DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road Suite 200
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores **DATE SURVEY COMPLETED: July 14, 2023**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint Survey was conducted at this facility from July 5, 2023, through July 14, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day was 137. The sample totaled 26 residents.		
3201.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by the following: Cross Refer to the CMS 2567-L survey completed July 14, 2023: F584, F585, F609, F610, F622, F623, F644, F645, F655, F656, F657, F660, F677, F684, F695, F711, F756, F758, F790, F802, F812, and F924.	Cross refer answers to CMS 2567-L on 7/14/23: F584, 585, 609, 610, 622, 623, 644, 645, 655, 656, 657, 660, 677, 684, 695, 711, 756, 758, 790, 802, 812, 924.	9-6-23

Provider's Signature Shannon K Thornton Title Administrator Date 8/7/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Annual and Complaint Survey was conducted at this facility from July 5, 2023 through July 14, 2023. The facility census was 137 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, Office of Long Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were found.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from July 5, 2023 through July 14, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 137. The sample totaled 26 residents. Abbreviations/definitions used in this report are as follows: ADL's (Activities of Daily Living) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; AKA - above the knee amputation; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best.	F 000		

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

Electronically Signed | 08/07/2023

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 000	Continued From page 1 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Chronic - illness that is of a long duration; CNA - Certified Nurse Aide; Cognitively impaired - abnormal mental processes; thinking or mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DON - Director of Nursing; ESD - Environmental Service Director; Hemodialysis - procedure that removes waste and extra fluid from the body through the blood; Hoyer Lift - a sling type hydraulic lift; L - left; LLE - left lower extremity; Nebulizer - a drug delivery device used to administer medication in the form of a mist inhaled into the lungs; an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece; NHA - Nursing Home Administrator; NP - Nurse Practitioner; NSS - Normal Saline Solution; NWB - non-weight bearing; MDS (Minimum data set) - standardized assessment forms used in nursing homes; MRR (Medication Regimen Review) - monthly	F 000		

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F 000	Continued From page 2 review by Pharmacist of resident's medications, laboratory tests and any records necessary to determine whether irregularities exist; Ombudsman - resident representative who investigates reported complaints and helps to achieve an agreement between parties; ORIF (open reduction and internal fixation) - surgery that puts pieces of broken bone into place using screws, plates, sutures or rods to hold the broken bone together; Ortho - Orthopedic(s); PASRR (Preadmission Screening and Resident Review) - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions, to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; PCP - Primary Care Physician or Provider; PRN - as needed; Psychotic disorder(s) - severe mental disorders that cause abnormal thinking and perceptions; Psychotropic (medication)- any medication capable of affecting the mind, emotions and behavior; PT - Physical Therapy; S/P - status post; SW - Social Worker; WCT - wound care team; X - times.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		9/6/23

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F 584	Continued From page 3 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one out of five resident units,	F 584	F584 1. No resident was identified as being	

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F 584	Continued From page 4 the facility failed to provide a clean and homelike environment. Findings include: 7/13/23 10:15 AM - During an observation and interview on the 400 unit, E28 (Corporate) confirmed the extensive amount of dust and dirt on the baseboards, under the air conditioners in the halls, disrepair of the paint on the walls and that there was no molding or flooring next to the air conditioner in front of the 400 unit nurses' station. 7/13/23 10:40 - During the interview with E26 (ESD), stated that the condition of the facility was unacceptable. 7/14/23 - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference, beginning at 9:45 AM.	F 584	adversely affected. The 400 Unit baseboards and under the AC□s in the halls have been cleaned. Flooring/molding under the 400 nursing unit AC has been repaired. Renovations are ongoing, as during survey, and paint and paper are being replaced to create a homelike environment. 2.Any resident residing in the 400 unit had potential to be affected. 3.Root Cause was determined to be renovations going on at time of survey. Also, a breakdown of cleaning schedules do to vacancy. A systemic room cleaning schedule was implemented just prior to survey to keep common areas clean and homelike. New EVS Director will monitor. 4.Rounds will be made of building by Supervisory Personnel weekly x4; monthly x3. Problem areas will be immediately resolved through maintenance or housekeeping and results will be shared with QAPI on a monthly basis until 100% compliance results.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been	F 585		9/6/23

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F 585	Continued From page 5 furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is	F 585		

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F 585	Continued From page 6 responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents'	F 585		

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F 585	Continued From page 7 rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to take immediate action to resolve a resident grievance for one (R40) out of one resident reviewed for missing personal belongings. Additionally, the facility failed to make prompt efforts to permanently resolve multiple concerns repeatedly brought forth by R195's family. The facility also failed to consistently issue written grievance decisions to R195 and his family in response to their grievances. Findings include: The facility policy on grievances, last updated January 2023, indicated, "A family member may voice grievances. Grievances may be voiced in the following forums: Verbal complaint to a staff member. The staff member receiving the grievance will record the specifics on the... grievance form... The facility will make prompt efforts to resolve grievances." 1. During an interview on 7/7/23 at 10:57 AM, F4, relative of R40, stated R40's "Coat is still missing and we paid over $100.00 for it. I told them about it months ago and they said they would look for it, but there was nothing that they could do. I still have the receipt and everything." 7/7/23 - Review of R40's clinical record revealed a personal possessions list that documented, "1 coat black with fur" signed by E24 (CNA) and dated 12/20/17.	F 585	F585 1.A. R40 coat has been reimbursed during survey, as soon as it came to attention of current administration. R40 guardian was notified. Aug 16 Guardian has returned money to facility because coat was found in family possession. 1.B. R195 no longer resides in facility. Alleged grievances go back 3 years, do not involve missing property, and are unable to be resolved at this time. 2. Root Cause was determined to be breakdown in the grievance process due to vacancy in social services. Any resident has the potential to be affected by this practice. Resident Council was asked to help determine if any grievances were missed or outstanding. None were found. 3. A formal grievance procedure was reinstated and reassigned to the new Social Services Director to be monitored by that department. Procedure includes a form, a log, and a plan for giving written resolution to residents and/or their responsible party. 4. Grievances are reviewed during morning meeting. Audit of grievance log will be conducted weekly x4; monthly x3; and results brought forward to QAPI committee on a monthly basis. Results will also be monitored quarterly by	

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F 585	Continued From page 8 During an interview on 7/10/23 at 10:54 AM, E5 (SW) stated that she was unaware that R40 had a missing coat. E6 stated, "I just started that unit in December, but I never heard anything about that. I don't have information about that." During an interview on 7/10/23 at 11:26 AM, E1 (NHA) denied knowledge of R40's missing coat and stated,"We replace lost items, I haven't heard anything about this." During an interview on 7/10/23 at 11:39 AM, E12 (RN) stated that R40's family reported the residents missing coat to E12 "Six months ago, during the winter months. When it wasn't located, I told her that if it wasn't labeled, the facility is not responsible. I told her we can have laundry look to see, it wasn't labeled so I told her it couldn't be replaced." E12 confirmed that she did not complete a written grievance at that time. 7/10/23 12:35 PM - A social work progress note documented, "This worker contacts [resident] Guardian for resident to resolve issue relative to loss of a coat at Atlantic Shores. This worker offers to replace the value of the coat per instruction of [E1(NHA)]. Guardian very pleased with offer and will actually bring a receipt for the coat." During an interview on 7/11/23 at 9:42 AM, E1 (NHA) confirmed the facility did not have evidence of a written grievance nor a prompt response/resolution for R40's missing coat that was reported several months prior. E1 confirmed the facility was resolving the grievance that day with reimbursement.	F 585	external compliance group	

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F 585	Continued From page 9 2. The following was reviewed in R195's record: 5/30/18 - R195 was admitted to facility with diagnoses including a stroke affecting the left dominant side, difficulty swallowing, and need for assistance with personal care. 5/31/18 - R195's Baseline Care Plan under Assistance with ADL's stated, "Nursing staff to provide care as needed related to deficits to ensure ADL care is being met." 1/31/20 - A Grievance Written Decision signed by E15 (former NHA) stated, "Orders added to clarify resident needs assistance with feeding for every meal and to remove dietary trays upon completion of feeding. Staff to review voiding diary in accordance with toileting plan and to check/change resident prior to meals being offered to resident. Based on... findings... grievance was confirmed." 12/16/20 2:12 PM - A Grievance email from F2 (R195's stepdaughter) to E15 (former NHA) stated, "Good afternoon (E15), My mother (F3) just had a facetime with her husband (R195) who is my stepfather... She called me very upset. (R195) was lying in bed eating lunch with only an undershirt on. He is suppose (sic) to be up in his wheelchair for all meals due to aspiration risk and dressed in an undershirt, shirt and flannel day pants everyday...". The facility was unable to provide any evidence of a written response to this Grievance by R195's family. 9/11/21 - R195's quarterly MDS (Minimum Data Set) assessment documented R195 as an	F 585		

