STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR ROAD SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An onsite revisit and a complaint investigation were conducted on 11/5/21. Tags F550, F 677, F 687, and F 725 were corrected as of 11/5/21. However, new tags were cited as a result of the complaint investigation survey that was conducted at the same time as the revisit. The facility is still out of compliance. Four of the eight complaint allegations were substantiated. (Event GN8111)	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		11/30/21

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

Electronically Signed | 11/23/2021

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F 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, Physician, and Nurse Practitioner interview, the facility failed to notify the physician when the resident returned from the emergency department. The emergency room physician had recommended the facility physician should have seen the resident within one to two days after emergency room discharge for one (Resident # 1) of three residents reviewed for change in condition. The findings included: Record review revealed Resident # 1 was admitted to the facility on 3/18/21. The resident had diagnoses of Alzheimer's disease, peripheral artery disease; history of deep vein thrombosis,	F 580	Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Barbour Court Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor	

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F 580	Continued From page 2 history of right femoral artery (the main blood vessel supplying blood to the lower body) to distal popliteal artery bypass surgery, and stent placement to both legs. Resident # 1's quarterly minimum data set assessment, dated 8/16/21, coded the resident as severely cognitively impaired. According to the facility nursing notes and physician telephone orders, on 10/22/21 the resident was found by the nurse to have discoloration to her right great toe, right third toe, and right 5th toe, edema, and no pedal pulse. She was transferred to the hospital per a nurse practitioner's telephone order for hospital evaluation. Hospital records revealed Resident # 1 was evaluated in the emergency department on 10/22/21. The hospital physician noted the resident's right great toe, middle and fifth toe had a bluish discoloration. The hospital did a CTA (computerized tomography angiography) and determined there was no acute arterial abnormality in the right lower extremity. While the resident was at the hospital a urinalysis and culture were obtained. The physician noted the urinalysis was concerning for a urinary tract infection. According to hospital discharge notations, it was recommended that the resident follow up with her primary care provider or referral physician in one to two days. Review of nursing notes revealed the resident returned to the facility on 10/23/21 at 3:00 AM. The hospital "After Visit Summary" sent back to the facility on 10/23/21 noted the resident had	F 580	does it constitute and admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 580 Notify of Changes On 10/29/21, the assigned nurse notified the on-call provider of resident #1 change in condition following readmission on 10/23/21. Resident #1was seen by the facility provider on 11/2/21. On 11/17/21, the Administrator initiated an audit of all hospital transfers with re-entry/readmissions from 10/17/21-11/16/21 to include resident #1. This audit is to ensure the provider was notified of resident return to the facility, status of visit to the hospital and any recommendations. The Unit Managers will address all concerns identified during the audit. Audit will be completed by 11/30/21. On 11/11/21, the Administrator initiated an in-service with all nurses in regards to Notification of Changes. Emphasis of in-service is notification of physician and resident representative for acute changes to include but limited to the development or worsening of wounds or changes in skin integrity, discharge from or admission/readmission to the facility, significant change in the resident's	

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F 580	Continued From page 3 been diagnosed with bluish skin discoloration, decreased circulation, and infection or inflammation of the bladder. The "After Visit Summary" also noted the resident was being placed on an antibiotic for a urinary tract infection. The summary did not include any orders for an antibiotic. Review of nursing notes revealed an entry by Nurse # 2 on 10/23/21 at 3:00 AM noted the resident had been diagnosed with bluish skin discoloration, decreased circulation, and infection or inflammation of the bladder; and there had been no new orders received. Review of the urine culture collected on 10/22/21 revealed the culture was completed on 10/24/21 and grew >100,000 colonies of the bacteria Proteus mirabilis (signifying a bladder infection). Review of the physician orders revealed the 10/22/21 verbal order that had been given by the NP to send the resident to the hospital was signed by Resident #1's physician on 10/26/21. The physician did not make at progress note at the time. On 10/29/21 at 6:55 PM, Nurse # 1 documented Resident # 1's right great toe was purplish in color and painful. The on-call provider was contacted and ordered blood work, an x-ray, and placed the resident on an antibiotic. On 11/2/21 the NP (Nurse Practitioner) examined Resident #1 and noted she was following up on the resident's right foot pain and swelling. The x-ray showed no evidence of acute pathology. The resident was observed with at least 2 black toes. Since being started on the antibiotic for the	F 580	physical, mental or psychosocial status. In-service will be completed by 11/30/21. All newly hired nurses will be in-serviced during orientation in regards to Notification of Changes. The IDT Team will review all hospital transfers with re-entry/readmissions to the facility to include resident #1 weekly x 4 weeks then monthly x 1 months utilizing Notification Audit Tool. This audit is to ensure the provider and resident representative (RR) were notified of return to the facility, status of visit and any recommendations. The Unit Managers will address all concerns identified during the audit to include notification of the provider and/or RR. The Director of Nursing review the Notification Audit Tool weekly x 4 weeks then monthly x 1 months to ensure all concerns addressed. The DON will forward the results of the Notification Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Notification Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 580	Continued From page 4	F 580		

