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F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rush L Walker | TITLE: Administrator | (X6) DATE: 3/2/24

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 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff treated each resident with respect and dignity when staff left two residents (Residents #42 and #27) exposed during transfer and/or incontinent care, stood over two residents (Residents #15 and #8) while assisting the residents to eat, and cursed at one resident (Resident #43). The facility census was 60. Review of a facility policy entitled "Resident Rights," undated, showed the following: -It is the purpose of this facility to meet the Federal and State mandate in respect to resident rights. The resident has a right to a dignified existence. A facility must protect the rights of each resident; -Rights include privacy and respect. Review of a facility policy entitled "Perineal Care," undated, showed to provide privacy for the resident. Review of the facility policy, "Feeding the Resident (Dependent Eating)", undated, showed the following: -Purpose to assist the resident with feeding and provide adequate nutrition; -Do not discuss unpleasant subjects while resident is eating; -Never make the resident feel that the meal must be hurried, but that the experience is pleasant; -Sit so you (staff) are at the same level as the	F 550		

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F 550	Continued From page 2 resident when possible. 1. Review of Resident #42's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 12/02/23, showed the following information: -Admission date of 10/30/19; -Diagnoses included dementia, anxiety, and high blood pressure; -Severely impaired cognition; -Incontinent of bowel and bladder. Review of Resident #27's annual MDS, dated 11/17/23, showed the following information: -Admission date of 10/18/22; -Diagnoses included dementia, Parkinson's disease (disorder of the central nervous system that affects movement), anxiety, depression, high blood pressure, and gastroesophageal reflux disease (GERD - stomach acid backs up into the esophagus); -Moderately impaired cognition; -Incontinent of bowel and bladder. Observation on 01/29/24, at 1:14 P.M., showed Nurse Aide (NA) A and Certified Nurse Aide (CNA) B entered the room of Residents #42 and #27 and closed the residents' door. The NA and CNA used a Hoyer (mechanical) lift to transfer Resident #42 from a Broda chair (specialty reclining wheelchair) to his/her bed. The privacy curtain between the roommates remained open. Resident #27 sat in his/her wheelchair facing Resident #42. NA A and CNA B lowered Resident #42's pants and rolled him/her to his/her right side facing the wall. Without closing the privacy	F 550		

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curtain, CNA B removed the resident's wet brief and cleaned the buttocks and coccyx (tailbone) area of feces smear. NA A applied barrier cream to the buttocks and coccyx before covering the resident.

Observation on 01/30/24, at 1:26 P.M., showed the room door remained closed, but the privacy curtain between the roommates remained open. NA A and CNA B used a sit-to-stand mechanical lift to raise Resident #27 from his/her wheelchair. With the resident suspended in the lift and facing the door and roommate, NA A lowered the resident's pants and removed his/her wet brief. The resident was left exposed from waist to knees for two to three minutes while the NA retrieved supplies. NA A then used wipes to clean the resident's perineal area and buttocks. NA A and CNA B then turned the lift around and lowered the resident onto his/her bed before covering him/her.

During an interview on 02/01/24, at 8:30 A.M., CNA D said staff should always close the room door and pull the privacy curtain closed when provided personal cares for a resident to provide privacy. He/she said it was not okay to not close curtain if resident has roommate during cares.

During an interview on 02/01/24, at 8:55 A.M., CNA I said that staff should shut the room door and pull curtain for privacy when completed personal hygiene cares for a resident. He/she said it was not okay to keep curtain open if resident has roommate.

During an interview on 02/01/24, at 10:35 A.M., Certified Medication Tech (CMT) J said that staff should always ensure that the room door and

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privacy curtain was closed for privacy during resident personal cares. He/she said it would not be okay to leave the curtain open, especially if there was a roommate in room.

During an interview on 02/01/24, at 10:55 A.M., CMT K said staff should close the door and pull the privacy curtain when providing care for a resident. The privacy curtain should not remain open when there is a roommate.

During an interview on 02/01/24, at 11:05 A.M., Registered Nurse (RN) H staff should close the room door and pull the privacy curtain when assisting the resident with personal cares. Staff should not leave the curtain open if the resident has a roommate.

2. Review of Resident #15's face sheet (gives basic profile information) showed the following information:

-Admission date of 08/06/20;
-Diagnoses included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and personal history of traumatic brain injury (TBI - Brain dysfunction caused by an outside force, usually a violent blow to the head).

Review of the resident's annual MDS, dated 06/26/23, showed the following:

-Severe cognitive deficit;
-Required supervision or touching assistance with eating;
-Resident received a mechanically altered diet.

Review of the resident's care plan, last updated

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F 550	Continued From page 5 09/18/23, showed the following: -The resident was unable to perform activities of daily living (ADLs - fundamental skills required to independently care for oneself); -The resident was not able to feed him/herself; -Staff should place a clothing protector on the resident and over the resident's lap to protect the clothing. Observation on 01/28/24, at 5:50 P.M., showed CNA L stood over the resident and gave him/her bites of pureed food. The resident sat in a Broda chair (a specialized type of wheelchair that assists in positioning and helps resolve seating issues such as slumping, sliding, poor lateral support and patient falls) with a clothing protector on. 3. Review of Resident #8's face sheet showed the following information: -Admission date of 07/04/21; -Diagnoses included Parkinson's disease with dyskinesia (abnormality or impairment of voluntary movement), psychotic disorder (group of serious illnesses that affect the mind) with hallucinations, chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), and Type 2 diabetes mellitus (a problem in the way the body regulates and uses sugar as a fuel). Review of the resident's annual MDS, dated 11/16/23, showed the following: -Severe cognitive deficit; -Resident received a mechanically altered diet; -Resident received a therapeutic diet.	F 550		

