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	345172	A. BUILDING _____ B. WING _____	C 05/17/2024

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/13/24 through 05/17/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 8BX711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/13/24 through 05/17/24. Event ID# 8BX711. The following intakes were investigated: NC00201401, NC00202532, NC00203803, NC00203988, NC00204959, NC00205967, NC00206941, NC00207092, NC00207365, NC00207466, NC00207784, NC00207865, NC00207913, NC00208234, NC00208311, NC00208375, NC00208441, NC00208670, NC00208774, NC00209434, NC00209906, NC00210449, NC00211404, NC00211419, NC00212316, NC00212410, NC00213377, NC00213458, NC00214986, NC00215137, NC00215279, NC00216060, NC00216096, NC00216688, NC00216951 21 of the 95 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity D	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but	F 561		6/14/24

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

Electronically Signed | 06/06/2024

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F 561	Continued From page 1 not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to honor a resident's choice to receive showers as scheduled or requested. This was for 1 (Resident #88) of 3 residents reviewed for choices. The findings included: Resident #88 was admitted on 12/4/23 with cumulative diagnoses of atrial fibrillation, cerebral vascular accident with left sided paralysis and chronic obstructive pulmonary disease (COPD). Review of the facility's Recreation	F 561	F561 – Self Determination: Resident #88 was discharged from the facility on 05/27/2024. A quality review was completed by the Director of Nursing and Nurse Manager of current interviewable residents to ensure residents are receiving showers per residents choice by 06/06/24. Care plan, Kardex and shower schedule updated to reflect resident’s shower preference.	

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F 561	Continued From page 2 Comprehensive Assessment dated 12/4/23 read choosing between and bath or shower was very important to him. Resident #88 quarterly Minimum Data Set dated 3/27/24 indicated he had moderate cognitive impairment, exhibited no behaviors, coded for impairment on one side for his upper and lower extremities and set up only for bathing. He was also coded with occasional bladder incontinence and always continent of bowels. Review of Resident #88's care plan last revised on 5/9/24 read he required extensive staff assistance for bathing. There was no care plan for the refusal of showers. An interview was completed with Resident #88 on 5/13/24 at 11:07 AM. His hair appeared to be oily and unwashed. He stated the staff do not give him his showers like they were supposed to. He stated his shower days and time was on Wednesdays and Saturdays on second shift. Resident #88 stated staff never showered him on third shift because he was sleeping at that time. An interview was completed with the Director of Nursing (DON) on 5/14/24 at 9:40 AM. She stated showers were given on first and second shifts only. She stated the only time a shower would be given on third shift would be for a resident with an extreme accident or going to the hospital for a procedure. She provided documentation that Resident #88's shower days were Wednesday and Saturdays on second shift. +Review of December 2023 bathing/shower records indicated Resident #88 received a	F 561	An Ad hoc Quality Assurance Performance Improvement meeting will be held on 06/12/2024 to formulate and approve a plan of correction for the deficient practice. The Director of Nursing or designee will educate all nursing staff on residents' choice related to receiving showers by 06/13/24. The Director of Nursing or Nurse Manager will conduct random quality reviews by resident interviews of 10 residents to ensure residents receive showers per residents choice 2 times per week for 8 weeks and then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated. Date of Compliance: 06/14/24.	

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shower on the following days: 12/6/23, 12/16/24 and 12/20/24.
*12/8/23-documneted for 4:35 AM by Nursing Assistant (NA) #3. A telephone interview was attempted with NA #3 on 5/14/24 at 6:20 PM but the mailbox was full and she was no longer employed by the facility.
There were a total of 3 showers for December 2023 with no documentation of any refusals.

+Review of January 2024 bathing/shower records indicated Resident #88 received a shower on the following days: 1/2/24, 1/3/24, 1/13/24, 1/28/24
There were a total of 4 showers for January 2024 with no documentation of any refusals.

+Review of February 2024 bathing/shower records indicated Resident #88 received a shower on the following days: 2/3/24, 2/10/24
*2/4/24-documented for 12:28 AM, 2/5/24 at 3:59 AM, 2/9/24 at 6:50 AM, 2/11/24 at 5:02 AM and 2/12/24 at 6:59 AM by NA # 5. A telephone interview was attempted with NA #5. Message left but no return calls at the time of exit. She was no longer employed by the facility.
There were a total of 2 showers for February 2024 with no documentation of any refusals.

+Review of March 2024 bathing/shower records indicated Resident #88 received a shower on the following days: 3/16/24, 3/27/24, 3/30/24
*3/8/24-documented for 4:42 AM by NA # 9. A telephone interview was attempted and a message was left for NA #9 on 5/15/24 at 6:44 PM with no return call at the time of exit. She was no longer employed by the facility.
*3/16/24 at 11:59 AM-documented by NA # 7. A telephone interview was attempted to NA #7 but her mailbox was full. At the time of exit, she had

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F 561	Continued From page 4	F 561		

not returned calls to the facility.
There were a total of 3 showers for March 2024 with no documentation of any refusals.

+Review of April 2024 bathing/shower records indicated Resident #88 received a shower on the following days:4/7/24, 4/10/24. 4/27/24
*4/15/24-documented at 3:55 AM and again at 3:57 AM by NA #6. A telephone interview was completed on 5/15/24 at 6:24 PM with NA #6. She stated she documented both showers on 4/15/24 on third shift in error because there were no showers given on third shift unless a resident was extremely soiled and Resident #88 was continent.
*4/28/24-documented at 6:59 AM by NA #6. A telephone interview was completed on 5/15/24 at 6:24 24. She stated it was a documentation error and she did not complete a shower.
There were a total of 3 showers for April 2024 with no documentation of any refusals.