resident's foot, there had been improvement in the resident's pain and swelling. A vascular appointment would be sought as soon as possible. Per the ER (emergency room) report of 10/22/21, the resident had a urinary tract infection (UTI) but was never started on an antibiotic for the urinary tract infection. The resident had been started on the antibiotic, cephalexin, for cellulitis of the lower extremity. The NP also noted the resident was at high risk for complications.

On 11/4/21 at 2:40 PM Resident # 1's toes were observed. The whole fifth toe was observed to be purplish black; the third toe was purplish black to the end of the nail bed; and the right great toe was purplish black behind the toe, and the skin was open and draining.

Nurse # 2 was interviewed on 11/5/21 at 4:09 PM and reported the hospital paperwork she received back on 10/23/21 "had not made sense" because it indicated the resident had a urinary tract infection and was started on an antibiotic but there were no orders for an antibiotic. It was the middle of the night and therefore she had asked the next nurse to follow up when she reported off duty.

Resident # 1's physician was interviewed on 11/5/21 at 3:30 PM and reported when he signed the 10/22/21 telephone order on 10/26/21, he had not realized on 10/26/21 the resident had not been admitted to the hospital and that she had instead been returned to the facility. When he is informed a resident has returned from the ER, then he can pull the full Emergency Department record and see what care was done and what follow up is needed. According to the physician there was not really a good notification system to

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F 580	Continued From page 5	F 580		

let the providers know a resident had returned from the emergency department. He also had not been informed the resident had a positive urine culture that grew out > 100,000 Proteus mirabilis. The physician reported assessing and treating Alzheimer's residents for urinary tract infections can be "tricky" because they cannot always convey their discomfort or symptoms. He stated he would have treated the UTI if the staff had told him about the positive culture results. According to the physician the resident had since been placed on an antibiotic for drainage of her right great toe and this antibiotic would also address the bladder infection. Regarding the resident's toes, the physician did not see the resident's toes on 10/26/21 since on that date he thought she was kept at the hospital. He had been made aware by one of the NPs who had been called the previous week when the facility called for orders.

The NP, who saw the resident on 11/2/21 and routinely cared for Resident # 1, was interviewed on 11/4/21 and reported she did not recall the facility staff talking to her about the resident's toes being black. She did not find out until she was checking on 11/2/21 which residents the facility had contacted the on-call provider about over the weekend prior to 11/2/21 and saw there had been orders given for Resident # 1. When she went to check on the resident on 11/2/21, that was the first time she recalled finding out about her toes being black. She was usually in the facility almost every weekday. She would have expected the staff to bring black toes to her attention. According to the NP, even though the staff had not told her, as the NP, she felt they should have. The NP did feel the resident had received treatment in that the resident had been sent to the hospital, the on-call provider was notified with

