STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK ROAD HENDERSON, NC 27537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		12/31/24

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

Electronically Signed | 12/24/2024

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to have a process for EP collaboration with local, tribal, regional, State, and Federal EP officials, failed to have emergency official contact information listed, and failed to provide annual training for the emergency prep training program. The findings included: A review of the facility's Emergency Preparedness (EP) plan was conducted on 12/05/24 and revealed the following: a) The EP plan did not include any documentation regarding a process for EP collaboration with local, tribal, regional, State, and Federal EP officials' efforts to maintain an integrated response during a disaster or emergency situation. b) The EP plan revealed the facility did not have emergency officials contact information for Federal, State, tribal, regional or local emergency preparedness staff. c) The EP plan revealed no documentation regarding annual training to staff, or contracted providers. An interview was conducted on 12/05/24 at 10:44	E 001	No resident was affected by this deficient practice All residents have the potential to be affected by this deficient practice. On 12/9/24 the administrator updated the EPP to include documentation regarding a process for collaboration with local, tribal, regional, state and federal EP officials to maintain an integrated response during an emergency. The facility has updated the contact list for these officials. On 12/11/24 the Administrator initiated annual education of the Emergency Preparedness plan to staff and providers that include testing exercises, activation of the Emergency preparedness plan, and community-based exercises. Documentation to be retained for record keeping. To protect residents from similar occurrences, on 12/18/2024 the Regional Director of Clinical Services re-educated the Administrator regarding the requirements on maintaining a comprehensive Emergency Preparedness Plan. Monitoring will be done by the Regional	

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E 001	Continued From page 2 am with the previous Maintenance Manager who revealed she started at the facility approximately 6 months prior and was responsible for the Emergency Preparedness (EP) Plan. The previous Maintenance Manager stated she did not have any information regarding the process of EP collaboration or emergency officials' contact information because she was not aware that was required. The Maintenance Manager stated she had not provided any training to facility staff regarding the EP Plan. During an interview with the Administrator on 12/05/24 at 10:57 am she revealed she was new to the facility and stated she was unable to locate any documentation that annual training was provided to the facility staff. The Administrator stated she did not have the emergency officials contact information or the process for EP collaboration.	E 001	Director of Clinical Services or designee to monitor and ensure that through observation and review, a comprehensive Emergency Preparedness Plan is maintained. This monitoring process will take place weekly for 4 weeks then monthly for 2 months. The Regional director of Clinical Services or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/02/24 through 12/05/24. Event ID# Y9ZD11. The following intakes were investigated NC00218681, NC00219613, and NC00219912. 8 of the 8 complaint allegations did not result in deficiency.	F 000		
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:	F 641		12/31/24

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F 641	Continued From page 3 Based on observations, record reviews, resident interview, and staff interviews the facility failed to correctly code the Minimum Data Set (MDS) assessment in the areas of falls and restraints for 2 of 23 residents whose MDS assessments were reviewed for accuracy (Residents #45 and #23). The findings included: 1. Resident #45 was admitted to the facility on 6/12/23 with diagnoses that included osteoarthritis, dementia, and a history of a stroke. An incident report dated 8/5/24 at 5:37pm stated Resident #45 was observed laying on the floor in front of her personal recliner. The note stated Resident #45's lower extremities had normal range of motion and were without pain. The facility Nurse Practitioner (NP) was notified and an order for an x-ray of the Resident's left hip was received. The quarterly MDS dated 9/29/24 revealed Resident #45 was severely cognitively impaired and was coded no for any falls since admission/entry, reentry, or prior assessment. The review further revealed the questions regarding the number of falls and major injury since admission/entry, reentry or prior assessment sections were disabled. An interview was completed on 12/4/24 at 10:46am with the MDS Nurse. The Nurse stated the MDS assessment was coded inaccurately and should have been coded for 1 fall with a major injury. An interview was completed on 12/5/24 at 10:01am with the Director of Nursing (DON). The	F 641	Residents #45 and #23 were affected by this deficient practice. A modification of MDS dated 9/29/24 for resident #45 was completed on 12/4/24 to reflect a fall had occurred. A modification for MDS dated 10/31/24 for resident #23 was completed on 12/4/24, to reflect that resident did not have a restraint. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: A 100% audit was completed on 12/20/24 by the DON coordinator to ensure that all side rails and falls were accurately coded on the MDS. No other inaccuracies were identified. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 12/05/2024 the Director of Nursing reeducated the MDS nurse regarding the need for accurate coding on the MDS to reflect the use of side rails and falls. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Director of Nursing or designee will audit five MDS weekly for twelve weeks to ensure any side rails or falls are accurately coded.	

