br><br>F550: Based on record review, resident, staff interviews and student interviews, the facility failed to treat a resident in a dignified manner for 1 of 23 residents reviewed for dignity (Resident #17). Nurse #2 told Resident #17, in a loud and demeaning tone, to get back in her room and stop "stalking" her. Resident #17 stated Nurse #2's statement made her feel embarrassed and humiliated to be spoken to as if she were a child.<br><br>During the recertification and complaint survey on 6/17/21, the facility failed to treat a resident in a respectful and dignified manner for 1 of 1 resident reviewed for dignity when the Speech Therapist and a Nursing Assistant referred to a resident as a feeder.<br><br>During the complaint investigation survey on 2/24/22, the facility failed to treat residents in a dignified manner when residents did not receive | F 867 | assigned as appropriate.<br><br>On 5/7/2024 the corporate facility consultant in-serviced the administrator related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying concerns and correcting repeat deficiencies related to F550-Dignity, F584-Safe, Clean Homelike Environment, F553-Care Plan Invitation, and F656 Comprehensive Care Plans.<br><br>On 5/7/2024 the administrator in-serviced the department managers related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying concerns and correcting repeat deficiencies related to F550-Dignity, F584-Safe, Clean Homelike Environment, F553-Care Plan Invitation, and F656 Comprehensive Care Plans.<br><br>As of 5/7/2024 after the facility corporate consultant in-service, the facility QAPI committee will determine if other areas of concern are identified through the QI review process using the environmental rounds tools, review of work orders, daily review of Point Click Care(Electronic Medical Record), Grievance concern review, review of Resident Council minutes, care plan reviews, and any other review of regional facility consultant recommendations.<br><br>Corrective action has been taken for the identified areas of concern related to | |

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| F 867 | Continued From page 33<br>incontinent care for several hours during a period when there was just one Licensed Practical Nurse and two Nursing Assistants in the facility to provide care for 98 residents. 2 of 5 interviewed residents stated the lack of incontinent care for an extended period of time made them feel like they were defeated, not treated with dignity, neglected, dirty, mad, sad, helpless, and abandoned. Emergency personnel reported that residents were observed crying. This deficient practice negatively impacted residents in the facility.<br><br>F553: Based on record reviews, residents, family and staff interviews the facility failed to offer 3 of 5 residents (Residents #47, #49 and #80) reviewed for care planning, the opportunity to participate in care plan meetings.<br><br>During the recertification and complaint survey on 6/17/21, the facility failed to invite 2 of 2 residents reviewed for care plan meeting invitations.<br><br>F584: Based on observations and staff interviews, the facility failed to maintain walls (Rooms 111 B, 114 B, and 115 A) and a door (Room 111B) in good repair for 3 of 15 rooms (Rooms 111, 114, and 115) on the 100-hall reviewed for environment.<br><br>During a complaint investigation survey on 2/24/22, the facility failed to provide a clean environment for 2 of 2 days investigated for environment. Interviews with first responders who arrived at the facility described and provided photographic evidence bags of garbage in the hallways and an observation on 1/17/22 revealed | F 867 | F550-Dignity, F584-Safe, Clean Homelike Environment, F553-Care Plan Invitation, and F656 Comprehensive Care Plans.<br><br>The Quality Assurance Process Improvement committee will continue to meet at a minimum quarterly.<br>The Quality Assurance Process Committee, including the Medical Director, will review quarterly compile Quality Assurance Process Improvement report information, review trends, and review corrective actions taken and the dates of completion. The Quality Assurance Process Improvement Committee will validate the facility's progress in the correction of deficient practices or identified concerns.<br><br>The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions.<br><br>The administrator is responsible for implementation of the acceptable plan of correction. | |

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| F 867 | Continued From page 34<br>a room with overflowing garbage, garbage on the floor, garbage under the bed, and spilled fluids.<br><br>F656: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan which included an area of focus related to nutrition for 2 of 5 residents (Resident #90 and Resident #75) reviewed for nutrition.<br><br>During a recertification and complaint survey on 6/17/21, the facility failed to develop a care plan for discharge plans for 2 of 4 residents reviewed for discharge planning.<br><br>During an interview on 4/13/24 at 3:37 p.m., the Administrator stated the QA (Quality Assurance) committee met monthly and consisted of the Administrator, Director of Nursing, Medical Director and the Directors of the facility's departments. When an area of concern was identified during an IDT (Interdisciplinary Team) meeting, a PIP (performance improvement project), including audits with results was submitted to the QA committee every month until the concern was resolved. She further revealed that as oversight, the corporate consultants also have access to this information via SharePoint to audit, submit recommendations, and follow-up to the QA Committee. | F 867 | | |
| F 887 SS=D | COVID-19 Immunization<br>CFR(s): 483.80(d)(3)(i)-(vii)<br><br>§483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: | F 887 | | 5/9/24 |

