STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 08/01/2024

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ROCKY MOUNT REHABILITATION CENTER	**160 S WINSTEAD AVENUE ROCKY MOUNT, NC 27804**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/29/24 through 08/01/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #WVO311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/29/24 through 08/01/24. Event ID# WVO311. The following intakes were investigated NC00204830, NC00204893, NC00207077, NC00208593, NC00211022, NC00211160, NC00211846, NC00212732, NC00212901, NC00214378, NC00214388, NC00214838, NC00215276, NC00215749, NC00215808, NC00215955, NC00216023 and NC00218950. 2 of the 44 complaint allegations resulted in deficiency. The 2567 was amended on 08/14/24 as result of a decision to delete a deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident, Power of Attorney, and staff interviews, observations and record review, the	F 558	Preparation and/or execution of this plan of correction does not constitute	8/23/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/23/2024

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

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F 558	Continued From page 1 facility failed to provide a bariatric shower bed to accommodate the needs of a resident who preferred to take showers. This was for 1 of 2 residents reviewed for accommodation of needs (Resident #68). The findings included: Resident #68 was admitted to the facility on 8/1/22 and readmitted on 4/12/24. Resident #68 was care planned on 8/3/22 for impaired physical mobility and activities of daily living (ADL) self-care performance disease process and fatigue. Interventions included: showers provided on Wednesday and Saturday during the day shift with extensive assistance from 2 members. The most recent comprehensive Minimum Data Set (MDS) assessment, an annual Minimum Data Set (MDS) assessment, dated 8/8/23 revealed that within the resident preferences section, the choice between a tub bath, shower, bed bath, or sponge bath was very important to Resident #68. On 11/14/23 Resident #68's care plan was updated with a concern area related to refusal of care related to history of refusing care and showers. Interventions included: Allow resident to make decisions about treatment regime to provide a sense of control. Encourage as much participation/interaction by the resident as possible during care activities. Give a clear explanation of all care activities prior to and as they occur during each contact. Inform resident about risks of non-compliance. Provide resident with opportunities for choice during care provision.	F 558	admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. A bariatric shower bed was ordered and received on 8/5/24 to accommodate the needs and preference to take showers for Resident #68. On 8/19/24 the Director of Nursing/ designee completed an audit of current residents to determine the appropriate shower bed or chair needed to accommodate the needs and preferences of those identified to want to take showers. The Staff Development Coordinator will provide education to licensed nurses and nursing assistance regarding the importance of accommodating the resident’s needs and preferences to includes taking a shower. If any issues or complications arise that prevent anyone from fulfilling these preferences, it is to be communicated to facility management immediately to be addressed and resolved. This education is to be completed by 8/23/24. The Director of Nursing / designee will audit clinical documentation to validate that showers were offered to residents who prefer them. These audits will be	

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F 558	Continued From page 2 The Medicare 5-day MDS assessment dated 5/7/24 indicated Resident #68 was moderately cognitively intact, exhibited no behaviors and was dependent on staff for bathing and showering. Resident #68's weight value was 228 pounds, and she was 5 feet tall. A nursing note dated 7/14/24 indicated Resident #68 was sent to the emergency department for a change in condition. Review of the hospital discharge summary dated 7/20/24 revealed that Resident #68 was hospitalized from 7/14/24 until 7/20/24. Resident #68's ADL shower/bathing history from 7/20/24 - 7/31/24 revealed that she was only provided with a bed bath during the review period. A phone interview was conducted with Resident #68's Power of Attorney on 7/31/24 at 12:48 PM. He stated Resident #68 wanted a shower on 7/31/24, but she was told that the shower bed was broken, and a shower was not possible. During an observation and interview with Resident #68 on 7/31/24 at 2:09 PM, she revealed that the Director of Nursing (DON) asked her around 8:30 AM if she wanted a shower on 7/31/24. Resident #68 replied "yes", and the DON walked out of the room. Resident #68 then asked Nursing Assistant (NA) #5 if she could use the shower bed and NA #5 told her that it was still broken. She indicated NA #2 was assigned to her and gave her a thorough bed bath, which included a dry shampoo hair wash. Resident #68 indicated that the last time she received a shower was before her hospitalization	F 558	conducted three times a week for four weeks; then weekly times two months. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 558	Continued From page 3	F 558		

on 7/14/24. She stated that she preferred 2 showers per week, and she had not gotten them within the last few weeks. Resident #68 reported showers were very important to her.