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F 585	Continued From page 10 extensive, two person assistance (assist) for bed mobility, transfer, dressing and toilet use, and extensive, one person assist for eating and personal hygiene. 11/9/21 - A Family Grievance by F2 documented concern that R195 "... was not dressed and no teeth in at 11 AM." 11/9/21 - E6's (NP) verbal order stated, "Ensure resident is OOB (out of bed) for all meals with dentures in place. Soak dentures overnight two times a day." 11/9/21 - R195's Care Plan was updated under Nutritional problem to "Encourage OOB for all meals." 11/16/21 - A Grievance Written decision signed by E14 (another former NHA) on 11/17/21 stated, "The CNA that was assigned to R195 works for an agency and 'isn't here often.' She was not aware of the visitation schedule and was educated on the spot where to locate the sheet from this point on. She had provided incontinent care to him (R195) but he was still in a gown until able to provide full bath and dressing, acknowledged that his dentures were not in. She was also educated on the spot regarding ensuring dentures are provided at meals. E2 (DON) spoke to stepdaughter (F2) and notified her of all... Based on... findings... grievance was confirmed." 1/14/22 - R195's quarterly MDS assessment documented R195 as an extensive, two plus person assist for transfers and toilet use, and extensive, one person assist for bed mobility, dressing, eating and personal hygiene.	F 585		

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F 585	Continued From page 11 2/15/22 - A Family Grievance by F3 (R195's wife) documented on 2/14/22 "(R195) still in bed at 11:55 AM and he was not shaved plus hair a mess, food was all over him and in bed (sic). The room was a mess. Food was not double portions, there was no gravy or soup which is suppose (sic) to be at every meal." 2/15/22- A Grievance Written Decision signed by E14 stated, "(F3) had concerns about room cleanliness, food portion size, food items not being present, resident not being out of bed in a timely manner... Based on... findings... grievance was confirmed." 11/10/22- A Grievance email from F2 stated, "Good Morning, I was in and visited with my stepfather (R195) last PM and wanted to report a few things. I also took photos which I have attached. I discovered mouse droppings on his nightstand. His meal ticket did not state what the meal was and he only received mashed potatoes, meat and ½ cup mandarin oranges. No vegetable or soup. The meal issues have been previously reported several times. I did report the mouse droppings issue to the nurse on duty, showed her and asked for a resident concern form to be filed. She stated she was contacting the supervisor on duty but I never heard anything further. I expect a resident concern report to be filed for the mouse and dietary issues with a timely action and resolution reported back to me and my mother (F3). As you are aware my mother is out of the country... I can be reached on my cell (phone number)...". The facility was unable to provide any evidence of a written response to this Grievance by R195's	F 585		

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F 585	Continued From page 12 family. 12/12/22 - R195's quarterly MDS assessment documented R195 as an extensive, two plus person assist for bed mobility, transfers, and toilet use and extensive and a one person assist for dressing, eating and personal hygiene. 7/11/23 11:59 AM - During an interview, E1 (NHA) stated, "Previously the backup battery (for Hoyer lifts) was in maintenance and if the Hoyer battery was dead, the staff would have to go to maintenance to get the replacement battery. Now they have extra back up batteries available on the floors." E1 confirmed that this change was initiated during her time as NHA. E1 has been the facility's NHA since April 2023. 7/11/23 1:48 PM - During a telephone interview, F2 (stepdaughter) stated, "There were more issues with getting R195 out of bed on weekends. Staff would report that the Hoyer lift battery was dead and they could not get to the replacement." F2 stated, "After complaining to the State, the Ombudsman got involved. There was a meeting scheduled at the facility for 11/17/2022 that the facility Administration, my mom (F3), myself, the Ombudsman (C3) and a representative from (name), R195's insurance company, to discuss our care concerns. The then Administrator (E22) did not even show up." 7/12/23 10:50 AM - During an interview, E1 (NHA) stated, "The facility does not have documentation for the 2021 grievances, as they only keep grievance documentation from survey to survey." 7/12/23 12:22 PM - During a telephone interview,	F 585		

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F 585	Continued From page 13 E3 (R195's wife) stated, "I was afraid for his safety. I got to the point where I was considering withholding his portion of the monthly bill ($3000) because the care was that bad." 7/12/23 1:25 PM - E1 (NHA) confirmed that on weekends, the Nursing Supervisor had the key to the Maintenance Office and that they would need to get the replacement battery for the Hoyer lift for staff. 7/13/23 11:43 AM - E1 stated, "We found grievances back to 2010." 7/13/23 1:34 PM - E1 confirmed the facility was unable to provide Grievance Written Decision statements for 12/16/20 and 11/10/22. E2 (DON) confirmed that the facility was not able to provide notes regarding the 11/17/22 meeting with R195's family, Ombudsman (C3) and insurance Representative. E2 stated he recalled that the then Administrator (E22) had car trouble that day and was unable to attend the meeting. 7/14/23 10:30 AM- Findings were reviewed during the Exit Conference with E1, E2, and E3 (ADON).	F 585		
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	F 609		9/6/23

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F 609	Continued From page 14 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. §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 interview and record review, it was determined that for one (R32) out of eight residents reviewed for abuse, facility staff failed to immediately report an allegation of abuse to the Administrator and the State Agency within two hours. Findings include: Cross refer F610 The facility policy titled "Abuse Policy and Procedure", revised 1/2023, stated, "once an allegation of abuse has been made, the supervisor who initially received the report must inform the Administrator/Director of Nursing immediately and initiate gathering requested information. An investigation must be directed by the Administrator or designee immediately."	F 609	F609 1.R32 was not harmed. Facility submitted report to state within the 2 hour timeframe after being notified by the State of the allegation at 3:15 pm that day. Result of this investigation revealed no evidence of abuse. 2.Any resident has potential to be affected if allegations of abuse are not reported or investigated timely. 3.Root Cause determined to be a misunderstanding by staff of classifying a conflict reported by staff as an allegation. In March there was no allegation of abuse by R32 reported to staff. There was a conflict reported by staff to unit manager that was investigated. R32 stated no abuse had occurred, and made no	

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F 609	Continued From page 15 Review of R32's clinical record revealed: 8/20/21 - R32 was admitted to the facility. 7/5/23 9:25 AM - An interview with R32 revealed an allegation of abuse by a staff member (CNA - [E10]). R32 alleged that E10 punched him in the stomach during care. 7/5/23 3:15 PM - An allegation of abuse was reported to E1 (NHA) and E2 (DON) by the Surveyor. 7/5/23 4:51 PM - An incident report was submitted to the State Agency for an allegation of abuse for R32. 7/10/23 12:48 PM - An interview with E1 revealed that the allegation of abuse (for R32) occurred several months prior and that documentation of a formal investigation does not exist. E1 stated the current investigation did not reveal any evidence of abuse and that E10 was able to return to work. The facility failed to identify an allegation of abuse and lacked evidence of reporting the allegation of abuse to the State Agency within designated timeframe. 7/12/23 1:20 PM - An interview with E12 (Unit Manager) revealed that the allegation of abuse was reported to her and it was investigated. E12 stated that an incident report to notify leadership or initiating a report to the State Agency was not completed. R32 was physically assessed after the allegation revealing no injuries. E12 interviewed E10 (CNA)and R32 and determined that the allegation was not abuse.	F 609	allegation of abuse, during the conversation, therefore documentation of a formal investigation was not performed, nor report made. Staff have been reeducated on the reporting requirements of allegations of abuse and need to document investigations or conversations. 4.Audits will be completed by nurse supervisory team on all allegations of abuse to determine compliance of reporting requirements. Audits will be done weekly x4; monthly x3; and reviewed by the QAPI team monthly to determine compliance. QA Nurse will monitor.	