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| F 887 | Continued From page 35<br>(i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;<br>(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;<br>(iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;<br>(iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses;<br>(v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision;<br>(vi) The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and<br>(B) Each dose of COVID-19 vaccine administered to the resident; or<br>(C) If the resident did not receive the COVID-19 vaccine due to medical | F 887 | | |

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| F 887 | Continued From page 36<br>contraindications or refusal; and<br>(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:<br>(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;<br>(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and<br>(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to provide consents with the benefits and risks of receiving the influenza vaccine for 2 of 5 residents (Resident #64 and Resident #80). Resident #64 did not receive the influenza vaccine at the Responsible Party's request and Resident #80 was not offered the influenza vaccine.<br><br>Findings included:<br><br>a. Resident #64 was admitted to the facility on 7/2/2021 with diagnoses of dementia with anxiety and stroke.<br><br>A quarterly Minimum Data Set assessment dated 2/13/2024 indicated Resident #64 was severely cognitively impaired.<br><br>During a review of Resident #64's medical record a consent with benefits and risks was not found for an influenza vaccine for the last year.<br><br>The Director of Nursing was interviewed on | F 887 | F887 Influenza Immunization<br><br>On 5/1/2024 Residents/RP #64 and #80 were provided education on the benefits and potential side effects of the Influenza immunization. They were informed that the physician does not recommend they get the immunization at this time.<br><br>On 5/1/2024 the physician was notified of missing immunizations and does not currently wish to provide to residents due to low prevalence time of year. Facility will educate residents/RP and offer immunizations in the fall of the year.<br><br>On 4/20/2024 Director of Nursing/Unit Manager will audit all residents to ensure they have vaccination history documented as in Point Click Care (PCC) Immunizations section. The audit will be completed by 5/7/2024. Director of Nursing/Unit Managers will address all concerns identified during the audit. | |

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| F 887 | Continued From page 37<br>4/11/2024 at 4:49 pm and she stated she could not find consents with the benefits and risks of taking the influenza vaccine for 2023 that should have been reviewed with Resident #64's Responsible Party. The Director of Nursing stated before residents were given a vaccine the nursing staff should obtain a signed copy of the consent which included the risks and benefits of the vaccine and if they could not get a signed consent two nurses should witness a verbal consent with the Responsible Party by phone if the resident was cognitively impaired and cannot give consent. The Director of Nursing stated Resident #64 was not given the influenza vaccine at the Responsible Party's request.<br><br>b. Resident #80 was admitted to the facility on 10/28/2022 with diagnoses of respiratory disease and dementia with agitation. A quarterly Minimum Data Set assessment dated 2/23/2024 indicated Resident #80 was severely cognitively impaired.<br><br>During a review of Resident #80's medical record a consent with benefits and risks was not found for an influenza vaccine for the last year.<br><br>On 4/11/2024 at 4:53 pm an interview was conducted with the Director of Nursing, and she stated she could not find a consent with the benefits and risks of taking the influenza vaccine for 2023 for Resident #80. The Director of Nursing stated they had issues with getting consent signed by the family members of residents that are cognitively impaired and unable to sign for themselves. The Director of Nursing stated Resident #80 did not receive the influenza vaccine.<br><br>The Administrator was interviewed by phone on | F 887 | On 4/12/2024, The Nursing Consultant in-serviced the Director of Nursing/SDC/Unit Manager on the policy and procedure for offering residents the Influenza Immunizations on admission and on the resident and resident representative receiving education regarding the benefits and potential side effects of each immunization annually. Any new hires will be educated on the immunizations during the new hire orientation process.<br><br>On 5/10/2024The Unit Manager/Director of Nursing will audit all new admission charts to ensure the Influenza immunization has been offered and documenting consent or refusal of the immunizations under the immunizations tab in the resident chart.<br><br>Immunizations will be audited one time weekly x four weeks and then one time monthly x one month. The Director of Nursing will address all concerns identified during the audit to include additional education of nurses to include agency and contract staff.<br><br>The Director of Nursing/Unit Managers will forward the results of Audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Quality Assurance Performance Improvement (QAPI) Committee will meet monthly x 2 months and review Immunization Audit to determine trends and / or issues that may | |

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| F 887 | Continued From page 38<br>4/11/2024 at 6:37 pm and stated Resident #64 and Resident #80 should have been provided the benefits and risks of receiving the influenza vaccine and if a resident is not cognitively intact the Family Member should be contacted for consent for the influenza vaccine. | F 887 | need further interventions put into place and to determine the need for further and / or frequency of monitoring.<br><br>The Director of Nursing is responsible for the plan of correction and the administrator for sustained compliance. | |