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F 550	Continued From page 6 Review of the resident's care plan, last updated 11/28/23, showed the following: -The resident would continue to assist with care task completion to the extent possible, related to the disease process; -The resident was able to feed self with set up assist at meals; -The resident preferred someone to feed him/her most of the time; -Staff should allow plenty of time to eat the meal; -Staff should not allow the resident to feel rushed; -Staff should encourage meals in the dining room unless contraindicated. Observation on 01/29/24, at 12:20 P.M., showed Licensed Practical Nurse (LPN) M stood over the resident and gave him/her bites of pureed food. The resident sat in a Broda chair with a clothing protector on. Observation on 01/30/24, at 12:32 P.M., showed CNA I was stood over the resident and gave him/her bites of pureed food. The resident sat in a Broda chair with a clothing protector on. 4. During an interview on 02/01/24, at 8:30 A.M., CNA D said that staff should assist the resident with items at meals, including opening items. The CNA said that staff should be seated next to the resident and said that it was okay to stand over the resident during meals. During an interview on 02/01/24, at 8:45 A.M., CNA I said that generally staff should sit next to a resident to assist with meals. The CNA said if the resident was in a Broda chair he/she could not reach the resident, so he/she had to stand up to	F 550		

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help. The CNA said that staff should try to remain at the resident's level when talking to or assisting a resident.

During an interview on 02/01/24, at 10:35 A.M., CMT J said that he/she was usually seated when providing feeding assistance to residents at mealtime. He/she said that he/she was so short that sometimes he/she would have to stand to feed residents in Broda chairs.

During an interview on 02/01/24, at 11:05 A.M., Registered Nurse (RN) H said that he/she was unsure if it mattered if staff were standing above a resident when feeding. He/she said that he/she liked to sit with the resident to keep eye contact.

During an interview on 02/01/24, at 12:25 P.M., the Assistant Director of Nursing (ADON) said staff are not supposed to stand over resident when assisting with feeding. The ADON said that staff should sit and chat to make the resident have a more homelike environment.

During an interview on 02/01/24, at 2:05 P.M., the Administrator said staff should not be standing over the residents when assisting with meals and should only be feeding or assisting one resident at time.

5. Review of Resident #43's face sheet showed the following information:

-Admission date of 08/17/23;
-Diagnoses included cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis on one side of the body) affecting left non-dominant side following cerebral infarction, congestive heart failure (CHF - a condition in which the heart can't

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pump enough blood to the body's other organs), and generalized anxiety disorder.

Review of the resident's care plan, last updated 11/28/23, showed the following:

-Resident had an ADL self-deficit;
-Staff will assist the resident with ADLs as needed;
-Resident at risk for behavioral episodes;
-Staff should report any behavior changes and/or verbal behaviors to the charge nurse for assistance.

Review of the resident's significant change in status MDS, dated 11/29/23, showed the following:

-Cognitively intact;
-Resident has almost constant pain;
-Resident has physical and verbal behavioral symptoms directed to others daily.

Review of the facility Grievance/Complaint Report, dated 12/21/23, showed the following:

-Resident and resident representative initiated the complaint;
-Housekeeper E came into Resident #43's room and he/she was taking a "piss". The housekeeper told the resident to cover it up. The resident told him/her to pull the curtain which the staff did and called the resident "little fucking asshole". The resident told the staff to look in the mirror. The staff was always hateful when coming into the resident's room. Then the staff threatened the resident saying, " I'll go get the Administrator on your ass;"
-The Administrator took a statement from

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Housekeeper E via telephone with Social Service Director (SSD) and the Housekeeping Supervisor present as witnesses;
-Education to staff and discipline write-up completed;
-Housekeeper E was given a write-up and educated on abuse of residents, including verbal, physical, and emotional abuse. Staff notified the resident of the results in one-to-one conversation and notified resident's representative phone.

During an interview on 01/30/23, at 11:15 A.M., the resident said that only one staff member had talked to him/her without respect by yelling and cursing at him/her. He/she said that the Administrator took care of it and there were no other problems.

During an interview on 02/01/24, at 11:20 A.M., Housekeeper E said that he/she received abuse and neglect training at least once per year, and this included resident right to be treated with respect and dignity. The staff said that he/she knocked on the resident's door one day in December and after entering the room he/she started coughing. The housekeeper had recently recovered from being ill, but had a continued lingering cough. The resident said, "Don't bring that shit in to me". The staff said he/she told the resident that he/she was not ill and only had a cough. The resident then said, "pull that curtain closed bitch". The staff then said he/she called the resident an "asshole." Housekeeper E said that he/she should not have cursed at the resident.

During an interview on 02/01/24, at 8:30 A.M., CNA D said that he/she received training on hire that included the resident rights to be treated with

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dignity and respect. He/she said it was not okay for staff to curse or yell at residents.

During an interview on 02/01/24, at 8:55 A.M., CNA I said he/she received abuse and neglect training, which included resident rights to be treated with dignity and respect. He/she said it was not okay to talk mean or yell at residents, and it was not okay to curse at residents. He/she would notify the charge nurse and DON of any concerns.

