STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/22/24 through 4/26/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #FIYW11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/22/24 through 4/26/24. Event ID# FIYW11. The following intakes were investigated NC00214582 and NC00213234. 1 of the 7 complaint allegations resulted in deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident	F 600	F600	5/24/24

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

Electronically Signed | 05/23/2024

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F 600	Continued From page 1 interviews, and staff interviews, the facility failed to protect a resident's right to be free from physical abuse when a resident (Resident #8) was punched in the face multiple times with a closed fist by a resident who resided in the Assisted Living Facility (ALF) on the same campus. On the evening of 4/22/24 while in facility's courtyard, Resident #8 and the ALF resident engaged in a verbal disagreement that escalated into a resident-to-resident physical altercation that resulted in Resident #8 sustaining a small laceration to the left upper eye lid. This deficient practice was for 1 of 3 residents reviewed for physical abuse. Findings included: Resident #8 was admitted to the facility on 8/7/2023 with diagnoses including anxiety, depression and non-Alzheimer's dementia. The care plan for Resident #8 dated 12/5/2023 included a focus for manipulative and inappropriate behaviors. Interventions included monitoring and documenting behaviors, not arguing with Resident #8 and talking in a calm voice when disruptive behaviors occurred. The quarterly Minimum Data Set (MDS) assessment dated 2/9/2024 indicated Resident #8 was moderately cognitively impaired, exhibited disorganized thought processes, used a wheelchair and was independent with ambulation for 10 feet, 50 feet, and 150 feet. The MDS did not report Resident #8 displaying any behaviors toward others in the 7-day look back period. An observation conduced on 4/22/2024 at 12:28 p.m. revealed the facility's campus consisted of	F 600	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Unit manager #1 completed a head to toes assessed for resident #8 on 4/23/2024, there were no signs of any injuries. Unit manager #1 consulted the attending physician for resident #8 related to the presence of altered mental status on 4/23/2024. New orders to collect urine to rule out UTI, and blood work to determine the causative factor for the increased agitation obtained. On 4/23/2024, facility staff collected urine from resident #1 and sent it to the lab for analysis. As of 4/24/2024, resident #8 urine analysis shown traces of bacteria, and nitrate with urine culture shown no growth. Resident #8 has shown no aggressive behavior since the incident. On 05/15/2024, resident #8 was assessed by the licensed nurse practitioner to ensure that resident #15 is in an appropriate setting. The nurse practitioner determined that resident #8 was in proper placement. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 100% interview of all residents in the skilled nursing facility who are alert and	

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F 600	Continued From page 2 two separate buildings, the ALF and the Skilled Nursing Facility (SNF) that were connected by a long kitchen corridor. There was a keypad lock on the door to access the SNF from the kitchen corridor. ALF residents entered the SNF through the front entrance. The courtyard was located in the center of the SNF building. An incident report dated 4/22/2024 at 7:00p.m. completed by Nurse #1 reported there was a resident-to-resident altercation outside in the courtyard between Resident #8 and a resident who resided in the ALF. Resident #8 reported he had a disagreement with the ALF resident and then he (the ALF resident) walked up to him and punched him in the eye multiple times. Resident #8 had no complaints of pain and a small abrasion was noted to left eye with bruising. The left eye was cleaned with normal saline, antibiotic ointment and a bandaid was applied. Nursing documentation dated 4/22/2024 at 10:10 p.m. by Nurse #1 reported while Resident #8 was outside in the courtyard, a disagreement occurred between Resident #8 and the ALF resident, who resided in the adjoining Assisting Living Facility (ALF). The two residents were separated and the ALF resident went back to his home at the ALF. Resident #8 reported the ALF resident walked up and punched him in the eye multiple times. Nurse #1 documented treatment was provided to a small abrasion observed to Resident #8's bruised left eye. Nurse #1 further recorded Resident #8 had no complaints of pain, he did not feel threatened, he felt safe at the facility, and stated he did not want to press charges against the ALF resident. Nurse #1 further recorded the Director of Nursing was informed of the incident.	F 600	oriented completed by the facility social worker #1, #2, and #3 on 5/21/24 & 5/22/24 to identify any other resident with an allegation of abuse/neglect, or who allege to be pushed by a staff member. No other resident(s) voiced any allegation of abuse/neglect or allege to be pushed by a staff member. Findings of this audit are documented on a resident abuse interview tool located in the facility compliance binder. 100% interview of residents in the skilled nursing facility who are alert and oriented were completed by the facility social worker #1, #2, and #3 on 5/21/23 & 5/22/24 to identify any other resident with behavior symptoms that may result onto abuse. No other resident identified with behaviors that may result onto physical abuse to another resident. 100% audit of current residents' medical records in skilled nursing facility completed by director of Nursing, Unit coordinator #1, and/or unit coordinator #2 on 5/21/24 & 5/22/24, to identify any other resident with behavior symptoms that may result onto resident-to-resident abuse. No other resident identified to have behaviors that may result onto resident-to-resident abuse. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Effective 5/24/24, the facility will ensure each resident retains the right to be free from abuse, neglect, misappropriation of	

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F 600	Continued From page 3 On 4/24/2024 at 4:44 p.m. in an interview with Nurse Aide #5, she stated when she observed Resident #8 and the ALF resident fighting they were standing up and swinging with closed fists at each other in the courtyard on 4/22/2024. She indicated she ran out to the courtyard and separated the two residents with help of other staff members. She explained she helped Resident #8 back into his wheelchair and had him (Resident #8) report to the nurse's station for treatment of the cut on his left eyelid, and Nurse #4 was informed of the incident. She said she told the ALF resident, who was ambulatory and did not use a mobility device, to go back to the ALF and was escorted by a staff member to the front door of the SNF On 4/23/2024 at 3:45 p.m. in an interview with Nurse #4, she didn't know anything about the altercation between Resident #8 and the ALF resident on 4/22/2024 until Resident #8 came up to the nurse's station requesting something to cover his left eye and stated the ALF resident had hit him. She stated she called Nurse #1 to report the incident. On 4/23/2024 at 3:47p.m. in an interview with Nurse #1, she stated Nurse #4 called on 4/22/2024 at 7:05 p.m. to report the resident-to-resident altercation between Resident #8 and the ALF resident. She said she spoke to Resident #8 on the morning on 4/23/2024 who stated he was fine. She stated Resident #8 reported that although he thought about hitting the ALF resident first, he didn't because he decided violence was not the answer. On 4/23/2024 at 3:55 p.m. during an interview with Resident #8, a half inch laceration to the	F 600	resident property, and/or exploitation, to include freedom from resident-to-resident abuse. This systemic change will be accomplished through the implementation of the following measures: Effective 5/24/24 all new residents will have a behavior assessment completed on admission, re-admission, annually, and with any changes in their behavior status by the licensed nurse. The appropriate measures will be implemented to manage identified behaviors and deescalated such behaviors to prevent resident to resident abuse. Effective 5/24/24, all new resident's medical records will be reviewed for any behaviors that may result in resident-to-resident abuse. Any resident identified with any behavior symptoms will have appropriate interventions to reduce escalation of behaviors that may result in resident-to-resident abuse. This will be reviewed in the daily clinical meeting (Monday through Friday) and be documented on each resident's medical records. Effective 5/24/24, the facility clinical team to include the Director of Nursing, assistant director of Nursing, Unit Manager #1 and/or Unit Manager #2 revised the process of reviewing new admits/readmits in a daily clinical meeting. The revised process includes the provision for behavior assessment, ensuring it is completed, documented, with an appropriate care plan in place. Any discrepancies identified will be	

