STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345053	A. BUILDING _____ B. WING _____	C 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETTIGREW REHABILITATION CENTER	1515 W PETTIGREW STREET DURHAM, NC 27705

(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 04/15/24 through 04/18/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FPWL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/15/24 through 04/18/24. Event ID# FPWL11. The following intakes were investigated NC00212107, NC00212785 , NC00215338 , NC00213866 and NC00215816. 16 of the 16 complaint allegations did not result in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		5/16/24

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

Electronically Signed | 05/13/2024

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on records review, and staff interviews, the facility failed to obtain and verify Advance Directives (code status) in the residents' records (Resident #191) and failed to clarify code status in the residents' record (Resident # 75) for 2 of 2 residents reviewed for Advance Directives. Findings included: 1. Review of Resident #191's hospital discharge summary dated 4/13/24 revealed the resident was coded as "Full Code". Resident #191 was admitted to the facility on 4/13/24. Resident's admission Minimum Data Set (MDS)	F 578	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. 1. Center failed to obtain and verify Advance Directive for Resident #191. Resident #191 Advance Directive was obtained and verified on 4/17/24 by LPN UM, resident #191 discharged Center 4/23/24. Center failed to clarify Code Status in the medical record for Resident	

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F 578	Continued From page 2 dated 4/16/24 was in progress. At the time of review on 4/15/24, there was no active order for code status in Resident #191's medical record {electronic health record (EHR)}. The facility did not use any hard copy chart. During an interview on 4/17/24 9:28 AM, Nurse #1 stated she would look in the EHR for a resident's code status. The code status was usually displayed next to the resident's picture or would be in the physician's orders. Nurse #1 reviewed Resident #191's electronic medical record and stated the resident did not have a code status. Nurse #1 explained if there was no code status then the hospital discharge summary would be reviewed. Nurse #1 stated the Unit Manager, was responsible to review the discharge summary and notify the physician about the discharge medications and code status. Once verbal and/or written orders were received this was entered in the resident's EHR by the Unit Manager. During an interview on 4/17/24 at 10:45 AM, Unit Manager #1 stated when any resident was newly admitted or readmitted, the Unit Managers would verify the code status with the admission / medical record staff. Once the code status was verified, the Unit Managers would send/ notify the physician about the resident's discharge medications and the code status for approval. The orders would be approved verbally or written. Once the orders were approved by the physician, the residents code status would be entered in the resident's EHR. Unit Manager stated the resident's code status was missed. The Unit Manager stated the code status should be entered within 24 hours after admission or	F 578	#75. Code status was clarified in the Electronic Medical Record (EMR) on 4/17/24 by RN UM #1. 2. Director of Nursing/Designee to complete an audit of current resident's Advance Directives to ensure order is in place and care plan reflective of order. Audit completed on 5/8/24. Any discrepancies corrected immediately. 3. Staff Development Coordinator/designee educated Licensed Nurses and Social Services Director on ensuring Residents have an Advance Directive order upon admission and a care plan reflective of order. Education completed by 5/15/24. Newly Hired Licensed Nurses and Social Services Director will be educated on Advance Directives during department orientation by the Staff Development Coordinator/Designee. Audit of newly admitted residents by the Director of Nursing/designee 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks to ensure that they have an Advance Directive order and care plan. Audit will be conducted by the Social Services Director/Designee weekly for current residents to ensure that they have an advance directive order and care plan. Audit will be completed weekly x 12 weeks.	

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F 578	Continued From page 3 readmission. During an interview on 4/17/24 at 1:14 PM, Nurse Practitioner #1 stated that the staff would discuss with the resident and/or resident representative about Advance Directives and code status. This information was notified to her, and the order was signed. The staff would then enter the information in the resident's record. The Director of Nursing was unavailable for interview at the time of the survey. During an interview on 4/18/24 at 4:32 PM, the Administrator stated the resident's code status should be entered in the resident's EHR at admission. the Administrator indicated all residents should have code status orders and they should be care planned based on their code status. The Administrator further stated the Unit Managers were responsible for verifying the code status of residents upon admission or readmit admission and entering them in their EHR. 2. Resident #75 was admitted to the facility on 01/02/24 and had diagnoses that included chronic obstructive pulmonary disease, chronic congestive heart failure, and chronic kidney disease. A review of Resident #75's electronic medical record (EMR) and an order dated 01/02/24 revealed Resident's #75's code status was do not resuscitate (DNR). A review of Resident # 75's care plan last revised 04/13/24 revealed the Resident had an advance directive in place for full code. The goal was the advance directive would be honored by staff. The interventions included advance directive	F 578	4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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F 578	Continued From page 4	F 578		

acknowledgement signed on admission on consent to treat, advance directive in medical record, CPR (cardiopulmonary resuscitation) will be provided in the event of cardiac arrest and ensure provider's order is in place.