+Review of May 2024 from 5/1/24 to 5/15/24 bathing/shower records indicated Resident #88 received a shower on the following days: 5/1/24, 5/5/24, 5/8/24
*5/3/24-documented at 1:57 AM by NA #6. A telephone interview was completed on 5/15/24 at 6:24 24. She stated it was a documentation error and she did not complete a shower.
*5/5/24 -documented at 12:45 AM by NA #6. A telephone interview was completed on 5/15/24 at 6:24 24. She stated it was a documentation error and she did not complete a shower.
There were a total of 3 showers from 5/1/24 to 5/15/24 with no documentation of any refusals.

An interview was completed on 5/14/24 at 12:19 with Nurse #1. She stated Resident #88 had left

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F 561	Continued From page 5 side paralysis and required staff assistance with some of his activities of daily living (ADLs). She stated he required extensive staff assistance with his showers and was not aware of any shower refusals. An interview was completed on 5/14/24 at 12:31 PM with NA #4. She stated Resident #88 required assistance with his showers, but he refused them at times. She stated his refusals were documented in the task section of the electronic medical record NA #4 also stated the aides were to let the nurse know of any shower refusals. Review of Resident #88's nursing notes from 12/4/23 to 5/15/24 did not include any notes regarding his refusals of his showers. An interview was completed on 5/15/24 at 2:35 PM with NA #1. She stated Resident #88 required extensive staff assistance with showering and rarely refused. An interview completed on 5/15/24 at 3:30 PM with NA #10. She stated Resident #88 did not refuse his showers and looked forward to them. An interview was completed with the Administrator on 5/16/24 at 10:30 AM. He stated Resident #88's shower preference were to honored.	F 561		
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,	F 600		

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F 600	Continued From page 6 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 observations, record and staff interviews the facility failed to protect a resident's right to be free from abuse when Resident #420 struck Resident #133 with a cane. This affected 1 of 9 residents reviewed for abuse. The findings included: Resident #420 was admitted to the facility on 3/19/20 with diagnoses that included post-traumatic stress disorder (PTSD), unspecified psychosis not due to a substance or known physiological condition, insomnia, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) dated 8/4/23 revealed Resident #420 was cognitively intact with no behaviors. Resident #420's Care Plan dated 4/1/20 included the focus area of risk for distressed/fluctuating mood symptoms related to: neurocognitive disorder, encephalopathy, new environment, anxiety, PTSD, new roommate. Interventions included observe for signs of delirium, including delusions/hallucinations; notify physician/advance	F 600	Past noncompliance: no plan of correction required.	

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practitioner as needed; encourage Resident #420 to seek staff support for distressed mood.

Resident #133 was admitted to the facility on 3/2/23 with diagnoses that included unspecified severe dementia with other behavioral disturbance and long term use of aspirin.

Review of the quarterly MDS dated 9/11/23 revealed Resident #133 was severely cognitively impaired with no behaviors.

Resident #133's Care Plan updated 6/11/23 included the focus area of risk for elopement due to history of wandering in residents' rooms. Interventions included divert resident/patient by giving alternative objects or activities and redirect resident/patient if near exits or doorways.

Review of a Facility Reported Incident (FRI) 24-hour report dated 10/13/23 revealed that there was a resident to resident altercation. Resident #133 wandered into Resident #420's room and Resident #420 struck Resident #133 with her cane. Residents were immediately separated. Resident #133 was sent to the emergency room for further evaluation. This allegation type was classified as resident abuse.

A review was completed of the 5-working day investigation report dated 10/18/23. The review revealed staff reported a resident-to-resident altercation. Resident #133 allegedly wandered into Resident #420's room, which startled Resident #420. Resident #420 struck Resident #133 with her cane multiple times. Residents were immediately separated. Police were called, skin assessments were completed, Resident #133 was noted with bruising and was sent to the

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emergency room. Resident #133's family was made aware of altercation. Alleged aggressor (Resident #420) was placed on 1:1 immediately and telehealth psych evaluation was conducted with new orders to send to the emergency room for further evaluation. Upon return of Resident #133 safety checks were initiated. Upon return of Resident #420, room change was completed and 1:1 was initiated. Clinical nurse practitioner, psych nurse practitioner and social work support continued. Resident #420 sustained medication adjustments. Family meeting was held with Assistant Administrator, Social Services Director, Nurse Practitioner, and Director of Nursing on 10/18/23. Allegation was substantiated. Resident #133 was noted as alert and confused, severely impaired, and had a history of dementia with behavioral disturbances, anxiety and care planned for wandering. Resident #420 was noted as alert with history of anxiety disorder, PTSD, psychosis, and major depressive disorder.

A review of the hospital after visit summary on 10/13/23 for Resident #133 revealed there were no bony injuries, computed tomography scan (CT) revealed head and neck without any acute findings. Also, CT of pelvis without any acute findings. Resident #133 had soft tissue trauma to both knees and to the head.

A review of the skin assessment on 10/13/23 for Resident #133 revealed that there was one hematoma above the right eye, one hematoma on the right knee, one hematoma on the left upper thigh, and three hematomas on the left knee.

An observation and interview were conducted with Resident #133 on 5/14/24 at 2:40 PM.

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Resident #133 was sitting in a chair, spoke very low and unable to answer questions.

Resident #420 no longer resided in the facility.

A phone interview was conducted with Nurse #5 on 5/15/24 at 5:28 PM and revealed she didn't witness the incident, but heard some commotion on the hall, when she arrived on the hall the two residents were in the hall and Resident #420 had a cane in her hand and Resident #133 indicated Resident #420 "beat" her. Resident #133 was not crying; she had a knot on her head. The interview further revealed Nurse #5 was familiar with both residents and indicated Resident # 133 would wander around the facility and Resident #420 could be "territorial" of her space. Nurse #5 indicated that both residents were very pleasant, and the incident caught everyone off guard as there had been no altercations before.

A phone interview was conducted with Nurse #6 on 5/15/24 at 5:48 PM and revealed she didn't see the incident, when she saw Resident #420 and Resident #130, they were in the hall and the incident had just occurred. Nurse #6 indicated that Resident #420 indicated she hit Resident #130 because she was startled that she came in her room. Resident #133 wasn't crying, but indicated that her head hurt, Nurse #6 gave Resident #133 acetaminophen. Residents were immediately separated. Resident #133 went to the hospital for evaluation.