On 7/31/24 at 1:37 PM, NA #5, who was assigned to assist residents with showers on 7/31/24, was interviewed. She indicated that the shower bed was not broken; however, it was too narrow and unsafe for Resident #68. She did not indicated how Resident #68 was showered prior to her hospitalization in July. She reported the shower chair was also not an option because Resident #68 could not bend her upper and lower body very well. NA #5 stated that Central Supply was responsible for ordering shower beds. Resident #68 was scheduled for a shower this day, and she wanted her hair washed.

During an interview with Central Supply on 7/31/24 at 1:47 PM, she revealed that the bariatric shower bed was discussed last month with the Administrator, who gave her the "go ahead" to purchase. However, the dimensions would not fit the current shower room. Maintenance was supposed to measure the door of the shower rooms, but she had not heard any updates.

NA #2, who was assigned to Resident #68 during the day shift on 7/31/24, was interviewed on 7/31/24 at 2:29 PM. NA #2 stated that she did not feel that Resident #68 was safe in the current shower bed because she cannot help with rolling and all her weight rests on staff. The last time she received a shower was before her most recent hospitalization on 7/14/24. She did not indicate how Resident #68 was showered prior to the hospitalization. NA #2 stated that Resident #68

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F 558	Continued From page 4	F 558		

told her she was upset that she could not receive a shower this day, so she was given a bed bath, and her hair was washed. She further stated that Resident #68 was adamant about getting a shower and often inquired if the shower bed issue was resolved. Showers were very important to Resident #68.

During an interview with the DON on 7/31/24 at 2:55 PM, she indicated that Resident #68 could not sit in the shower chair because she could not bend well and would slide out of the chair. The DON indicated that there was nothing wrong with the current shower beds. On 7/31/24 around 9:30 AM, she asked Resident #68 if she wanted a shower because it was her scheduled shower day. Resident #68 said she wanted a shower. Then the DON went to get NA #5 and was told the new bariatric shower bed was not in the facility yet. Then the DON inquired with the Administrator about the bariatric shower bed, and the Administrator was going to let her know the status. The last time Resident #68 had a shower was before she went to the hospital on 7/14/24. She did not indicate how Resident #68 was showered prior to the hospitalization. The DON stated that showers were very important to Resident #68.

An interview was conducted with the Vice President of Operations on 7/31/24 2:47 PM. He stated all current shower beds were functional, and he purchased a bariatric shower bed on 7/31/24 as a result of Resident #68.

Review of an invoice dated 7/31/24 revealed that a bariatric manual shower bed was purchased.

The Administrator was interviewed on 7/31/24 at

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F 558	Continued From page 5 3:11 PM. He stated Central Supply had told him within the last few weeks that a new shower bed for larger residents was needed. He instructed her to research bariatric shower beds. Central Supply showed him an option, and he then measured the doorframe, and the measurements would fit the new bed. He was uncertain what happened thereafter. The Administrator stated he agreed with the DON that the current shower bed was not safe for larger residents. He was unaware if showers were very important to Resident #68, but he was aware that her scheduled shower days were Wednesday and Friday. He stated that Resident #68 should have received showers as scheduled.	F 558		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews, and staff interviews, the facility failed to accurately code the resident assessment in the area of hearing for 1 of 27 residents reviewed (Resident #87). The findings included: Resident #87 was admitted to the facility on 7/26/22. The hearing consultation report dated 4/26/23 revealed Resident #87 was seen for a hearing aid service. The left hearing aid was in good working order and the right hearing aid was noted to need	F 641	The MDS assessment dated 7/17/24 for resident #87 was corrected by the facility MDS Coordinator on 8/23/24 to reflect the presence of an assistive device for hearing. An audit was conducted, by the MDS Coordinator, of current residents' most recent MDS assessment to determine if those residents who have assistive hearing devices were accurately coded on their MDS assessments. Those identified as incorrect during this audit will be recorded and corrected by 8/23/24.	8/23/24

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F 641 Continued From page 6
replacement.