On 04/17/24 at 11:57 am an interview with Nurse #6 was conducted. She indicated she checked the EMR for resident's code status when a resident's health declined. Nurse #6 opened Resident # 75's EMR and the information indicated Resident was a DNR. She then checked Resident #75's care plan and it indicated Resident had an advance directive in place for full code. Nurse #6 then checked Resident #75's physician orders and read an order dated 01/02/24 for DNR and checked the code status book located at the Nurses station and it had a DNR form with an effective date of 03/04/24 for Resident # 75.

An interview was conducted on 04/17/24 at 12:15 pm with Unit Manager #2 and she indicated all the interdisciplinary team had portions of the care plan they were responsible to update on the care plan, and she was not sure why Resident 75's care plan was not updated. She stated, "maybe he went to the hospital, but I will update it now."

The MDS Nurse was unavailable for interview.

During an interview on 04/18/24 at 4:32 pm, the Administrator stated all residents should have a code status order and they should be care planned based on their code status. She indicated the code status, and the care plan should match, and the Unit Managers should ensure that the care plan reflected the correct and current code status of the resident.

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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 record review and staff interviews, the facility failed to complete the Interview for Activity Preferences of the comprehensive Minimum Data Set (MDS) for 2 of 2 cognitively impaired residents reviewed for activities (Resident #12 and Resident #81). The findings included: 1. Resident #12 was admitted to the facility on 3/6/24 with diagnoses including cognitive impairment. The admission MDS dated 3/12/24 noted Resident #12 had cognitive impairment and required assistance with activities. The MDS did not include the Interview for Activity Preferences. Resident #12's care plan dated 3/12/24 included an area of focus: Resident #12 has impaired cognitive function/impaired thought process related to encephalopathy. The goal included: The resident would communicate with family/caregivers regarding resident's capabilities and needs. The interventions included: the resident would engage in simple, structured activities that avoid overly demanding tasks. An interview was conducted on 4/17/24 at 4:00 PM with the Activity Director (AD). The AD stated that one-on-one in room activities were Resident# 12's preference which included story time, music, sensory stimulation of hand rubs, television programs of her choice, and family visits. The AD confirmed while completing the Preferences for	F 641	1. Center Failed to complete Interview with Resident #12 and Resident #81 for activity preferences. Resident #12 was interviewed on 5/10/24 by Activities Director and activities preferences updated. Medium Data Set (MDS) will be updated on next Comprehensive Assessment by Resident Care Specialist (RCS). Resident #81 was interviewed on 5/10/24 by Activities Director and activities preferences updated. Medium Data Set (MDS) will be updated on next Comprehensive Assessment by RCS. 2. All residents have the potential to be affected by the deficient practice. 3. Senior Resident Care Specialist to provide education to the RCS and Activities Director on completion/accuracy of Preferences for Customary Routine and Activities Assessment section of the Minimum Data Set. Education to be completed by 5/15/24. Newly hired RCS and Activity Director will be educated during department orientation on completion/accuracy of the Preferences for Customary Routine and Activities Assessment by the Staff Development Coordinator/Designee.	5/16/24