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F 609	Continued From page 16 7/14/23 9:45 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 interview, record review, and review of other facility documentation as indicated, it was determined that for one (R32) out of eight residents reviewed for abuse, the facility failed to have evidence of a thorough investigation of an allegation of abuse. Findings include: Cross refer F609 Review of R32's clinical record revealed: 8/20/21 - R32 was admitted to the facility.	F 610	F610 1.Written investigation of allegation of abuse by R32 was submitted to the State agency at the end of the 5 day period. No evidence of harm or abuse was substantiated. 2.Any resident has potential to be affected if allegations of abuse are not investigated and reported. 3.The root cause was determined to be lack of written investigative information gathered at time of conflict and follow up	9/6/23

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F 610	Continued From page 17 7/5/23 9:25 AM - An interview with R32 revealed an allegation of abuse by a staff member (CNA - [E10]). R32 alleged that he was punched in the stomach during care. 7/5/23 3:15 PM - An allegation of abuse was reported to E1 (NHA) and E2 (DON) by the Surveyor. 7/5/23 4:51 PM - An incident report was submitted to the State Agency for an allegation of abuse for R32. 7/10/23 12:48 PM - An interview with E1 revealed that the allegation of abuse from (R32) occurred on or around March/ April (2023) timeframe. The facility failed to report or investigate the allegation of abuse. E1 stated the current investigation did not reveal any evidence of abuse and that E10 was able to return to work. 7/12/23 1:20 PM - An interview with E12 (Unit Manager) confirmed that the allegation of abuse was reported to her and was investigated, however, there was no investigation on record. E12 stated that an incident report to notify leadership or initiating a report to the State Agency was not completed. R32 was physically assessed after the allegation revealing no injuries, however, no record reveals this. E12 stated she interviewed E10 and R32 and she determined that the allegation was not abuse. The facility lacked evidence of a thorough investigation at the time of the allegation of abuse. 7/14/23 9:45 AM - Findings were reviewed with	F 610	by administrative staff.Staff was reeducated on regulation to report allegations of abuse. DON/ADON or designee will coordinate documentation of abuse allegations and investigations, and monitor and submit according to reporting obligations. 4.Audits will occur per occurrence and reported to the monthly QAPI team.	

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F 610	Continued From page 18 E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident	F 622		9/6/23

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F 622	Continued From page 19 exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident.	F 622		

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F 622	Continued From page 20 (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R597) out of three residents reviewed for discharge, the facility failed to provide evidence of the required documentation, including an interagency transfer sheet with Physician orders and Physical Therapy (PT) recommendations for R597's transfer to another facility on 12/20/22. Findings include: Cross refer F677 Review of R597's clinical record revealed: 12/18/22 - R597 was admitted to the facility with diagnoses including a right femur (thigh bone) fracture with surgical repair and the need for assistance with personal care. 12/18/22 - R597's Baseline Care Plan documented "R597 at risk for developing complications related to needing assistance with ADL's related to: poor motivation, weakness... CNA Intervention- Functional status as per therapy recommendations." The Baseline Care Plan did not specifically	F 622	F622 1.R547 no longer resides here and transferred to another facility on 12/20/22. Unable to correct for this resident. 2.Any resident transferred to another facility has potential to be affected by this practice. 3.Root cause was determined to be failure to keep a copy of the intrafacility transfer sheet. Procedure has been modified.Medical Records will now upload a copy of the intrafacility transfer sheet to the electronic resident chart upon discharge. Staff Development nurse will reeducate licensed staff on the needed information to place on the form, and to make a copy for medical records. 4.Compliance will be monitored in morning meeting, after a discharge; audited weekly x4; monthly x3; and reported monthly to QAPI team who will determine when continued compliance has been achieved.	

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F 622	Continued From page 21 address R597's functional status for her ongoing care related to bed mobility, toilet use and hygiene. 12/21/22 - R597 was transferred to another rehabilitation facility at her request. 12/21/22 10:39 AM - E6's (Nurse Practitioner/NP) Progress Note documented R597's Assessment/Plan as "Unspecified fracture of right femur... WBAT (weight bear as tolerated) to RLE (right lower extremity)...". The 12/21/22 Progress Note written by E6 only referenced R597's transfer as an addendum on 1/6/23. There were no special instructions regarding R597's care. 12/22/22 - R597's admission MDS (Minimum Data Set) assessment documented bed mobility and toilet use as extensive two plus person assistance and personal hygiene as extensive one person assistance. 12/23/22 - E5 (Social Worker) documented R597's BIMS (Brief Interview for Mental Status) score as 15 in the MDS assessment, which reflected normal cognition. 1/6/23 11:15 AM - E6's (NP) addendum to the 12/21/22 Progress Note stated, "Patient discharged to another facility on 12/21/2022 per patient preference." 7/7/23 10:41 AM - During an interview, E1 (NHA) stated, "We did not keep a copy of the interfacility transfer sheet for R597's transfer to another facility on 12/21/2022." E2 (DON) stated, "But we would have sent a copy of the face sheet, care	F 622		

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F 622	Continued From page 22 plan, H&P (admission history and physical) and current orders. We would also send a copy of the Advance Directive if there was one." 7/14/23 10:30 AM - The findings were reviewed during the Exit Conference with E1, E2 and E3 (ADON).	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		9/6/23

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F 623	Continued From page 23 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 623		

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	085037	A. BUILDING _____ B. WING _____	C 07/14/2023

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F 623	Continued From page 24 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R599) out of three residents reviewed for discharge, the facility failed to provide written notice to R599's resident representative regarding the resident's discharge. Findings include: Review of R599's clinical record revealed: 4/12/22 - R599 was admitted to the facility for rehabilitation.	F 623	F623 1.R599 received a NOMNC when their skilled stay was ended. This is written notice of end of short term treatment and rehabilitation stay. R599 is no longer at facility. Unable to correct for this resident. 2.Any resident discharging from the facility has potential to be affected if written notice is not given. 3.Root cause was determined to be a failure to identify which additional parties were responsible to receive discharge	

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F 623	Continued From page 25 4/29/22 - A Physician Discharge Summary stated the discharge date was 4/29/22. R599's clinical record lacked evidence that R599 and their representative were provided with a written discharge notice that included: The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged; A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. 7/12/23 1:06 PM - An interview with E13 (Unit Manager) confirmed there was no documentation in the clinical record that showed R599's resident representative was notified prior to discharge. In the aforementioned note, the lack of notification of discharge resulted in the resident remaining at the facility as private pay until 5/2/22. 7/14/23 9:45 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 623	information. Procedure has been modified for short term stay residents. Social Services has been educated on need to clarify with a resident who is own responsible party, who they want notified regarding discharge plans at end of a short term stay. This will be done at the initial SPARK care plan meeting, and reviewed at the discharge plan meeting. The practice of discharging long term residents remains the same, and does not apply in this case. Notification of ombudsman remains the same for short term residents or long term residents, and was given in this case. 4.Discharges will be reviewed in morning meeting, audited weekly x4; monthly x3; and results reviewed by the QAPI team at the monthly meeting. Social Services will monitor for compliance.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination.	F 644		9/6/23

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F 644	Continued From page 26 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 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 interview and record review, it was determined that for one (R16) out of two residents reviewed for PASARR, the facility failed ensure that a referral for a PASARR screening was completed following new diagnosis of psychotic disorder which was not listed on the previous PASARR. Findings include: The facility policy on PASARR, last updated October 1, 2022, indicated that the Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability or related condition will be referred promptly to the State authority for a review. Review of R16's clinical record revealed;	F 644	F644 1.A PASRR screening referral has been made for R16. 2.Any resident has potential to be affected by this practice. 3.Root cause was due to prior vacancy and process being dropped. New Social Services Director was placed as overseer of the PASRR process. The PASRR□s of current residents were reviewed for accuracy. Corrected PASRR screening referrals are being initiated following the care plan schedule, which includes significant changes or new diagnosis. The IDT will alert SS when dx are reviewed in morning clinical meeting. 4.Care plan team will monitor and review PASRR□s for accuracy quarterly and as needed. Weekly review of list will be done	

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F 644	Continued From page 27 8/9/21 - A level I PASARR screening was completed for R16 that determined no level II PASARR was required and that R16 did not have a diagnosis of dementia or any mental health diagnoses. 8/11/21- R16 was admitted to the facility with multiple diagnoses listed including delusional disorder, unspecified mood disorder and anxiety. 8/18/21- An admission MDS assessment documented R16 as severely cognitively impaired with active diagnoses that included non-Alzheimers dementia, depression and psychotic disorder. 10/7/21- A level I PASARR was completed for R16 and diagnoses of depressive disorder, anxiety and dementia were determined. A level II PASARR was not required. The PASARR did not list R16's diagnosis of a psychotic disorder. During an interview on 7/10/23 at 10:56 AM, E5 (SW) confirmed that R16 did not receive any PASARR referrals after the 10/7/21 PASARR was completed. Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) at the exit conference on 7/14/23 at 9:45 AM.	F 644	by Social Services and Administration until PASRR□s are current. Monthly report will be made to QAPI team for oversight.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		9/6/23