An interview was conducted with Nurse Aide #2 on 5/16/24 at 8:10 AM. Nurse Aide #2 revealed she worked the day of the incident, but she was doing patient care with another resident when the incident occurred. She was familiar with Resident

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#133 and worked with her regularly. Nurse Aide #2 indicated that sometimes Resident #133 would wander and if she saw her try to go in other resident's rooms, she would redirect her. Nurse Aide #2 further revealed that to her knowledge, this was the first time either resident had been in an altercation.

An interview was conducted with Nurse #1 on 5/16/24 at 8:18 AM and revealed she was not working on the day of the incident but was familiar and had worked with both residents. The interview further revealed Resident #133 had dementia and sometimes would wander in and out of resident's rooms and in the hall and sometimes, due to her dementia, redirection was a little harder than other times. Resident #420 mostly kept to herself and there was never a problem, until that incident. Nurse #1revealed nothing like this had ever happened and they didn't "see it coming," Resident #420 was protective over her room and things.

An interview was conducted with the Social Worker on 5/16/23 at 8:23 AM and revealed she had worked with both residents and knew them well. Resident #133 had dementia and would wander up and down the halls and was easy to redirect. There had been no incidents like this before and they were "shocked." Resident #420 kept to herself, saw a psychiatrist, and had a state appointed guardian; Resident #420 had experienced trauma in her life. Resident #420 was very neat, and her room was clutter free and she didn't want anyone "messing" in her room, unless they notified her first and then she would usually be okay with it. The Social Worker indicated on the day of the incident, she heard a commotion, because her office was close in

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proximity Resident #420's room and when she walked in the hall Resident #420 was telling Resident #133 to get away. The residents were immediately separated; responsible parties were notified, and police were notified. Police came and interviewed Resident #420 and were unable to interview Resident #133 due to her dementia. No charges were filed against Resident #420 due to her being a ward of the state. Both residents were sent to the hospital for evaluation. Psychiatry was notified and Resident #420 was seen on 10/13/23. Resident #420 had no injuries and Resident #133 had a knot on her head, but she didn't seem to be in any pain.

An interview was conducted with Director of Nursing (DON) and Social Services Director on 5/16/24 at 8:43 AM and revealed they were familiar with both residents. DON revealed Resident #133 had dementia and would wander up and down the halls, Resident #420 was private, but she did like to attend activities. Resident #420 was never known to be aggressive. Interview with DON further revealed that after altercation, residents were immediately separated, and skin checks were performed. Social Services Director indicated Resident #420 had no injuries and Resident #133 had some bruising but had no pain. Both residents were sent to the hospital. Interview further revealed that the DON felt like this could not have been prevented and they had no way of knowing this was going to happen, but after it happened the facility took all measures to ensure safety.

An interview was conducted with the former Administrator on 5/16/24 at 12:15 PM and revealed Resident #133 was pleasantly confused and would harmlessly wander the halls and she

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supposedly wandered into Resident #420's room. Resident #420 was startled, and it appeared that she hit Resident #133 with her cane. Residents were separated and both residents went to the hospital. Resident #133 didn't seem to be in any pain, there was a knot on her head and bruising on her leg. Interview further revealed that Resident #420 had never done anything like this before and they couldn't predict this, the incident was "out of the blue." Resident #420 did indicate that Resident #133 startled her.

The facility implemented the following Corrective Action Plan with a completion date of 10-18-23.

On 10/13/23, Resident #133 with a history of dementia wandered in Resident #420's room resulting in a resident-to-resident physical encounter on 2 south.
10/13/24, the residents were immediately separated upon identification by staff, with an RN physical assessment completed both residents.
10/13/24, the aggressor female resident (Resident #420) was immediately placed on 1:1 and High Point Police Department called. Center arranged immediate FaceTime eval on 10/13/24 from the center psych provider and subsequently sent to hospital for further evaluation.
10/13/24, the victim's family was notified of the physical encounter and was offered room change to a homestead/secured unit which was declined.
10/13/24, the victim (Resident #133) was transferred out of the center post event for further evaluation.
10/13/23, Upon return resident (Resident #133) will be placed on safety checks related to wandering behaviors.

On 10/13/23, Resident #133 with a history of

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dementia wandered in Resident #420's room resulting in a resident-to-resident physical encounter on 2 south. Both residents were immediately separated upon identification by staff, with an RN physical assessment completed. Immediate investigation of concerns began by center leadership the aggressor female resident (Resident #420) was immediately placed on 1:1 and High Point Police Department was called. The facility arranged immediate FaceTime eval on 10/13/24 from the center psych provider and subsequently sent to hospital for further evaluation. The victim's family was notified of the physical encounter and was offered room change to a homestead/secured unit which was declined. The victim (Resident #133) was transferred out of the center post event for further evaluation. Upon return resident (Resident #133) will be placed on safety checks related to wandering behaviors.

On 10/13/23, Resident interviews were conducted on 2 south to identify any other residents with wandering behaviors noted by staff and/or residents, with no other resident identified. Review of residents on antipsychotics was completed to ensure behavior-monitoring tools were in place along with corresponding care task management behavioral monitoring.

10/14/24, Education provided to staff on Behaviors: Management of Symptoms, regarding ensuring resident safety by reporting, identifying, preventing and managing behavioral symptoms and importance of reporting and redirecting wandering residents.

Administrator and/or Director of Nursing will interview five staff members per week for twelve weeks to validate staff knowledge of abuse and

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neglect reporting and notifying the supervisor if conflicts with a resident occur.

Director of Nursing/Social Work or designee to complete 5 random audits weekly with residents and/or staff members to inquire and evaluate interaction/response to wandering and inquire as to any resident behaviors that need to be addressed x 6 weeks. Immediate action to be taken for any positive findings. Results of these audits/interviews will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.