During an interview on 02/01/24, at 10:35 A.M., CMT J said residents have the right to be treated with dignity and respect, and staff should not curse or yell at residents.

During an interview on 02/01/24, at 10:45 A.M., Housekeeper G said that staff should not cuss at a resident and staff should notify the supervisor if witness any incident.

During an interview on 02/01/24, at 11:05 A.M., RN H said that he/she had received resident right training and in-services, that included the right to be treated with respect. Staff should not cuss or speak inappropriately to residents.

During an interview on 02/01/24, at 11:10 A.M., Housekeeper F said he/she received training on hire that included treating resident with respect and dignity. He/she said that if he/she heard anyone yell or curse at a resident, he/she would go to the supervisor.

During an interview on 02/01/24, at 12:25 P.M., the ADON said that the facility reviews abuse and neglect in-service every February and more often any time there is an incident. The training

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F 550	Continued From page 11 includes resident rights to be treated with dignity and respect. He/she said that staff should report any allegation of staff not treating residents with respect to the supervisors. During an interview on 02/01/24, at 2:05 P.M., the Administrator said that on 12/21/23 there was an incident with a housekeeper cussing at a resident. This occurred during the holiday weekend. She said that she was notified on Monday 12/25/23 by finding a note on her desk that evening when she came into the facility. She had to wait until the following day to talk to the supervisors to see if anyone had done anything about the incident. At that time a full investigation was started, and the resident's representative was notified. During the interview with Housekeeper E, he/she said that Resident #43 was rude and yelling at him/her. Housekeeper E said that the resident called him/her a "grumpy old bitch" and he/she called the resident an "asshole". The employee was given a first and final warning, and educated on resident rights, as well as education on de-escalating situation with a resident in the nursing home.	F 550		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure one	F 678		

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resident's (Resident #36) code status (if the resident wished to received cardiopulmonary resuscitation (CPR - a lifesaving technique that is used when someone's breathing or heartbeat has stopped) was consistent and accurate throughout the resident's medical record. The facility census was 60.

Review showed the facility did not provide a policy regarding code status.

1. Review of Resident #36's face sheet showed the following information:

-Admission date of 01/07/23;
-Diagnoses included dementia (progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), cerebral infarction (stroke), unstageable pressure ulcer (full-thickness pressure injuries in which the base is obscured by eschar (dry, dark scab) of left heel, and left knee osteoarthritis (degeneration of joint cartilage and the underlying bone);
-Do not resuscitate (DNR - person has decided not to have CPR attempted on them if their heart or breathing stops);
-On hospice services (program designed to make the process of dying as comfortable as possible for patients and their families).

Review of the resident's physician order sheet, current as of 02/01/24, showed the following:

-An order, dated 04/27/23, for full code (if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive).

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Review of the resident's care plan, last reviewed 01/24/24, showed the following:

-Resident on hospice services;
-Resident chooses to be full code and plan long term care;
-Staff should start CPR and call 911, in case of no pulse or no respirations.

Review of the resident's nursing progress note, dated 01/24/24 showed the following:

-Staff documented there was a care plan meeting on 01/23/24, at 11:25 A.M. The resident's family members were in attendance, along with facility staff and hospice provider. The family chose hospice on 01/23/24.

Observation of the resident's room door showed a name tag, along with a red dot on the tag. (The red tag indicated the resident wished to be a DNR.)

During an interview on 02/01/24, at 8:30 A.M., Certified Nurse Aide (CNA) D said resident code status can be located on the resident's name tag at room door. A red dot indicated DNR code status and a green dot indicated full code status. The aide said that he/she believed it was also in electronic medical chart and the information should match.

During an interview on 02/01/24, at 8:45 A.M., CNA I said that resident's code status was located on the resident room door name tags by a red or green sticker. The information was also located in the electronic medical record by their name and the information should match.

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F 678	Continued From page 14 During an interview on 02/01/24, at 10:35 A.M., Certified Medication Tech (CMT) J said that resident code status was located on the medication administration record and the face sheet. He/she said the information should match. During an interview on 02/01/24, at 11:05 A.M., Registered Nurse (RN) H said the following: -Resident code status was located on the resident door and in computer; -Code status was also in a code book at the nurses' station with a purple sheet if resident was a DNR; -Review of the book with the nurse showed that Resident #36 did not have a purple sheet in the book; -The nurse said that the resident had recently changed to hospice status; -The nurse said that the code status should match throughout chart. During an interview on 02/01/24, at 12:25 P.M., the Assistant Director of Nursing (ADON) said that code status was located on resident doors with a red or green dot. The red dot was for DNR and green dot was for full code. The information would also be on the resident's face sheet and on the physician order sheet. This information is printed when sending a resident out of the facility. The care plan will also indicate if the resident wishes for full code or DNR. The information should match throughout the records. During an interview on 02/01/24, at 2:05 P.M., the Administrator said resident code status was on resident doors by red or green dot, and on the staff computer kiosk with the resident names. There was also a book up front with all the face	F 678		

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F 678	Continued From page 15 sheet with code sheet on the front of it. Code status would be noted on the physician orders. The Social Service Designee (SSD) checks all code status at least once week to make sure they are accurate. The information should match throughout chart.	F 678		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure residents were free of significant medication errors when staff attempted to provide one resident (Resident #27) with a double dose of medication during a random medication pass observation. The facility had a census of 60. Review of the facility policy titled "Medication Administration," undated, showed the following: -Staff should read the label three times before administering medication: -First when comparing the label top the medication sheet; -Second when setting up the medication; -Third when preparing to administer the medication to the resident. 1. Review of Resident #27's face sheet showed the following: -Admission date of 10/18/22; -Diagnoses included Parkinson's disease	F 760		

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(disorder of the central nervous system that affects movement, often including tremors) with dyskinesia (abnormality or impairment of voluntary movement), dementia without behavioral disturbance, and drug induced akathisia (state of agitation, distress, and restlessness that is an occasional side-effect of antipsychotic and antidepressant drugs).

