STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 03/28/2024

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PINE ACRES CENTER FOR NURSING AND REHABILITATION	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/18/2024 through 3/28/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9BNO11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/18/2024 through 3/22/2024. The survey was continued on 3/25/2024 when immediate jeopardy was identified at CFR 483.21 at tag F660 and a surveyor returned to validate the credible allegation; from 3/26/2024 until 3/27/2024 the survey continued remotely; and survyor returned on 3/28/2024 to validate the credible allegation for F684 and F760. Survey ID # 9BNO11. The following intakes were investigated: NC00203363 NC00204372 NC00210752 NC00213560 NC00215072 NC00215091 NC00199716 NC00204755 NC00208111 NC00211889 NC00211079 10 of 23 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.12 at tag F607 at a scope and severity of J which began on 2/13/2024 and ended on	F 000		

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

Electronically Signed | 04/12/2024

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F 000	Continued From page 1 2/15/2024. Immediate Jeopardy was identified at : CFR 483.12 at tag F600 at a scope and severity of K which began on 7/14/2023 and ended on 3/28/2024. CFR 483.12 at tag F607 at a scope and severity o.f J which began on 2/13/2024 and ended on 2/15/2024. CFR 483.21 at tag F660 at a scope and severity of J which began on 2/14/2024 and ended on 3/24/2024. CFR 483.25 at tag F684 at a scope and severity of K which began on 7/14/2023 and ended on 3/28/2024. CFR 483.45 at tag F760 at a scope and severity of K which began on 7/14/2023 and ended on 3/28/2024. The tags F600, F607, F684, and F760 constituted Substandard Quality of Care. An extended survey was conducted remotely.	F 000		
F 550 SS=G	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	F 550		4/23/24

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F 550	Continued From page 2 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 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to treat a resident in a dignified manner when two Nurse Aides (NAs) were talking about the residents' wounds in front of her, but not to her, and were rough during incontinent care, and when the resident was screaming and crying in pain (Resident #35) they did not stop the care. The resident stated the interactions with the NAs made her feel angry and upset that they treated her that way for 1 of 1	F 550	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following	

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F 550	Continued From page 3 resident reviewed for pain. The findings included: Resident #35 was admitted to the facility on 04/06/22 with diagnoses that included: diabetes melilites, chronic obstructive pulmonary disease, respiratory failure, a pressure ulcer to left lower leg, and a pressure ulcer to the right lower leg. An observation and interview were conducted with Resident #35 on 03/18/24 at 12:01 PM. Resident #35 was resting in bed on her back and had a very flat affect, her voice was very soft in tone almost a whisper. Resident #35 stated that two Nurse Aides (NA) had just given her a bed bath, the one with short hair was very nice and the one with long hair was very rough. Resident #35 was asked to describe what rough meant, she stated that the long-haired NA, identified as NA #2 was giving her a bed bath and she was washing with a rag that was very rough and then the short haired NA identified as NA #3 came in and they turned me onto my side and "I was in so much pain" from my wounds on my bottom. Resident #35 stated that she was crying and hollering out in pain and both NAs kept saying "we are sorry" but just kept on "wiping me." She added that NA #2 and NA #3 were talking to each other about the wounds on my bottom but not to me directly. Resident #35 stated it made her "feel angry and upset that they treated me that way" referring to the staff talking about her wounds but not her and then being in so much pain during incontinent care and the staff did not stop the care but continued to wipe her. Resident #10 was admitted to the facility on 02/07/23.	F 550	plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F550 Resident #35 was discharged from the facility on 3/22/24. NA# 2 and NA#3 were educated on 4/11/24 by the Director of Nursing (DON) for resident rights, dignity, and respect. This education included stopping care when resident verbalizes or demonstrates pain with care, and talking to resident, not about resident while providing care. All residents have the potential to be affected by this deficient practice. All alert and oriented residents and non-alert and oriented residents responsible party were interviewed by the Interdisciplinary Team (IDT) and completed on 4/11/24 related to dignity while performing care. The Regional Clinical Consultant conducted visual audits during care on 4/5/24 and no other issues were identified. On 3/25/24 the DON and Administrator initiated an in-service to all staff (to include contract staff) on resident rights and promoting dignity while providing care and services. This education included not speaking in front of a resident regarding care related issues and not addressing the resident, and stopping care if resident verbalizes or demonstrates signs or symptoms of pain while care being performed. This education was completed on 4/22/24. Any staff or contract staff who did not receive the in-service prior to 4/22/24 will not be allowed to work until	