The Administrator will interview five residents with a brief interview of mental status of eight or greater per week for twelve weeks to inquire if they have felt abused or have witnessed or suspected abuse / neglect.

In the monthly Quality Assurance and Performance Improvement Meeting, the Interdisciplinary Team will review all resident to resident / abuse allegations to ensure appropriate interventions are in place and care plan updated x8 weeks.

The Administrator will report the results of the monitoring to the QAPI committee to review audits and make recommendations to assure compliance is maintained ongoing.
QAPI Committee will determine the need for further intervention and auditing beyond three months to assure compliance is sustained ongoing.

The facility's alleged compliance date was 10/18/23.

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F 600	Continued From page 15 The Corrective Action Plan was validated onsite on 5/17/24 and concluded the facility had implemented an acceptable corrective action plan on 10/18/23. Interviews with current nursing staff revealed they received education on and training on abuse, neglect, reporting and resident to resident physical altercations. The audits conducted on 10/13/23 revealed residents were asked about residents with wandering behaviors with no other resident identified. On 5/17/24 there was sufficient evidence to support the facility's Corrective Action Plan that was implemented and carried out by 10/18/23.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		6/14/24

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F 609	Continued From page 16 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report allegations of abuse to Adult Protective Services (APS). This deficient practice was for 3 of 3 residents reviewed for abuse. (Resident # 11, Resident #319, Resident #133). Finding included: a. A review of the Initial Allegation Report for an allegation of misappropriation of property submitted on 5/12/2024 at 2:17 p.m. indicated the facility became aware of an incident on 5/12/2024 at 6:42 a.m. for Resident #11. The allegation details revealed Resident #11 alleged that a staff member took Resident #11's earphones one day last week without permission. The initial report indicated local law enforcement was notified on 5/12/24 at 10:00 am. The initial report did not indicate whether APS was notified. The Investigation Report completed on 5/16/24 for the 5/12/24 incident concerning Resident #11 indicated APS was notified on 5/15/24. During an interview on 5/16/24 at 2:30 PM with the Regional Director of Clinical Services, he indicated that he assisted with a mock survey on 5/9/24 and they identified an issue with the facility not reporting abuse to APS. He educated the	F 609	F609 - Reporting of Alleged Violations: Adult Protective Services (APS) was notified regarding Resident #11's allegation of misappropriation on 05/15/2024. A quality review was completed by the Regional Director of Clinical Services of reportable allegations on 06/03/2024. During the quality review it was identified that Adult Protective Services had not been notified of reportable allegations. An Ad hoc Quality Assurance Performance Improvement meeting was held on 06/12/2024 to formulate and approve a plan of correction for the deficient practice. The Regional Director of Clinical Services educated the Administrator, Assistant Administrator and Director of Nursing on reporting all reportable allegations to Adult Protective Services on 06/03/2024. The Regional Director of Clinical Services will conduct random quality reviews of reportable allegations to ensure all reportable allegations are reported to	

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F 609	Continued From page 17 Administrator, the Assistant Administrator and the Director of Nursing (DON) on the reporting process to APS. During an interview on 5/16/24 3:24 PM with the Administrator he stated once he was made aware of the results of the audit, he initiated performance improvement plan to ensure that all required agencies are contacted per regulatory requirements, and this was completed 5/19/24. He stated that he was unaware that APS was not contacted about Resident #11's report until after the regulatory 24-hour period therefore, past non-compliance (PNC) can't be validated. b. A review of the Initial Allegation Report for an allegation of abuse with no serious bodily injury was submitted on 10/19/23 at 6:12 pm. The report indicated the facility became aware of the incident on 10/19/23 at 9:00 am for Resident #319. The allegation details indicated Resident #319 alleged that a nurse grabbed his arm. The initial report indicated the alleged perpetrator was suspended and law enforcement was notified on 10/19/23 at 9:00 am. The initial report did not indicate that APS was notified. The Investigation Report completed on 10/25/23 for the 10/19/23 incident concerning Resident #319 indicated that APS was not notified. During an interview with the former Administrator on 5/14/24 at 1:15 pm she indicated that she did not know it was a requirement to contact APS and that she did not feel she needed to call APS because the resident was safe in the facility. c. A review of the Initial Allegation Report for an allegation of resident-to-resident altercation with	F 609	Adult Protective Services 2 times per week for 8 weeks and then weekly for 4 weeks. The Regional Director of Clinical Services will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated. Date of Compliance: 06/14/2024.	

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F 609	Continued From page 18 no serious bodily injury was submitted on 10/13/23. The report indicated the facility became aware of the incident on 10/13/23 at 2:45 PM for Resident #133. The allegation details revealed Resident #133 wandered into another resident's room and was struck with a cane by the other resident. Both residents were immediately separated. The report indicated that law enforcement was notified on 10/13/23 at 3:48 PM. The initial report did not indicate that APS was notified. The Investigation Report completed on 10/18/23 for the 10/13/23 incident concerning Resident #133 did not indicate that APS was notified. During an interview on 5/16/24 at 12:15 PM with the former Administrator she indicated that the allegation was not reported to APS because she felt like the resident was safe and did not know that APS was required to be contacted.	F 609		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		6/14/24

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F 657	Continued From page 19 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to revise the comprehensive care plan in the area of staff assistance with dressing and bathing for 1 (Resident #88) of 15 residents reviewed for activities of daily living (ADLs). The findings included: Resident #88 was admitted on 12/4/23 with diagnoses including cerebral vascular accident with left sided paralysis. Resident #88 quarterly Minimum Data Set (MDS) dated 3/27/24 indicated he had moderate cognitive impairment, coded for set-up only assistance with bathing and independence with dressing his upper and lower extremities. Review of Resident #88's ADL care plan last revised on 5/9/24 read he required extensive staff assistance for dressing and bathing. An interview was completed on 5/15/24 at 10:20 AM with Resident #88. He stated he was able to dress himself and independently washed himself	F 657	F657 - Care Plan Timing and Revision: Resident #88 was discharged from the facility on 05/27/2024. A quality review will be completed by the Director of Nursing / Designee on all residents to ensure care plans are revised timely to accurately reflect functional status with dressing and bathing by 06/07/2024. An Ad hoc Quality Assurance Performance Improvement meeting was held on 06/12/2024 to formulate and approve a plan of correction for the deficient practice. The Director of Nursing or designee will educate MDS Nursing staff on accurate and timeliness of care plan revision by 06/13/2024. The Director of Nursing will conduct	