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F 641	Continued From page 4 DON stated the MDS assessment was coded in error. The DON stated the MDS Nurse had completed a modification to the inaccurate MDS assessment on 12/5/24. An interview was completed on 12/5/24 at 11:09am with the facility's Administrator. The Administrator stated it was her expectation that the MDS assessment be coded correctly and reflect an accurate picture of the Resident. 2. Resident #23 was admitted to the facility on 11/30/21. Resident #23 had an active physician order dated 12/31/21 for 1/4 bed rails to be used as assist device for bed mobility only. The care plan last reviewed on 5/27/24 revealed Resident #23 had an activities of daily living self-care performance deficit related to limited mobility with an intervention of 1/4 side rails to assist with bed mobility. The Minimum Data Set (MDS) quarterly assessment dated 10/31/24 revealed Resident #23 was cognitively intact and was coded for physical restraints noted as bed rails, used daily. An observation and interview were conducted on 12/02/24 at 11:34 am with Resident #23. The bed was noted to have 2 upper side rails in place. Resident #23 stated she used the side rails to move and turn herself when she was in bed. A telephone interview was conducted on 12/04/24 at 8:15 am with MDS Nurse #2 who stated when a resident used side rails for mobility they were not to be coded as a restraint. MDS Nurse #2	F 641	The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 641	Continued From page 5 stated she must have made an error when she coded Resident #23's side rails as a restraint. During an interview on 12/05/24 at 9:40 am with the Director of Nursing (DON) who revealed Resident #23 used the side rails to allow for turning and repositioning in bed and they should not have been coded as restraints. An interview was conducted with the Administrator on 12/05/24 at 10:44 am who revealed the MDS Nurse was responsible to ensure the resident assessments were coded accurately.	F 641		
F 657 SS=E	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	F 657		12/31/24

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F 657	Continued From page 6 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 record review and staff interviews, the facility failed to conduct quarterly reviews of resident care plans for 5 of 23 resident care plans that were reviewed (Resident #23, Resident #6, Resident #9, Resident #8, and Resident #45). The findings included: 1. Resident #23 was admitted to the facility on 11/30/21 with chronic obstructive pulmonary disease (COPD) and osteoarthritis. A review of Resident #23's care plan revealed the most recent review date of 7/30/24 and no further reviews or updates had been completed. The Minimum Data Set (MDS) quarterly assessment dated 10/31/24 revealed Resident #23 was cognitively intact. An interview was completed on 12/3/24 at 10:03 am with the Director of Nursing (DON) who revealed she was both the MDS Nurse and the DON for the facility. She stated she was responsible for reviewing resident care plans. The DON verified Resident #23's care plan review was overdue. The DON stated she was aware the resident care plans were behind, and she was working on getting them completed. An interview was completed on 12/5/24 at 11:07	F 657	Corrective action for resident(s) affected by the alleged deficient practice: Residents 23, 6,8,9 and 45 was affected by this deficient practice. care plans were updated for these residents on 12/20/24. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: An audit was completed by the Director of Nursing on 12/20/24 to ensure all care plans are up to date. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 12/5/24 the Director of Nursing educated the MDS nurse on the importance of timely care plans. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: The Administrator or designee will review the Care plan schedule weekly for twelve weeks to ensure all residents have care	