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F 600	Continued From page 4 outside left eye lid was observed. The area was slightly swollen and observed red coloration to the corner of the left eye and side of his face. Resident #8 stated there were a bunch of people in the courtyard on the evening of 4/22/2024 and explained when he said something to Resident #25 on the other side of the courtyard, Resident #25 told him to mind his own business and that's when the ALF resident got up from the chair and walked over to him and started swinging his fist. He stated the ALF resident hit him several times with his closed fist and he raised his arms to block the punches. He explained he did not know he was bleeding until someone told him and that's when he went back inside from the courtyard to the nurse's station to receive treatment for the cut to the left eye. He stated he felt safe at the facility. Resident #8 denied having any other resident-to-resident altercations in the past with the ALF resident or other residents. On 4/24/2024 at 2:09 p.m. in an interview with Resident #25, she stated the ALF resident, Resident #57 and herself were outside in the courtyard on 4/22/2024 in the evening. She described Resident #8 as being loud verbally although he was sitting on the other side of the courtyard with other SNF residents. She stated when she asked Resident #8 if he could quiet down, he asked her if she could take her hearing aids out. She stated the ALF resident told Resident #8 to come over where he (the ALF resident) was sitting and say that. Resident #8 walked over to where they were sitting and the ALF resident hit Resident #8 several times. She stated Resident #8 and the ALF resident had stopped fighting when she saw staff at the entrance door to the courtyard to help Resident #8 back into the facility. She stated the ALF	F 600	corrected promptly. Finding of this systemic change is documented on the daily clinical meeting report form located on the daily clinical meeting binder. 100% education of all current staff to include full-time, part-time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to; the importance of completing behavior assessment on admission, annually, and with changes of behavior status, abuse prohibition policy and procedures to include resident to resident abuse, the importance of identifying, managing and deescalating resident behaviors to prevent resident to resident abuse, reporting any incident/accident to a licensed nurse, and the requirements to follow up with resident/residents post incident to ensure their physical and psychosocial wellbeing is not affected. This education will be completed by 5/24/24. Any staff members not educated 5/24/24, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new employees effective 5/24/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 5/24/24, the Director of Nursing, Assistant Director of Nursing, and/or Unit	

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F 600	Continued From page 5 resident went back to the ALF where he resided. On 4/23/2024 at 4:21 p.m. in an interview with Resident #57, he stated the ALF resident, Resident #25 and himself were outside in the courtyard talking about the birds on 4/22/2024. He stated Resident #8 butted into their conversation from across the courtyard and the ALF resident told Resident #8 "we didn't need his two-cents worth". Resident #8 told the ALF resident to shut his d*** ear. He stated when Resident #8 started to get up on the other side of the courtyard to walk over to where they were sitting, Resident #57 told Resident #8 not to start anything. He stated the ALF resident got out of his chair and met Resident #8 in the middle of the courtyard and told Resident #8 to "say it again." He explained that was when Resident #8 swung at the ALF resident with a closed fist but did not hit the ALF resident because he moved out of the way. He stated the ALF resident defended himself and punched Resident #8 two to three times with his closed fist in the face. On 4/23/2024 at 2:55 p.m. in an interview with the Resident Care Coordinator of the ALF, she stated when the ALF resident went to the skilling nursing facility (SNF) on 4/22/2024 he was visiting a friend that used to live in the ALF. She explained she was notified by Nurse #1 about the resident-to-resident altercation between the ALF resident and Resident #8 sometime after 6:00 p.m. and was informed the ALF resident had been sent back to the ALF. She described the ALF resident as alert and oriented with some confusion at times (not knowing what town he lived in). He was able to independently perform his activities of daily living. She stated the ALF resident had been in an altercation with another	F 600	Coordinators (#1, #2) will review all new admissions for the last 24 hours or from last clinical meeting to ensure behavior assessment has been completed, and appropriate intervention are implemented to ensure that behaviors are not escalating to cause resident to resident abuse. Any negative findings will be corrected promptly.This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the behavior assessment tool for new residents located in the facility compliance binder. Effective 5/24/24, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will monitor incident/accident reports to ensure resident/residents involved have been assessed to ensure their physical and/or psychosocial wellbeing are not affected. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the incident report monitoring toollocated in the facility compliance binder. Compliance Date: 05/24/24	

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F 600	Continued From page 6	F 600		

resident in the past.

On 4/23/2024 at 3:12 p.m. in an interview with the ALF resident, he stated he went to the SNF to visit Resident #57 and was the at SNF on 4/22/2024. He explained he (the ALF resident) and Resident #57 had gone into the courtyard to smoke and Resident #25 had joined them. He stated when Resident #8 started yelling at Resident #25 to hush, he told Resident #8 to hush and to leave Resident #25 alone. He stated Resident #8 informed the ALF resident that he knew karate and started walking toward him. Resident stated he told Resident #8 to leave him alone but Resident #8 came over to where he was sitting. He explained after Resident #8 swung his arm toward him and missed hitting him, he hit Resident #8 in the head a few times with his closed fist. He stated a nurse (name unknown) came out to the courtyard and directed him to return to his living quarters in the ALF. He stated no one had told him he could not go back to the SNF to visit.

On 4/23/2024 at 4:08 p.m. in an interview with the DON, she stated she was notified by Nurse #1 on 4/22/2024 around 7:00p.m. of the physical resident-to-resident altercation between Resident #8 and the ALF resident. The DON explained residents from the ALF could visit SNF residents and be in the facility courtyard, and the facility was responsible in keeping all residents' safe. She said the ALF resident was sent back to the ALF after the altercation between the residents for the safety of the residents in the SNF, and Nurse #1 spoke with the Resident Care Coordinator at the ALF and informed her that the ALF resident was not allowed to come back to the SNF to visit. The DON stated based on her past

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F 600	Continued From page 7 experiences of abuse, physical abuse was when there was staff to resident abuse. She explained abuse was not when a resident-to-resident physical altercation occurred between two residents with behaviors and impaired judgments. She reported Resident #8 was known to speak stern and loud when talking with others and was not aware of Resident #8 having any past resident-to- resident physical altercations. On 4/23/2024 at 2:55 p.m. in an interview with the Administrator, he stated he was aware of the resident-to-resident physical altercation between Resident #8 and the ALF resident on the evening of 4/22/2024. He explained the ALF resident was the attacker, and Resident #8 was the victim. He stated the ALF resident was cognitively impaired and was not allowed to return to the skilled nursing facility. On 4/26/2024 at 5:40 p.m. in an interview with the Administrator, he stated a resident-to-resident altercation could be considered abuse if the act was performed willfully. He explained with the resident-to-resident altercation on 4/22/2024 resulting in a laceration to Resident #8's eyelid, it indicated willfulness and would be defined as abuse. He stated the nursing staff would need education on how to differentiate resident-to-resident altercations as abuse.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		5/24/24

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F 607	Continued From page 8 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement the facility's abuse policy in the areas reporting, investigating, and/or protection in response to allegations of physical abuse. This deficient practice affected 2 of 3 residents reviewed for abuse (Resident #6 and Resident #8). Findings included: The facility's policy abuse, prevention, intervention, reporting and investigation dated February 2021 defined abuse as willful infliction of	F 607	F607 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/23/2024, Nursing assistant #2 was immediately suspended to allow further investigation of the allegation of abuse/neglect of Resident #6. The allegation of abuse for resident #6 reported to DHHS on 5/23/24.	

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F 607	Continued From page 9 injury resulting in physical harm, pain or mental anguish, and stated abuse may be resident to resident, staff to resident or visitor to resident. The policy stated staff were state mandated reporters and must comply with state regulations regarding reporting suspected abuse with federal regulations regarding reporting any reasonable suspicion of crime against a resident or other individual receiving care by the facility. It stated all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made to the Executive Director of the facility, and other officials (state agency, adult protective services). In addition, local law enforcement will be notified of any reasonable suspicion of crime against a resident in the facility. In staff to resident investigations, the accused employees were to be removed from resident contact immediately and may be suspended from duty until the results of the investigation were reviewed by Human Resource policy. If the investigation should reveal abuse occurred, the Executive Director reports the findings to the local police department, ombudsman, state agency, and other required by state, federal and local laws within required time frame. 1. Resident #6 was admitted to the facility on 1/20/23. Review of Resident #6's Minimum Data Set (MDS) assessment dated 1/19/24 revealed she had moderate cognitive impairment. Review of Resident #6's nursing notes completed by Nurse #5 dated 4/02/24 revealed the resident requested to see the nurse because the nursing assistant (NA) had pushed her into bed. Nurse #5	F 607	On 5/23/24, facility social workers #1 & #2 interviewed resident #6 in relation to the allegation. Resident #6 denied remembering being pushed by a staff member. On 5/23/24 facility social workers #1 & #2 interviewed resident #6 room mate who was present in the room on the date of allegation. The interview focused on identifying any witness account to the allegation. Resident #6 roommate denied any knowledge or witness account to the alleged incident. On 5/23/2024, Director of Nursing completed one on one education for nurse #5 on abuse prohibition policy and procedures to include the importance of reporting the allegation to the Director of nursing and the administrator, importance of suspending the alleged perpetrator until the investigation is completed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 100% interview of all residents in the skilled nursing facility who are alert and oriented completed by the facility social worker #1, #2, and #3 on 5/21/23 & 5/22/24 to identify any other resident with an allegation of abuse/neglect, or who allege to be pushed by a staff member. No other resident(s) voiced any allegation of abuse/neglect or allege to be pushed by a staff member. Findings of this audit are documented on a resident abuse	