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F 641	Continued From page 6 Customary Routine and Activities assessment she did not conduct the Interview for Activity Preferences which would include Resident #12's specific activity interests. The AD indicated she was not formerly trained on the completion of the MDS assessment. 2. Resident #81 was admitted on 12/26/23 with diagnoses including cognitive impairment. The admission MDS dated 12/29/23 noted Resident #81 had cognitive impairment and required assistance with activities. The MDS did not include the Interview for Activity Preferences. An admission activity assessment dated 1/4/24, revealed no information was included about Resident 81's preferences or interests in activities. A focus area on the care plan dated 12/29/23 revealed Resident #81 enjoyed participating in favorite activities and spending time outdoors. There was no further information provided on the care plan regarding Resident# 81's activity interests. An interview was conducted on 4/17/24 at 4:00 PM with the Activity Director (AD). The AD confirmed while completing the Preferences for Customary Routine and Activities assessment she did not conduct the Interview for Activity Preferences which would include Resident #81's specific activity interests. The AD indicated she was not formerly trained on the completion of the MDS assessment. An interview was conducted on 4/17/24 at 4:30 PM with the Administrator and the Regional Director of Operations. Both stated the activity section on the MDS for both Resident #12 and	F 641	Audit will be completed by the Administrator/Designee 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks to ensure that Comprehensive MDS assessments to include Admission, Annual, and Significant Change assessments are accurately coded for Preferences for Customary Routine and Activities. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Administrator monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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F 641	Continued From page 7 Resident #81 were incomplete, and they were unable to provide any further information.	F 641		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews, the facility failed to provide an on-going activity program that met the individual interests and needs for 2 of 2 cognitively impaired residents reviewed for activities (Resident #12 and Resident #81). The findings included: The activity calendar was posted and offered the following scheduled activities: 4/15/24 at 10:00 AM morning stretch, 10:15 AM current events, 10:30 AM creative corner, 2:00 PM, movies and popcorn, 4:00 music and sensory. 4/16/24 at 10:00 AM news and views, 10:15 AM puzzles and coloring, 10:30 AM music and manicures, 2:00 PM arts and crafts, 2:45 PM bingo with friends and 4:00 PM music and reminiscing.	F 679	1. The Center failed to provide on-going activity program to meet the interests and needs of cognitively impaired Resident #12 and Resident #81. Resident #12 and #81 were interviewed on 5/8/24 by Activities Director to update preference of activities. Care Plan updated on 5/10/24 to reflect activity preferences by the Regional Clinical Director. 2. Current cognitively impaired residents and resident representatives as applicable were interviewed by Interdisciplinary Team (IDT) for activity preferences. Care plan updated with person centered activity program to meet to needs/interest of residents by Resident Care Specialist/Designee. Audit will be completed by 5/15/24.	5/16/24

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F 679	Continued From page 8 4/17/24 10:00 AM coffee and chat, 10:30 AM arts and crafts, 11:00 AM music and sensory, 2:00 PM, Bible study, 3:15 PM Bible study social and 4:00 PM create club. 1. Resident #12 was admitted to the facility on 3/6/24, with a diagnosis of encephalopathy. Resident #12 was coded on the admission Minimum Data Set (MDS) assessment dated 3/12/24 as having moderate cognitive impairment and she needed assistance with activities of daily living and assistance to attend activities. The MDS also did not code any of Resident #12's activity interests. The resident was coded for total assistance with transfers and locomotion. A focus area of the care plan dated 3/12/24 revealed Resident #12 had impaired cognitive function/impaired thought process. The goal included the resident would communicate with family/caregivers regarding resident's capabilities and needs. The intervention included the resident would engage in simple, structured activities that avoid overly demanding tasks. Record review revealed there were no activity notes available after the 3/12/24 assessment for Resident #12. There were no preferences listed. There were no documented notes or activity participation records for Resident #12. A continuous observation of Resident #12 was conducted on 4/16/24 from 10:00 AM to 11:30 AM. Resident #12 was in her room sitting in her wheelchair with no television on or any other form of social stimulation. The scheduled activities were held in the activity room during the time of the observation were news and views at 10:00 AM, 10:15 AM puzzles and coloring, and 10:30	F 679	3. All Licensed Nurses, Certified Nursing Assistants, and Activity staff will be educated by the Administrator/Designee on ensuring that cognitively impaired residents are provided with and offered activities of interest. Education completed by 5/15/24. Activity Staff will be educated by the Administrator regarding interviewing resident and resident representative(s) for activity preferences, documenting preferences in residents electronic medical record, providing and documenting activity participation. Education will be completed by 5/15/24. New hires will be educated on ensuring that cognitively impaired residents are provided with and offered activities of interest during Department Orientation by the Staff Development Coordinator/designee. Random audit of cognitively impaired residents will be completed by the Administrator/Designee to ensure that resident□s activity preference is provided and documented. 10 residents per week x 4 weeks, 5 residents per week x 4 weeks, then 2 residents per week x 4 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness	