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F 657	Continued From page 20 up in the sink in the room. An interview was completed on 5/15/24 at 2:35 PM with Nursing Assistant (NA) #1. She stated Resident #88 was able to wash up by himself and only required some assistance with setting up the supplies. She also stated he dressed himself independently. An interview was completed on 5/16/24 at 9:30 AM with the MDS Nurse. She stated Resident #88's care plan was last revised with new ADL interventions on 5/9/24. She reviewed her coding for his quarterly MDS dated 3/27/24 in the areas of dressing and bathing. The MDS Nurse stated Resident #88's comprehensive care plan for ADLs should have been revised to reflect his abilities with dressing and bathing. She stated it was an oversight. An interview was completed with the Administrator on 5/16/24 at 10:30 AM. He stated it was the expectation that Resident #88's care plan be an accurate reflection of his functional status.	F 657	random quality reviews of resident care plans to ensure care plans are revised timely to accurately reflect functional status with dressing and bathing on 10 random residents 2 times per week for 8 weeks and then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated. Date of Compliance: 06/14/2024	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews the facility failed to provide nail care to 1 of 7 residents who were dependent on staff for assistance with activities of daily living	F 677	F677 - ADL Care Provided for Dependent Residents Resident #102 was provided nail care to	6/14/24

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F 677	Continued From page 21 (Resident #102). Findings included: Resident #102 was admitted to the facility on 1/27/21 with diagnoses that included a stroke, compressed spinal cord, and contracture of right elbow. Review of the quarterly Minimum Data Set (MDS) dated 3/12/24 revealed Resident #102 was cognitively intact and was assessed as being dependent on staff for personal hygiene. Resident #102's care plan dated 4/2/24 showed he needed assistance with activities of daily living related to quadriparesis from compressed spinal cord. Interventions included provide extensive assistance from one staff member for personal hygiene. An observation was made on 5/13/24 at 1:08 P.M. of Resident #102's fingernails. Resident #102 had a finger nail on his right fourth finger that was approximately 1 inch longer than the tip of his finger, the fingernail on his right fifth finger was approximately ½ an inch longer than the tip of the finger, fingernail on his first finger (thumb) was jagged, and the fingernail on his left third finger was half an inch long on half the nail and ¼ inch long on the other half of the nail where the nail was broken. Residents' right fingernails appeared to have a fungus and the nails had thickened and curved. An interview was conducted on 5/13/24 at 1:08 P.M. with Resident #102 who stated the person who normally cuts his nails had not been at the facility for a while and when they returned, they	F 677	include cleaning and trimming their nails on or by 05/17/2024. A quality review will be completed by the Nurse Manager on current residents on ADL care specific to nail care by 06/07/2024 Identified residents were provided nail care to include cleaning and trimming at that time. An ADHOC Quality Assurance Performance Improvement Committee was held on 06/12/2024 to formulate and approve a plan of correction for the deficient practice. The Director of Nursing or designee will educate all nursing staff on ADL care specific to nail care by 06/13/2024. The Nurse Manager will conduct random Quality Reviews of residents to ensure residents are provided nail care with ADL care on 10 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Nurse Manager will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring (audit) updated as indicated. Date of Compliance: 06/14/2024.	

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were unable to find the tool to cut his nail. Resident #102 stated he was unsure of the employee's name. During the interview, Resident #102 stated he wanted his nails cut and had been asking multiple people to please cut his nails because they had become too long. Resident #102 was unable to recall the names of the staff he had asked to cut his nails.

An observation was made on 5/16/24 at 11:16 A.M. of Resident #102's fingernails. The nails on Resident #102's left hand and been trimmed and smooth. Resident #102's right hand nails were still long and curved.

A follow up interview was conducted on 5/16/24 at 11:16 A.M. with Resident #102 who stated the nails on his right hand were last cut about 3-4 months ago by someone at the facility. Resident #102 explained when he told people his nails needed to be cut and the staff responded We'll try to see about getting someone to trim them and that was as far as it ever got.

An interview was conducted on 5/16/24 at 12:56 P.M. with Nurse Aide (NA) #3 who had been assigned to provide care to Resident #102 5/14/24 through 5/16/24. NA #3 stated she cut Resident #102's nails on Tuesday, 5/14/24. NA #3 stated she was unable to cut Resident #102's right first and third fingernails due to fungus. NA #3 indicated reported to Nurse #2 Resident #102 had fungus on the nails of his right hand. The NA did not state if she reported the length of Resident #102's fingernails.

An interview was conducted on 5/16/24 at 1:15 P.M. with Nurse #2, the assigned nurse for Resident #102 on Tuesday 5/14/24, who stated

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F 677	Continued From page 23 NA #3 had not reported Resident #102's long nails or him having a fungus on his fingernails to her during the shift. An interview was conducted on 5/16/24 at 12:18 P.M. with Unit Manager #1 who explained Resident #102 had a fungus on the nails of his right hand. Unit Manager #1 observed Resident #102's right hand with this writer and stated she was unaware the fourth fingernail on his right hand had grown to approximately one inch or that Resident #102 had requested staff to cut his fingernails. Unit Manager #1 stated staff should have brought this to her attention so his nails could have been trimmed. Unit Manager #1 indicated she was unaware of any employee using a special tool to cut his fingernails and she is unsure why his fingernail had grown this length without staff addressing his concern. An interview was conducted on 5/16/24 at 2:14 P.M. with the Director of Nursing (DON) who stated when Resident #102 had previously told her when his nails needed cutting and she would cut his fingernails. The DON indicated she had not recently cut his fingernails and she was unaware his fingernails had grown that long. During the interview, the DON stated she expected staff to frequently provide residents with nail care to prevent the unwanted growth of nails and when staff were unable to cut Resident #102's fingernails, it should have been reported to a manager so assistance could have been found to ensure his nails were trimmed.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		6/14/24