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F 657	Continued From page 7 am with the Administrator who revealed she was not aware the resident care plans were not being reviewed. The Administrator stated the MDS Nurse was responsible to review and update resident care plans as required. 2. Resident #6 was admitted to the facility on 5/31/18 with diagnoses which included diabetes, chronic kidney disease, and stroke. A review of Resident #6's care plan revealed the most recent review date of 5/23/24 and no further reviews or updates had been completed. The MDS quarterly assessment dated 9/20/24 revealed Resident #6 was cognitively intact. An interview was completed on 12/3/24 at 10:03 am with the Director of Nursing (DON) who revealed she was both the MDS Nurse and the DON for the facility. She stated she was responsible for reviewing resident care plans. The DON verified Resident #6's care plan review was overdue. The DON stated she was aware the resident care plans were behind, and she was working on getting them completed. An interview was completed on 12/5/24 at 11:07 am with the Administrator who revealed she was not aware the resident care plans were not being reviewed. The Administrator stated the MDS Nurse was responsible to review and update resident care plans as required. 3. Resident #9 was admitted to the facility on 1/11/22 with diagnoses that included heart disease, chronic obstructive pulmonary disease, and atrial fibrillation.	F 657	plans in the quarter. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance	

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F 657	Continued From page 8	F 657		

A review of Resident #9's care plan list revealed the most recent review date of 7/15/24 and no further reviews or updates had been completed.

A Minimum Data Set (MDS) assessment dated 10/22/24 revealed Resident #9 was cognitively intact.

An interview was completed on 12/5/24 at 9:59am with the Director of Nursing (DON). The DON verified Resident #9's care plan review was overdue. The DON stated she was currently working to ensure all resident care plans were reviewed and updated in a timely manner.

An interview was completed on 12/5/24 at 11:15am with the facility's Administrator. The Administrator stated it was her expectation residents' care plan were reviewed and updated timely.

4. Resident #8 was admitted to the facility on 11/18/22 with diagnoses that included dementia and atrial fibrillation.

A review of Resident #8's care plan list revealed the most recent review date of 7/22/24 and no further reviews or updates had been completed.

A MDS assessment dated 10/20/24 revealed Resident #8 was severely cognitively impaired.

An interview was completed on 12/5/24 at 9:59am with the Director of Nursing (DON). The DON verified Resident #8's care plan review was overdue. The DON stated she was currently working to ensure all resident care plans were reviewed and updated in a timely manner.

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F 657	Continued From page 9 An interview was completed on 12/5/24 at 11:15am with the facility's Administrator. The Administrator stated it was her expectation residents' care plan were reviewed and updated timely. 5. Resident #45 was admitted to the facility on 6/12/23 with diagnoses that included diabetes, dementia, and a history of a stroke. A review of Resident #45's care plan list revealed the most recent review date of 7/15/24 and no further reviews or updates had been completed. A MDS assessment dated 9/29/24 revealed Resident #45 was severely cognitively impaired. An interview was completed on 12/5/24 at 9:59am with the Director of Nursing (DON). The DON verified Resident #45's care plan review was overdue. The DON stated she was currently working to ensure all resident care plans were reviewed and updated in a timely manner. An interview was completed on 12/5/24 at 11:15am with the facility's Administrator. The Administrator stated it was her expectation residents' care plan were reviewed and updated timely.	F 657		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 698		12/31/24

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F 698	Continued From page 10 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a physician order for dialysis in the medical record for 1 of 1 resident reviewed for dialysis (Resident #204). Findings included: Resident #204's hospital discharge summary dated 11/21/2024 included instructions that included the name, address and telephone number of the dialysis center and indicated Resident #204's chair time was Monday, Wednesday, and Friday at 12:00 PM. Resident #204 was admitted to the facility on 11/21/2024 with diagnosis including end stage renal disease stage 5. The admission Minimum Data Set (MDS) assessment dated 12/4/2024 revealed Resident #204 was coded for dialysis. During an interview with the Unit Manager on 12/3/2024 at 2:51 p.m. she revealed she was responsible for admitting Resident #204 to the facility. She stated she reviewed the hospital discharge summary for Resident #204, and she did not remember how she omitted entering the physician order for dialysis in his medical record. In an interview with Nurse #2 on 12/3/2024 at 2:58 p.m. she revealed she could not locate a physician order for dialysis for Resident #204 but was aware Resident #204 received dialysis. During an interview with the Director of Nursing	F 698	How corrective action will be accomplished for resident(s) found to have been affected. The physician's order for resident #204 was transcribed on 12/04/24 by the Unit Manager. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: There are no other dialysis patients at this time. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? ON 12/4/24 the Director of Nursing educated licensed nurses on obtaining and transcribing physician orders for dialysis. Indicate how the facility plans to monitor its performance to make sure that solution is achieved and sustained: The Director of Nursing will audit new admissions five times a week for twelve weeks for any new dialysis residents to ensure physician orders have been obtained and transcribed.	