The hearing consultation report dated 11/22/23 revealed Resident #87 was seen for a hearing aid fitting of replacement hearing aid.

The hearing consultation report dated 2/21/24 revealed Resident #87 was seen for a hearing aid service visit. The consultation further noted the hearing aids were worn daily and no adjustments were required. The hearing aids were cleaned and checked, and the batteries were changed.

The Minimum Data Set (MDS) quarterly assessment dated 7/17/24 revealed Resident #87 was cognitively intact and was coded for adequate hearing without the use of hearing aids.

Review of the hearing consultation visit list revealed Resident #87 was scheduled to be seen on 8/08/24 for follow-up.

An observation and interview were conducted on 7/29/24 at 12:10 pm with Resident #87. This surveyor was told by Resident #87 to "get close" so he could hear the questions. This surveyor had to be within a few inches of the left ear and speak loud and slow to interview Resident #87. No hearing aids were observed in Resident #87's right or left ear at the time of the observation. Resident #87 stated he was hard of hearing, and he needed to keep the television "very loud" to hear it. Resident #87 stated he did have hearing aids, but he was not sure if he had them any longer.

An interview was conducted on 7/31/24 at 8:47 am with Nurse #1 who revealed Resident #87 was "very" hard of hearing, but she did not think

F 641

The facility Administrator will provide education to the MDS department on the requirement of assessments to be an accurate representation of the resident status, to include coding of assistive hearing devices. This education is to be completed by 8/23/24.

The facility Director of Nursing / designee will conduct an audit of ten sampled MDS assessments to ensure that the use of assistive hearing devices is coded accurately. The audits will be completed weekly times eight weeks, then two times a month for one month. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly times three months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

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F 641	Continued From page 7 Resident #87 had hearing aids. During an interview on 7/31/24 at 2:42 pm with the Medical Records Clerk she revealed Resident #87 had one hearing aid, but Resident #87 reported he did not like to wear it because it did not fit well. She stated Resident #87 had a hearing amplifier (device used to maximize the volume of sound) that he preferred to use in place of the hearing aid. The Medical Records Clerk provided the following items for Resident #87: one hearing aid with clothing clip attached and one hearing amplifier with earphones. An interview was conducted on 7/31/24 at 3:09 pm with MDS Nurse #1 who revealed she did not feel Resident #87 had difficulty hearing when she completed the assessment, and she was not aware of the hearing aids. An interview was conducted on 8/01/24 at 10:03 am with the Administrator who revealed MDS Nurse #1 was able to review Resident #87's hearing consultations on the hard chart (paper records) to ensure the MDS assessment was coded accurately for hearing and hearing aids.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		8/23/24

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F 644	Continued From page 8 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer a resident with newly evident mental health diagnosis for a Preadmission Screening and Resident Review (PASRR) for 1 of 3 sampled residents reviewed for PASRR (Resident #40). Findings included: Resident #40 was admitted to the facility on 06/12/2024 with diagnoses that included major depressive disorder and dementia with and other behavioral disturbances. Resident #40 had a Level I PASRR number upon admission to the facility. The admission 5-day Minimum Data Set (MDS) assessment dated 06/18/2024 had Resident #40 coded as moderately cognitively impaired and was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS assessment further revealed there were verbal behavioral symptoms directed towards others (threatening others, screaming at others, and cursing at others) during the lookback	F 644	A PASARR screening was submitted for resident #40 by the facility Admissions Director on 7/30/24 for reconsideration for level 2. An audit was conducted on 7/30/24 by the Facility Social Worker / designee of facility residents to ensure that no new mental health diagnosis had been added to a resident after their recorded PASARR screening. For those identified to have new mental health diagnosis since their last PASARR screening, they were re-submitted for level 2 screening on 7/30/24 by facility social worker. The facility Administrator provided education to the facility Social Services and Admissions departments explaining the requirements of PASARR screenings being conducted prior to admission to the	

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F 644 Continued From page 9
period.

An additional diagnosis of anxiety disorder was added to Resident #40's cumulative diagnoses on 07/03/2024.

The medical record revealed a PASRR referral was not completed for the newly identified serious mental illness.

The care plan dated 07/19/2024 had a focus area of impaired cognitive function and impaired thought process related to dementia and uses psychotropic medication therapy related to agitation and uses antidepressants for depression and anxiety.