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F 550	Continued From page 4 Review of the quarterly MDS dated 01/19/24 revealed that Resident #10 was cognitively intact. An interview with Resident #35's roommate (Resident #10) was conducted on 03/18/24 at 12:06 PM, she stated NA #2 came in and told Resident #35 she was going to give her a bed bath and got the basin and filled it with water and went to Resident #35's bedside to begin her bed bath. She stated she did pull the privacy curtain, but she heard the entire exchange of care being provided to her roommate. Resident #10 stated that she could hear NA #2 scrubbing Resident #35 and heard Resident #35 state to NA #2 that she was scrubbing her too hard. When NA #2 had completed washing the front of Resident #35 she went and got NA #3 to help turn her and wash her back side. Resident #10 stated that during the process both NA #2 and NA #3 were talking to themselves about how bad it was, and indicated they were referring to the size and color of Resident #35's sores on her bottom were but not talking to Resident #35. She stated the whole time NA #1 and NA #2 were washing her Resident #35 was crying and screaming saying it hurt. NA #2 was interviewed on 03/18/24 at 2:23 PM, she stated she had been coming to the facility for 4 days as agency staff. NA #2 confirmed she had given Resident #35 a bed bath earlier today. She stated that Resident #35 "was in pain and crying" especially when she rolled her over to her side. NA #2 stated, "She is raw in her peri area and on her back side." NA #3 came in and helped turn Resident #35 onto her side to help wash her back side. NA #2 explained while washing Resident #35's other body parts she was fine and had no	F 550	complete. The Director of Nursing added this to the new hire orientation on 4/12/24. The Administrator or designee will conduct 3 random resident audits on dignity while performing care weekly x 4 weeks, then 2 random resident audits on dignity while performing care weekly x 4 weeks. The Administrator or designee will bring these audit results to the Quality Assurance Performance Improvement (QAPI) Committee x 2 consecutive meetings. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 4/23/24	

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F 550	Continued From page 5 complaints of pain, but when she started washing her peri area and her back side, she began to cry but did not see real tears, but she was moaning and saying that it hurt. NA #2 stated, "If you see it you will understand," referring to Resident #35's peri area and bottom. NA #3 was interviewed on 03/18/24 at 2:56 PM who confirmed she assisted NA #1 with completing Resident #35's bed bath. She stated that when she entered the room Resident #35 was resting on her back, NA #2 had washed and dried her front side and they turned Resident #35 onto her side to wash her peri area and her back side. She stated when they turned Resident #35 over, she was moaning and saying ouch and at one point put her hands over her face. The Director of Nursing (DON) was interviewed on 03/21/24 at 10:28 AM. She stated she expected the staff to treat each resident as though they are family and in a respectful and professional manner. She explained she did a lot of customer service training to remind staff on treating the residents in a dignified manner.	F 550		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.	F 565		4/23/24

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F 565	Continued From page 6 (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews the facility failed to provide resolution of Resident Council Meeting group grievances for 4 of 6 monthly Resident Council Meetings. The Resident Council had repeated concerns regarding evening snacks and ice water being delivered in the evening (11/9/2023, 12/7/2023, 2/22/2024, and 3/21/2024). Findings included: On 11/9/2023 the Resident Council Meeting minutes noted residents continued to have issues	F 565	F565 Residents # 67, #64 and #59 were interviewed on 4/9/24 and 4/11/24 by the Social Services Director and/or Administrator regarding resident council grievances on ice water and snack delivery. Grievance was written and these issues were addressed with the nursing department. All residents have the potential to be affected by this deficient practice. Resident council meeting was held on 4/11/24, by the Activities Director and no	