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F 679	Continued From page 9 AM music and manicures. An observation was conducted on 4/16/24 at 2:16 PM. Resident #12 was observed in bed with television on low volume and the remote control was across the room on the counter. There were no other stimulatory items in the room or within reach of the resident. An interview was conducted with Nurse Aide # 8 on 4/16/24 at 2: 16 PM, who stated she had not seen Resident #12 involved in group activities or provided with One-to-One (1:1) activities by the activity staff. Nurse Aide #8 further stated the aides try to assist with getting residents to activities, but if they were providing care to other residents, they were unable take residents to activities. An interview was conducted on 4/17/24 at 10:57 AM with Resident #12 during which she stated she enjoyed religious services, sports, gospel music and food events. Resident #12 further stated she had limited physical mobility and was unable to go to activities herself. Resident #12 reported she was not provided with in-room activities or offered to attend group activities. A continuous observation was conducted 4/17/24 from 3:15 PM to 3: 30 PM of Resident #12 seated in her room. The observation revealed she was not provided with any form of activity or stimulation while in her room. The television and the radio were off. The scheduled activity during the time of the observation was Bible study social at 3:15 PM. An interview was conducted on 4/17/24 at 4:00 PM with the Activity Director who stated that one	F 679	of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator	

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F 679	Continued From page 10	F 679		

to one (1:1) in room activities were Resident# 12's preference which included story time, music, sensory stimulation of hand rubs, television of her choice and family visits. The Activity Director confirmed the Minimum Data Set (MDS) assessment, or activity assessment completed on 3/12/24 did not include Resident #12's specific activity interest. The Activity Director further stated documentation of the resident's response would be in the activities note. The Activity Director could not confirm Resident #12 received any 1:1 activity or been offered any group activities of preferences based on the activities that were being provided. The Activity Director further stated she did not have a specific 1:1 schedule that was consistent with residents who needed 1:1 activity or that assistance was provided for residents to participate in small group activities.

An interview was conducted on 4/17/24 at 9:15 AM with the Administrator who stated the expectation was for the activities team to develop a program, to include residents in small group activities and develop a system to ensure residents received 1:1 activity. The activities staff would document participation and refusal of activities in notes.

An interview was conducted on 4/17/24 at 4:30 PM with the Regional Director of Operations and the Administrator. Both stated they were unable to provide documentation of the resident activity assessment for Resident #12, that included preference list or any actual participation records for group activity or 1:1 record of the resident's involvement.

2. Resident #81 was admitted to the facility on

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12/26/23. The diagnoses included both hemiparesis, hemiplegia, and cerebral infarction.

Resident #81 was coded on the admission MDS assessment dated 12/29/23 as having severely impaired cognition and he needed assistance with activities. The MDS coded Resident #81 needed assistance with ADLs and assistance to recreational activity. The MDS also did not code any of Resident #81's activity interests. The resident was coded for total assistance with transfers and locomotion.

A focus area on the care plan dated 12/29/23 revealed Resident #81 enjoys participating in favorite activities spending time outdoors. There was no further information provided on the care plan regarding Resident# 81's activity interests.

Record review revealed there were no activity notes available after 3/21/24.

Observation was conducted on 4/15/24 at 10:30 AM of Resident #81 who sat in his wheelchair in the doorway of his room and there was no social stimulation. The Activity Director was in a group activity (creative corner) with 6 other residents in the activity room. The resident indicated he wanted to go the activity but did not know what activity was happening.

Observation and interview were conducted on 4/15/24 at 2:00 PM with Resident #81 who sat in his wheelchair in the doorway of his room without staff interaction or any other sensory stimulation. The activity being offered was a movie and popcorn. Resident #81 asked staff what's going on. Staff briefly spoke with the resident and walked away. Resident #81 stated he had limited

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physical mobility and was unable to go to activities himself. Resident #81 reported he was not provided with in-room activities, offered to go to activities. There was no other stimulation in the room.