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F 580	Continued From page 6 changes, and the plan was for the resident to follow up with the vascular physician. The Administrator was interviewed on 11/5/21 at 9:20 AM, 2:30 PM and 4:15 PM. According to the Administrator, nurses are to use a 24-hour report between shifts to make sure information is passed along between shifts and communicated to the physician and NP.	F 580		
F 684 SS=D	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 observation, record review, staff interview, family interview and physician interview, for one (Resident # 1) of three residents reviewed for changes in condition, the facility failed to assure the resident saw a consulting specialty physician who routinely followed the resident and who had established a plan for follow up. The facility also failed to assure the resident was evaluated by her primary physician per the emergency department's recommendations for a follow up plan. The findings included: Record review revealed Resident # 1 was admitted to the facility on 3/18/21. The resident	F 684	F 684 Quality of Care On 10/19/21 the facility rescheduled the missed appointment for resident #1 to 12/18/21. Resident was see by the vascular surgeon on 11/5/21 during recent hospitalization, prior to the rescheduled appointment with no further follow up recommended. Resident #1was seen by the facility provider for follow up visit on 11/2/21 per emergency room recommendation. On 11/10/21, the Administrator initiated an audit of all scheduled consults to include	11/30/21

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F 684	Continued From page 7 had diagnoses of Alzheimer's disease, peripheral artery disease; history of deep vein thrombosis, history of right femoral artery (the main blood vessel supplying blood to the lower body) to distal popliteal artery bypass surgery, and stent placement to both legs. Review of consultation reports, located on the facility record, revealed Resident # 1 was seen by the Physician Assistant (PA) at her vascular physician's office on 4/14/21. The PA noted the resident had stable right lower extremity arterial findings and a follow up was recommended for 6 months for arterial duplex and ABIs (arterial brachial index) studies to be completed. (These are tests to help show how well the blood is flowing). Resident # 1's quarterly minimum data set assessment, dated 8/16/21, coded the resident as severely cognitively impaired. Resident # 1's care plan, reviewed on 8/25/21, noted the resident was cognitively impaired and needed assistance with activities of daily living. Review of physician progress notes, revealed on 9/2/21 Resident # 1's physician saw the resident and noted she had good pulses and warm extremities. The physician noted the plan was for the resident to follow up in October related to her peripheral artery disease. There was no record of the resident being seen by her vascular physician in October, 2021. According to the facility nursing notes and physician telephone orders, on 10/22/21 the resident was found by the nurse to have discoloration to her right great toe, right third toe,	F 684	resident #1 in the last 60 days to ensure recommendations and follow up appointment were scheduled/completed as recommended. The Medical Records Coordinator/Appointment Scheduler and/or assigned nurse will address all concerns identified during the audit. Audit will be completed by 11/30/21. On 11/17/21, the Administrator initiated an audit of all hospital transfers with re-entry/readmissions from 10/17/21-11/16/21 to include resident #1. This audit is to ensure the provider was notified of resident return to the facility, status of visit to the hospital and any recommendations to include follow up visits. The Unit Managers will address all concerns identified during the audit. Audit will be completed by 11/30/21. On 11/10/21 the Administrator initiated an in-service regarding Notifications of Changes with all nurses and the Medical Records Coordinator/Appointment Scheduler regarding reviewing consult sheets and Hospital Discharge Summary/ER Visit Form to identify, but not limited to follow-up appointments and/or recommendations for follow up visits by the primary provider. The in-service will be completed by 11/30/21. All newly hired nurses and Medical Records Coordinator/Appointment Scheduler will be in-serviced during orientation regarding Notification of Changes. The Unit Managers will audit 10% of	

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F 684	Continued From page 8	F 684		

and right 5th toe, edema, and no pedal pulse. She was transferred to the hospital per a nurse practitioner's telephone order for hospital evaluation.

Hospital records for 10/22/21 were reviewed and revealed the following. Resident # 1 was evaluated in the emergency department (ED) on 10/22/21. The hospital physician noted the resident's right great toe, middle and fifth toe had a bluish discoloration. The hospital did a CTA (computerized tomography angiography) and determined there was no acute arterial abnormality in the right lower extremity. The hospital noted the resident appeared to have missed a previously scheduled appointment with her vascular physician. (The vascular physician was part of the hospital network). Under the ED discharge notes, it was recommended that the resident follow up with her primary care provider or referral physician in one to two days.