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F 645	Continued From page 28 §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission	F 645		

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F 645	Continued From page 29 to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R118) of two sampled residents reviewed for Preadmission Screening and Resident Review (PASRR) Level I, the facility failed to have a currently dated PASRR Screening. Findings include: Review of R118's clinical record revealed: 3/26/23 - R118 was admitted to the facility. 3/24/23 - A review of the Initial PASARR revealed it was completed on 3/24/23 and was approved for a 60 day short term convalescence admission. The PASARR also revealed if the short term stay	F 645	F645 1.R118 no longer resides in the facility. Unable to correct. 2.Any resident currently residing in the facility has potential to be affected. 3.Root cause was due to prior staff vacancy. New Social Services Director was placed as overseer of the PASRR process. The PASRR□s of current residents were reviewed for expiration and referred for a new screening. Any future resident converting from short stay to long term stay will be referred during the UR meeting to get a new screening, if required.	

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F 645	Continued From page 30 surpassed the expiration date, a new screening would have to be initiated by the Provider for completion. 7/7/23 - A review of R118's electronic medical record revealed a PASARR was completed on 3/24/23 to determine placement in a medical facility for a short term convalescence admission. 7/7/23 1:10 PM - An interview with E5 (Social Worker) confirmed that a PASARR was not completed for R118 after the 60 day expiration. The facility failed to maintain a current PASARR screening for R118. 7/14/23 9:45 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 645	4.New admissions will be reviewed in morning meeting for PASRR receipt and accuracy. Any resident converting to LTC will be referred to Social Services for a new screening by the UR team, if they had a contingent PASRR. Audits will be done weekly x4; monthly x3; reported to QAPI team for review monthly.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		9/6/23

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F 655	Continued From page 31 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for one (R194) out of twenty six residents reviewed for comprehensive care planning, the facility failed to develop and implement a baseline care plan for R194 that provided effective and person-centered care that met professional standards of care regarding R194's left fibula and ankle fractures and LLE (left lower extremity) surgical incision care. Findings include: 6/24/22 - R194 was admitted to the facility with	F 655	F655 1.R194 no longer resides in the facility, so unable to correct. 2.Any resident admitted in the future with a casted wound has potential to be affected. 3.The root cause was due to staff failed to include principal medical problem and intervention when completing the baseline care plan for one out of twenty six residents. Licensed Staff have been	

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F 655	Continued From page 32 diagnoses including: left fibula (lower leg bone) and ankle fractures, dementia and need for assistance with personal care. 6/25/22 - R194's Baseline Care Plan documented four areas: Potential Nutritional problem, at risk for falls, at risk for chronic, acute breakthrough pain and at risk for developing complications related to needing assistance with ADL's related to fracture. The Interventions/Task sections of these areas failed to address R194's principle medical problem, her fractured left fibula and ankle and the requisite assessment of the limb and incision as a professional standard of care. 7/14/23 10:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (ADON).	F 655	reeducated on the necessity of placing casted wounds on the baseline care plan and clarifying with admitting surgeon the treatment orders. If not to be touched or opened, that will be placed on baseline care plan. An audit will be completed of any residents with current casted wounds to determine if care plans need to be updated. 4.New admissions will be reviewed in morning clinical meeting and treatments including don□t touch instructions will be placed on the baseline care plan. Findings of initial audit will be shared with QAPI team and Medical Director. Wound Nurse to monitor.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		9/6/23

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F 656	Continued From page 33 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R7 and R32) out of twenty six residentssampled, the facility failed to develop and implement a comprehensive person-centered care plan. Findings include: 1. 8/2/21 - R7 was admitted to the facility. 7/5/23 1:25 PM - During an interview, R7 stated she feels "chained to the bed."	F 656	F656 1.R7 care plan was updated to reflect refusal of ADL care. R32 care plan was updated to reflect refusal of dental services and care. 2.Any current resident has potential to be affected. 3. Root cause was staff failure to document refusals of care. Current residents who refuse ADL care have been	

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F 656	Continued From page 34 7/7/23 approximately 8:50 AM - An interview with E17 (Rehabilitation Director) revealed that R7 was receiving PT, but she often refused to get out of bed, although R7 will usually do bed exercises. 7/7/23 approximately 11:06 AM - An interview with E16 (Unit Manager) confirmed that the resident prefers to stay in bed and typically refuses to get out of bed. 7/7/23 untimed - A review of the care plan revealed there was no specific care plan for refusal of care or getting out of bed. 7/10/23 approximately 1:30 PM - An interview with E18 (Activities Director) and E19 (Assistant Activities Director) both said that R7 has not "been out of bed in years." 7/11/23 approximately 1:40 PM - An interview with E5 (SW) stated it was R7's preference to not get out of bed. 7/12/23 1:11 PM - An interview with E2 (DON) stated that he has only seen R7 out of bed "a handful of times over the past few years." 7/12/23 2:02 PM - An interview with E16 (Unit Manager) confirmed there was no care plan for refusal of care and/or getting out of bed, but she will look into it. 2. Review of R32's clinical record revealed: 8/20/21 - R32 was admitted to the facility. 8/23/21 - A comprehensive care plan was initiated for R32.	F 656	reviewed and care plans updated.Current residents□ dental status has been reviewed and offered services as applicable. Staff Development will reeducate staff on importance of documenting refusals of care. 4.Audits will be conducted of refusals of ADL care and compared to the comprehensive care plan. Audits weekly x4; monthly x3, and results brought forward to QAPI team for review for review. Findings of one time dental audit will be brought to QAPI team for review and instruction for further action. Quality Assurance Nurse to monitor.	

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ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

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F 656	Continued From page 35 7/5/23 - An interview with R32 revealed that R32 has dentures, but is unable to wear them related to a loose fitting bottom plate. The interview further revealed that R32 has not seen a Dentist or had dental services since admission. 7/10/23 9:57 AM - An interview with R4 (Medical Records) revealed that R32 has not seen an outside Dentist or the in house Dental Provider. 7/10/23 10:14 AM - A review of facility communication with regard to the in house Dental Provider revealed that R32 was offered dental services on 2/9/23 and R32's decisionmaker refused services. 7/10/23 11:01 AM - A review of R32's careplan initiated on 8/23/21 revealed no evidence of the resident's use of dentures or dental services. The facility failed to develop and implement a comprehensive person-centered care plan. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 7/14/23 at 9:45 AM.	F 656		
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.	F 657		9/6/23

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F 657	Continued From page 36 (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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R32) out of twenty six sampled residents for care plans, the facility failed to ensure that the required interdisciplinary team (IDT) members participated in the care plan meetings. Findings include: Review of R32's clinical record revealed: 8/20/21 - R32 was admitted to the facility. 5/31/22 10:00 AM - A review of R32's comprehensive resident centered care plan conference notes revealed the following attendees were present: Unit Manager, Social Worker and R32. 3/30/23 - A review of Care Plan meeting notes	F 657	F657 1.Documentation has been placed in R322 record that physician input, dietary review, and C.N.A. input has been considered and reviewed with resident and responsible party as part of a care conference. 2.Any resident in facility has potential to be affected. 3.Root cause was determined to be vacancies in Social Services. A QAPI Performance Improvement Plan was developed and initiated in June to place care plans and reviews on a required schedule with interdisciplinary team input. This practice was identified by the facility and is being corrected. 4.QAPI team will continue to monitor the	

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F 657	Continued From page 37 revealed the following attendees were present: R32, Unit Manager, R32's decisionmaker and the Admissions Director. The facility lacked evidence that the post-admission care plan conference attendees included: Physician input, Food and Nutrition Services staff input and CNA (Certified Nursing Aide) input with responsibility for the resident. 7/14/23 9:45 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 657	care plan development and comprehensive review process until the PIP is completed and compliance is achieved.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability	F 660		9/6/23

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F 660	Continued From page 38 and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment	F 660		