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F 565	Continued From page 7 with ice water not being passed out. A Complaint/Grievance Report dated 11/9/2023 indicated the Resident Council reported ice water was not being passed out at night. The Complaint/Grievance Report noted the Director of Nursing (DON) had monitored and re-educated the evening shift staff on passing out snacks and ice water before bedtime. The Resident Council Minutes for 12/7/2023 were reviewed and noted the residents talked about having issues with ice water not being passed out on night shift. A Complaint/Grievance Report dated 12/7/2023 indicated the Resident Council reported ice water was not being passed out at night. The Complaint /Grievance report noted under the Findings of Investigation the DON had monitored ice water being passed out at night and the DON would continue to monitor. A review of the Resident Council Minutes for 2/22/2024 noted residents had discussed issues that continued to be ongoing, and the issues would be followed up by the Grievance Committee. The Resident Council Minutes did not elaborate on what the issues were. On 3/21/2024 at 10:00 am during the Resident Council Meeting the following residents voiced concerns that had been brought up before in Resident Council Meetings and they continued to have issues with the concerns: a. Resident #67 was admitted to the facility on 3/24/2022.	F 565	grievances filed for ice water or snack delivery. On 4/11/24 the Administrator in-serviced the Activities Director on recording concerns of the residents during the resident council meeting and giving the concerns to the appropriate department head for resolution. Once the department head resolves the concerns it is to be given to the Administrator and Activities Director in writing and presented in the next council meeting. The Administrator educated the department heads on resolving concerns with written resolutions and to be given to the Administrator and Activities Director. All new employees hired to the facility will have orientation on resident council/resident group participation and the right to voice a grievance. This education will become a part of the "new hire" packet/orientation for all new hires. The Administrator will review resident council meeting minutes for concerns and writing resolutions from the appropriate department x 2 months. Results of these audits will be presented by the Administrator or designee and will be reviewed by the Quality Assurance Performance Improvement Committee x 2 consecutive meetings. Date of Compliance: 4/23/24	

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A review of Resident #67's annual Minimum Data Set assessment dated 2/12/2024 indicated he was cognitively intact and had no behaviors present.

Resident #67 stated during the Resident Council Meeting on 3/21/2024 at 10:00 am that snacks were not delivered during the day or in the evenings and he has not received ice at night. Resident #67 stated both issues had been brought up in the Resident Council Meeting last month.

b. Resident #64 was admitted to the facility on 11/1/2023.

Resident #64's quarterly Minimum Data Set assessment dated 3/6/2024 indicated she was cognitively intact and had no behaviors.

On 3/21/2024 at 10:00 am during the Resident Council Meeting Resident #64 stated the evening snacks and ice were delivered inconsistently and the issue had been brought up in the Resident Council Meetings in the past few months.

c. Resident #59 was admitted to the facility on 4/15/2021.

A quarterly Minimum Data Set assessment dated 1/4/2024 indicated Resident #59 was cognitively intact and had no behaviors.

Resident #59 stated on 3/21/2024 at 10:00 am that she was on the Grievance Committee with the Resident Council President and met with the Administrator regarding any grievances brought up during Resident Council. She stated when they meet with the Administrator, they report any

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new grievances, and the Administrator speaks with the staff regarding the issues. Resident #59 stated she was not aware the complaints about snacks and water being delivered at night had continued to be a problem.

On 3/20/2024 at 12:05 pm an interview was conducted with the Activity Director (AD). She stated when there are grievances from the Resident Council Meetings, the Grievance Committee, which consists of the Resident Council President (who is currently hospitalized) and Resident #59, meet with the Administrator who then follows up on the concerns. The AD explained ice water not being delivered in the evenings had been a recurring issue. The AD also explained she gave the grievances for the ice water not being passed out to the DON when it had come up in the Resident Council Meetings.

During an interview with the Director of Nursing (DON) on 3/20/2024 at 12:19 pm she stated she had provided education for the staff at night and had come in late in the evening to ensure ice water had been given to the residents. She also explained she had checked to make sure snacks were available for the residents. The DON explained she had not initiated a plan of correction or documented when she had checked to make sure the residents had snacks and ice water. The DON stated snacks should be passed out in the evening before bedtime and ice water provided before each meal and before bedtime.