Review of nursing notes revealed the resident returned to the facility on 10/23/21 at 3:00 AM.

Review of physician orders revealed on 10/26/21 Resident # 1's physician signed the 10/22/21 verbal order that had been given by the NP to send the resident to the hospital on 10/22/21. He did not make a progress note at the time.

On 10/29/21 at 6:55 PM, Nurse # 1 documented Resident # 1's right great toe was purplish in color and painful. The on- call provider was contacted and ordered blood work, an x-ray, and placed the resident on an antibiotic.

On 11/2/21 the NP (Nurse Practitioner), who routinely sees residents at the facility, saw the

scheduled appointment consults and ER visits/hospital admissions and/or readmissions weekly x4 weeks then monthly x1 month utilizing Notification Audit Tool. This audit is to ensure the resident completed the scheduled consult and/or recommendations to include follow up visits by the primary provider. The Medical Records Coordinator/Appointment Scheduler and or assigned nurse will address all concerns identified during the audit. The Director of Nursing will review and initial the Notification Audit Tool weekly x4 weeks then monthly x1 month to ensure all concerns were addressed.

The Director of Nursing will present the findings of the Notification Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Representative Audit Tool to determine trends and/or issues that may need further interventions put in to place and to determine the need for further frequency of monitoring

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F 684	Continued From page 9	F 684		

resident and noted the following. She was following up on the resident's right foot pain and swelling. The X-ray showed no evidence of acute pathology. The resident was observed with at least 2 black toes. Since being started on the antibiotic, there had been improvement in the resident's pain and swelling. A vascular appointment would be sought as soon as possible.

On 11/3/21 an order was obtained to cleanse the resident's right great toe and apply a 2 X 2 dressing; securing the dressing with a woven gauze wrap.

On 11/4/21 at 2:40 PM Resident # 1's toes were observed. The whole fifth toe was observed to be purplish black; the third toe was purplish black to the end of the nail bed; and the right great toe was purplish black behind the toe, and the skin was open and draining.

Resident # 1's family member (FM # 2) was interviewed on 11/4/21 at 3:15 PM and reported the following. Resident # 1 had an appointment with her vascular physician scheduled for 10/14/21 and never went. The facility had taken Resident # 1 to her 4/14/21 appointment and they had made the return appointment for 10/14/21 and should have known she was due to attend.

Resident # 1's physician was interviewed on 11/5/21 at 3:30 PM and reported the following. He had checked the resident in September, 2021 and her leg and foot appeared fine. It was his expectation the resident would have been seen for her 10/14/21 vascular appointment prior to her developing problems. The physician stated reoccurring embolic disease could happen