Review of the resident's physician order sheet, current as of 02/01/24, showed the following:

-An order, dated 07/10/20, to rush or alter mediations unless otherwise indicated;
-An order, dated 11/22/23, for carbidopa/levodopa (used to treat Parkinson's) 25-100 milligram (mg), two tablets orally three times per day;

Review of the resident's care plan, dated 11/17/23, showed the following:

-Resident at risk for behaviors related to diagnosis of Parkinson's, dementia, depression, and anxiety;
-Staff should administer medications as directed;
-Staff should monitor for signs and symptoms of adverse effects.

Observation on 01/31/24, at 11:20 A.M., of the medication pass showed the following:

-Certified Medication Technician (CMT) J and Registered Nurse (RN) N were at the medication cart near the nursing station preparing medication administration;
-The CMT had multiple empty medication cups that were labeled with resident names;
-The CMT removed a medication card from the cart for Resident #27 and found the medication

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card to be empty;
-The CMT and RN went to the medication room to the stat safe;
-The CMT held the empty medication card with the pharmacy label;
-The RN entered his/her access information into the stat safe;
-The RN then entered the resident and the medication needed - carbidopa/levodopa (brand name Sinemet CR) 25-100 mg (milligram, dosage of medication);
-The CMT and RN reviewed the medication card and noted it to say carbidopa/levodopa 25-100 mg, administer carbidopa/levodopa two tablets (50-100 mg) three times per day;
-The stat safe drawer opened, the RN removed the appropriate medication box;
-The RN removed four tablets of carbidopa/levodopa 25-100 mg and put into the medication cup;
-The RN and CMT returned to the medication cart;
-The CMT took a small plastic bag out of medication cart and stated that the resident's medications were to be crushed;
-As the CMT began to pour the four tablets into the plastic bag, the state surveyor requested the CMT stop and review the orders again in the computer;
-The CMT reviewed the orders again and said that his/her calculation was off and he/she should have only provide two tablets.

During an interview on 02/01/24, at 10:35 A.M., CMT J said the following:

-Staff should review the physician orders and the medication card when providing medications to residents;

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F 760	Continued From page 18 -Staff should double and triple check the orders and the medication administration record; -Medication errors should be reported the nurse and the Director of Nursing (DON); -Providing a double dose of carbidopa/levodopa would not be good for the resident. If a resident received too much medication, he/she would require increased monitoring and observation and staff would notify the physician. During an interview on 02/01/24, at 10:55 A.M., CMT K said the following: -Staff should review medication cards and medication orders multiple time when administering medications; -Medication should not be given as a double dose during medication administration; -A medication error should be reported immediately when staff become aware and staff would have to explain what occurred; -He/she do not know what the outcome would be if a resident received an overdose of any medication. During an interview on 02/01/24, at 11:05 A.M., Registered Nurse (RN) H said the following: -Staff should triple check the directions and dose on the medication cards and the electronic medication administration record before completing medication administration; -A a resident should not receive four tablets of a medication if the order was for two tablets. That would be a medication error; -Staff would report to the DON and the physician for any medication error. The resident would likely require increased monitoring.	F 760		

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F 760	Continued From page 19 During an interview on 02/01/24, at 12:25 P.M., the Assistant Director of Nursing (ADON) said that staff should not provide residents with a double dosage of medication. Staff should be checking the orders to verify medication provided each time. Medication errors should be reported, doctors should be notified, and residents should be monitored or follow doctor new orders. During an interview on 02/01/24, at 2:05 P.M., the Administrator said that staff should follow physician orders for medication administration and should not give four tablets if the order was for two tablets. If a medication error occurs the staff should notify the DON or ADON and fill out the medication error form. Staff should contact the physician, chart the error, and provide extra monitoring of resident.	F 760		
F 812 SS=F	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	F 812		

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serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to keep food safe from potential contamination or bacterial growth when staff stacked wet dishware inside one another, trapping moisture, which could potentially contaminate food served from those items. The facility census was 60.

Review of the facility's policy titled "General Dish Room Sanitation, by Nutrition and Dining Services Manual," dated April 2011, showed the following information:

-All items are to be air dried;
-No moisture can be found on any stacked item.

Review of the 1999 Food Code, issued by the Food and Drug Administration, showed the following information:

-After cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food;
-Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow.

1. Observations on 01/28/24, beginning at 9:57 A.M., of the kitchen showed 48 juice cups with water droplets trapped inside, upside down, stacked on top of one another on trays.

Observations on 01/30/24, beginning at 12:20

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P.M., of the kitchen showed the following:

-There were 41 juice cups with water droplets trapped inside, upside down on top of each other, stacked on trays;
-Three clear, square measuring bowls with water droplets trapped inside, upside down, stacked trapping the moisture.