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F 660	Continued From page 39 preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R595) out of three residents reviewed for discharge, the facility failed to develop and implement an effective discharge planning process that focused on R595's discharge goals and effectively prepared her to transition to post discharge care as evidenced by failure to communicate arrangements for home health nursing, physical therapy (PT) and occupational therapy (OT) to R595 and her family. Findings include: 1/25/23 - R595 was admitted to the facility with diagnosis including: a stroke with left sided paralysis, heart failure, end-stage kidney failure on hemodialysis and a seizure disorder. 2/1/23 - R595 had a documented BIMS score of 9, which reflected moderate cognitive impairment. 2/24/23 - R595 was discharged home "with family" was documented on the discharge paperwork (referred to as Transition booklet). The transition booklet documented that R595 required follow-up medical care with C1 (Primary Care NP), but did not supply contact information for	F 660	F660 1.R595 is no longer at facility. Unable to correct. 2.Any resident who discharges from the facility to home has potential to be affected. 3.Root Cause had been identified and a correction implemented prior to this survey. Due to vacancies, Social Work didn't fully document at the time all information. A QAPI Performance Improvement Plan was initiated in May to make sure appointments were scheduled and placed in the discharge plan paperwork. Social Service staff was reeducated during survey of the necessity of completely filling out the Transition of Care (TOC) to include home health information, and dialysis plans and contacts/arrangements. 4.Each TOC will be reviewed during morning meeting prior to discharge, and then the next day to determine if resident and families have the necessary information for a smooth transition to home. Social Services or Administration	

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F 660	Continued From page 40 this Provider and required home health care services of PT, OT and Nursing from a local home health care agency, but the facility did not supply any contact information or the frequency of the services. 7/6/23 2:05 PM - During an interview, E5 (Social Worker) stated, "R595's discharge was at the resident's initiation and R595's family was not happy about it" as R595's family thought she should stay as a long-term care resident. E5 confirmed that she did not discuss the pending discharge with R595's family, despite R595 having moderate cognitive impairment. 7/6/23 2:20 PM - During an interview, E1 (NHA) stated, "The Transition booklet should have all the discharge information, except the medication list. In theory the names and phone numbers of the home health agencies are supposed to be in the booklet, but currently the Social Work department consists of one person in a three man job, so sometimes not all the information is there." 7/7/23 1:23 PM - During a telephone interview with F1 (R595's daughter), F1 stated that the building did not supply in the discharge paperwork the contact information regarding the home health care agency and did not contact R595's dialysis transportation to alert them that she was being discharged, which left the family scrambling to obtain transport to R595's dialysis session on Monday. Fi stated, "My Mom has been in and out of facilities over the years. I know how this should be done. They did not do it right." 7/12/23 10:47 AM- During an interview, E1 (NHA) stated, "We don't normally arrange dialysis	F 660	will audit TOC□s weekly x4; monthly x3, and report findings to the QAPI team for review.	

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F 660	Continued From page 41 transportation for established dialysis residents as long as the resident previously had transportation arranged and a dialysis chair time from before this admission." 7/14/23 10:30 AM- The findings were reviewed during the Exit Conference with E1, E2 (DON), and E3 (ADON).	F 660		
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 observation and interview, it was determined that for three (R47, R195 and R597) out of seven residents reviewed for ADL, the facility failed to ensure ADLs were provided to dependent residents. Findings include: 1. Review of R47's clinical record revealed; 3/1/23 - R47's care plan for ADL's related to needing assistance, cognitive impairment and weakness included the intervention for staff to provide care to R47 as needed related to deficits to ensure ADL care is being met. 5/23/23 - A quarterly MDS assessment documented that R47 was moderately cognitively impaired and required extensive assistance of one staff member for completion of hygiene which includes shaving. R47 was observed with facial hair unkempt on the	F 677	F677 1.R47 was shaved. His tasks and PCC were updated to include shaving daily. R195 and R597 no longer reside in facility. R195 cannot be corrected. R597 issue was reported and acted upon at time of incident in January, but no further action can be taken now. 2.Any resident dependent upon staff for ADL cares has potential to be affected. 3.Root cause was staff lack of timeliness on delivery of care. Residents dependent upon staff for daily cares have been reviewed to determine that these tasks are accurate in PCC. Staff Development to reeducate care staff on importance of documenting daily cares given or refusals. 4.Audits will be conducted by nurse management of documentation, and rounds will be completed by supervisors to determine compliance. Audits weekly	9/6/23

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F 677	Continued From page 42 following dates: 7/5/23 10:57 AM 7/6/23 9:45 AM 7/10/23 9:26 AM. 7/10/23 - Review of 30 days of CNA documentation for completion of resident care revealed hygiene was documented as completed for R47. During an interview on 7/10/23 at 11:30 AM, E25 (CNA) confirmed that R47's facial hair was unkempt and that the resident was not offered a shave. 2. Review of R195's clinical record revealed: 5/30/18 - R195 was admitted to the facility with diagnoses including: a stroke affecting the left dominant side, difficulty swallowing and need for assistance with personal care. 5/31/18 - R195's Baseline Care Plan under Assistance with ADL's stated, "Nursing staff to provide care as needed related to deficits to ensure ADL care is being met." 12/14/20 - R195's quarterly MDS (Minimum Data Set) assessment documented R195 as an extensive, two plus person assist for transfers and toilet use, limited one person assistance (assist) for eating and extensive, one person assist for bed mobility, dressing, and personal hygiene. 12/16/20 2:12 PM - A Grievance email from F2 (R195's stepdaughter) to E15 (NHA) stated, "Good afternoon E15 (former NHA), My mother (F3) just had a facetime with her husband (R195)	F 677	x4; monthly x3; findings brought to QAPI team for review and monitoring.	

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F 677	Continued From page 43 who is my stepfather... She called me very upset. R195 was lying in bed eating lunch with only an undershirt on. He is suppose (sic) to be up in his wheelchair for all meals due to aspiration risk and dressed in an undershirt, shirt and flannel day pants everyday...". The facility was unable to provide evidence of an investigation into this grooming/ mobility allegation. 9/11/21 - R195's quarterly MDS assessment documented R195 as an extensive, two plus person assist for bed mobility, transfers, dressing and toilet use and extensive one person assist for eating and personal hygiene. 11/9/21 - A Family Grievance Report by F2 documented concern that R195 "...was not dressed and no teeth in at 11 AM." 11/9/21 - E6's verbal order stated, "Ensure resident is OOB (out of bed) for all meals with dentures in place. Soak dentures overnight two times a day." 11/9/21 - R195's Care Plan was updated under Nutritional problem and stated, "Encourage OOB (out of bed) for all meals." The facility confirmed R195's family concern by obtaining a medical order to have dentures in and to get R195 out of bed for meals. 1/14/22 - R195's quarterly MDS assessment documented R195 as extensive, two plus person assist for transfers and toilet use and an extensive one person assist for bed mobility, dressing, eating and personal hygiene.	F 677		

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F 677	Continued From page 44 2/15/22 - A Family Grievance Report by F3 (R195's wife) documented on 2/14/22 "resident (R195) still in bed at 11:55 AM and he was not shaved plus hair a mess, food was all over him and in bed (sic). The room was a mess. Food was not double portions, there was no gravy or soup which is suppose (sic) to be at every meal." The facility confirmed R195's wife's allegation of nutritional issues and mobility regarding R195's care. 11/10/22 8:16 AM - A Grievance email from F2 to E8 (ADON) and E22 (a different former NHA) stated, "Good Morning, I (F2) was in and visited with my stepfather (R195) last PM and wanted to report a few things... His meal ticket did not state what the meal was and he only received mashed potatoes, meat and ½ cup mandarin oranges. No vegetable or soup. The meal issues have been previously reported several times...". 12/13/22 - R195 was discharged/transferred to another facility at the family's request. 3. Review of R597's clinical record revealed: 12/18/22- R597 was admitted to the facility with diagnoses including a right femur (thigh bone) fracture with surgical repair and the need for assistance with personal care. 12/18/22 - R597's Baseline Care Plan documented "...at risk for developing complications related to needing assist with ADL's related to: poor motivation, weakness... CNA Intervention - Functional status as per therapy recommendations."	F 677		