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F 698	Continued From page 11 (DON) on 12/4/2024 at 9:50 a.m. she revealed that it was the responsibility of the admission nurse to ensure the physician orders were entered. The DON stated that the Unit Manager omitted the order for dialysis for Resident #204 in error. During an interview with the Administrator on 12/5/2024 at 8:25 a.m. she revealed it was the responsibility of nursing staff to ensure physician orders were transcribed upon receipt. She further stated that the admitting nurse should have reviewed the hospital discharge summary for Resident #204 and included the order for dialysis.	F 698	The Director of Nursing will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 732		12/31/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 12 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to post accurate licensed nurse staffing data for 18 of 30 days reviewed for sufficient staffing (11/02/24, 11/03/24, 11/05/24, 11/06/24, 11/09/24, 11/10/24, 11/13/24, 11/15/24, 11/16/24, 11/17/24, 11/18/24, 11/22/24, 11/23/24, 11/24/24, 11/25/24, 11/27/24, 11/28/24, 11/30/24). The findings included: A review of the posted Daily Nursing Staffing Forms from 11/01/24 through 11/30/24 revealed the following: a. A review of the Daily Nursing Staffing Form for the 7:00 am-3:00 pm shift revealed the licensed nursing staff was not recorded accurately for the following days: 11/02/24-Daily Nursing Staffing Form recorded 3 Licensed Practical Nurses (LPNs); the Daily Staffing Sheet recorded 1 LPN.	F 732	How corrective action will be accomplished for resident(s) found to be affected: No residents were affected. How the corrective action will be accomplished for resident(s)having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this alleged non-compliance and as a result, the systemic changes stated below have been put into place to prevent any risk of affecting the residents The posted census/staffing sheets have been corrected to reflect actual census and hours per position per shift. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future?	

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	345316	A. BUILDING _____ B. WING _____	C 12/05/2024

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F 732	Continued From page 13 11/03/24- Daily Nursing Staffing Form recorded 1 Registered Nurse (RN) and 3 LPNs; the Daily Staffing Sheet recorded 0 RN and 2 LPNs. 11/09/24-Daily Nursing Staffing Form recorded 1 RN and 3 LPNs; the Daily Staffing Sheet recorded 0 RN and 2 LPNs. 11/10/24-Daily Nursing Staffing Form recorded 3 LPNs; the Daily Staffing Sheet recorded 1 LPN. 11/16/24-Daily Nursing Staffing Form recorded 3 LPNs; the Daily Staffing Sheet recorded 1 LPN. 11/17/24-Daily Nursing Staffing Form recorded 3 LPNs; the Daily Staffing Sheet recorded 1 LPN. 11/23/24-Daily Nursing Staffing Form recorded 1 RN and 3 LPNs; the Daily Staffing Sheet recorded 0 RN and 2 LPNs. 11/24/24-Daily Nursing Staffing Form recorded 1 RN and 3 LPNs; the Daily Staffing Sheet recorded 0 RN and 2 LPNs. 11/28/24-Daily Nursing Staffing Form recorded 1 RN and 3 LPNs; the Daily Staffing Sheet recorded 1 LPN. 11/30/24-Daily Nursing Staffing Form recorded 1 RN and 3 LPNs; the Daily Staffing Sheet recorded 0 RN and 2 LPNs. b. A review of the Daily Nursing Staffing Form for the 3:00 pm-11:00 pm shift revealed the licensed nursing staff was not recorded accurately for the following days:	F 732	On 12/4/24 The Director of Nursing educated the scheduler and Unit manager on the daily staff posting information requirements that it needs to match the assignment sheet to ensure all staff is counted on the daily posting. The staff posting needs to be in a prominent area and easily visible and accessible to both the residents and visitors. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: The Administrator will audit the staffing sheets daily for 2 weeks, weekly for 2 weeks, monthly for 2 months to ensure that records are maintained according to regulation. Any issues during monitoring will be addressed immediately. The Administrator, Director of Nursing, or designee will report findings of the monitoring process monthly for 3 months to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 732	Continued From page 14 11/02/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. 11/06/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. 11/09/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. 11/10/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. 11/13/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. 11/17/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. 11/23/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. 11/24/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. 11/28/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. 11/30/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN.	F 732		