Observation on 01/31/24, beginning at 12:30 P.M., showed the following items stacked, and/or placed upside down on one another, not allowing for air flow and keeping and trapping moisture:

-102 clear juice cups;
-Two small round clear measuring bowls;
-Five plastic bowls;
-Nine plastic plates;
-Three large metal baking bins from the steam table
-One metal cup with lid

During an interview on 02/01/24, at 11:58 A.M., Dietary Aide P said he/she knows not to put dishes away wet, but thinks the kitchen staff still needs to be educated about this.

During an interview on 02/01/24, at 12:18 A.M., Dietary Aide Q said he/she has not been trained on how to stack the dishes once clean.

During an interview on 02/01/24, at 11:58 A.M., the Dietary Manager said the following:

-He/she knows that dishes cannot be stacked or placed upside down if they still have moisture in them;
-He/she is aware of the fact that bacteria can possibly grow if the dishes are not air dried.

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F 812	Continued From page 22 During an interview on 02/01/24, at 2:08 P.M., the Administrator said all items should be left out until done being air dried.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		

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F 880	Continued From page 23 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program when staff administered medication to one resident (Resident #2) after touching the medication with	F 880		

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bare hands and placing the medication directly on top of the medication cart, and when staff failed to complete routine hand hygiene during and after wound care for three residents (Resident #8, Resident #37, and Resident #11). The facility census was 60.

Review of the Centers for Disease Control and Prevention's (CDC) "Hand Hygiene Guidance," dated 01/30/20, showed the following in reference to healthcare settings:

-Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately before touching a patient; before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same patient; after touching a patient or the patient ' s immediate environment; after contact with blood, body fluids, or contaminated surfaces; and immediately after glove removal;
-Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled.

Review of the facility policy entitled "Wound Care and Treatment," undated, showed the following:

-Care must be taken to prevent contamination of the supplies and surfaces used in wound care;
-The treatment cart should be left in the hall and locked. Move the cart to the resident's room and park it outside the room. Remove the supplies needed and re-lock the cart;
-Medications should be for one designated resident only except large volume liquids (i.e.,

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saline). These may be poured into a cup to take to the bedside;
-Set up the supplies on a clean surface. Cover the surface with a clean, impervious barrier before putting the supplies down;
-Hand washing must be done as outlined in the guidelines;
-Cut the tape with clean scissors;
-Put gloves on;
-Remove the soiled dressing and place in the trash bag. Place the soiled scissors on one corner of setup, not touching any other supplies;
-Remove the gloves and discard in the bag;
-Clean scissors with 60 seconds of contact with alcohol and place on a clean corner of setup;
-Wash hands and put on clean gloves;
-Clean the wound according to the order;
-Place soiled gauze in the trash bag;
-Remove gloves, place in trash bag, and put on clean pair of gloves;
-Apply clean dressing as ordered;
-Wash hands.

1. Review of Resident #'2's face sheet showed the following:

-Admission date of 10/24/23;
-Diagnoses included Parkinsonism (umbrella term that refers to brain conditions that cause slowed movements, rigidity (stiffness) and tremors), bipolar disorder (mental health condition that causes extreme mood swings), and dementia (progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking).

Review of the resident's Physician Order Sheet (POS), current as of 02/01/24, showed the following:

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F 880	Continued From page 26 -An order, dated 10/23/23, for carbidopa/levodopa (used to treat Parkinson symptoms) 25-100 milligram (mg), administer one tablet three times per day; -An order, dated 10/23/23, for gabapentin (used to treat nerve pain) 100 mg, administer one capsule three times per day; -An order, dated 10/24/23, for ropinirole (used treat the symptoms of Parkinson's disease and restless legs syndrome) one mg, administer one tablet three times per day; -An order, dated 02/01/24, for acetaminophen (used to relieve mild or chronic pain and to reduce fever) 325 mg, administer two tabs three times per day; -An order, dated 02/01/24, for lorazepam (used to treat anxiety) 0.5 mg, administer one tablet three times per day. Observation on 01/31/24, at 10:45 A.M., showed Certified Medication Tech (CMT) J and Registered Nurse (RN) N preparing medications at the medication cart near the nurses' station: -CMT J removed the medication cards for the resident from the medication cart; -CMT reviewed the orders and began popping medications out of the card and into the cup; -The CMT popped the gabapentin 100 mg pill into his/her hand and then put the pill into the medication cup; -The CMT completed putting the medications into the cup, including lorazepam, ropinirole, carbidopa/levodopa, and acetaminophen; -The CMT handed the cup to RN N; -RN N attempted to deliver the medications to the resident near the nurses' desk; -The resident refused the medications and said	F 880		

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HERMITAGE NURSING & REHAB	18599 FIRST STREET HERMITAGE, MO 65668

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F 880	Continued From page 27	F 880		

that he/she would only take the medication for Parkinson's;
-The RN returned the medication cup to the CMT and the CMT poured the pills out into his/her bare hand without completing hand hygiene;
-The CMT then removed the carbidopa/levodopa pill with his/her fingers from his/her hand and put into a new medication cup.
-He/she then put the remaining tablets into the medication cup and put into the medication cart drawer to be disposed of later;
-The resident took the medication.

During an interview on 02/01/24, at 10:35 A.M., CMT J said the following:

-Staff should not touch pills when preparing medications, the medication should be popped into a medication cup;
-If a resident refused a medication, the staff should put away the medications to be disposed of properly and notify the charge nurse;.
-He/she said that he/she should probably have put on a glove to touch the pills when the resident only wanted one of the prepared pills;
-He/she said that he/she sanitizes the medication cart before every shift, so if a pill fell on the cart, he/she would pick it up and put into the medication cup.