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F 607	Continued From page 10 noted Resident #6 said she requested NA #2 and NA #3 to assist her to bed. Resident #6 stated that NA #2 instructed her to get close to the bed and move her bedside table. Resident #6 rolled her wheelchair parallel to the bed. Resident #6 then stated NA #2 got behind her wheelchair and started counting to three. Resident #6 thought that NA #2 was going to help her up by putting her arms under Resident #6's arms to help her stand. Resident #6 said NA #2 pushed Resident #6 out of the chair and she fell across the bed. She stated that both NAs then left the room. Nurse #5 noted Resident #6's room was reassigned to another NA and Nurse #5 had the staff write statements of what occurred. Nurse #5 noted she called the Director of Nurses (DON), left a message, and then texted the DON about the incident. In an interview on 4/26/24 at 1:08 AM, Nurse #5 said she was the night shift supervisor on 4/2/24. Nurse #5 said she was told by Medication Aide (MA) #4 that Resident #6 said she wanted to speak with the nurse. Resident #6 told her (Nurse #5) that the NA pushed her in the midback and Resident #6 fell sideways into the bed. Nurse #5 assessed the situation and had concerns about Resident #6's accusations. There were no injuries or marks on Resident #6's back. Nurse #5 moved Resident #6's room assignment from NA #2 to another NA as a safety precaution. Nurse #5 did not want NA #2 to be hurt or for another accusation to come out against her. Nurse #5 said she called the DON but the call was not answered. Nurse #5 texted the DON as well. The DON called Nurse #5 back approximately an hour or so later. Nurse #5 explained what Resident #6 said and said she moved the NA's room assignment. Nurse #5 said	F 607	interview tool located in the facility compliance binder. 100% audit of current residents' clinical documentation written in the last 30 days completed on 05/21/2024, by Director of Nursing, Unit coordinator #1, and/or Unit coordinator #2 to identify any other incident and/or allegation of abuse, neglect, (to include allegation to be pushed by a staff member). No other incidents or allegation identified as not reported to a nurse for proper follow ups. Findings of this audit are documented on an "incident report audit tool" located in the facility compliance binder. 100% interview of all residents in the skilled nursing facility who are alert and oriented were completed by the facility social worker #1, #2, and #3 on 5/21/23 & 5/22/24 to identify any other resident with behavior symptoms that may result onto abuse. No other resident identified with behaviors that may result onto physical abuse to another resident. 100% audit of current residents' clinical documentation written in the last 30 days completed on 05/21/2024 by director of Nursing, Unit coordinator #1, and/or unit coordinator #2 on 5/20/24 & 5/21/24, to identify any other resident with behavior symptoms that may result onto resident-to-resident abuse. No other resident identified to have behaviors that may result onto resident-to-resident abuse.	

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F 607	Continued From page 11 the DON understood the interventions put in place and did not provide any further guidance or instructions. Nurse #5 was not sure what the abuse policy said because she was a new employee. Nurse #5 said she did not notify the Administrator, just the DON. In an interview on 4/25/24 at 08:35 PM, MA #4 said she was told by NA #2 that night that Resident #6 said someone pushed her. MA #4 did not know details of the incident. MA #4 said that Resident #6 made accusations about a staff member talking to her rudely, saying things such as "I'm not going to babysit you." Resident #6 also confused the day and night shift, blaming one shift about something that happened on the other shift. In an interview on 4/26/24 at 3:54 PM, the DON said she received a missed call at 2:38 AM and a text message at 2:39 AM from Nurse #5 saying to call her when the DON received the message. The DON called Nurse #5 at 5:42 AM and found out Resident #6 alleged staff had pushed her. The DON sent a message to the Administrator at 6:03 AM saying that Resident #6 alleged that staff pushed her. The DON called Nurse #5 again at 6:04 AM and went to the facility. The DON clocked in at the facility at 7:17 AM. The DON spoke with Resident #6, who did not allege that she was pushed, just that the transfer was bad and the staff should be retrained. The DON wanted to address the issue with the resident, who had been going through significant emotional distress due to a family situation, but address it in a way that the staff would feel they were being protected as well. The DON did not want the staff upset at an allegation, which could potentially cause staff to treat Resident #6 with an attitude or	F 607	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Effective 5/24/24, the facility will ensure each resident retains the right to be free from abuse, neglect, misappropriation of resident property, and/or exploitation, to include freedom from resident-to-resident abuse. This systemic change will be accomplished through the implementation of the following measures: Effective 5/24/24 facility employees follow the company abuse prohibition policy and procedures, in the areas to include reporting, investigating, and/or protecting residents in response to allegations of abuse. This will be accomplished by assuring the alleged perpetrator is suspended until the investigation is completed. Effective 5/24/24 all new residents will have a behavior assessment completed on admission, re-admission, annually, and with any changes in their behavior status by the licensed nurse. The appropriate measures will be implemented to manage identified behaviors and deescalated such behaviors to prevent resident to resident abuse. Effective 5/24/24, all new resident's medical records will be reviewed for any behaviors that may result in resident-to-resident abuse. Any resident identified with any behavior symptoms will	

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F 607	Continued From page 12	F 607		

to not want to help her when she needed it. The DON did not feel that a formal investigation was needed because Resident #6 said it was a training concern. If Resident #6 had told the DON she was pushed, it would be considered an allegation of abuse. Due to Resident #6 saying it was a training concern, the DON and Administrator decided to address the issue as a grievance.

In an interview with the Administrator on 4/23/24 at 3:47 PM, he said he was notified of the incident at 6:03 AM. He said the DON went to talk with Resident #6, and the resident told her it was a bad transfer and that staff needed retraining. He said it was a grievance and not an abuse allegation. He said Resident #6 had a history of being manipulative with staff and they felt the grievance was appropriate.

In a further interview with the Administrator on 04/26/24 at 5:41 PM, he said that due to Resident #6 withdrawing her statement about being pushed, the facility did not feel it was an allegation of abuse. The Administrator confirmed that until the time Resident #6 spoke with the DON, Nurse #5 had an allegation from Resident #6 of being pushed at 1:45 AM and he, the abuse prohibition coordinator, was not notified until 6:03 AM. The Administrator acknowledged that he was not notified for more than 4 hours. The Administrator said he did not feel the staff should have been suspended because the statement was retracted. The Administrator confirmed that NA #2 continued working at the facility since the allegation. The Administrator acknowledged and agreed that the facility's abuse policy said when there was an abuse allegation, the staff involved should be suspended. The Administration said no

have appropriate interventions to reduce escalation of behaviors that may result in resident-to-resident abuse. This will be reviewed in the daily clinical meeting (Monday through Friday) and be documented on each resident's medical records.

Effective 5/24/24, the facility clinical team to include the Director of Nursing, assistant director of Nursing, Unit Manager #1 and/or Unit Manager #2 revised the process of reviewing new admits/readmits in a daily clinical meeting. The revised process includes the provision for behavior assessment, ensuring it is completed, documented, with an appropriate care plan in place. Any discrepancies identified will be corrected promptly. Finding of this systemic change is documented on the daily clinical meeting report form located on the daily clinical meeting binder.