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c. A review of the Daily Nursing Staffing Form data sheets for the 11:00 pm-7:00 am shift revealed the licensed nursing staff was not recorded accurately for the following days:

11/05/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN.

11/09/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN.

11/15/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN.

11/17/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN.

11/18/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPN; the Daily Staffing Sheet recorded 1 RN and 1 LPN.

11/22/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN.

11/25/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN.

11/27/24-Daily Nursing Staffing Form recorded 0 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN.

11/30/24-Daily Nursing Staffing Form recorded 0

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F 732	Continued From page 16 RN and 2 LPNs; the Daily Staffing Sheet recorded 1 RN and 1 LPN. An interview was conducted on 12/04/24 at 12:37 pm with the Scheduler who revealed she used a staffing template when she completed the Daily Staffing Form, and she tried to make sure the staffing numbers were correct when she completed the form. The Scheduler stated she must have missed the days where the staffing was incorrect when she completed the form. During an interview with the Director of Nursing (DON) on 12/05/24 at 9:42 am who revealed she was new to the facility, and she was not aware the Daily Staffing Form information was being completed incorrectly. The DON stated she had not checked the Daily Staffing Forms for accuracy in the past, but she stated the Scheduler should verify the information was correct before posting the information.	F 732		
F 838 SS=F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment.	F 838		12/31/24

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F 838	Continued From page 17 §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or	F 838		

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F 838	Continued From page 18	F 838		

training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1).

§ 483.71(b) In conducting the facility assessment, the facility must ensure:
§ 483.71(b)(1) Active involvement of the following participants in the process:
(i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and
(ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable.
(iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.

§483.71(c) The facility must use this facility assessment to:
§483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and

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F 838	Continued From page 19 plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the Facility Assessment the facility failed to ensure the required parties were involved in developing the Facility Assessment, failed to evaluate contracted services utilized by the facility to provide necessary care for its residents during normal operations and emergencies, and failed to ensure the staffing plan considered specific staffing needs for each unit and shift as required, which had the potential to affect 49 of 49 residents. The findings include:	F 838	Corrective action for resident(s) affected by the alleged deficient practice: No resident was affected by this deficient practice. How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected by this deficient practice. As a result of this deficient practice systemic changes have been put into place to	