During an interview on 02/01/24, at 10:55 A.M., CMT K said that staff should complete hand hygiene between every resident when administering medications. He/she said that medications should be popped into medication cup and staff should not touch the pills with their bare hands.

During an interview on 02/01/24, at 11:05 A.M.,

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F 880	Continued From page 28 RN H said that staff should not pop medications into hands. Staff should put on a glove if need to touch any pills. Hand hygiene should be completed between each resident. During an interview on 02/01/24, at 12:25 P.M., Assistant Director of Nursing (ADON) said that staff should complete hand hygiene between each resident when administering medications. Staff should not touch any pills with their bare hands. Staff should not pour medications into their bare hand and pick out the one pill the resident wanted. During an interview on 02/01/24, at 2:05 P.M., Administrator said that staff should complete hand hygiene in between resident with medication pass. Staff should not touch the pills with their hands. 2. Review of Resident #8's face sheet showed the following: -Most recent re-admission on 04/04/21; -Diagnoses included open wound on right foot and open wound on left lower leg. Review of the resident's POS, current as of 02/01/24, showed the following: -An order, dated 01/25/24, for staff to clean the left ankle with wound cleanser, apply skin prep (barrier wipe to create an invisible layer on your skin to protect it from adhesive), apply gentamicin (used to treat skin infections), and optifoam (adhesive foam dressing that is waterproof and has a high fluid-handling capacity). Staff to wrap with kerlix (bandage roll) and secure with tape. Staff to change daily and as needed.	F 880		

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F 880	Continued From page 29 Observation on 01/30/24, at 1:10 P.M., showed the following: -RN C prepared supplies for wound care; -The RN entered the resident's room with the wound cleanser bottle and resident's antibiotic gentamicin tube, dry gauze and two skin prep pads; -The resident was seated in the Broda chair (a specialized type of wheelchair that assists in positioning and helps resolve seating issues such as slumping, sliding, poor lateral support and patient falls) in room; -The nurse placed the supplies on the top of the resident's dresser with no clean barrier; -The nurse removed protective the boot and put it on the resident's bed. The nurse then took off the sock on the left foot to show a dressing dated 01/29/24; -The nurse applied gloves without performing no hand hygiene; -The nurse wiped the scissors with an alcohol wipe and removed the dressing using the scissors. The nurse then removed the optifoam cover from wound; -Without changing gloves or completing hand hygiene, the nurse picked up the wound cleanser bottle and sprayed onto dry gauze pads. The nurse then wiped the wound and entire foot with the wound cleanser gauze; -The nurse removed his/her gloves and disposed of the gloves. The nurse donned new gloves without completing hand hygiene; -The nurse opened the gentamicin ointment tube and squeezed it onto the optifoam dressing. The nurse then applied the dressing to the open wound; -He/she opened the skin prep wipe and wiped	F 880		

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F 880	Continued From page 30 entire left ankle, heel, foot, and toes with same skin prep; -He/she used a second skin prep wipe and wiped entire foot with wipe a second time; -The nurse removed his/her left glove to return to nurse cart at room door and obtain an ABD (highly absorbent gauze) pad; -He/she entered room and removed his/her right glove; -Without completing hand hygiene, the nurse opened the ABD pad package, applied it to leg and covered with kerlix. The nurse applied tape and dated the dressing; -The nurse re-applied the resident's sock; -Without completing hand hygiene the nurse removed the resident's right sock and inspected resident's foot, reapplied sock; -The nurse removed the supplies and washed hands at sink; -The nurse left the resident's room and put the wound cleanser on the top of the cart and the ointment into the cart without cleaning the containers. 3. Review of Resident #37's face sheet showed the following: -Admission date of 04/25/23; -Diagnoses included superficial (shallow) injury of left lower leg and laceration (cut or skin wound) of right lower leg. Review of the care plan, last reviewed on 11/28/23, showed the following: -Resident had a wound on the left lower leg; -The goal was for the wound was to heal without signs and symptoms of infection; -Staff should complete treatments as ordered;	F 880		

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F 880	Continued From page 31 -Wound care clinic to be involved as ordered. Review of the resident's physician orders, current as of 02/01/24, showed the following: -An order, dated 01/03/24, for skin prep on right lower extremity once per day. -An order, dated 01/29/24, for wound care on left lower extremity. Staff to cleanse with Pure & Clean (brand name of a wound cleanser), blot dry, apply collagen wound dressing (protein dressing used to encourage wound healing), cover with ABD, wrap with kerlix, secure with tape, and change every other day and as needed for soiling; Observation on 01/31/24, at 8:55 A.M., showed the following: -RN H applied hand sanitizer, applied gloves, put wound cleanser on dry gauze, and entered the resident's room with supplies; -The nurse put the supplies on the residents bedside table on a clean paper towel. -The nurse cut the gauze wrap off the resident's left lower leg. The dressing was dated 01/29/24; -The nurse removed soiled dressing and placed it in trash bag; -The nurse applied wound cleanser gauze to remove the stuck on optifoam on the wound bed; -The nurse removed his/her gloves and without completing hand hygiene and applied new gloves; -The nurse cut the collagen to the wound size and placed it on the wound bed. He/she then applied an ABD pad, wrapped with Kerlix, secured the wrap with tape, and dated the dressing 01/31/24; -Without removing his/her gloves or completing	F 880		

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F 880	Continued From page 32	F 880		

hand hygiene, the nurse moved to right leg and applied skin prep to two areas of dried unopened wounds;
-The nurse disposed of supplies into trash bag and removed gloves;
-The nurse washed his/her hands at the sink and left the room.