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F 684	Continued From page 10 quickly. When he signed the 10/22/21 telephone order on 10/26/21, he had not realized on 10/26/21 the resident had not been kept at the hospital and that she had instead been returned to the facility. The hospital "After Visit Summary" information that the Emergency Department usually returned with the resident was more in laymen's terms for a patient. When he was informed a resident had returned, then he could pull the full Emergency Department record and see what care was done and what follow up was needed. Therefore, since he had not been notified on 10/26/21, he had not seen the resident as recommended by the ED. Given that the hospital did not keep the resident, he considered the plan of care to be as it was established; to send the resident for a vascular consult. The Administrator was interviewed on 11/5/21 at 9:20 AM, 2:30 PM and 4:15 PM and reported the following. Nurses are to use a 24-hour report between shifts to make sure information is passed along between shifts and that following nurses know what information needs to be conveyed to physicians. Regarding the missed vascular appointment, the facility's staff member who handled appointments had quit on 8/1/21 and a new staff member had moved into that position. The facility did not know the resident had missed her 10/14/21 appointment until 10/19/21 when the vascular office called to inform them of the missed appointment and to reschedule. Up until 11/5/21 the resident's next vascular appointment was scheduled for 12/16/21 but the facility had managed to have the vascular office move the appointment forward so she could be seen in the next week.	F 684		
F 745 SS=D	Provision of Medically Related Social Service	F 745		11/30/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 11 CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and family interview for one (Resident # 1) of one resident reviewed for social service needs the facility failed to identify a responsible party for a cognitively impaired resident who was experiencing both an acute medical condition and whose responsible party was deceased. The findings included: Record review revealed Resident # 1 was admitted to the facility on 3/18/21. The resident had diagnoses of Alzheimer's disease, peripheral artery disease, history of deep vein thrombosis, history of right femoral artery (the main blood vessel supplying blood to the lower body) to distal popliteal artery bypass surgery, and stent placement to both legs. A review of Resident # 1's electronic record on 11/4/21 revealed there was only one person listed as a responsible party (RP). This was the resident's son, and there was only one number listed for a contact. Resident # 1's quarterly minimum data set assessment, dated 8/16/21, coded the resident as severely cognitively impaired. According to facility and hospital records, the resident was transferred to the emergency department (ED) on 10/22/21 for evaluation of	F 745	F 745 Provision of Medically Related Social Services On 11/5/21, the Administrator determined that the resident's #1 sister qualified as next of kin to this resident. This entitles resident's #1 sister to information and notification regarding this resident as well as places her in a position to make medical decisions. The resident's face sheet was updated by the Social Worker. On 11/12/2021, a meeting with the facility, Resident #1's sister, and the local Ombudsman was held. Resident #1 sister indicated that she would be applying for guardianship. On 11/10/21, the Administrator initiated an audit of all residents emergency contact information to include resident #1. This audit is to ensure the facility had current information for all residents' emergency contact to include phone number, address and alternate contact information. The Social Worker and Administrator will address all concerns identified during the audit to include but not limited to updating name of current contact, phone number, address and/or alternate contact. Audit will be completed by 11/30/21.	

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	345237	A. BUILDING _____ B. WING _____	C 11/05/2021

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F 745	Continued From page 12 three right toes which were purplish/blue in color. A CTA (computerized tomography angiography), completed in the ED, revealed there was no acute arterial abnormality in the right lower extremity. The ED physician noted the resident would need further follow up by her primary and vascular physician related to the issue According to the facility record, Resident # 1 returned to the facility on 10/23/21 at 3:00 AM. On 10/29/21 at 6:55 PM, Nurse # 1 documented the following information. A nurse aide had informed Nurse # 1 that Resident # 1's right toe had drainage; the right toe was purplish in color and painful to touch; the right foot was swollen and warm to touch; the on-call provider was notified and orders received for an x-ray, antibiotics, and blood work. Nurse # 1 further documented "RR called and made aware." ON 11/2/21 Resident # 1's regular NP (Nurse Practitioner) saw the resident and noted there was a concern for dry gangrene, the vascular appointment was pending, and the resident was at high risk for complications. Nurse # 1 was interviewed on 11/4/21 at 5:05 PM and reported the following. When she called Resident # 1's son she had gotten a voice mail that just said you had reached a number (and the voicemail named the number reached). It did not identify a person and no one answered or called her back. She did not know if anyone else had heard back from the son, but she had not personally spoken to the son. On 11/3/21 at 1:04 PM another family member (FM # 2) was interviewed via phone. FM # 2 was	F 745	On 11/10/21, the Administrator initiated an in-service with the Social Services, Medical Records, nurses, Therapy Staff, Activities, and Business Office regarding Resident Contact Information. Emphasis in ensuring the Social Worker is informed and the resident contact information updated for all changes in resident's representative contact information. This includes but not limited to inability to reach a resident representative after two attempts to contact, changes in person or persons designated as resident representative, emergency contact, phone number and or address. In-service will be completed by 11/30/21. All newly hired Social Services, Medical Records, nurses, Therapy Staff, Activities, and Business Office will be in-serviced during orientation in regards to Resident Contact Information The Social Workers will validate the resident representative information of 10 residents to include resident #1 per week utilizing the Resident Representative Audit Tool weekly x4 weeks, then monthly x1 month to ensure the face sheet accurately reflects the identified Resident Representative to include a valid phone number and current address. The Administrator will review the Resident Representative Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will present the findings of the Resident Representative Audit Tool	