100% education of all current staff to include full-time, part-time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but not limited to; the importance of completing behavior assessment on admission, annually, and with changes of behavior status, abuse prohibition policy and procedures to include resident to resident abuse, the importance of identifying, managing and deescalating resident behaviors to prevent resident to resident abuse, reporting any

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F 607	Continued From page 13 one had interviewed Resident #6's roommate or other residents who worked with NA #2 or NA #3 about the incident and about care provided. 2. Resident #8 was admitted to the facility on 8/7/2023. On 4/23/2024 at 2:30 p.m. a review of nursing documentation dated 4/22/2024 at 10:10 p.m. by Nurse #1 reported while Resident #8 was outside in the courtyard, a disagreement occurred between Resident #8 and a resident who resided in the adjoining Assisting Living Facility (ALF). The two residents were separated and the ALF resident went back to his home at the ALF. Resident #8 reported the ALF resident walked up and punched him in the eye multiple times. Nurse #1 documented treatment was provided to a small abrasion observed to Resident #8's bruised left eye. Nurse #1 further recorded Resident #8 did not feel threatened and he felt safe at the facility. Nurse #1 further recorded the Director of Nursing (DON) was informed of the incident. A resident incident report dated 4/22/2024 at 7:00p.m. was completed by Nurse #1 and reported a resident-to-resident altercation. Resident #8 stated he was outside in the courtyard when he had a disagreement with an ALF resident. He stated the ALF resident walked up to him and punched him in the eye multiple times. Resident #8 had no complaints of pain and a small abrasion was noted to his left eye with bruising. On 4/23/2024 at 4:31 p.m. in an interview with Nurse #1, she explained she sent the Administrator a text message at 7:10 p.m. on 4/22/2024 informing him of a resident-to-resident altercation and requested a return call. She	F 607	incident/accident to a licensed nurse, and the requirements to follow up with resident/residents post incident to ensure their physical and psychosocial wellbeing is not affected. This education will be completed by 5/24/24. Any staff members not educated 5/24/24, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new employees effective 5/24/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 5/24/24, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all new admissions for the last 24 hours or from last clinical meeting to ensure behavior assessment has been completed, and appropriate intervention are implemented to ensure that behaviors are not escalating to cause resident to resident abuse. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the behavior assessment tool for new residents located in the facility compliance binder. Effective 5/24/24, the Director of Nursing, Assistant Director of Nursing, and/or Unit	

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F 607	Continued From page 14 stated she did not receive a call from the Administrator and spoke to the Administrator about the incident upon reporting to work before 8:00a.m on 4/23/2024. She stated based on past abuse training resident-to-resident altercations were not considered abuse. On 4/24/2024 at 4:44 p.m. in an interview with Nurse Aide #5, she stated following the incident between Resident #8 and the ALF resident on 4/23/2024 the ALF resident was instructed to return to the ALF section of the facility and not return to the nursing home section of the facility. On 4/23/2024 at 4:08 p.m. in an interview with the DON, she stated Nurse #1 called her around 7:00 pm on 4/22/2024 to report the altercation between Resident #8 and the ALF resident. She explained the two residents were having a verbal altercation in the courtyard that ended up in a physical altercation, and she informed Nurse #1 to notify the Administrator of the incident. She stated it was her understanding that a resident-to-resident altercation due to impaired mental function was not considered abuse and did not require the facility to report to the state agency unlike a staff member hitting a resident. On 4/23/2024 at 2:40 p.m. in an interview with the Administrator, he stated he had not submitted an initial allegation report to the state agency for abuse at the present time because it was an altercation between two residents. He stated since the ALF resident attacked Resident #8 and Resident #8 was the victim, he had 24 hours to report the incident to the Department of Social Services (DSS) under ALF regulations. An Initial Allegation Report for reasonable	F 607	Coordinators (#1, #2) will monitor incident/accident reports to ensure resident/residents involved have been assessed to ensure their physical and/or psychosocial wellbeing are not affected. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the incident report monitoring toollocated in the facility compliance binder. Compliance date 5/24/2024	

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F 607	Continued From page 15 suspicion of a crime related to the incident between Resident #8 and the ALF resident was submitted to the state agency and Division of Social Services on 4/23/2024 at 3:07 p.m. It reported the facility was aware of an incident on 4/22/2024 at 7:00 p.m. when the ALF resident punched Resident #8 in the eye multiple times following a disagreement between the two residents in the courtyard. Resident #6 did not want to press charges and did not feel threatened. The report indicated the incident was reported to the law enforcement on 4/23/24 at 3:04 p.m. In a follow up interview with the Administrator on 4/23/2024 at 4:45 p.m., he explained he became aware of the incident on 4/22/2024 at 7:10 p.m. in a text message. He explained the incident with Resident #8 was not viewed as abuse or a suspected crime since the attacker was from the ALF and not the skilled nursing facility. He explained this did not require the facility to report the incident to the state agency in two hours. On 4/26/2024 at 5:40 p.m. in an interview with the Administrator, he stated a resident-to resident altercation could be abuse and as the Administrator he was responsible for reporting allegations of abuse to the state agency within two hours under the skilled nursing requirements in reporting abuse. He explained with the resident-to-resident altercation resulting in a laceration to Resident #8's eyelid it indicated willfulness and would be defined as abuse.	F 607		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		5/24/24

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F 684	Continued From page 16 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, Responsible Party interview, staff interviews, and a Physician interview, the facility failed to provide wound management to a skin tear that was recorded occurring initially on 3/12/2024 and reoccurring on 3/30/2024 for a resident. The resident's skin tear was reported infected on 4/3/2024 and was treated with antibiotics. There were no treatments for wound care ordered until 4/9/2024, and there were no weekly wound assessments (appearance and measurements of the wound) documented on the skin tear as of 4/26/2024 in the resident's medical record. This deficient practice occurred for 1 of 3 residents reviewed for skin conditions (Resident #118). Findings included: Resident #118 was admitted to the facility on 2/13/2024 with diagnoses including a stroke. The care plan dated 2/23/2024 for Resident #118 included a focus for the risk for skin alterations and recorded there were scabbed wounds to the left lower extremity. Interventions included to assess the skin daily with routine care with baths and showers. Resident #118's care plan also included a focus for a potential in bleeding and bruising due to anticoagulation (receiving	F 684	F684 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 04/09/2024, Treatment nurse #1 assessed resident #118's right lower leg skin tear and obtain an order to clean the area with normal saline or wound cleanser, apply xeroform and cover with a dry dressing every other day. On 4/30/24, Treatment nurse #1 assessed resident #118's right lower leg skin tear to include appearance and measurement. The assessment is documented in resident #118 electronic medical records. On 5/6/24, the treatment nurse obtained a clarification order for treatment of skin tear to right lower leg. The clarification order corrected the wound location to the right lower leg from left lower leg. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 684	Continued From page 17 medications that prevent or break down blood clots) therapy. Interventions included gently handling the skin, observing for signs of bleeding that included changes in skin color, bruising and bleeding, and notifying the physician of bleeding or changes in skin condition. The admission Minimum Data Set (MDS) assessment dated 3/1/2024 indicated Resident #118 was severely cognitively impaired, and there was no limitation of mobility to her lower extremities. The MDS further indicated Resident #118 had no skin conditions. A facility's incident report dated 3/12/2024 completed by Nurse #1 recorded Resident #118 had a small skin tear to right shin after a fall. Nurse #1 recorded the area was cleaned with normal saline, and a dressing was applied. Resident #118's weekly skin assessment since 3/15/2024 reported skin was not intact. Nursing documentation on 3/15/2024 at 4:33 p.m. by unknown nurse reported a right lower leg skin tear was covered with an ABD pad (non-woven thick absorbent dressing) and wrapped with kerlix (a gauze bandage used to dress wounds or absorb fluids) at the request of Resident #118's Responsible Rarty, and Treatment Nurse #1 was notified. Nursing documentation on 3/30/2024 at 6:12 p.m. by Nurse #2 reported the scab of an old skin tear to the right lower leg was removed with some bleeding when Resident #118 slipped out of her wheelchair to the floor. Nurse #2 documented cleansing the right lower leg with wound cleanser and applying a bandage.	F 684	100% of skin inspection for all current residents in the facility conducted on 5/21/2024, by Director of Nursing, Unit coordinator #1, Unit manager #2, and/or treatment nurse #1 to identify any other resident with a skin tear and or skin alteration and validate the proper assessment, orders, and plan of care is initiated and implemented. No other resident identified with a skin alteration without assessment and/or orders. Findings of this audit are documented on a “skin inspection tool” located in the facility compliance binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Effective 5/24/2024, treatment nurse #1, unit coordinator #1, unit coordinator #2, and/or Director of nursing will assess all wound alterations to include skin tear and document the assessment finings in electronic medical records for each resident within 72 hours, and weekly thereafter until the alteration is resolved. The assessment will include appearance and measurement of wounds. 100% education of all current nursing staff to include full-time, part-time, and as needed employees will be completed by the Director of Nursing, Assistant Director of Nursing, treatment nurse #1, and/or Unit Coordinators (#1, #2). The emphasis of this education includes but is not limited	