An interview on 4/17/24 at 2:45 PM, of Resident #81 revealed he was in bed with the ability to communicate his social interest. Resident#81 stated he enjoyed cooking, electronics, sports movies, cards and wanted to go to activities. Resident #81 further stated no one asked him to go to anything, so he did not know what was offered.

An interview was conducted on 4/17/24 at 10:16 AM, with the Activity Director who stated she did not have any documentation of the actual group or one to one activity that the resident participated in or a complete activity assessment of the resident's activity preference. The Activity Director stated she did not have time to do a lot of the one-to-one activities because she was the only person who provided the activities for the entire building. Staff had not consistently brought residents to activities, therefore she had to go around the facility to get those who wanted to go and escort them to the activity.

An interview was conducted on 4/17/24 at 4:30 PM with the Regional Director of Operations and the Administrator. Both stated they were unable to provide documentation of the resident activity assessment for Resident #81, that included preference list or any actual participation records for group activity or 1:1 record of the resident's involvement.

An interview was conducted on 4/17/24 at 9:15

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F 679	Continued From page 13 AM with the Administrator who stated the expectation was for the activities team to develop a program, to include residents in small group activities and develop a system to ensure residents received 1:1 activity. The activities staff would document participation and refusal of activities in notes.	F 679		
F 687 SS=E	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interview and record reviews, the facility failed to provide foot care and arrange podiatry services for 2 of 2 dependent residents reviewed for foot care. Resident #4 was discovered to have a buildup of skin between her toes and had curled toenails which extended 1.5 inches beyond the base of the nail. Resident #81 was discovered to have thick layers of skin between the toes, thick, dry patches on the bottoms of his feet and long toenails beyond the base of the nail growing into the next toe. (Resident #4 and Resident #81). The findings included:	F 687	1. Center failed to provide Foot Care for Resident #4 and Resident #81. Resident #4 attended podiatry visit on 4/18/24. Resident # 81 was offered foot care/nail care by RN Unit Manager on 4/17/24 and 4/18/24 and refused. 2. Audit completed by Licensed Nurses of current residents to identify those in need of foot care. Any identified residents will be referred to podiatry services. Audit was completed on 5/9/24. All referrals were placed on 5/9/24.	5/16/24

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F 687	Continued From page 14 1. Resident #4 was admitted on 10/19/23 and readmitted 2/2/24. The diagnoses included cognitive impairment, Parkinson's disease, chronic pulmonary obstructive disease, and diabetes. The significant change Minimum Data Set (MDS) dated 2/4/24 coded Resident #4 as having moderate cognitive impairment and he needed assistance with activities of daily living. A care plan focus area dated 2/4/24 revealed Resident #4 was at risk for impairment to skin integrity related to incontinent of bowel and bladder. The goal included risk for injury would be minimized. The interventions included Resident #4 would avoid mechanical trauma of constrictive shoes and cutting/trimming corns/callouses. Review of the podiatry schedule from January 2024 and April 2024 revealed no consultation report or notation was made in Resident #4's chart that she had been seen by the podiatrist or had been scheduled to be seen. Review of Resident #4's skin assessments done by nursing dated 3/13/2024, 3/17/24, 3/28/24 and 3/30/24. There was no information documented about the condition of Resident #4's feet. An observation was conducted on 4/15/24 at 10:15 AM with Resident #4. The resident was in her room seated in a wheelchair pulling her socks off, the big toenails and 2nd toes on both feet were discovered to have a buildup of skin between her toes and had curled toenails which extended 1.5 inches beyond the base of the nail. Resident #4's toenails on both feet were observed to have visible thick layers of what appeared to be dirt and thick layers of skin between the toes, and thick, dry patches on the	F 687	3. Staff Development Coordinator/Designee educated Licensed Nurses on ensuring that residents receive foot care services. Residents that are identified with complex disease processes will be referred to podiatry. Social Services Director/Designee will ensure that referrals are communicated to the podiatry provider. Education will be completed by 5/15/24. Newly Hired Licensed Nurses and Social Services Director will be educated on Foot Care during department orientation by the Staff Development Coordinator/Designee. Audit will be completed with 15 residents per week x 4 weeks, then 10 residents per week x 4 weeks, then 5 residents per week x 4 weeks to ensure they have appropriate foot care. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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bottoms of her feet.