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F 689	Continued From page 24 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview and Nurse Practitioner interview, the facility failed to provide assistive devices to prevent accidents for 1 of 4 residents (Resident #110) reviewed for falls. Resident #110 fell out of bed, hit her head on the floor, yelled, and screamed of pain, sustaining a 36 centimeters [cm] full thickness curvilinear (crescent) wound to the lateral aspect of the right lower leg and the right first toenail was almost completely avulsed (torn off) with only attachments on the lateral proximal (from the side to the center) nail. Findings included: Resident #110 was admitted to the facility on 05/06/21 with diagnosis that included chronic respiratory failure, morbid obesity, chronic obstructive pulmonary disease (COPD) and hypertension (HTN). Resident #110's Quarterly Minimum Data Set (MDS) dated 09/21/23 revealed she was cognitively intact and with no behaviors. The quarterly assessment further indicated Resident #110 required extensive assistance of two persons physical assist with bed mobility, transfers, and total assistance of two persons physical assist with bathing. The care plan revised on 08/28/23, indicated	F 689	F689 - Free of Accident Hazards/Supervision/Devices: Resident #110 discharged from the facility on 05/15/2024. A quality review will be completed by the Director of Nursing/Nurse Manager of all current residents with side rails/assist rails to ensure accurate orders are present, assessment completed, and care plans have been reviewed and updated by 06/07/2024. An Ad hoc Quality Assurance Performance Improvement Committee will be held on 06/12/2024 to formulate and approve a plan of correction for the deficient practice. The Director of Nursing or designee will educate all nursing staff on ensuring ordered and care planned side rails/assist rails are in place for resident use by 06/13/2024. The Director of Nursing or Nurse Manager will conduct random quality reviews by observation of residents to ensure ordered side rails/assist rails are in place	

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F 689	Continued From page 25 Resident #110 required assistance with activities of daily living (ADL's) and mobility. The goal for this care plan was Resident #110 would improve the level of function in ADL's and mobility. The interventions included transfer/assist rail as an enabler for turning and repositioning in bed. This intervention was initiated on 03/01/23. The admission/readmission nursing documentation version-11 assessment that was completed on 11/23/23 by Nurse #3 at 02:42 pm was reviewed. The documentation indicated that the integumentary system was reviewed and revealed that Resident #110 had no new skin injury /wounds identified. The documentation further indicated that Resident #110 did have a previously noted skin injury/wound of a stage 1 to buttocks that was healing. No other skin injuries/wounds were identified in the assessment. An interview was conducted with Nurse #3 on 05/17/24 at 10:47 am. After a short hospital stay on 11/23/23, Nurse #3 indicated that she physically assessed Resident #110 upon readmission. Nurse #3 indicated her assessment revealed that Resident #110 only had a stage 1 to buttocks that was healing and no other skin injuries/wound. Nurse #3 indicated that stage 1 to buttocks was a preexisting wound. Nurse #3 indicated that Resident #110 did not have any pain on readmission. Review of incident report provided by facility, dated 11/24/23 at 09:04 pm indicated that Resident #110 had an incident in her room. The report indicated that NA #8 called Nurse #4 to Resident #110's room. Report indicated Resident #110 was on the floor closer to the window.	F 689	on 10 residents 2 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated. Date of compliance: 06/14/2024.	

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Report indicated that Resident #110 denied hitting her head. Report indicated an extremely large amount of blood was noted and it was difficult to determine where the blood was coming from. Report indicated Resident #110 was face down and there was difficulty seeing where blood was coming from. Report indicated Resident #110 was repositioned on her back and a large flap of skin 7inches x 8 inches was noted. Report indicated Resident #110 toenail was almost off. Report indicated that Resident #110 stated she kept rolling when her position changed while rolling from back to left side. Report indicated Emergency Medical Services (EMS) called and Resident #110 transported to Emergency Room (ER) for evaluation. Report indicated that Resident #110 description of the incident was "rolled out of bed while being changed."

Review of eInteract (Situation, Background, Assessment and Recommendation) SBAR change in condition evaluation dated 11/24/23 and completed by Nurse #4 at 10:20 pm indicated Resident #110 had a fall and sustained a laceration. The evaluation further indicated that Resident #110 had a new onset of pain with a pain intensity of 10 (rated on a scale of 1-10, with 10 being the worst). The evaluation also indicated that pressure was applied to Resident #110's leg until emergency medical services (EMS) arrived.

Review of progress note dated 11/24/23 at 10:36 pm, written by Nurse #4, indicated that NA #8 called Nurse #4 to Resident #110's room. Nurse #4 note indicated that Resident #110 was on the floor closer to the window. Note further indicated that Resident #110 was facedown, and an extremely large amount of blood noted.

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The eInteract change in condition evaluation guide assessment completed by Nurse #4 on 11/24/23 at 10:57 pm was reviewed. Evaluation indicated that Resident #110 had a fall at night that required sutures to the leg. Evaluation indicated physician orders obtained to transfer Resident #110 to the ER. Evaluation also indicated that Resident #110 had a very large laceration front/lateral right lower leg approximately 8inches x 7 inches and right toenail was hanging off. Evaluation also indicated that Resident #110 pain level was 10 (rate pain on a scale of 0 to 10. 0=no pain, 4-5=moderate pain, 10=excruciating pain). The evaluation indicated the exact location of Resident 110's pain was the right lower leg (front) that had a large flap of skin hanging off leg.

Multiple attempts were made to reach Nurse #4 for an interview were unsuccessful.
Interview was conducted with Resident #110 on 05/13/24 at 02:24 pm. Resident #110 indicated that she could not remember what happened on 11/24/23.