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F 677	Continued From page 45 12/21/22 - E8 (ADON) obtained E7's (CNA) Witness Statement via telephone and documented E7 as stating, "She (R597) didn't ring the bell during the night. I thought she was independent and didn't ask her about the bathroom. I walked by her room several time throughout my shift. I didn't go in the room at all and did not give her water. The hallway has a lot of bell ringers so I was by her room a lot. She was sleeping on top of the sheets." 12/21/22 - E9's (LPN) Witness Statement documented "07:45 AM. As I was making rounds before my Medpass after 11-7/7-3 report, I went to resident (R597), noted her crying & had her personal cell phone speaker phone with facility message. Noted resident was fully dressed lying on top of her blanket. R597 stated that she was never changed into bedclothes, offered water or checked on all night. Noted resident's pants and bed linen under her were soaked with pee. I immediately notified ADON (E13 - Unit Manager) was not here yet. I found her 7-3 caregiver and she immediately went to her to get her straightened up. She wanted to notify or speak to unit manager." 12/21/22 - E11's (CNA) Witness Statement documented "R597 was really wet. She was not happy. She said that no one changed her all night and they didn't even cover her up." 12/22/22 - R597's admission MDS assessment documented bed mobility and toilet use as extensive two plus person assist and personal hygiene as extensive one person assist. 12/23/22- E5 (Social Worker) documented	F 677		

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F 677	Continued From page 46 R597's BIMS score as 15 in the MDS assessment, which reflected normal cognition. 1/2/23- E7 (CNA) was terminated from employment at the facility for "Failure to complete assigned tasks." 7/14/23 10:30 AM- The findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (ADON).	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to provide R194 care and treatment in accordance with professional standards of care regarding her LLE (left lower extremity) surgical incision as evidenced by failure to assess, initiate orders and provide care until 7/18/22, which was 24 days after R194's admission to the facility. Findings include: Review of R194's record revealed the following: 6/24/22 - R194 was admitted to the facility with diagnoses including: left fibula (lower leg) fracture, dementia and need for assistance with	F 684	F684 1.R194 is no longer in facility.Unable to correct. 2.Any resident with a surgical wound has potential to be affected. 3.Root cause was staff failure to completely assess and plan for care of this resident. An audit was completed on current residents with a surgical wound to determine that documentation and orders for treatment are in place. This included verifying an assessment, orders initiated, and care is reflected as provided. Staff Development provided reeducation to	9/6/23

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F 684	Continued From page 47 personal care. Discharge Instructions from the hospital included: "Follow-ups for After discharge ... (name of MD), Specialty Orthopedic Surgery, Why: 1-2 weeks If you have a boot or splint, wear the boot or splint as told by your doctor. Take it off only as told by your doctor." 6/25/22, 6/26/22, 6/27/22 - E9 (LPN) documented in Prestige Daily Skilled Note "no" skin conditions on Section 1 Standard and did not fill in the box for Skin in Section 2 Systems. For three days' worth of assessments, E9 failed to acknowledge the presence of R194's LLE surgical incisions. 6/27/22 - E34's (MD) Admission History and Physical documented "Patient had a fall and presented to the hospital, found to have a left distal fibula fracture and transverse medial malleolus (ankle) fracture... underwent ORIF (open reduction and internal fixation(surgery)." The facility used a Prestige Daily Skilled Note to docuement daily assessments. On the following dates (16 days) staff documented "no" skin conditions, often wrote "skin is warm and dry" and failed to document under the Surgical Wound subsection on 6/28, 6/29, 6/30, 7/1, 7/2, 7/3, 7/4, 7/5, 7/6, 7/8, 7/9, 7/10, 7/11, 7/12 and 7/13/22. A total of seven nurses (E9, E36, E37, E38, E39, E41 and E42) documented inaccurate assessments. 6/29/22 - C4's (Consultant Wound Care NP) Skin/Wound Note documented "Comprehensive skin and wound evaluation for new admission to facility Exam: Dermatologic- Wound(s) present;	F 684	licensed staff regarding surgical wound documentation on daily skilled notes. 4.Audits will be conducted weekly x4; monthly x3 and audit findings reviewed monthly by the QAPI team. Wound Care nurse will monitor compliance.	

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F 684	Continued From page 48 Please see wound assessment below. Wounds-Pt (patient) has surgical site to left ankle See TA (Tissue Analytics) documentation for full wound assessment details. Plan: Wound Plan of care... RN to return later to assess area and notify PCP of any concerns... recommend extensive wound care to site...". There was no follow up documentation by the RN regarding R194's wound. Additionally, there was no documentation regarding R194's LLE wound using the Tissue Analytics documentation program at this time. 7/7/22 - E40 (LPN) documented in Prestige Daily Skilled Note "no" skin conditions on Section 1 Standard and Section 2 Systems documented "skin is warm and dry..." and in the Surgical Wound subsection documented "Surgical wound noted." This was the first documentation by nursing staff acknowledging the LLE surgical incisions. The next time the wound was acknowledged was 7/14/22. 7/15/22 - E6 (NP) ordered "Doxycycline Monohydrate 100mg by mouth two times a day for Ortho (Orthopedic) infection LLE X (times) 7days." 7/18/22 - E6's (NP) Progress Note documented "... Physical exam...Skin: Warm, dry. Limited Exam. See nursing notes and skin/wound care notes... Assessment/Plan: Closed left ankle fracture... Per ortho- had follow-up on 7/15/22. S/P (status post) L (left) ankle ORIF. Possible infection. Recommend Doxycycline X 7 day course (started 7/15/22)... Continue local wound	F 684		

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F 684	Continued From page 49 care... Encounter for other specified surgical aftercare, ... had Ortho appt 7/15/22, possible infection. Started on Doxycycline... continues on currently....". 7/18/22 - E35 (NP) ordered "Treatment- left medial and anterior ankle- cleanse are with NSS (normal saline solution)/wound cleanser, apply xeroform (medicated mesh dressing) and cover with dry dressing. Notify wound care /provider for worsening wound. As needed for wound care AND every shift." The order on 7/18/22 was the first medical order acknowledging R194's LLE surgical incisions. 7/18/22 - E9 (LPN) documented in Prestige Daily Skilled Note "no" skin conditions in Section 1 Standard and did not fill in the box for Skin in Section 2 Systems. 7/19/22 - E37 (RN) documented in Prestige Daily Skilled Note "no" skin conditions in Section 1 Standard and Section 2 Systems documented "skin is warm and dry..." and in the Surgical Wound subsection documented "Surgical wound noted- Right foot." E37 (RN) acknowledged the presence of a surgical wound; however R194's surgical incision was on her left leg, not her right leg as E37 documented. 7/20/22 9:03 AM - C4 (Consultant Wound Care NP) documented Tissue Analytics wound measurements for left lateral and medial ankle wounds. This is the first and only documentation of wound	F 684		

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F 684	Continued From page 50 measurements using the tissue Analytics program in R194's medical record. 7/10/23 3:33 PM During a phone interview, F5 (R194's granddaughter) stated, "I visited my grandmom almost everyday after work. I asked several times different nurses about the dressing on her leg and changing it. My grandmom was a diabetic. F5 stated, "I was told 'no instructions were sent from the hospital.'" 7/14/23 10:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (ADON).	F 684		
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 observations, interview and record review, it was determined that for one (R67) out of one sampled resident reviewed for respiratory care, the facility lacked evidence that R67's nebulizer reservoir and tubing were labled with a date of use and were stored in a sanitary manner. Findings include: Review of R67's clinical record revealed:	F 695	F695 1.R67 orders were updated to reflect care and storage of nebulizer tubing and machine. 2.Any resident receiving a nebulizer treatment had potential of being affected. These residents were reviewed and orders updated as necessary. 3.Root cause was an omission after last hospitalization. Also resident rearranges	9/6/23

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F 695	Continued From page 51 6/10/21 - R67 was admitted to the facility with COPD (Chronic Obstructive Pulmonary Disease). 5/12/2023 - A Physician's order for R67 included to administer a nebulizer treatment every four hours for shortness of breath or wheezing related to COPD. 5/13/23 - A Physician's order for R67 included to administer a nebulizer treatment once a day related to chronic sinusitis (inflammation of the nasal passage cavities). 7/5/23 12:10 PM - During a random observation during screening, R67's nebulizer reservoir and tubing were noted to be on his bedside table covered with clothing and a pair of shoes next to it. The nebulizer equipment was not contained to keep it sanitary. In addition, the equipment was not labeled with a date to discern when it had last been changed. 7/5/23 12:23 PM - During an observation and interview, E27 (LPN) confirmed that the nebulizer tubing and reservoir were not labeled and were not contained to remain sanitary. E9 stated that the equipment should have been placed in a plastic bag. 7/14/23 - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference beginning at 9:45 AM.	F 695	belongings. Staff Development reeducated nursing staff on nebulizer tubing changes, and storage of machine. Nursing staff instructed to document when resident refuses or interferes. 4.Audits of nebulizer orders and rounds of resident rooms who get nebulizer treatments will be conducted by nurse supervisors weekly x4; monthly x3; and results brought to QAPI team for review monthly. Infection Control nurse to monitor.	
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must-	F 711		9/6/23