A follow-up observation in conjunction with an interview on 04/16/24 at 10:38 AM revealed Resident #4 's bilateral toenails were long and sharp on the big and second toes. Resident #4 reported her feet were hurting due to the long toenails and has reported the need to see the podiatrist several times to the aides and nursing , but no-one responded. The resident stated her feet had been in this condition since admission. Resident #4 stated staff were not washing her feet regularly.

An observation was conducted of Resident #4 on 4/17/24 at 9:47 AM, in conjunction with an interview with the Director of Nursing from another facility (the current Director was out due to illness) revealed the condition of Resident #4's feet. The Director of Nursing confirmed Resident #4's feet needed to be cleaned and the toenails needed to be cut/trimmed. The Director of Nursing further stated it was the responsibility of the nurse aides to report to nursing when the toenails needed to be cut for all residents, especially diabetic residents. She explained nursing staff were responsible for doing a full head to toe assessment and document on the weekly skin assessment for any changes of the resident's body including the condition of the toenails.

An interview was conducted on 4/17/24 at 9:54 AM, Nurse #7 stated the nursing staff were responsible for doing a head-to-toe assessment of the resident and document any change of condition including the condition of the resident's feet. She was unaware of the condition of Resident #4's feet or the need to see a podiatrist.

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The last skin assessment was on 3/30/24 done by Nurse #7.

An interview was conducted on 4/17/24 at 10:15 AM with the Social Work Director who stated the podiatrist visited the facility every three months and any diabetic resident would be added to the schedule when nursing reported a resident needed podiatry services. The Social Work Director confirmed Resident #4 had not been on the podiatry list for the April visit on 4/11/24. She was unaware the resident needed to be seen by the podiatrist. She further stated nursing was responsible for letting the social work department know when podiatry services were needed.

An interview was conducted on 4/17/24 on 10:30 AM with the Administrator who stated Nurse Aides and nursing were responsible for ensuring residents skin/toenails were being checked and cleaned during personal care and Nurse Aides should report to nursing any resident that needed podiatry services. He explained Nurse Aides could cut resident toenails that were not diabetic and should be cleaned. Nurse Aides should clean and check between toes to ensure the area was thoroughly clean. The Administrator added residents' feet should be checked on all residents when skin assessments were being completed and the condition of the resident's feet/toenails should be reflected on the assessment. The Administrator stated nursing should be notifying the social workers to let them know when a resident needed to be seen by an outside service. In addition, the Administrator added nursing should be cutting residents' toenails in between appointments until the resident could be scheduled.

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An interview was conducted on 4/18/24 at 11:20 AM, Nurse #8 stated she did the weekly skin checks but did not document the condition of the resident's feet or toenails. She explained that unless there was an impairment documented, the form does not advance to document any other condition. The nurse stated if a skin impairment was checked then the full body diagram would come up and nursing would then document what they observed. Nurse #8 confirmed a complete assessment of head-to-toe findings would include the condition of a resident's feet and/or need for podiatry services.

2. Resident #81 was admitted to the facility on 12/26/23. The diagnoses included cognitive impairment, diabetes, hemiparesis, hemiplegia, and cerebral infarction.

Resident #81 was coded on the admission Minimum Data Set (MDS) dated 12/29/23 as having severe cognitive impairment and he needed assistance with activities of daily living.

A focus area on the care plan dated 3/29/23 Yves is at risk for impairment to skin integrity related to decreased mobility. The goal included the resident's risk for injury would be minimized. The interventions included avoid scratching and keep hands and body parts from excessive moisture; encourage good nutrition and hydration to promote healthier skin; and identify potential causative factors and eliminate/resolve where possible.

Review of the podiatry schedule from January 2024 and April 2024 revealed no consultation report or notation was made in Resident #81's chart that he had been seen by the podiatrist or

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had been scheduled to be seen.

Review of 81's head-to-toe skin assessments done by nursing dated 3/4/2024, 3/11/2024, 3/12/2024, 3/18/2024, 3/25/2024, 4/1/2024, 4/6/2024 and 4/8/2024 revealed no documentation of the condition of Resident #81's toenails from either foot, or other concerns regarding the resident's feet.