An interview was conducted on 3/21/2024 at 3:32 pm with the Administrator. She explained the facility had developed a Grievance Committee, who meet with her and bring the resident complaints. She stated no other staff members or

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F 565	Continued From page 10 residents attend these meetings. She stated the Activity Director is responsible for putting the Resident Council grievances into the Resident Council Minutes which are reviewed the next day after the Resident Council meeting, during the morning meeting. This is part if the facility's monthly Quality Assurance Program.	F 565		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, Emergency Service Services (EMS) Personnel, Infectious Disease Nurse Practitioner, facility Nurse Practitioner, Medical Director, family, and Physician Assistant interviews the facility neglected to provide intravenous (IV) antibiotic medication as ordered for 14 days to a resident when his IV access became dislodged and neglected to direct him to a higher level of care, to replace the IV access line for 1 of 3 residents reviewed (Resident #244) for abuse/neglect.	F 600	F600 1. Resident # 244 was discharged from the facility on 7/24/23. On 03/27/2024 the Director of Nursing reviewed all current residents receiving IV antibiotics for IV access placement/ patency/ function, orders for administration of IV antibiotic therapy course to ensure residents are receiving their antibiotics as ordered by the	4/23/24

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F 600	Continued From page 11 There was the the high likelihood of physical harm by not administering the IV antibiotic as ordered by the infectious disease clinic. The untreated bacterial infection had the high likelihood of causing loss of function to his extremities or possible amputation of his extremities. The facility also failed to protect a resident's right to be free of sexual abuse for 1 of 3 residents reviewed for abuse/neglect (Resident #38). A cognitively intact male resident (Resident #241) was discovered in the bathroom of his room with a female resident (Resident #38), a severely cognitively impaired resident, with her pants off, brief off, and shirt pulled up near her breasts. During the facility's investigation in an interview, Resident #38 stated Resident #241 had stimulated and rubbed her breast(s) and stated she felt like she was being taken advantage of by Resident #241. Immediate jeopardy began on 07/14/23 when Resident #244's IV access become dislodged, and the facility neglected to re-establish his IV access or direct him to a higher level of care to ensure his IV access was restored and he could receive the IV medication he was prescribed. Immediate jeopardy was removed on 03/28/24 for Resident # 244 when the facility implemented a credible allegation of immediate jeopardy removal. Immediate jeopardy began on 2/13/24 for Resident # 241 and was removed on 2/15/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring system are in place.	F 600	physician and do not require a higher level of care to meet resident current needs. On 03/27/2024 the Director of Nursing educated all licensed nurses on directing residents to a higher level of care if the needs of the resident cannot be met in the facility to avoid serious harm or impairment/ neglect of services needed. On 03/27/2024, the Director of Nursing educated all licenses nurses on following physician orders, notification of physician and documenting any barriers to IV antibiotic administration. On 03/27/2024 the Director of Nursing educated all certified nursing assistants on reporting changes in resident baseline, and any new acute observations to include observed IV issues. On 03/27/2024 the Director of Nursing educated all staff on heightened awareness of the definition of neglect, what constitutes neglect, and how to provide necessary care and services to the residents to ensure resident receive appropriate goods and services. On 03/27/2024, the Director of Nursing reviewed all current residents receiving IV antibiotics for IV access placement/patency/ function, orders for administration of IV antibiotic therapy course to ensure residents are receiving their antibiotics as ordered by the physician and do not require a higher level of care to meet resident current needs. The Director of Nursing will educate newly hired licensed nurses. Education completed 3/27/24. The Director of Nursing or designee will review all residents receiving IV medications to ensure IV access and	