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F 711	Continued From page 52 §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility failed to ensure that the physician reviewed R194's total program of care at each visit, including assessments of the left lower extremity (LLE) as evidenced by the lack of orders for assessment and care for the LLE surgical incision until 7/15/22, 21 days after R194's admission. Despite multiple Provider visits, the Physician/NP notes lacked first-hand assessments or interventions for R194's LLE incision. Findings include: 6/24/22 - R194 was admitted to the facility with diagnoses including: left fibula (lower leg bone) and ankle fractures, dementia and need for assistance with personal care. Discharge Instructions from the hospital included: "Follow-ups for After discharge... (name of MD), Specialty Orthopedic Surgery, Why: 1-2 weeks... If you have a boot or splint, wear the boot or splint as told by your doctor. Take it off only as told by your doctor." 6/27/22 - E34's (MD) Admission History and	F 711	F711 1.R194 is no longer in facility.Unable to correct. 2.Any resident with a surgical wound has potential to be affected. Physician progress notes have been reviewed to determine that surgical wounds have been assessed. Wound care nurse and consultant notes have been reviewed to determine that care orders are in place. 3.Root Cause was detrmined to be lack of identification of wounds on nurse charting. DON or designee will review with Nurse Practitioners and Medical Director the requirements for documentation of assessment and interventions for surgical wounds. 4.Audits of surgical wound assessments and interventions will be done by nurse management weekly x4; monthly x3; and findings brought forward to QAPI team for review. Wound Nurse to monitor.	

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F 711	Continued From page 53 Physical documented "... Patient had a fall and presented to the hospital, found to have a left distal fibula fracture and transverse medial malleolus (ankle) fracture... underwent ORIF (open reduction and internal fixation [surgery])... Physical exam... Skin: see nursing admit note... Assessment/Plan: Closed left ankle fracture, S/P ORIF- NWB, some pain as expected ..." 6/29/22 - C4's (Consultant Wound Care NP) Skin/Wound Note documented "...Comprehensive skin and wound evaluation for new admission to facility... Exam: Dermatologic - Wound(s) present; Please see wound assessment below. Wounds - Pt has surgical site to left ankle See TA (Tissue Analytics) documentation for full wound assessment details. Plan: Wound Plan of care... RN to return later to assess area and notify PCP (Primary Care Physician or Provider) of any concerns... recommend extensive wound care to site...". There was no follow up documentation by the RN (bedside nurse as referenced in the above note) regarding R194's wound. Additionally, there was no note regarding R194's LLE wound using the Tissue Analytics documentation program at this time. Lastly, there was no explicit wound care recommendations or orders written to coincide with this note. 7/1/22 - E6's (NP) Progress Note documented "... Physical exam... Skin: Warm, dry. Limited Exam. See nursing notes and skin/wound care notes... Assessment/Plan: Closed left ankle fracture - left distal fibula fracture and transverse medial malleolus fracture. Now S/P ORIF procedure 6/15/22. Remains NWB, has LLE cam brace/boot in place. Some intermittent pain as expected,	F 711		

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F 711	Continued From page 54 pain meds help...". 7/5/22 - E6's (NP) Progress Note documented "... Physical exam... Skin: Warm, dry. Limited Exam. See nursing notes and skin/wound care notes... Assessment/Plan: Encounter for other specified surgical aftercare, S/P ORIF to LLE ankle. WCT (Wound Care Team) following. Nursing to monitor ongoing, treatment as ordered/recommended. LLE distal neurovascular exam intact on exam today." 7/6/22 - E6's (NP) Progress Note documented "... Assessment/Plan: Encounter for other specified surgical aftercare, S/P ORIF to LLE ankle. WCT following. Nursing to monitor ongoing, treatment as ordered/recommended. LLE distal neurovascular exam intact." This progress note lacked documentation of the Skin system under the Review of Systems and Physical Exam section. 7/12/22 - E6's (NP) Progress Note documented "... Physical exam... Skin: Warm, dry. Limited Exam. See nursing notes and skin/wound care notes... Assessment/Plan: Left... fibula and... malleolus fracture... has follow-up with Ortho 7/15/22... Encounter for other specified surgical aftercare, S/P ORIF to LLE ankle. WCT following. Nursing to monitor ongoing, treatment as ordered/recommended. LLE distal neurovascular exam intact." 7/15/22 - E6's (NP) Progress Note documented "... Physical exam... Skin: Warm, dry. Limited Exam. See nursing notes and skin/wound care notes... Assessment/Plan: ...WCT following... Nursing to monitor ongoing, treatment as	F 711		

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F 711	Continued From page 55 ordered/recommended. LLE distal neurovascular exam intact." 7/15/22 - R194's Ortho Consultation Findings note documented... " S/P L (left) ankle ORIF, poss (possible) infection, recommend doxycycline (antibiotic). F/U (follow-up) with (MD name) next Tuesday... Local wound care...". 7/15/22 - E6 (NP) ordered "Doxycycline Monohydrate (antibiotic) 100mg by mouth two times a day for Ortho infection LLE times 7days." 7/18/22 - E35 (NP) ordered "Treatment - left medial and anterior ankle - cleanse area with NSS/wound cleanser, apply xeroform (a type of wound dressing) and cover with dry dressing. Notify wound care/provider for worsening wound. As needed for wound care AND every shift." The order on 7/18/22 was the first order acknowledging R194's LLE surgical incision in the medical orders. 7/18/22 - E6's (NP) Progress Note documented "...Physical exam... Skin: Warm, dry. Limited Exam. See nursing notes and skin/wound care notes... Assessment/Plan: Closed left ankle fracture... malleolus fracture... Per ortho - had follow-up on 7/15/22. S/P L ankle ORIF. Possible infection. Recommend Doxycycline X 7 day course (started 7/15/22)... Continue local wound care... Encounter for other specified surgical aftercare... had Ortho appt 7/15/22, possible infection. Started on Doxycycline of which patient continues on currently....". 7/20/22 9:03 AM - C4 (Consultant Wound Care NP) documented Tissue Analytics wound	F 711		

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F 711	Continued From page 56 measurements for the left lateral and medial ankle wounds. This is the first and only documentation of wound measurements using the tissue Analytics documentation program in R194's medical record. 7/14/23 10:30 AM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), and E3 (ADON).	F 711		
F 756 SS=C	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756		9/6/23

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F 756	Continued From page 57 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop policies and procedures for the monthly MRR (Medication Regimen Reviews) that included time frames for different steps in the MRR process. Findings include: 7/7/23 11:52 AM - Review of the facilities undated policy titled, "Medication Regimen Review," lacked information regarding the time frames for a pharmacist response, urgent and non-urgent medication recommendations, or a time frame for a facility response to recommendations. 7/14/23 - An interview during exit conference with E2 (DON) confirmed the MRR policy did not meet the expected requirements. 7/14/23 9:45 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 756	F756 1. No resident was harmed by the lack of time frames in the policy. 2.Any resident could have potential to be affected by the lack of time frames for review. Policy for drug regimen review has been revised to include time frames for each step of the process. 3.Root cause was determined to be inadvertant deleting of timelines when policy was revised. Staff Development to educate licensed personnel on revised policy time frames. 4.QAPI team will review and approve revised policy at next monthly meeting.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		9/6/23

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F 758	Continued From page 58 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

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F 758	Continued From page 59 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R16) out of two residents reviewed for PASARR, the facility failed to ensure that PRN orders for psychotropic drugs were limited to 14 days. Findings include: The facility policy on psychotropic medications last updated October 2022, indicated, "A psychotropic drug is any drug that affects brain activities... include but not limited to antianxiety [medications]. If the attending physician or prescribing practitioner believe it is important for the PRN to be extended beyond 14 days, they shall document their rationale in the residents medical record and indicate the duration for the PRN order." Review of R16's clinical record revealed: 6/1/23 - A hospice nursing note documented "Recommendations: per hospice when patient unable to swallow, antianxiety medication every morning and evening as needed for anxiety." 6/2/23 - A Physicians order was written by R16's Attending Physician for R16 to receive an antianxiety medication every 12 hours as needed with no stop date.	F 758	F758 1.R16 never received a dose of the PRN psychotropic medication, and it is now discontinued. 2.Any resident placed on a PRN dose of psychotropic medication has potential to be affected. A review of current PRN psychotropic medications was done to determine and place stop dates on any that were lacking. None were found without stop dates. 3.Root Cause was related to the starting of hospice services and an oversight that was caught in review and corrected. Staff Development will reeducate licensed personnel on need for stop date of PRN psychotropic medication. 4.Audits of PRN psychotropic medication will be conducted weekly x4; monthly x3; and findings brought for review to monthly QAPI Team. Quality Assurance nurse to monitor.	