An observation was conducted on 4/17/24 at 2:45 PM of Resident #81. The resident was lying in bed with their feet exposed from under the covers a strong foul odor was detected near his feet as he moved them around in the bed. Resident #81's toenails on both feet were observed to have visible thick layers of what appeared to be dirt and thick layers of skin between the toes, thick, calcified, dry patches on the bottoms of his feet. The toenails were several inches beyond the base of the nail growing into the next toe.

An observation was conducted 4/17/24 03:28 PM with the Unit Manager #2 of Resident #81's feet. Unit Manager #2 confirmed the condition of the resident's feet had visible thick layers of what appeared to be dirt and thick layers of skin between the toes, and thick, calcified, dry patches on the bottoms of his feet. The toenails were dirty, and a strong foul odor was detected near his feet as he moved them around in the bed.

An interview with Resident #81 was conducted during the observation with Unit Manager #2. Resident #81 stated that he needed his feet checked and cleaned.

During an interview on 4/17/24 at 3:28 PM Unit Manager #2 stated the nurse aides were

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expected to provide foot care during baths/showers, report any change of condition of the resident's feet, and notify the nurse if the resident's toenails needed to be cut/trimmed. She further stated the charge nurse would do a weekly full body assessment on the residents and document any changes, including the condition of the resident's feet, so appropriate referrals could be made. She explained the charge nurse would then provide the social workers with the names of the residents who would need to be seen for podiatry. She indicated the nurses would also document in the physician/nurse practitioner notebook to inform them of the change in the resident foot condition as they would for other concerns. Unit Manager #2 stated she had also done skin checks on Resident #81 but did not document the condition of the resident's feet. The current skin check form only asked 2 questions. She explained, if there was not an impairment with the skin, the form did not allow for other documentation.

During an interview on 4/17/24 at 4:25 PM the Social Worker stated based on her podiatry schedule and list of residents seen in January 2024 and April 2024, Resident #81 was not seen by podiatry. The Social Worker further stated she had not received notification from nursing that Resident #81 needed to be scheduled.

An interview was conducted on 4/17/24 at 4:45 PM, in conjunction with a record review with the Regional Clinical Nurse the current head-to-toe skin assessment form was reviewed. She confirmed the 2 questions on the form did not include the condition of the resident's feet. She stated unless the nurse checked an impairment was observed there was no way of nursing

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F 687	Continued From page 20 documenting foot care or other concerns. The Regional Clinical Nurse further stated if a skin impairment was checked then the full body diagram would come up and nursing would then document what they observed. She indicated it would be expected that nursing checks the condition of resident feet for further evaluation and treatment and do a referral for podiatry care.	F 687		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a performance review every 12 months to provide in-service education based on the outcome of the performance reviews for 3 of 5 nursing assistants (NAs) reviewed (NA # 1, #2, and #3). The findings included: 1a. Review of NA #1's employee file revealed a date of hire of 2/3/2016. The employee file for NA #1 did not include annual performance review documents based on the date of hire including February 2023 and February 2024. b. Review of NA #2's employee file revealed a date of hire of 12/23/2021. The employee file for NA #2 did not include annual performance review	F 730	1. Center failed to complete Yearly Performance Reviews with Certified Nursing Assistants (CNA) #1, #2, and #3. Yearly Performance Reviews were completed with the Administrator on 5/8/24. In-Service Skills training was completed with CNA #1and CNA #3 on 5/9/24 by Staff Development Coordinator. CNA #2 will complete In-Service Skills training by 5/13/24 with the Staff Development Coordinator. 2. An audit was completed by the Staff Development Coordinator/Designee to identify Center staff that have worked for the Center for greater than one year and have not had their Yearly Performance Review completed. Audit to be completed	5/16/24