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F 745	Continued From page 13 interviewed again in -person on 11/4/21 at 3:15 PM. During the in-person interview, FM # 2 provided a copy of Resident # 1's facility face sheet which had been printed on 8/18/21. On the printed face sheet, FM # 2 was listed as Resident # 1's primary representative and there were two phone numbers listed for FM # 2. Resident # 1's son was listed as the second contact for emergency. FM # 2 reported the following in the interviews. Resident # 1 had lived with FM# 2 up until the resident's facility admission, FM # 2 had been highly involved in her care, and was the family member who had admitted Resident # 1 to the facility. As FM # 2 was signing the facility's admission paperwork, FM # 2 interpreted that that the paperwork would require her to also accept financial liability for Resident # 1, and she could not do that. The resident's son lived out of state and was terminally ill at the time of the resident's facility admission, but he was contacted to sign the paperwork with the understanding of FM # 2 that she would still be involved in Resident # 1's health care decisions. During the in- person interview, FM # 2 also presented a copy of a facility "Authorization for Disclosure of Medical Information." The form was dated 3/18/21 (the resident's admission date), signed by Resident # 1's son, and authorized FM # 2 to have medical information. In the past few months, FM # 2 had a conversation with the facility staff and was informed that they were going to petition to become the resident's payee so they could handle the financial aspect of her bills. FM # 2 stated she still wanted to be involved in the care decisions and thought that was established. On 9/14/21, Resident # 1's son passed away, and she and the son's attorney had informed the facility of the sons' death. About a week ago, she had visited Resident # 1 and saw her toes were	F 745	to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Representative Audit Tool to determine trends and/or issues that may need further interventions put in to place and to determine the need for further frequency of monitoring	

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black and started asking questions. She learned Resident # 1 had been to the hospital but the staff would not tell FM #2 anything that was going on with Resident # 1. She had not been called when the resident went to the hospital. The staff claimed they could no longer talk to her because she was not listed as one of the contact representatives for the resident. She was concerned because she knew that Resident # 1 had stints in both legs. She also felt there was a risk the resident might lose her foot and the resident needed help with medical decisions.

The attorney of Resident # 1's son was interviewed on 11/4/21 at 4:40 PM via phone and confirmed that Resident # 1's son had passed away. He stated he had informed Resident # 1's facility sometime near the end of September or first of October 2021 that the resident's son was deceased.

The facility social worker was interviewed on 11/4/21 at 9:30 AM and reported the following. He did not know until 11/2/21 that Resident # 1's son had passed away. He was not sure why FM # 2 was no longer listed as a contact person for Resident # 1's medical concerns. The resident did not have a guardian at the current time.

The facility Administrator was interviewed on 11/5/21 at 9:20 AM and reported the following. She had not been aware that Resident # 1 's son was deceased and the resident was without a representative until the current week of 11/5/21. She had validated the previous day (11/4/21) that the business office manager had been contacted around the first of October by the attorney of Resident # 1's son. The attorney had informed the business office manager that he would be

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handling all of the son's affairs. The business office manager was also informed by the attorney that someone else would need to be designated as the financial payee. The business office manager did not understand that the son had passed away from the conversation she had with the attorney. According to the Administrator when the son failed to return the facility's phone calls about Resident # 1's foot and the attorney had informed the facility an alternative payee would need to be designated, the staff "had not put 2 and 2 together" and questioned that that the son might have expired. According to the Administrator the son had a history of not returning phone calls. The Administrator also validated that FM # 2 had been listed as the facility's primary contact for Resident # 1 at least through August of 2021. She was not sure how FM # 2's name got deleted off of the emergency contact list and thought it could have been that FM #2 was never supposed to have been listed on the form initially and therefore FM #2's name was removed to correct that mistake. The Administrator presented a form the facility had retained, which was dated by Resident # 1's son on 3/18/21, and which did not include FM #2's name as a person to receive health care information. The Administrator did not know why FM # 2's copy of the form was different than theirs.

During the interview with Nurse # 1 on 11/4/21 at 5:05 PM, Nurse # 1 stated she knew FM # 2 was wanting to know information about the resident's foot, but her name was not on the form to let her know medical information.