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F 684	Continued From page 18 Nursing documentation on 4/3/2024 at 5:40 p.m. by Nurse #3 reported Resident #118's Responsible Party reported to Nurse #3 the right lower dressing was coming off. Nurse #3 documented there was serosanguineous drainage observed on the right lower leg dressing, and there was odor from a small open, whitish/yellow area to the right lower leg. Nurse #3 recorded the right lower leg was cleansed with wound cleaner, covered with an ABD pad, and wrapped with kerlix. Nurse #3 documented an order for doxycycline, an antibiotic, was received from Physician #1 for an infected wound. There were no further nursing assessments of Resident #118's right lower leg skin tear wound documented in her medical record. There was no assessment of Resident #118's right lower leg skin tear wound located in the physician progress notes in the medical record. There were no wound treatments recorded for Resident #118's right lower leg on the March 2024 Treatment Administration Record (TAR). A physician order dated 4/3/2024 requested Resident #118 receive doxycycline hyclate (an antibiotic) 100 milligrams(mg) twice a day for ten days for a wound infection. On 4/9/2024, a physician order was written by Treatment Nurse #1 to cleanse skin tear to Resident #118's left (should be right) lower leg with normal saline or wound cleanser, apply xeroform and cover with a dry dressing every other day. Resident #118's April 2024 Medication Administration Record recorded doxycycline hyclate 100mg was administered twice a day	F 684	to, the importance of writing a physician order in electronic medical records when a skin alteration is identified, document the appearance of the alteration in resident in medical records, and communicating all new alterations through the wound communication binder located at each nurse's station. This education also emphasized the importance of completing skin assessment on admission, readmission, weekly and with significant changes. This education will be completed by 5/24/2024. Any nursing staff members not educated by 5/24/24, will not be allowed to work until educated. This education will be provided annually and will be added to the new hire orientation for all new nursing employees effective 5/24/24. Director of Nursing will complete an education for clinical leaders to include, Assistant Director of Nursing, treatment nurse #1, unit coordinator #1 and Unit Coordinator #2. The emphasis of this education includes but not limited to, the importance of ensuring physician orders for wound alteration is completed and followed, skin alteration, to include skin tears, are assessed within 72 hours, and weekly afterwards and documented in electronic medical records. This education will be completed by 5/24/24. Any clinical leader not educated by 5/24/24, will not be allowed to work until educated. This education will be provided annually and will be added to new hire orientation for all new clinical leaders effective 5/24/2024.	

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F 684	Continued From page 19 from 4/4/24 to 4/13/2024. The April 2024 Treatment Administration Record (TAR) recorded Resident #118's left (should be right) lower leg skin tear was cleansed with normal saline or wound cleanser, xeroform was applied and covered with a dry dressing every other day. On 4/26/2024 at 4:10 p.m., Nurse #4 and NA #1 were observed changing Resident #118's right lower leg dressing. An outer right lower leg wound was observed as an oblong shaped superficial area measuring 2 by 1 centimeters (cm) with light pink granulation tissue. An inner right lower leg wound was observed as a linear shaped open area measuring 3 by 1 cm with red granulated tissue. Both areas were cleansed with wound cleaner and patted dry, and xeroform and a kerlix dressing was applied. In an interview with Resident #118's Responsible Party (who was present during the dressing change of the right lower leg) on 4/26/2024 at 4:10 p.m., she stated on 4/3/2024 it was the outer right lower leg wound that was covered with pus. She explained the inner right lower leg wound was there also on 4/3/2024 and became infected later. She explained both wounds were looking better than a couple weeks ago. In a phone interview with Nurse #2 on 4/26/2024 at 3:25 p.m., she explained Resident #118 was on a blood thinner (prevent blot clots) medication and had a dark blue discolored area the size of a baseball to her right lower leg on 3/30/2024. She stated on 3/30/2024, a scabbed area in the center of the dark blue area came off with some bleeding. She explained she cleansed the skin	F 684	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 05/24/24, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all incident reports for the last 24 hours or from last clinical meeting to ensure that any identified skin alteration has had proper follow through to include treatment order and assessment entered in electronic medical records. Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the “incident report monitoring tool” located in the facility compliance binder. Effective 5/24/24, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review treatment communication binders at the daily clinical meeting to ensure that all identified skin alteration were communicated through the binder and followed up promptly (this includes verifying orders and assessment in electronic medical records). This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of	

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F 684	Continued From page 20 tear to the right lower leg with wound cleanser and applied a dressing. She stated she reported Resident #1's skin tear directly to Treatment Nurse #1 verbally. She explained Treatment Nurse #1 was responsible for wound management (assessing the wound, ordering and providing treatments, and evaluating wound care) once a skin tear or wound was communicated. In a phone interview of 4/26/2024 at 6:34 p.m. with Nurse #3, she explained on 4/3/2024 she was not aware of Resident #118's right leg wound until Resident #118's Responsible Party reported the dressing to the right lower leg was off. She described the right lower leg wound as infected with a white material covering the wound. She explained she cleansed the area, applied a dressing and texted the physician. She stated based on her assessment of the wound Physician #1 started Resident #118 on antibiotics and did not order any further wound care. She stated she also notified either Treatment Nurse #1 or Nurse Aide #1 (NA who assisted Treatment Nurse #1 with wound care) who was in the facility at the time, Nurse #1 and the Director of Nursing of the wound. She stated the nursing staff had standard orders for wound care but since Resident #118's right leg wound was infected, she needed more than the standard wound care. She explained it was Treatment Nurse #1's responsibility to assess the wound, determine the type of wound care and obtain a physician order for wound care. In an interview with Nurse #1 on 4/26/2024 at 10:03 a.m., she explained there was a treatment communication binder at the nurse's station to notify Treatment Nurse #1 of changes in a residents' skin, and Treatment Nurse #1 was to assess and order treatments. Nurse #1 stated	F 684	compliance is maintained. Findings of this monitoring process will be documented on the “wound care communication binder monitoring tool” located in the facility compliance binder. Effective 05/24/24, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (#1, #2) will review all new admissions for the last 24 hours or from last clinical meeting to ensure that a skin assessment has been completed, and any alteration of skin to include skin tear has an order and assessment in electronic medical records.Any negative findings will be corrected promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the “skin assessment tool for new residents” located in the facility compliance binder. Effective 5/24/24, the Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. Compliance date 05/24/24	

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there was no documentation in the treatment communication binder Treatment Nurse #1 was notified of Resident #118's right lower leg skin wound.

In an interview with Nurse Aide #1 on 4/26/2024 at 2:37p.m, she explained she helped Treatment Nurse #1 in providing wound care, and Treatment Nurse #1 was responsible for assessing Resident #1 wounds and calling the physician to develop a plan of care. She stated she only provided and documented the wound care as ordered, and since 4/9/2024 when an order was written, she had performed Resident #118's wound care to the right lower leg. She stated she was not able to recall whether she was informed about Resident #118's right lower leg skin tears prior to 4/9/2024.

In an interview with Treatment Nurse #1 on 4/26/2024 at 9:47 a.m., she explained nursing staff were to notify her of skin tears or wounds by recording the wounds in the treatment communication book at the nurse's station, and she couldn't recall the staff notifying her of Resident #118's right lower leg wound. She stated Resident #118's treatments to the right lower leg started (4/9/2024) after she assessed the wounds. Treatment Nurse #1 stated she was unable to recall the exact date of her assessment of Resident #118's right lower leg wound. She stated skin tear wound assessments were not documented in the electric medical record under wound assessments, and she did not have any records documenting the appearance or measurement of Resident #118's right lower leg wounds. She explained when Resident #118's wound became infected that changed the requirement for assessing and documenting of Resident #118's right lower leg wounds, and she

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F 684	Continued From page 22	F 684		

should had assessed and documented Resident #118's right lower leg wounds for wound management weekly in the nurse notes or under wound assessments in the electrical medical record. She stated there were standing physician's orders to use for treatment of skin tears. She explained Resident #118 was not followed by the wound physician and could not say that Physician #1 had seen the wounds to her right lower leg.