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F 600	Continued From page 12 The findings included: 1. This tag is crossed referred: F684: Based on record review, staff, family, Emergency Medical Services (EMS) personnel, Infectious Disease Nurse Practitioner, facility Nurse Practitioner #2, and Medical Director interviews the facility failed to send Resident #244 to the Emergency Room (ER) as directed by the Infectious Disease office on 07/14/23 to have his intravenous (IV) access restored and to resume his previously prescribed IV antibiotics. Resident #244's peripherally inserted central catheter (PICC) line became dislodged on 07/11/23 and on 07/14/23 Nurse #10 was notified by the Infectious Disease office to send Resident #244 to the ER to have his PICC line reinserted so that he could resume his antibiotics as ordered and Nurse #10 failed to send him to the ER. Resident #244 was discharged from the facility on 07/24/23 and followed up at the Infectious Disease office on 07/26/23, had his IV access restored and his IV antibiotics resumed at an outpatient infusion center. This deficient practice affected 1 of 2 residents reviewed for significant medication errors. F760: Based on record review, staff, family, Infectious Disease Nurse Practitioner, facility Nurse Practitioner #2, and Medical Director interviews the facility failed to prevent a significant medication error when staff failed to administer 14 ordered doses of intravenous (IV) antibiotic from 07/11/23 to 07/24/23 after the residents peripherally inserted central catheter (PICC line) was dislodged for 1 of 2 residents reviewed for significant medication error (Resident #244). Resident #244's infection if left untreated could	F 600	medication delivery according to orders. This audit will be conducted twice weekly x 2 months, then one-time weekly x month. The Director of Nursing will bring the IV medication audits to the Quality Assurance Performance Improvement Committee x 3 consecutive months. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 4/23/24 2. Resident #241 was discharged from the facility on 2/14/24. On 2/13/2024, social worker completed 100% interviews of alert and oriented residents for sexual abuse. On 02/13/2024 the treatment nurse completed 100% skin checks of cognitively impaired residents for signs of abuse. Findings included: No other residents affected by alleged abuse. On 02/13/2024 the Director of Nursing began in-service of all full-time, part-time, and PRN (as needed) staff, administration, housekeeping, dietary, nursing, therapy, and maintenance (including agency) on the abuse prohibition/reporting policy. This training will include all current staff including the agency. This training included: Residents' right to be free from abuse, Abuse Types, screening of residents for red flags indicative of potential perpetrator behavior, identifying what constitutes	

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F 600	Continued From page 13 lead to loss of limb function. During an interview with the Director of Nursing (DON) on 03/21/24 at 4:14 PM, she stated if the infectious disease office called on 07/14/23 and gave an order to send Resident #244 to the ER then they should have sent him to the ER. She explained that there was no documentation of Resident #244's refusal to go to the ER and she stressed the importance of documentation to the nursing staff all the time. The DON stated that it was not acceptable to not administer Resident #244's IV antibiotics as prescribed and they should have sent him to the ER so his IV access could be restored, and his IV antibiotics resumed. The Administrator was interviewed on 03/21/24 at 4:53 PM, she stated that Resident #244 was "very difficult and extremely non complaint with staff," she further stated, "What he did not want he did not want." She explained he pulled his PICC line out and the staff attempted to get vascular access and it was unsuccessful. The nursing staff spoke to Infectious Disease on 07/17/23 and made them aware that he was still receiving antibiotic by mouth and not receiving the IV antibiotic. The Administrator stated, "I feel like we did everything we could have done, we notified the provider and did our due diligence." "He refused everything." The Administrator was notified of the immediate jeopardy on 03/27/24. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as	F 600	abuse, recognizing signs of abuse, understanding behavioral symptoms of residents that may increase their risk of abuse and/or of being victimized, what to do if abuse is observed or suspected, and assuring resident safety. Staff were also educated to have heightened awareness, understanding, and identifying resident #38 behaviors that placed her at an increased risk of abuse and monitoring, prohibiting, and preventing abuse for resident#38. Staff were also asked if they were aware of any abuse occurring of any resident in the facility. No staff were aware of any other alleged abuse occurring in the facility. The Director of Nursing will ensure that any of the above-identified staff (all staff including agency) who do not complete the in-service training by 02/13/2024 will not be allowed to work until the training is completed. The Director of Nursing will ensure this training will be included in the new hire orientation for any newly hired staff. The Director of Nursing or designee will conduct resident behavior monitoring audits of staff for knowledge of Abuse and neglect policy, signs, and symptoms, and reporting with education 12 times weekly x 4 weeks, then 5 times weekly x 4 weeks, then 1 time a week x 4 weeks. The Director of Nursing will bring these audits to the Quality Assurance Performance Improvement committee x 3 consecutive meetings. The QAPI committee will evaluate the effectiveness of the above plan and will make additional	