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	085037	A. BUILDING _____ B. WING _____	C 07/14/2023

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F 758	Continued From page 60 During an interview on 7/10/23 at 11:44 AM, E23 (RN) confirmed that "Typically psychotropic have a 14 day limit and we check, but this was recommended by hospice." The facility did not provide evidence of a rationale for the extension nor a duration documented by R16's Attending Physician. Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) at the exit conference on 7/14/23 at 9:45 AM.	F 758		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;	F 790		9/6/23

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F 790	Continued From page 61 §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R32 and R118) out of four sampled residents for dental services, the facility failed to assist the resident in obtaining routine dental services. Findings include: Cross refer F656 The facilities policy titled, "Dental Services", revised 10/2022, indicated "The dental needs of each resident are identified through the physical assessment and MDS assessment process and addressed in each resident's plan of care." 1. Review of R32's clinical record revealed: 8/20/21 - R32 was admitted to the facility. 8/21/21 - Review of the care plan initiated 8/21/21 revealed no evidence of R32 having a care plan related to dentures or dental needs.	F 790	F790 1.A. R32 has been offered dental services and has declined them. Care plan has been updated. B. R118 was offered dental services but no longer resides in the facility. 2. Any resident who converts to long term care after a short stay has potential to be affected. Current residents dental status has been reviewed and offered services as applicable. 3.Root cause was determined to be a failure to offer dental services when a resident converts to long term care. Also, a failure to document declination. Procedure has been revised so that residents converting to long term care are offered dental services by the BOM and/or Social Services. Staff Development will reeducate staff on need to document dental needs as well as refusals for care and treatment.	

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F 790	Continued From page 62 5/28/22 - Review of the MDS (Minimum Data Set) assessment documented that R32 had broken teeth or loosely fitting full or partial dentures. 5/28/23 - Review of the MDS assessment documented that R32 does not have broken teeth or loosely fitting full or partial dentures. 7/5/23 9:33 AM - An interview with R32 revealed that R32 has dentures that do not fit, resulting in R32 not wearing dentures due to the lower plate not fitting properly. R32 stated he has not seen the Dentist regarding his dentures. 7/10/23 9:57 AM - An interview with E4 (Medical Records) confirmed that R32 had not been scheduled with the facilities Dentist or an outside Dentist. E4 stated the scheduler was calling to set up an appointment for R32 today. 7/10/23 10:30 AM - Review of an email with the facility Dentist revealed that R32 was offered a dental appointment on 2/9/23 and R32's decisionmaker declined the visit. The facility failed to offer dental services from 8/20/21 to 2/9/23. 2. Review of R118's clinical record revealed: 3/23/23 - R118 was admitted to the facility. 3/31/23 - Review of the admission MDS assessment revealed that R118 had obvious or broken natural teeth. 7/6/23 9:43 AM - An interview with R118 revealed broken natural teeth and the need to see the Dentist.	F 790	4.Findings of the one time audit of dental services will be brought to the QAPI team for review and to propose further action.	

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F 790	Continued From page 63 7/10/23 9:57 AM - An interview with E4 (Medical Records) confirmed that R118 had not been scheduled with the facilities Dentist or an outside Dentist. E4 stated the scheduler was calling to set an appointment for R118 today. 7/14/23 9:45 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F 790		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that a qualified person in charge was present during all hours of Kitchen operation. Findings include:	F 802	F802 1.No resident was harmed by the lack of a certified dietary manager. 2.Any resident in the facility has potential	9/6/23

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F 802	Continued From page 64 7/5/23 11:05 AM - During an observation and interview, E32 (Regional Dining Consultant) and E33 (Assistant Dining Services Manager), disclosed that no members in the facility's food service department possessed valid Food Protection Manager certificates from an Accredited Food Safety Program. 7/5/23 3:22 PM - Findings were confirmed with E32 and E33. 7/14/23 9:45 AM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F 802	to be affected, but none have been noted through resident council or other means. 3.Root cause was a staff vacancy. New Certified Dietary Manager hired with start date of August 10, 2023. 4 cooks trained in ServSafe. 4.Staffing report will be made to QAPI team at monthly meeting and Administrator will monitor.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		9/6/23

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F 812	Continued From page 65 by: Based on observation and interview, it was determined that the facility failed to prevent the occurrence of mold in high moisture areas, ensure safe storage of food and provide the sanitizing solution required for disinfecting food preparation surfaces. Findings include: 7/5/23 9:25 AM - During a tour of the kitchen, no red sanitizer buckets containing sanitizing solution were available in the kitchen for disinfecting food preparation surfaces. 7/5/23 9:32 AM - During a kitchen tour, an improperly covered tray of sliced ham and turkey, a partially covered container of leftovers and a tray of sliced cheese and bread with the plastic film cover peeled up at the corner exposing the contents to moisture and other debris were observed in the walk-in refrigerator. 7/5/23 1:08 PM - During a tour of the kitchen, numerous areas of black spotted staining, which appeared to be mold, were observed on the kitchen ceiling directly above the water pipes that hang several inches below the ceiling. 7/5/23 3:22 PM - Findings were confirmed with E32 (Regional Dining Consultant) and E33 (Assistant Dining Services Manager). 7/14/23 9:45 AM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F 812	F812 1.No resident was named or shown to have harm from practices named. Red sanitizer buckets were ordered during survey and put into use. Plastic wrap that came loose has been secured on dated, labeled, and covered items in the kitchen. Black spotted staining above the water pipes has been scheduled to be removed with a lift ladder. 2.Any resident had potential to be affected. 3.Root cause was found to be related to vacancies in managerial staff in housekeeping, maintenance and kitchen. Vacancies have been filled. Staff have been reeducated and cleaning schedules revised to include routine cleaning of kitchen areas. Staff have also been reeducated on proper storage of food items. 4.Audits of kitchen cleanliness and labeling of food items will be done by Asssistant Food Service Manager and corporate support team weekly x4; monthly x3; and findings reported to the QAPI team for review.	
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured	F 924		9/6/23

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F 924	Continued From page 66 handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that in one out of five units, the facility failed to ensure that a handrail in a resident corridor was firmly affixed to the wall. Findings include: 7/5/23 10:43 AM - During an observation and interview, E27 (LPN) revealed to the Surveyor that a handrail approximately four feet long, on the 400 unit, next to the linen room, was loose and about to fall off. The end closest to the unit could easily be pulled away from the wall. 7/5/23 10:50 AM - During an observation and interview, E26 (ESD) confirmed that the handrail was broken and could easily be pulled away from the wall. 7/5/23 11:24 AM - During an observation and interview, E29 (Maintenance) confirmed that the handrail could just "pop right off" when residents attempted to utilize it. 7/5/23 11:25 AM - During an interview, R36 (RN) stated that she observed other residents use the handrail and one end would fall off the wall. The interview occurred with E29 present. 7/10/23 2:26 PM - During an observation and interview, E1 (NHA) confirmed that the handrail was firmly secure to the wall. 7/14/23 - Findings were reviewed with E1, E2 (DON) and E3 (ADON) at the exit conference beginning at 9:45 AM.	F 924	F924 1.No resident was found to be affected or harmed by the loose handrail. 2.Any resident using that section of rail had potential to be affected. Handrail was fixed during survey. 3.Root cause was determined to be staff failure to place broken handrail into maintenance logbook. Staff Development has reeducated licensed staff and other nursing staff on how to place requests into the Maintenance Request portal called REQQER. 4.Rounds will be conducted by supervisory staff weekly x4; monthly x3; and findings brought to QAPI team for review and further action. Administrator to monitor.	