The July Medication Administration Record (MAR) revealed an order for risperidone (a medication used to treat certain mood disorders) oral tablet 0.5 milligrams (mg) every 8 hours as needed (prn) for excessive anxiety and response to internal stimuli (ordered for 14 days) and an order for buspirone (a medication used to treat anxiety disorders) oral tablet 15 mg three times a day for anxiety.

A telephone interview with the Social Worker (SW) was conducted on 08/01/24 at 10:53 AM. The SW stated she oversaw submitting PASRR referrals. When a resident had a new mental health diagnosis the facility she submitted a PASRR application for possible level II screening. Resident #40 had a new mental health diagnosis since her first screening and a new PASRR application was supposed to be submitted. She revealed she should have submitted it after the new diagnosis was identified, but it wasn't due to oversite.

F 644

facility and re- screening of residents identified with new mental health diagnosis. This education will be completed by 8/23/24.

The Director of Nursing /designee will review residents for new mental health diagnosis during clinical morning meeting. Residents identified will be reviewed by social services to determine if PASARR rescreening is needed.

The facility administrator /designee will conduct an audit of 10 sampled residents to ensure that any resident identified with a new mental health diagnosis has been submitted for a re screening of current PASARR. These reviews will be conducted weekly times eight weeks, then monthly times one month. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the facility administrator monthly times three months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

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F 644	Continued From page 10 An interview with the Administrator was conducted on 08/01/24 at 10:39 AM. The Administrator stated Resident #40 had PASRR level I and also had a new mental health diagnosis. The SW who oversaw the PASRRs should have submitted a new PASSR application at the time of diagnosis, but it was not done, and the Administrator did not know why it was not completed.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		8/23/24

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F 657	Continued From page 11 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview, and staff interviews, the facility failed to revise the care plan in the area of hearing difficulties for 1 of 27 residents reviewed for care plan revision (Resident #87). The findings included: Resident #87 was admitted to the facility on 7/26/22. The hearing consultation report dated 4/26/23 revealed Resident #87 was seen for a hearing aid service. The left hearing aid was in good working order and the right hearing aid was noted to need replacement. The hearing consultation report dated 11/22/23 revealed Resident #87 was seen for a hearing aid fitting of replacement hearing aid. The hearing consultation report dated 2/21/24 revealed Resident #87 was seen for a hearing aid service visit. The consultation further noted the hearing aids were worn daily and no adjustments were required. The hearing aids were cleaned and checked, and the batteries were changed. Review of the care plan last reviewed 6/11/24 did not reflect interventions for hearing impairment for Resident #87. The Minimum Data Set (MDS) quarterly assessment dated 7/17/24 revealed Resident #87 was cognitively intact and was coded for	F 657	The care plan for resident # 87 was reviewed and updated by the facility MDS Coordinator on 8/23/24 to reflect the usage of an assistive device to address hearing difficulties. An audit was conducted, by the MDS Coordinator, of residents identified with the usage of assistive device to address hearing difficulties to ensure that residents care plans reflected the device. The audit is to be completed by 8/23/24. The facility Administrator will provide education to the MDS and social services department regarding residents identified with assistive devices for hearing must be included in the care plan. This education is to be completed by 8/23/24. The facility Director of Nursing / designee will conduct an audit of five residents that are identified with assistive hearing devices to ensure that the devices are reflected on the care plan. The audit will be completed weekly times eight weeks, then two times a month for one month.	

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adequate hearing without the use of hearing aids.

An observation and interview were conducted on 7/29/24 at 12:10 pm with Resident #87. This surveyor was told by Resident #87 to "get close" so he could hear the questions. This surveyor had to be within a few inches of the left ear and speak loud and slow to interview Resident #87. No hearing aids were observed in Resident #87's right or left ear at the time of the observation. Resident #87 stated he was hard of hearing, and he needed to keep the television "very loud" to hear it. Resident #87 stated he did have hearing aids, but he was not sure if he had them any longer.

During an interview on 7/30/24 at 2:20 pm with Nurse Aide (NA) #4 she revealed she was able to communicate with Resident #87 by speaking loudly. NA #4 stated she did not know Resident #87 had hearing aids or a hearing amplifier.