Written statement from NA #8 dated 11/27/2023, used by the facility during their initial investigation, revealed NA #1 was providing ADL care to Resident #110 on 11/24/23 when Resident #110 fell out of bed. NA #8 indicated that she was assisting Resident #110 with turning to the left side of her bed. NA #8 further indicated that Resident #110 usually grabbed the side rail, but on this occurrence, Resident #110 did not grab rail and rolled off bed.

An Interview was conducted with NA #8 on 05/16/24 at 12:52 pm. NA #8 Indicated recalled

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the fall that occurred while she was providing care to Resident #110 on 11/24/23. NA #8 indicated that Resident #110 bed did not have the ¼ bed rails raised in an up position even though it was supposed to. NA #8 indicated after she was done with washing the front side of Resident #110, she proceeded to turn and reposition Resident #110 towards Resident #110 left side. NA #8 stated she informed Resident #110 that she was going to assist her to turn towards Resident 110's left side. NA #8 indicated that she placed her right hand on Resident #110 right hip while her left hand was flipping Resident #110 over. NA #8 indicated that Resident #110 was noted to be reaching out to grab the ¼ bed rail but was not able to because it was not raised to an up position. NA #8 indicated that Resident #110's right leg kept going over while upper body was still in bed. NA #8 indicated she was not able to stop Resident #110 from flipping over. NA #8 indicated that Resident #110 fell out of bed and hit the floor. NA #8 indicated Resident #110 hollered and screamed in pain. NA #8 indicated that Nurse #4 came into Resident 110's room after hearing the hollering and screaming. NA #8 indicated that she did not review the plan of care for Resident #110 prior to providing care. NA #8 indicated that she had worked with Resident #110 multiple times and did not need to review plan of care. NA #8 indicated that she did not raise the ¼ bed rails into an up position, because they are usually up when she comes into Resident 110's room.

Review of emergency department provider note completed on 11/25/23 at 12:35 am indicated that Resident #110 arrived at Hospital via EMS. Note indicated that Resident #110 presented with a large (36cm) full-thickness curvilinear wound to

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the lateral aspect of the right lower leg and the right first toenail was almost completely avulsed with only attachments on the lateral proximal nail. Note further indicated that these injuries occurred when staff were rolling Resident #110 and she fell out of the bed. Note also indicated that Resident #110 hit her head and was complaining of pain at the right first toenail where the nail was partially torn off.

Nurse Practitioner (NP) progress note dated 11/27/23 was reviewed. NP note indicated that Resident #110 was being evaluated following an emergency department visit due to rolling out of bed causing laceration. Note further indicated that Resident #110 was readmitted with staples in her right lower leg and sutures in her right great toe. Indicated that Resident #110 reported increased pain due to injuries.

Interview with NP was conducted on 5/16/24 at 05:01 pm. NP indicated that she evaluated Resident #110 on 11/27/23, after readmission back to facility. Indicated that Resident #110 indicated that she had rolled out of bed. Indicated that Resident #110 required a lot of help with moving in bed. Indicated that Resident #110 returned to facility with staples in her right lower leg and sutures in her right great toe. Indicated that Resident #110 reported increased pain due to injuries and ordered scheduled pain medication three times a day for three days for pain and resumed every 8 hours as needed.

Attempts were made to reach the Medical Director. The administrator indicated that the Medical Director was out of the country and did not have a replacement. Administrator indicated that Nurse practitioner was available.

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F 689	Continued From page 30 An interview was conducted with the Director of Nursing (DON) on 05/17/24 at 12:35 pm. DON indicated that residents should be free from accidents. An interview was conducted with the Administrator on 05/17/24 at 12:51 pm. The Administrator indicated that all residents should be free from incidents and accidents.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and the Medical Director interviews and record review, the facility failed to obtain Physician orders for continuous oxygen for a resident with a diagnoses of chronic obstructive pulmonary disease (COPD) and Emphysema. The facility also failed to adminster oxygen at the ordered rate for Resident #86. This was for 2 (Resident #16 and Resident #86) of 3 residents reviewed for respiratory care. The findings included: 1. Resident #16 was admitted on 1/9/24 with cumulative diagnoses of COPD, Emphysema, shortness of breath and chronic pain syndrome.	F 695	F695 - Respiratory/Tracheostomy Care and Suctioning: Respiratory Therapist evaluated resident #86 and #16 for oxygen need and provided education of oxygen use and safety related to adjusting of flow rate and removal. A clarification order for oxygen was obtained on 06/04/2024 for Resident's #86 and #16. A quality review of residents with oxygen was completed by the Nurse Manager to ensure accurate orders, care plan and	6/14/24

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F 695	Continued From page 31 Review of Resident #16's admission orders dated 1/9/24 on hospice services with orders for continuous oxygen at 2 liters per minute (2L/M) Resident #16 care plan was revised on 2/13/24 for her COPD, bronchitis and Emphysema. An intervention dated 4/11/24 read to administer oxygen as ordered/indicated. She was also care planned revised on 3/5/24 for noncompliance with wearing her oxygen as ordered. The quarterly Minimum Data Set dated 3/22/24 indicated she was cognitively intact, exhibited no behaviors, for hospice services and for the use of oxygen. An interview and observation was completed on 5/13/24 at 12:02 PM. Resident #16 was lying in bed wearing her oxygen with the nasal prongs and tubing below her chin. The oxygen concentrator was running at 2L/M. She denied shortness of breath but stated she required oxygen all the time due to her COPD. Resident #16 stated she removed her oxygen when she went outside to smoke and put it back on when she was done. Resident #16 stated she had been prescribed continuous oxygen since her admission. An interview was completed on 5/14/24 at 12:19 PM with Nurse #1. She stated Resident #16 was originally admitted to the facility on hospice services but the services were discontinued on 2/23/24 because it was determined she was not a candidate for the services. Nurse #1 stated the hospice orders included oxygen at 2L/M continuous admission but when hospice services ended, it was likely her orders for continuous	F 695	flow rate on 06/06/2024. An Ad hoc Quality Assurance Performance Improvement meeting will be held on 06/12/2024 to formulate and approve a plan of correction for the deficient practice. The Director of Nursing or designee will educate current licensed nurses on respiratory care related to oxygen orders, care planning and ensuring residents receive oxygen as ordered by 06/13/2024. The Director of Nursing or Nurse Manager will conduct random quality reviews of residents with oxygen to ensure residents receive oxygen as ordered on 10 random residents 2 times per week for 8 weeks and then weekly for 4 weeks. The Director of Nursing will report the results of the quality monitoring (audit) and report to the Quality Assurance Performance Improvement (QAPI) committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) updated as indicated. Date of Compliance: 06/14/2024.	