4. Review of Resident #11's face sheet showed the following:

-Re-admission to the facility on 06/05/23;
-Diagnoses included superficial injury of right thigh.

Review of the resident's POS, current as of 02/01/24, showed the following:

-An order, dated 01/11/24, for nystatin ointment (antibiotic used to treat fungal infections) 100,000 unit/gram. Mix with A&D (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations) and Zinc cream (used to treat and prevent diaper rash and other minor skin irritation). Staff to apply to left and right inner thigh wounds with incontinence (lack of voluntary control over urination and defecation) cares.

-An order, dated 01/28/24, to cleanse posterior (back) left thigh with wound cleanser, apply optifoam to open area, and cover with border gauze;
-An order, dated 01/28/24, to cleanse right posterior thigh with wound cleanser, apply optifoam to open area and cover with border gauze;

Review of the resident's care plan, dated 01/28/24, showed the following:

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F 880	Continued From page 33 -Resident currently had a pressure ulcer/wound; -The goal was for the wound to heal without signs and symptoms of infection; -Staff should complete treatments as ordered; -Wound clinic to be involved in treatment as ordered. Observation on 01/31/24, at 9:30 A.M., showed the following: -RN H applied hand sanitizer and prepared wound care supplies at the nurse cart. The nurse sprayed wound cleanser on dry gauze; -RN H and CNA D entered the resident's room; -The nurse brought the wound cleanser dry gauze to the resident room; -The nystatin powder and zinc oxide tube were on the resident's shelf in the room; -The nurse put on gloves and mixed the nystatin powder with zinc oxide in a mediation cup to make a paste; -The staff assisted the resident to roll to his/her right side; -The nurse placed the wound care supplies on the resident's bed; -The nurse wiped the back side of the upper left thigh with the gauze with wound cleanser, the wound area was bleeding; -The nurse wiped the right upper thigh area with wound cleanser on a gauze pad. The area was open with no drainage; -The nurse wiped fecal matter off the resident's buttock with the gauze and put the gauze on the bed pad. The nurse continued wiping the wounds with wound cleanser on a gauze pad. The nurse did not complete a glove change or hand hygiene; -The nurse applied the zinc nystatin paste with a wooden applicator with the same gloved hands;	F 880		

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F 880	Continued From page 34 -The nurse touched the resident's left hip area with his/her right gloved hand while applying paste to the wounds with left gloved hand; -The nurse wiped his/her soiled gloved left hand on the bed pad; -The nurse rolled the soiled pad under the resident and removed his/her gloves; -The nurse applied new gloves with no hand hygiene; -The nurse put clean bed pad under resident; -Staff then assisted the resident to roll to his/her left side; -The CNA pulled the soiled bed pad out from under the resident and pulled through the clean pad; -Staff then assisted the resident to roll to his/her right side; -The CNA went to the bathroom, removed his/her glove from the right hand and obtained a trash bag then put on a new glove on the right hand without completing hand hygiene; -The aide picked up the soiled laundry and put into the trash bag; -The nurse pulled the lift sheet through and assisted the resident to roll to his/her back; -The nurse and the aide pulled the resident up in the bed, to the head of bed with the same gloved hands; -The staff covered resident, ensured had call light and bed control in reach; -The nurse put a pillow under residents left buttock area for pressure relief; -The nurse removed his/her gloves and washed hands at sink; -The CNA cleaned up the room and removed gloves and washed hands at the sink. 5. During an interview on 02/01/24, at 8:30 A.M., CNA D said staff should complete hand hygiene	F 880		

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F 880	Continued From page 35	F 880		

before care and after resident cares. Depending on what the staff was doing, staff would only change gloves if soiled during cares.

During an interview on 02/01/24, 8:45 A.M., CNA I said staff should complete hand hygiene before entering any resident room, in between glove changes, when visibly soiled, and after completed with resident cares.

During an interview on 02/01/24, at 10:35 A.M., CMT J said that staff should be completing hand hygiene between every dirty and clean process, when assisting with resident meals, after every glove change, and before starting the shift.

During an interview on 01/31/24, at 10:00 A.M., RN H said the following:

-He/she washed hands before and after wound care;
-He/she liked to change gloves between clean and dirty;
-It was really not convenient to use hand sanitizer between glove changes, but it probably would be best practice.

During an interview on 02/01/24, at 11:05 A.M., RN H said that staff should complete hand hygiene before and after every resident care, including wound care, and between glove changes, and if visibly soiled.