An interview was conducted on 7/31/24 at 8:47 am with Nurse #1 who revealed she worked with Resident #87 often and stated he was "very" hard of hearing. Nurse #1 stated Resident #87 did not have a hearing aid that she was aware of.

During an interview on 7/31/24 at 2:42 pm with the Medical Records Clerk she revealed Resident #87 had one hearing aid, but Resident #87 reported he did not like to wear it because it did not fit well. She stated Resident #87 had a hearing amplifier (a device used to maximize the volume of sound) that he preferred to use in place of the hearing aid. The Medical Records Clerk provided the following items for Resident #87: one hearing aid with clothing clip attached and one hearing amplifier with earphones.

Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly times three months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

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F 657	Continued From page 13 An interview was conducted on 7/31/24 at 3:09 pm with MDS Nurse #1 who revealed all nursing staff were able to revise a resident care plan at any time. She stated MDS reviewed all care plans during the quarterly care plan meeting, but she was not aware Resident #87 had hearing aids to add appropriate interventions to the care plan. During an interview on 7/31/24 at 3:33 pm with the Director of Nursing (DON) she revealed the MDS Nurse was responsible for revisions to Resident #87's care plan. The DON stated the care plan should have been updated to reflect Resident #87's hearing aid use when Resident #87 was assessed by the MDS Nurse during the quarterly assessment. An interview was conducted with the Administrator on 8/01/24 at 10:03 am who revealed the MDS Nurse was responsible for Resident #87's care plan revisions.	F 657		
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 record review, observations and staff	F 695	Orders for oxygen and respiratory	8/23/24

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F 695	Continued From page 14 interviews, the facility failed to obtain an order for oxygen and respiratory therapy for 1 of 2 residents reviewed for respiratory care (Resident #86). Findings included: Resident #86 was admitted on 3/15/2022. Her diagnoses included acute respiratory failure, and tracheostomy (a surgically created hole made on the front of the neck into the windpipe to help with breathing). a. Resident #86's care plan related to impaired gas exchange/ineffective airway clearance related to respiratory failure and tracheostomy initiated on 3/15/2022 and last revised on 6/30/2022 included interventions for tracheostomy care and Respiratory Therapy. No interventions for oxygen use were included. Resident #86's most recent quarterly Minimum Data Set (MDS) assessment dated 6/10/2024 indicated she received tracheostomy care, suctioning and respiratory therapy. Oxygen use was not noted. Review of Resident #86's June and July 2024 Physician Orders did not include orders for oxygen use. The June and July 2024 Medication Administration Records (MARs) were reviewed and included: monitor oxygen saturation (O2 sat) every shift and notify provider if oxygen saturation less than 90% (normal range is 95-100%), tracheostomy care every shift, and suctioning every eight hours as needed. An observation of Resident #86 was conducted	F 695	therapy were obtained and entered for resident # 86 by the facility Director of Nursing on 8/1/24. The facility Director of Nursing / designee will conduct an audit of facility residents' clinical chart to ensure orders have been obtained for residents identified as receiving oxygen and or respiratory therapy. The audit and all corrections are to be completed by 8/23/24. The facility Staff Development Coordinator / designee will provide education to facility licensed nurses to ensure that any resident requiring oxygen or respiratory therapy has a physician order to administer. The education is to be completed by 8/23/24. The Director of Nursing / designee will conduct audits of resident's clinical charts to ensure that those receiving oxygen and respiratory therapy have adequate orders in place. These audits will be conducted weekly times eight weeks, then monthly times one month. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of	

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on 7/29/2024 at 10:54 AM. She was observed lying in bed with no difficulty breathing. A tracheostomy collar mask (allows for oxygen delivery) was in place, with tubing attached to a humidifier and an oxygen concentrator set to deliver 2.5 liters of oxygen per minute.

An interview with Nurse #2 was conducted on 7/31/2024 2:57 PM. Nurse #2 explained the monitoring of Resident #86's oxygen was noted on the MAR. She explained Resident #86 had been receiving oxygen at 3 liters a minute via tracheal collar for as long as she could remember, her O2 sats were stable, and she did not adjust the oxygen rate.