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oxygen were missed. Nurse #1 stated Resident #16 was noncompliant with wearing her oxygen and was also known to adjust the flow rate. She stated Resident #16 had been educated numerous times about the risk of increasing her oxygen flow rate.

An interview was completed on 5/14/24 at 12:53 PM with Nurse #2. She stated Resident #16 was ordered continuous oxygen at 2 L/M but she was often noncompliant with wearing it as ordered. When asked to pull up the Physician's order for her oxygen, Nurse #2 stated she thought there were orders for Resident #16's oxygen but apparently there was not. She stated she was on continuous oxygen when she was on hospice but maybe it was discontinued when hospice ended. Nurse #2 stated she or Nurse #1 would contact the Physician for clarification.

An interview was completed on 5/14/24 at 1:05 PM with the Medical Director. He stated he would address Resident #16's lack of oxygen orders and expected there to be orders for her continuous oxygen.

An interview was completed on 5/16/24 at 10:30 AM with the Administrator. He stated it was the expectation that there was Physician orders for the use of continuous oxygen for Resident #16.

2. Resident # 86 was originally admitted to the facility on 4/1/20 with diagnoses that included chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF).

A review of the May 2024 physician orders included a physician's order dated 11/6/23 for oxygen at 4 liters via nasal cannula continuously.

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F 695	Continued From page 33 An annual Minimum Data Set (MDS) assessment dated 4/9/24 indicated Resident #86 was cognitively intact, had shortness of breath when lying flat and utilized oxygen. Resident #86's active care plan, last revised 4/30/24, included a focus area for being at risk for respiratory complications due to history of a tracheostomy, history of respiratory failure and COPD. One of the interventions included oxygen at 4 liters via nasal cannula continuously. On 5/13/24 at 2:20 PM, Resident #86 was observed lying in bed with her eyes closed. The oxygen regulator on the concentrator was set at 4.5 liters flow when viewed horizontally, eye level. Resident #86 was observed sitting up in bed eating her lunch on 5/14/24 at 12:20 PM and indicated she was to be on 4 liters of oxygen and did not adjust the regulator on her own. The oxygen regulator on the concentrator was set at 4.5 liters flow when viewed horizontally at eye level. An observation was made with Nurse #1 of Resident #86's oxygen concentrator on 5/15/24 at 10:25 AM, who stated the oxygen regulator on the concentrator was set at 4.5 liters when viewed horizontally at eye level. Nurse #1 adjusted the flow to administer 4 liters of oxygen as ordered. During an interview with the Director of Nursing on 5/15/24 at 11:37 AM, she indicated it was her expectation for oxygen to be delivered at the ordered rate.	F 695		
F 867 SS=D	QAPI/QAA Improvement Activities	F 867		6/14/24

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F 867	Continued From page 34 CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to	F 867		

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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 resident events, analyze their causes, and implement preventive actions and mechanisms

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F 867	Continued From page 36 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 staff interviews and record review, the facility's Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented effective procedures and monitor	F 867	F867 - QAPI/QAA Improvement Activities: The Executive Director held a Quality Assurance Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 37 the interventions the committee put into place following the recertification and complaint survey dated 07/19/21 and on complaint survey on 04/14/22 for F 677. An F 677 was subsequently recited during the recertification and complaint survey dated 05/17/24. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included. This tag is cross referenced to: F 677:Based on record review, observations, resident, and staff interviews the facility failed to provide nail care to 1 of 7 residents who were dependent on staff for assistance with activities of daily living (Resident #102). During a complaint investigation on 04/14/22, the facility failed to provide personal grooming for hair, face, and nails for 1 of 3 dependent residents. During a recertification and complaint investigation on 07/19/21,the facility failed to provide care for dependent residents for nail care, hair wash, and bathing/showers and for incontinence care for 4 of 9 residents reviewed for activities of daily living (ADL). Interview was conducted with the Administrator on 05/17/23 at 3:25 pm and he indicated that he expected all citations to be monitored through the center's QAPI program. Any repeat citation would require continuous monitoring through monthly QAPI meetings until the deficient practice has been resolved. After resolved, the center would	F 867	meeting on 06/12/2024 with the Interdisciplinary Team (IDT) including the Director of Clinical Services, Assistant Administrator, Social Services, MDS Coordinator, focusing on the areas of F561 Self Determination; F609 Reporting of Alleged Violations; F657 Care Plan Timing and Revision; F677 ADL Care Provided for Dependent Residents; F689 Free of Accident Hazards/Supervision/Devices; F695 Respiratory/Tracheostomy Care and Suctioning; and F867 QAPI/QAA Improvement Activities. The facility Quality Assurance reviewed the new plan of correction for maintaining compliance in these areas. During the Quality Assurance Performance Improvement on 06/12/2024 the Regional Director of Clinical Services along with the Executive Director re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. The Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities will be	

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F 867	Continued From page 38 continue to monitor the resolved issue through its quarterly QAPI meetings. Education would be completed to ensure staff are aware of expectations and these expectations would be tracked by way of auditing.	F 867	corrected as identified by the Executive Director. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by IDT members each month for 12 months. The QAPI Committee will evaluate the effectiveness and amend as needed. Date of Compliance: 06/14/2024.	