During an interview on 02/01/24, at 12:25 P.M., Assistant Director of Nursing (ADON) said staff should complete hand hygiene before, during, and after wound care. Staff should always wash hands or use hand sanitizer between glove changes, and gloves should be change between

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F 880	Continued From page 36 any dirty to clean process. Staff should use hand sanitizer between each resident. During an interview on 02/01/24, at 2:05 P.M., the Administrator said staff should use hand sanitizer or wash hands before starting a resident care and after finished. Depending on the type of care, the staff should use hand sanitizer in between glove changes, and they should change gloves between the dirty to clean process. Staff should complete hand hygiene before wound care, and between dirty and clean process of glove changes.	F 880		

Missouri Department of Health and Senior Services

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A4055	19 CSR 30-85.042(46) Safe/Effective Medication System There shall be a safe and effective system of medication distribution, administration, control, and use. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F760.	A4055		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II 1. Please refer to F678.	A4075		
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by:	A4086		

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A4086	Continued From page 1 Class II 1. Please refer to F880.	A4086		
A7086	19 CSR 30-87.030(84) Equip/Utensils Air Dried, Self-Drain Utensils After mechanical or manual sanitization, all equipment and utensils shall be air dried. All utensils shall be stored in a self-draining position. III This regulation is not met as evidenced by: 1. Please refer to F812.	A7086		
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II* 1. Please refer to F550. *The higher classification merited due to the extent of the violation.	A8030		

PLAN OF CORRECTION

Provider/Supplier Name:	Hermitage Nursing and Rehab
Street Address, City, Zip:	18599 First Street Hermitage, Mo. 65668
Date of Survey:	02/01/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction ("POC") is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Hermitage Nursing and Rehab (the "Facility") as to the accuracy of the surveyors' findings, nor the conclusions drawn there from. The facility's submission of this POC does not constitute an admission on the part of the Facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Corrections on/by 03/17/2024	
F 550 SS=E	Resident Rights/Exercise of Rights. The Facility will ensure staff treats each resident with respect and dignity	03/17/2024 and ongoing
	Resident # 42 and # 27 have been assessed and was not affected by the alleged deficient practice. Resident # 8 has expired and no longer resides within facility. Resident # 15 have been assessed and was not affected by the alleged deficient practice. Resident # 15 will be provided with dignity and respect while dining in the dining room. Resident # 43 was assessed and was not affected by the alleged practice. Resident #43 will receive dignity and respect from the staff when having conversations with the resident. All current and future residents will be treated with dignity and respect during care. All staff was in serviced on dignity and respect on or before 03/12/2024 by the DON/Designee DON/Designee will observe incontinent care being performed 3 x a week x 4 weeks and monthly for 6 months.	

	DON/Designee will observe the dining room 3 x week x 4 weeks and ongoing to ensure staff is providing dignity while assisting residents with feeding. During rounds DON/Designee will observe conversations between residents and staff to ensure staff is providing dignity and respect to residents 2x a week x 4 weeks and monthly for 6 months. All finding will be discussed during monthly QAPI committee meeting.	
F 678 SS= D	CPR- CODE STATUS The facility will continue to ensure that residents code status is consistent and accurate throughout their medical record.	03/17/2024 and ongoing
	Resident # 36 was assessed and was not affected by the alleged deficient practice. All current and future residents will have an accurate and consistent code status throughout their medical record. All staff will be in-serviced on Code status on or before 03/08/2024. Social Service/Designee will audit all medical charts to ensure all Code Status are consistent and accurate by 03/01/2024. Social services/designee will audit all residents weekly x 4 weeks and monthly ongoing. All finding will be discussed during monthly QAPI committee meeting.	
F 760 SS=D	Residents are Free of Significant Med Errors. The facility will ensure residents are free of significant medication errors.	03/17/2024 and ongoing
	Resident #27 was assessed and was not affected by the alleged deficient practice. All current and future resident will be free from significant medication errors. All nursing staff was in serviced on medication errors on 03/12/2024 by DON/Designee DON/Designee will audit medication administration 3 x week x 4 weeks and monthly ongoing. All nursing that staff that administer medications will do a medication administration competency check off by 03/17/2024. All finding will be discussed during monthly QAPI committee meeting.	
F 812 SS=F	Food Procurement, Store/Prepare/Serve-Sanitary. The facility will keep food safe from potential contamination or bacterial growth when stacking dishes making sure all dishes are dry prior to stacking.	03/17/2024 and ongoing
	All residents have the potential to be affected by the alleged deficient practice.	

	All dietary staff was in-serviced on 02/02/2024 on potential contamination or bacterial growth when stacking dishes that are not given proper drying time. Dietary manager/ designee will monitor dishes 3 x week x 4 weeks and Monthly for 6 months to ensure that all dishes are dried prior to stacking. All findings will be discussed during monthly QAPI committee meeting.	
F880 SS=E	Infection Prevention and Control The facility will maintain an effective infection prevention and control program when administering medication and performing complete routine hand hygiene during and after wound care.	03/17/2024 and ongoing
	Resident #2 was assessed and was not harmed by the alleged deficient practice of administering medication without proper infection control. Resident #8 expired and no longer in the facility. Resident #37 and #11 were assessed and was not harmed by the alleged deficient practice of complete hand hygiene during and after wound care. All nursing staff was in-serviced on or by 03/08/2024 related proper hand hygiene with medication administration and proper hand hygiene during wound care. All nursing staff completed medication administration competency check offs on or by 03/17/2024. All nursing staff completed hand hygiene competency on or by 03/17/2024 DON/Designee will observe medication administration hand hygiene 3 x a week x 4 weeks and randomly ongoing. DON/Designee will observe proper hand hygiene during wound care 3x a week x 4 weeks and ongoing. All finding will be discussed during monthly QAPI committee meeting.	
A4055	Refer to F760	03/17/2024
A4075	Refer to F678	03/17/2024
A4086	Refer to F880	03/17/2024
A7086	Refer to F812	03/17/2024
A8030	Refer to F550	03/17/2024

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.