On 7/31/2024 at 3:28 PM Nurse #2 was observed checking Resident #86's oxygen saturation which was 96%.

On 8/01/2024 at 10:19 AM an observation of Resident #86 revealed no difficulty breathing, the tracheostomy and dressing appeared clean, tracheal collar mask was on, and the oxygen was set at 2.5 liters a minute.

An interview with MDS Nurse #1 was conducted on 8/01/2024 at 11:35 AM. She stated oxygen use was not counted on the MDS assessment because it had not been documented as used. She explained if she had noticed Resident #86 was receiving oxygen, and had no documentation, she would have addressed this to get the orders straightened out.

An interview with the Director of Nursing (DON) was conducted on 8/01/2024 at 11:57 AM. She explained Resident #86 had been in and out of the hospital several times and had been receiving

Nursing monthly times three months. At that time, the QA & A/QAPI committee will evaluate the effectiveness three months to determine if continued auditing is necessary to maintain compliance.

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oxygen since admission. She stated she was unsure how this order had been missed.

b. Resident #86's care plan related to impaired gas exchange/ineffective airway clearance related to respiratory failure and tracheostomy initiated on 3/15/2022 and last revised on 6/30/2022 included interventions for tracheostomy care and Respiratory Therapy.

Review of Resident #86's June and July 2024 Physician Orders did not include an order for Respiratory Therapy.

Resident #86's most recent quarterly Minimum Data Set (MDS) assessment dated 6/10/2024 indicated she received tracheostomy care, suctioning and respiratory therapy.

The most recent Respiratory Therapy note in the medical record dated 7/10/2024 at 5:29 PM indicated Resident #86 was resting comfortably in bed with the trach collar on (holds the tracheostomy tube in place) with oxygen bled in (oxygen attached).

An interview with Nurse #2 was conducted on 7/31/2024 2:57 PM. Nurse #2 explained the Respiratory Therapist visited Resident #86 several times a month.

An interview with the Director of Nursing (DON) was conducted on 8/01/2024 at 11:57 AM. She explained Resident #86 had been in and out of the hospital several times and had been receiving respiratory therapy since admission. The DON reviewed Resident #86's physician orders and explained an order for respiratory therapy should be part of the physician's standing orders, but it

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F 695	Continued From page 17 wasn't. She stated she was unsure how this order had been missed.	F 695		
F 868 SS=C	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §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: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality	F 868		8/23/24

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F 868	Continued From page 18 assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews, the facility failed to have the Infection Preventionist in attendance for 1 of 6 quality assessment and assurance (QAA) committee meetings. This could affect 110 of 110 residents. The findings include: A review of the facility "Monthly Meeting Agenda & Calendar" QAA sign in sheets from January through July 2024 revealed the Infection Preventionist (IP) was not present for the meeting held on 6/28/24. On 8/1/24 at 2:02 PM, the IP verified that she was not present for the 6/28/24 meeting due to illness. During an interview on 8/1/24 at 1:10 PM, the Administrator revealed that the IP might not have been in the facility or forgot to sign the Monthly Meeting Agenda & Calendar sign in sheet. There was no documentation of her participation because the committee was just reviewing the plans present at that time.	F 868	The facility administrator held a Quality Assessment and Assurance meeting on 8/23/24 to review the minutes of the QA & A/QAPI meeting that was held on 6/28/24, the Infection Preventionist Nurse was in attendance. The facility administrator received education by the Vice President of Operation regarding the Infection Preventionist Nurse is required to attend all facility Quality Assessment and Assurance meetings. The facility administrator will review the facility Quality Assessment and Assurance meetings from January through July 2024 to ensure that the Infection Preventionist Nurse was in attendance for each meeting. The review will be completed by 8/23/24. The facility administrator will provide education to facility Quality Assessment and Assurance committee team members that the Infection Preventionist Nurse of the facility is required to attend all meeting, attendance will be monitored going forward to ensure compliance by administrators. The education will be completed by 8/23/24.	

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F 868	Continued From page 19	F 868	The facility Administrator will perform a review of Quality Assessment and Assurance Committee minutes to ensure that Infection Preventionist Nurse was in attendances monthly times three months. Data obtained during the audit process will be analyzed for patterns and trends and reported to the Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly times three months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	