In an interview with the Director of Nursing (DON) on 4/26/2024 at 9:45 a.m., she explained the nursing staff were to assess skin tears, apply a dressing and notify Treatment Nurse #1 by recording the skin tear or wound in the treatment communication binder at the nurse's station. She stated Treatment Nurse #1 was to assess the skin tear or wound and initiate wound care as indicated. After reviewing Resident #118's electric medical record, the DON stated she was unable to locate nursing documentation of the weekly assessments (appearance and measurements) of Resident #118's right lower leg skin tear wound by Treatment Nurse #1. She stated there was not a physician order for wound care written until 4/9/2024, and wound care had been documented as provided since 4/9/2024.

In a follow up interview with the Director of Nursing on 4/26/2024 at 5:10 p.m., she recalled discussing Resident #118's use of antibiotics in clinical morning meetings for a comprised skin condition and explained Treatment Nurse #1 missed managing Resident #118's skin tear wound because Nurse #2 did not report the skin injury on the treatment communication book for Treatment Nurse #1, and the skin injury was not visual to the staff due to Nurse #1 applying a

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F 684	Continued From page 23 dressing. She stated nursing staff were to report changes in skin conditions to Treatment Nurse #1 by using the treatment communication book and not verbally communicating the changes because Treatment Nurse #1 could forget about the skin change. She explained based on the facility's plan of correction for wound management Treatment Nurse #1 was monitoring the treatment communication book at the nurse stations for reported changes in residents' skin daily and the shower sheets were checked daily for any new skin conditions observed on residents. The Director of Nursing stated she had not conducted any wound care monitoring to ensure a resident's wound care was initiated and/or conducted as ordered. In a phone interview with Physician #1 on 4/26/2024 at 9:31 a.m., he explained the effects of not assessing and implementing wound care to a skin tear would depend on the appearance of the skin tear wound and said he could not say that Resident #118 not receiving wound care to the right lower leg skin tear caused the skin tear to become infected. He stated when Resident #118's right lower leg was reported infected, she was started on antibiotics. He explained the Treatment Nurse #1 should had assessed Resident #118's open wound initially to implement wound care and continued to assess and document the appearance of Resident #118's right lower leg that would have shown the progression of healing or signs of infection.	F 684		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or	F 745		5/24/24

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F 745	Continued From page 24 maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and a physician interview, the facility failed to schedule an appointment for a urology consult as ordered by the physician for 1 of 1 resident (Resident #17) reviewed for medically related social services. Finding included: Resident #17 was initially admitted to the facility on 9/25/2008 and his latest admission date was 1/22/2024. Resident #17 had diagnoses that included obstructive uropathy. Review of Resident #17's physician's orders showed an order dated 1/23/24 read "follow up with urology". The quarterly Minimum Data Set (MDS) assessment dated 2/1/24 revealed Resident #17 was moderately cognitively impaired, and he had an indwelling catheter. Review of Resident #17's electronic medical record revealed no evidence of a urology appointment after 1/23/2024. An interview conducted on 4/24/24 at 3:19 P.M. with Medical Records Coordinator revealed she was responsible for scheduling appointments for Resident #17. She stated she was made aware residents needed to be scheduled for outside the facility appointments during clinical meetings and when she reviewed physician orders. Medical Records Coordinator stated she scheduled several appointments for Resident #17 and the	F 745	F745 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 04/26/2024, Medical record coordinator scheduled a urology appointment for resident #17. A new appointment is scheduled for 04/29/2024. Resident #17 went to the urology appointment on 04/29/2024, no new orders obtained following that appointment. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 100% audit of current resident clinical documentation for the last three months was completed by medical records coordinator on 5/21/2024, to identify any documented concerns related to missing appointments. No other issues were identified during this audit. Findings of this audit are documented on a “Medical appointment audit tool” located in the facility compliance binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Effective 5/24/24, the facility will provide	

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F 745	Continued From page 25 follow up with urology was overlooked. An interview was conducted on 4/24/24 at 3:38 P.M. with the Director of Nursing (DON) who stated she was unaware Resident #17's appointment had not been scheduled and she explained the appointment should have been scheduled when the physician placed the order. The DON stated when a resident returned to the facility, all follow up appointments for the resident were discussed in the morning clinical meeting. During the interview, the DON stated the Medical Records Coordinator attended the meetings and further explained the follow up appointment information was written down in a book and available to the Medical Records Coordinator if she hadn't attended the meeting. The DON stated she felt as though the appointment for the urologist was overlooked and that's why it hadn't been scheduled. An interview was conducted on 4/26/24 at 10:45 A.M. with the Administrator who stated he expected Resident #17's urology appointment to be scheduled when the order was placed in January 2024. The Administrator stated the appointment was not scheduled because of an oversite. An interview was conducted on 4/26/24 at 9:26 A.M. with the Physician who stated the appointment should have been scheduled when the order was entered for Resident #17 to see the urologist. The Physician stated Resident #17's urology appointment was for evaluation of an enlarged prostate. The Physician further stated the urology appointment wasn't for an imminent problem and the appointment not being scheduled until April did not cause any harm to	F 745	medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident to include ensuring medical related appointments are scheduled and rescheduled in a timely manner. Effective 5/24/24, the facility clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 and/or Unit coordinator #2 initiated a process for reviewing clinical documentation to include the review of medical appointments ordered and/or scheduled in the last 24 hours or from the last held clinical meeting to ensure the appointment is scheduled and take place as ordered. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or Unit coordinator #1/#two. Findings of this systemic change will be documented on the appointment tracking log and maintained in the daily clinical meeting follow up binder. 100% education of all current clinical team members to Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 and/or Unit coordinator #2 completed by the Facility Administrator. The emphasis of this education includes, but not limited to, the importance of ensuring each resident receive medically related social services	

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F 745	Continued From page 26 Resident #17.	F 745	to attain or maintain the highest practicable physical, mental, and psychosocial well-being to include ensuring medical related appointments are scheduled and followed through in a timely manner. The education also emphasized the process of reviewing medical appointments during the daily clinical meeting. This education will be completed by 05/24/24, any clinical team member not educated by 05/24/24, will not be allowed to work until educated. This education is added to new hire orientation for all clinical team members effective 5/24/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 5/24/24, Director of nursing, Assistant Director of Nursing, and/or Unit coordinator #1, Unit coordinator #2, and/or Quality assurance coordinator will monitor compliance with residents' medical appointments by reviewing the appointment logs to ensure completion and proper follow through. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on the appointment monitoring form located in the facility compliance binder.	

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F 745	Continued From page 27	F 745	Effective 5/24/24, the Director of Nursing Assistant, Director of Nursing, and/or medical record coordinator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved. Compliance date: 05/24/24	
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803		5/24/24

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F 803	Continued From page 28 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on a lunch meal tray line observation, staff interviews and record review the facility failed to: 1) ensure there was a pre-approved renal diet menu for 8 of 8 residents on a renal diet; 2) follow the approved pureed diet menu and serve pureed bread to 7 of 7 residents on a pureed diet; 3) serve residents on a mechanical soft diet the correct amount of meat. A 3-ounce scoop of ground meat was served instead of 4 ounces as per the menu; and serve residents the correct portion of potatoes. The facility served only 3 ounces of diced potatoes instead of 4 ounces as per the menu to 106 of 121 residents who ate a regular or mechanical soft diet. The findings included: 1. Continuous observation on 4/24/24 from 11:00 AM - 12:35 PM of lunch service revealed Cook #1 served residents on a renal diet meatloaf without providing a ketchup packet, black eyed peas, and mixed vegetables. In an interview on 4/24/24 at 12:36 PM, Cook #1 confirmed residents on a renal diet received meatloaf without providing a ketchup packet, black eyed peas, and mixed vegetables. Review of the facility's pre-approved Spring/Summer 2024 menu revealed there was no pre-approved diet for residents on a renal diet. Review of the facility Diet Order Roster dated 4/22/24 revealed there were 8 residents on a	F 803	F803 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1. On 4/26/2024, The facility administrator contacted the contracted food vendor and request the revised diet spreadsheet that includes renal diet. On 5/20/24, the revised spreadsheet that includes potassium restricted diet (renal diet) was obtained. New diet spreadsheet implemented in dietary department effective 5/21/24. 2. On 4/26/24, the Certified dietary manager conducted one on one education with a Cook #1 on the importance of following the approved menu and providing pureed bread to residents with ordered pureed diet. 3. On 4/26/24, the Certified dietary manager conducted one on one education with a Cook #1 on the importance of following the approved menu and using correct size scoop (example scoop #8 for ground meats), for residents on mechanical soft diet. 4. On 4/26/24, the Certified dietary manager conducted one on one education	