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F 730	Continued From page 21 documents based on the date of hire including December 2022 and December 2023. c. Review of NA #3's employee file revealed a date of hire of 5/1/2014. The employee file for NA #3 did not include annual performance review documents based on the date of hire including for May 2022 and May 2023. During an interview on 4/18/24 at 3:30 PM, the Staff Development Coordinator (SDC) stated she was hired 2 months ago by the facility and was in-training for the past month. She indicated she was currently doing new employee orientation in-services and competencies. She stated she had not been in the role of SDC for very long and she had not started to review employee training files or started training nursing staff to have started completing annual performance evaluation or review. During an interview on 4/18/24 at 4:25 PM, the Administrator stated Nurse Aides' skills assessment /competencies should be completed at hire and annually. The facility should also have a performance review completed annually to address the needs of staff. The Administrator stated at this time the facility was unable to provide documentation to indicate Nurse Aides' annual performance reviews were completed. The Administrator indicated the skill competencies evaluation and annual performance review should be completed and signed by Staff Development Coordinator (SDC) or her designee. The Administrator stated the facility had some turnover in the SDC position, resulting in not knowing if they were completed as no documentation was available.	F 730	by 5/15/24. Staff Development Coordinator/Designee to complete Yearly Performance Reviews and Skills Competencies with all identified Certified Nursing Assistants. Reviews and Skills In-Service will be completed by 5/15/24. 3. Staff Development Coordinator/Designee to educate Certified Nursing Assistants on required yearly training. Staff Development Coordinator/Designee to educate Clinical Leadership on Yearly Performance Review with required in-service training. Education to be completed by 5/15/24. Newly Hired Certified Nursing Assistants and Director of Nursing will be educated on required Yearly Performance Reviews with In-Service Training by the Staff Development Coordinator. Audit will be completed with 15 Certified Nursing Assistants per week x 4 weeks, then 10 Certified Nursing assistants per week x 4 weeks, then 5 Certified Nursing Assistants per week x 4 weeks to ensure they have completed skills competencies. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is	

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F 730	Continued From page 22 During an interview on 4/18/24 at 4:30 PM, the Regional Clinical Director stated she expected staff competencies and performance review of NA's to be completed annually. She indicated there had been some changes in SDC staffing and currently only new hire competency skills assessments were available. She explained there was an online education program which consisted of learning modules allowing the NAs to receive their 12 hours yearly education. The NA's education was not based on their annual performance review. She indicated the annual skill assessment and performance review documentations were not available at this time.	F 730	necessary to maintain compliance. 5. Person Responsible: Director of Nursing	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §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. §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	F 761		5/16/24

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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 761	Continued From page 23 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to secure medications stored in the room/bathroom for 1 of 1 resident (Resident #62) reviewed for medication storage. The findings included: Resident #62 was admitted to the facility on 08/19/23 with diagnoses that included osteoarthritis, hypertension, chronic pain, and spinal stenosis. Review of Resident #62's physician orders sheet dated April 2024 revealed an order dated 04/11/24 for Nystatin External Powder (Topical)) Apply to skin folds topically two times a day for yeast. On 04/17/24 at 9:53 am an observation of activities of daily living (ADL) care was conducted. After ADL care was provided by NA #3, the NA applied Nystatin powder (used to treat fungal infections of the skin) under Resident # 62's bilateral breast, under abdomen (panniculus), inner thigh creases and between legs. During an interview with NA#3 on 04/17/24 at 10:01am it was indicated she had applied the Nystatin powder to the same areas on Resident #62 after ADL care last week. On 04/17/24 at 12:17 pm an observation was	F 761	1. Center failed to secure medication that was stored in Resident #62 room and bathroom. Medication was removed and secured in the Treatment Cart on 4/17/24 by RN Unit Manager. 2. Audit completed on 5/2/24 by Guardian Angels of center resident rooms for medications not properly secure. Any medications identified were secured immediately. 3. Staff Development Coordinator/Designee educated Licensed Nurses, Certified Nursing Assistants, and Guardian Angels on ensuring that all medications are properly stored. Education to be completed by 5/15/24. Newly Hired Licensed Nurses, Certified Nursing Assistants, and Guardian Angels will be educated on Medication storage during department orientation by the Staff Development Coordinator/Designee Audits will be completed by Guardian Angels of resident rooms 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks to ensure that medications are not stored in resident rooms. 4. Data obtained during the audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345053	A. BUILDING _____ B. WING _____	C 04/18/2024

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F 761	Continued From page 24 conducted in Resident #62 room with Unit Manager #2. Two bottles of Nystatin powder were observed in Resident #62's bathroom, one bottle on her bedside table and 2 bottles in Resident's drawer. During an interview with the Administrator on 04/18/24 at 4:38 pm she indicated it was her expectation medications would not be at beside without physician orders.	F 761	process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	