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F 838	Continued From page 20 Review of the Facility Assessment revealed it was revised 8/13/24 and updated on 9/24/24 and 11/01/24. The persons involved in completing the assessment were listed as the Administrator, the Director of Nursing (DON), the Medical Director, Social Service Director, Food Service Director, Environmental Operations Director, Therapy Director, and a Governing Board Member. There was no indication that direct care staff were involved in completing the assessment or that the facility solicited and considered input from residents, resident representatives and family members. The Facility Assessment did not note if a contract or other agreement was in place related to which provider was responsible for medical supplies, ambulance, or emergency services, and dialysis services for the facility. Further review of the Facility Assessment revealed that the staffing plan listed the number of Nurses (Registered Nurse or Licensed Practical Nurse), and Certified Nursing Assistants (CNAs) noted as the desired number FTE (full-time equivalent, the total number of full-time employees working in an organization) of staff and the professional requirement for those staff members. However, the staffing plan did not address staffing needs for each shift and weekends, or address staffing needs in these areas based on changes to the resident population as required. During an interview with the Administrator on 12/05/24 at 10:57 am she revealed the facility assessment was usually completed as a collaboration of department heads. She stated she was not in the facility when the new process	F 838	prevent any risk to our residents. On 12/19/24 the Administrator revised the facility assessment to include input from direct care staff and residents and noted contracts in place related to medical supplies and dialysis. The revision also addressed staffing needs for each shift and weekends and any staffing needs due to changes to the resident population as required. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 12/18/24 the Regional Director of clinical Service educated the Administrator on the Facility Assessment requirements including the involvement of direct care staffing and residents, contract services needed in case of an emergency, and specific staffing needs for each shift and each unit. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: The facility Assessment Plan will be reviewed at the monthly QAPI meeting monthly for 3 months. Any necessary changes will be made at that time.	

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F 838	Continued From page 21 was implemented, and she did not complete the provided facility assessment. The Administrator reported she did update the new management team on the facility assessment when she started at the facility, but she did not update or review any other information.	F 838		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed	F 851		12/31/24

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F 851	Continued From page 22 practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit accurate payroll data on the Payroll Based Journal (PBJ) report to the Centers for Medicare and Medicaid Services (CMS) related to Registered Nurse (RN) hours and licensed nursing coverage 24-hours per day. This was for 1 of 3 quarters reviewed for sufficient nurse staffing (Quarter 3 2024).	F 851	Corrective action for resident(s) affected by the alleged deficient practice: No resident was affected by this deficient practice. How corrective action will be accomplished for resident(s) having potential to be affected by same issue	

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F 851	Continued From page 23 Findings included: Review of the PBJ for Fiscal Year Quarter 3 2024 (April 1 through June 30) revealed there were no Registered Nurse (RN) hours for 4/13/24, 4/14/24, 4/27/24, 4/28/24, and 6/15/24. The PBJ report also noted the facility failed to have licensed nursing coverage 24 hours per day for 4/13/24, 4/14/24, 4/28/24, 6/15/24, and 6/16/24. Review of the Posted Daily Nursing Staffing Forms, Daily Staffing Sheet, and the nursing staff time detail reports for 4/13/24, 4/14/24, 4/27/24, 4/28/24, and 6/15/24 revealed there were RN hours for the 3rd quarter of the fiscal year 2024. The Posted Daily Nursing Staffing Forms, Daily Staffing Sheet, and the nursing staff time detail reports for 4/13/24, 4/14/24, 4/28/24, 6/15/24, and 6/16/24 were reviewed and revealed there were 24-hour per day licensed nursing coverage for the 3rd quarter of the fiscal year 2024. An interview was conducted on 12/04/24 at 12:01 pm with the Human Resources Manager who revealed she was responsible for entering all nursing hours into the payroll system and the corporate office submitted the data to CMS for the PBJ reports. The Human Resources Manager stated she did recall that there were times that she submitted the payroll data to corporate without all the licensed nursing staff because she had not yet received the information from agency staff. The Human Resources Manager stated she did update the payroll system with the licensed nursing and RN hours when she received the information from the agency staff and she thought the PBJ reports would be resubmitted and updated once the payroll report	F 851	needing to be addressed: All residents have the potential to be affected. As a result of this deficient practice systemic changes have been put into place to prevent any risk to our residents. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? On 12//10/24 the Administrator will reeducate the Payroll Director on reviewing payroll nursing hours for accuracy and ensuring all agency hours are added for Payroll Base Journal submission. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained: The Administrator/ Director of Nursing will review nursing hours weekly for 12 weeks to ensure accurate submission of Payroll Base Journal.	

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F 851	Continued From page 24 was corrected. During an interview on 12/04/24 at 12:04 pm with the Administrator she revealed the PBJ data was submitted based off the information entered by the Human Resources Manager. The Administrator stated the facility had RN hours and licensed nursing staff as required but there must have been an error when the data was reported.	F 851		