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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 803	Continued From page 29 renal diet. Review of daily renal diet menu for 4/24/24 revealed residents were to receive meatloaf with no tomato sauce, buttered noodles, and vegetable blend. In an interview on 4/26/24 at 1:25 PM with the Certified Dietary Manager (CDM), she said the facility did not have a pre-approved menu for renal diets. She said the corporation changed food suppliers, and the new food supplier did not provide renal diet menus. The CDM said she and the cooks use their experience in choosing what to serve the residents. The CDM also said they had handouts about what foods were appropriate for renal diets. Review of Foods To Avoid For Renal Diets posting (undated), residents on a renal diet were to not eat dried beans or peas at all due to the amount of phosphorus in the beans. In an interview on 4/27/24 at 4:53 PM, the Registered Dietitian (RD) confirmed the facility did not have a pre-approved renal diet menu. The RD acknowledged black eyed peas could be problematic for renal diet residents due to the level of phosphorus but that she would have to do additional research. 2. Review of the facility's pre-approved Spring/Summer 2024 menu revealed residents on a pureed diet were to receive pureed bread, pureed meatloaf, mashed potatoes, and pureed tomatoes and okra. Continuous observation on 4/26/24 from 11:00 AM - 12:25 PM of lunch service revealed Cook #1	F 803	with a Cook #1 on the importance of following the approved menu and using correct size scoop (example scoop #8 for diced potatoes), for residents on both regular and mechanical soft diet. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/21/24, Certified Dietary Manager reviewed the revised spreadsheet to validate the presence of (potassium restricted diet, (renal diet). The CDM replaced all existing dietary spreadsheets with the revised one that includes renal diet. On 5/21/24, The contracted Registered Dietician reviewed the revised menu and diet spreadsheet that include potassium restricted diet and approved the spreadsheet for nutritional adequacy and equivalency of potassium restricted diet to Renal diet as ordered and used in the facility. 100% inspection of all scoops used in dietary inspected by the Certified dietary manager on 5/21/24 to ensure adequacy of each scoop size per approved menu. Findings of this audit are documented in facility scoop size audit located in facility compliance binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 803	Continued From page 30 served residents a pureed meal. The pureed meal served was pureed meat, mashed potatoes, and pureed okra. In an interview on 4/26/24 at 12:36 PM, Cook #1 said she did not prepare or serve any pureed bread that meal. She said she did not add any bread to any of the pureed food items. She said she normally made the bread but that it was just missed that day. In an interview on 4/27/24 at 4:53 PM, the RD stated the residents on a pureed diet needed the pureed bread served per the menu to consume the calculated number of calories. 3. Review of the facility's pre-approved Spring/Summer 2024 menu revealed residents on a mechanical soft diet were to receive 4 ounces (one #8 scoop) of ground meatloaf. Continuous observation on 4/26/24 from 11:00 AM - 12:35 PM of lunch service revealed Cook #1 served residents on a mechanical soft diet 3 ounces (one #12 scoop) of meatloaf. In an interview on 4/26/24 at 12:36 PM, Cook #1 said she served one scoop of a #12 scoop of ground meat to residents on a standard mechanical soft diet. In an interview on 4/27/24 at 4:53 PM, the RD stated the residents on a mechanical diet needed the correct serving sized served per the menu to consume the calculated number of calories and protein. 4. Review of the facility's pre-approved Spring/Summer 2024 menu revealed residents	F 803	Effective 5/21/24, dietary staff will use the approved-revised spreadsheet that includes potassium restricted diet (renal diet) during all meals. Residents on Renal diet orders will be served based on restrictions listed on potassium restricted column of the spreadsheet. On 05/21/24, the facility Certified Dietary Manager established a process for pre-setting the correct scoop on each served meal at the beginning of the tray line to ensure correct scoop size is used. (CDM, Kitchen manager or cook on duty will sort and select the correct scoop size and place the scoop on top of each meal at the beginning of the tray line. Dietary Employees on the tray line will validate the scoop size and use it to serve meals. 100% education of all current facility Dietary employees to include full-time, part-time, and as needed employees will be completed by the Certified Dietary Manager. The emphasis of this education includes, but not limited to the importance of ensuring the revised approved diet spreadsheet are used, that include renal diet, puree bread is served per preapproved menu, and the correct scoop size is used when serving meals. The education also emphasized the new process to preset the correct scoop size on each food item and validate the scoop size before using the scoop to serve meals. This education will be completed by 05/24/24. Any dietary employee not educated by 05/24/24 will not be allowed to work until educated. This education will	

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F 803	Continued From page 31 on a regular and mechanical soft diet were to receive 4 ounces (one #8 scoop) of diced potatoes. Continuous observation on 4/26/24 from 11:00 AM - 1:15 PM of lunch service revealed Cook #1 served residents on a regular and residents on a mechanical soft diet 3 ounces (one #12 scoop) of diced potatoes. In an interview on 4/26/24 at 1:15 PM, Cook #1 said she served one scoop of a #12 scoop of potatoes to residents on a standard regular and mechanical soft diet. In an interview on 4/27/24 at 4:53 PM, the RD stated the residents needed the correct serving size served per the menu to consume the calculated number of calories.	F 803	be provided annually and will be added on new hire orientation for all new dietary employees effective 05/24/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 05/24/2023, the Dietary Manager, kitchen manager or designee will complete food serving monitoring process by observing tray line on each meal to ensure; residents with renal diet order receive renal diet per revised approved diet spreadsheets, residents on puree diet receive puree bread per preapproved menu, and a correct scoop size is used to serve each food item per menu to ensure nutritional adequacy. This monitoring process will be completed daily for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on Food serving monitoring toollocated in the facility compliance binder. Effective 05/24/2023, the Dietary Manager, kitchen manager or designee will complete food serving monitoring process by observing tray line on each meal to ensure correct scoop size is preset for each food item before serving each meal. This monitoring process will be completed daily for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this	

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F 803	Continued From page 32	F 803	monitoring process will be documented on Food serving monitoring toollocated in the facility compliance binder. Effective 05/24/24, the Dietary Manager and/or Kitchen manager will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved established. Compliance date 05/24/2024	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		5/24/24

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F 812	Continued From page 33 by: Based on observation and staff interviews, the facility failed to prevent ice build-up on boxes of frozen food stored for use in 1 of 1 walk-in freezer. This practice had the potential to affect frozen foods served to residents. The findings were: During an initial tour of the facility kitchen on 4/22/24 at 9:41 AM, it was observed that the pipe from the condenser was insulated and had two large icicles and 3 small icicles attached to it. The largest icicle was attached to a box underneath labeled Green Sweet Peas. Another box of Green Sweet Peas was in front of the other. On the top of the first box, the box flaps were open approximately 2 inches. There were icicles coming from the freezer condenser unit pipe above and reaching the top of the box. There was a large section of ice covering approximately 75% of the boxes top and into the box through the open lid. On the second box of green sweet peas, approximately 25% of the box top was covered in ice. The second box top was open approximately half an inch and the ice was collected below the top of the box. In an observation on 4/24/24 at 1:25 PM with the Certified Dietary Manager (CDM) and Cook #2, the boxes with ice were examined. There were four boxes in total with ice on them. Cook #1 opened the first box of green sweet peas and the peas were in a large storage bag. The bag was not sealed but the top of the bag was folded over on itself. There was ice on top of the folded section of the bag. The second bag of peas was sealed by the manufacturer. There was a box of frozen corn with ice on top of approximately 50%	F 812	F812 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 4/24/24, the four boxes green sweet peas, frozen corn, and asparagus observed with ice covering in walk-in freezer were discarded immediately by the cook #2. On 4/24/24, Facility maintenance director inspected the walking freezer, no leakage identified, he also inspected and adjusted the freezer door lock that was loose, and hence allow air escape from the freezer that resulted on the condensation and ice buildup. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/21/24, Certified Dietary Manager conducted an inspection on all cold/frozen food storing areas to include walking freezer, walking refrigerator, 100 & 500 halls nourishment room refrigerators, to identify any other open food items affected by ice build-up, or icicles. No other food items identified as affected by icicles and/or ice-buildup. Findings of this audit are documented on the food storage audit tool located in the facility compliance binder. On 5/21/24, Facility maintenance director conducted an inspection on all cold/frozen	

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F 812	Continued From page 34 of the top. The flaps of the box top were open approximately 1 inch and there was ice going through the flaps of the top. Cook #2 opened the box and there was ice buildup on the storage bag. The bag was not sealed and the top of the bag was folded over on itself. The third box was labeled asparagus. The asparagus box was stuck with ice onto another box (unable to see label). In an interview on 4/24/24 at 1:35 PM, the CDM said she was not aware of the ice formations on the box or the icicles in the freezer and that she would alert maintenance. Cook #2 said the ice had been there for awhile but she did not know for how long. The CDM confirmed that the leaking pipe and ice in the boxes of vegetables could contaminate the food and had Cook #2 throw out the 4 boxes of food. In an interview on 4/28/24 at 7:00 PM, the Administrator confirmed the boxes should not have the ice on them. The Administrator called the Maintenance Director on his speaker phone. The Maintenance Director said he was not aware of the freezer pipe leaking ice. He said he did checks on the freezer monthly but did not report when he did the last check.	F 812	food storing areas to include walking freezer, walking refrigerator, 100 & 500 halls nourishment room refrigerators, to ensure the equipment's are functioning appropriately with no pipe leakage and/or air escape routes that may result onto condensation and/or ice build ups. All other equipment noted to function adequately. Findings of this audit are documented on the food storage equipment audit tool located in the facility compliance binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 05/22/24, the facility Certified Dietary Manager re-established a cleaning assignment for dietary staff on duty to ensure the cold/frozen food storage locations, to include walking freezer, and walking refrigerator, are cleaned and all open food items are free from ice buildup or icicles. The new cleaning assignment will be used effective 05/23/24. 100% education of all active/current facility Dietary employees to include full-time, part-time, and as needed employees will be completed by the Dietary Manager. The emphasis of this education includes, but not limited to the importance of ensuring the cold/frozen food storage locations, to include walking freezer, and walking refrigerator are cleaned and all open food items are free from ice buildup/icicles. This education	

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F 812	Continued From page 35	F 812	will be completed by 5/24/24, any dietary employee not educated by 5/24/24, will not be allowed to work until educated. This education will be provided annually and will be added on new hire orientation for all new dietary employee employees effective 05/24/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Effective 05/24/2023, the Dietary Manager will complete kitchen monitoring process to ensure food storage locations, to include walk in freezer, are clean and all open food items are free from ice buildup/icicles. Any identified deficiency will be addressed promptly by the dietary manager or designee. This monitoring process will be completed daily Monday through Friday for two weeks, weekly for two more weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on Food storage monitoring toollocated in the facility compliance binder. Effective 05/24/24, the Dietary Manager and/or Kitchen manager will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved established.	

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F 812	Continued From page 36	F 812	Compliance date 05/24/24	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §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	F 867		5/24/24

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adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

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

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F 867	Continued From page 38 resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility's Quality Assessment	F 867	F867 Address how corrective action will be	

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F 867	Continued From page 39 and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee following the recertification and complaint investigation surveys of 2/4/22 and 4/11/23. This was for four deficiencies that were recited on the current recertification and complaint investigation survey of 4/26/24 in the areas of Freedom from Abuse and Neglect (F600), Quality of Care (F684), Provision of Medically Related Social Services (F745), and Food and Nutrition Service (F812). The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F600: Based on record review, observation, resident interviews, and staff interviews, the facility failed to protect a resident's right to be free from physical abuse when a resident (Resident #8) was punched in the face multiple times with a closed fist by a resident who resided in the Assisted Living Facility (ALF) on the same campus. On the evening of 4/22/24 while in facility's courtyard, Resident #8 and the ALF resident engaged in a verbal disagreement that escalated into a resident-to-resident physical altercation that resulted in Resident #8 sustaining a small laceration to the left upper eye lid. This deficient practice was for 1 of 3 residents reviewed for physical abuse. During the recertification and complaint survey of 4/11/23, the facility was cited for failure to protect a severely cognitively impaired resident from	F 867	accomplished for those residents found to have been affected by the deficient practice: As of 5/21/24 facility Quality Assurance Performance Improvement (QAPI) process has put in place measures to address the repeated deficient practice for Freedom from Abuse and Neglect (F600), Quality of Care (F684), Provision of Medically Related Social Services (F745), and Food and Nutrition Service (F812). The plan implemented was approved by the QAPI committee on 5/22/24 to be effective to prevent repeat citation. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/22/2023, the facility Administrator conducted a review annual and complaint surveys for the prior 3 years to review all areas of repeat deficient practice. The review focuses on the action plans implemented to identify whether the repat citation resulted from the same component of regulatory requirements. No other repeat citation identified under the same component of regulatory requirements. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 5/24/24, the facility Administrator will discuss all cited deficiencies from the last annual inspection survey and/or from the complaint investigation sited in the	

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F 867	Continued From page 40 injury of unknown origin. F684: Based on record review, observations, Responsible Party interview, staff interviews, and a Physician interview, the facility failed to provide wound management to a skin tear that was recorded occurring initially on 3/12/2024 and reoccurring on 3/30/2024 for a resident. The resident's skin tear was reported infected on 4/3/2024 and was treated with antibiotics. There were no treatments for wound care ordered until 4/9/2024, and there were no weekly wound assessments (appearance and measurements of the wound) documented on the skin tear as of 4/26/2024 in the resident's medical record. This deficient practice occurred for 1 of 3 residents reviewed for skin conditions (Resident #118). During the recertification and complaint survey of 2/04/22, the facility was cited for failure to recheck a low blood pressure of 72/45 complete and document an admission assessment and vital sign data and failed to assess a resident after a fall before assisting back to bed. During the recertification and complaint survey of 4/11/23, the facility was cited for failure to have a nurse assess a severely cognitively impaired resident from an injury of unknown origin. F745: Based on record review, staff interviews, and a physician interview, the facility failed to schedule an appointment for a urology consult as ordered by the physician for 1 of 1 resident (Resident #17) reviewed for medically related social services. During the recertification and complaint survey of 2/04/22, the facility was cited for failure to ensure	F 867	previous 12 months to ensure the area remains in regulatory compliance. On 5/21/24 Director of Operations has re-educated the Administrator on the facility QAPI procedures for monitoring areas of identified deficient practice and process of removing monitoring of areas due to patterns of compliance, to prevent repeat deficiencies. 100% education of all current facility members of QAPI committee to includes Director of nursing, Assistant Director of nursing (ADON), business office manager, activities director, housekeeping manager, maintenance director, admissions director, medical records, Rehab Director, MDS Coordinators, Quality Assurance coordinator, and Central Supply coordinator, were completed by the facility Administrator. The emphasis of this education includes but is not limited to the contents of QAPI committee and the importance of developing and maintaining appropriate plans to correct identified quality deficiencies to prevent re-occurrences. This education will be completed by 05/24/24, any department head not educated by 05/24/24, will not be allowed to work until educated. This education will be provided annually and will be added on new hire orientation for all new Department heads effective 05/24/24. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	C 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 41 a resident's medical appointment was rescheduled. F812 Based on observation and staff interviews, the facility failed to prevent ice build-up on boxes of frozen food stored for use in 1 of 1 walk-in freezer. This practice had the potential to affect frozen foods served to residents. During the recertification and complaint survey of 2/4/2022, the facility was cited for failure to label, date and close open food items stored in the kitchen refrigerator and freezer. During the recertification and complaint survey of 4/11/2023, the facility was cited for failure to label, date, and/or remove expired food items stored in nourishment rooms. In an interview on 4/26/24 at 06:30 PM, the Administrator said the QAA Committee monitored issues that were cited on previous surveys. However, he believed the issues with the freezer were more related to an equipment failure, which had not been cited before. He reported the QAA Committee had implemented and monitored for the cleanliness of the kitchen.	F 867	Effective 5/24/24 Facility Administrator will review the Plan of Corrections Neglect (F600), Quality of Care (F684), Provision of Medically Related Social Services (F745), and Food and Nutrition Service (F812). during weekly ad hoc QAPI meeting to ensure the monitoring process is effective to attain and maintain compliance and prevent future repeat citation. This monitoring process will be completed weekly for eight weeks, then monthly for three months or until the pattern of compliance is maintained. Findings of this monitoring process will be documented on Quality Assurance monitoring tool located in the facility compliance binder. Effective 05/24/24, the facility administrator will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is achieved established. Completion date: 05/24/24	