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F 600	Continued From page 14 a result of the noncompliance. The facility neglected to provide intravenous antibiotics for 14 days to a resident when his intravenous access became dislodged. Administering the antibiotics was necessary to avoid physical harm. There was a high likelihood of serious hard or impairment when Resident #244's thoracis osteomyelitis (infection of the bone) and staphylococcus bacteremia (infection of the bloodstream left untreated for 14 days and the facility neglected to direct him to a higher level of care that could provide the ordered services. On 03/27/2024 the Director of Nursing reviewed all current residents receiving IV antibiotics for IV access placement/ patency/ function, orders for administration of IV antibiotic therapy course to ensure residents are receiving their antibiotics as ordered by the physician and do not require a higher level of care to meet resident current needs. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 03/27/2024 the Director of Nursing educated all licensed nurses on directing residents to a higher level of care if the needs of the resident cannot be met in the facility to avoid serious harm or impairment/ neglect of services needed. On 03/27/2024, the Director of Nursing educated all licenses nurses on following physician orders, notification of physician and documenting any barriers to IV antibiotic administration. On 03/27/2024 the Director of Nursing educated all certified nursing assistants on reporting changes in resident baseline, and any new acute	F 600	interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance 4/23/24	

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observations to include observed IV issues. On 03/27/2024 the Director of Nursing educated all staff on heightened awareness of the definition of neglect, what constitutes neglect, and how to provide necessary care and services to the residents to ensure resident receive appropriate goods and services. On 03/27/2024, the Director of Nursing reviewed all current residents receiving IV antibiotics for IV access placement/ patency/ function, orders for administration of IV antibiotic therapy course to ensure residents are receiving their antibiotics as ordered by the physician and do not require a higher level of care to meet resident current needs. The Director of Nursing will educate newly hired licensed nurses. Education completed 3/27/24.

Effective 3/28/24 the Director will be responsible for ensuring implementation of this immediate jeopardy removal for the alleged non-compliance.

Alleged Date of IJ Removal: 3/28/24

On 03/28/24 an onsite credible allegation validation was conducted. The audit of all in house residents on IV antibiotics was reviewed and revealed two residents. Those two residents' orders, administration record, dressings, and duration of medication were all verified, and no issues were identified. Interviews with all staff revealed that they had been educated on neglect, what it was, how to identify it, and who and when to report it to. Interviews with all nursing staff revealed that they had been educated on identifying and reporting any changes in resident status or barriers to medication administration to the medical provider and carrying out any orders received and the ensuring that it was documented in the medical record. If the new orders entailed

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transferring the resident to a higher level of care the staff were able to verbalize the process for transferring a resident to the ER for treatment. The IJ removal date of 03/28/24 was validated.

2. Resident #241 was admitted to the facility on 2/1/2024 with diagnoses of Parkinson's disease and weakness.

An admission Minimum Data Set (MDS) assessment dated 2/7/2024 indicated Resident #241 was cognitively intact and required moderate assistance with walking and used a wheelchair and walker for ambulation. There were no behaviors documented on the MDS.

Resident #241's Care Plan dated 2/9/2024 indicated he was independent but could require set-up assistance with transferring to his wheelchair. The Care Plan did not indicate he had behaviors.

Resident #38 was admitted to the facility on 10/13/2023. Resident #38 cumulative diagnoses included: dementia, schizoaffective disorder, bipolar disorder, and posttraumatic stress disorder.

A quarterly Minimum Data Set (MDS) assessment dated 1/19/2024 indicated Resident #38 was severely cognitively impaired, she did not ambulate, and she required extensive assistance for transfers and toileting, she did not have any behaviors, and she was occasionally incontinent of bowel and bladder.

Resident #38's Care Plan was reviewed and stated she had impaired cognitive function due to impaired thought process related to dementia,

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psychoactive medication use, and a history of head injury; she required care with all activities of daily living due to dementia, decreased balance, and limited mobility; and she had behaviors of wandering and decreased safety awareness. The Care Plan included interventions of monitoring and reporting any changes in cognitive function, providing a home like environment, and assisting with decision making for impaired cognitive function; assisting with activities of daily living such as showering, bathing and personal care as needed; providing medications as ordered, and anticipate the residents needs for behaviors.

Resident #47 was admitted to the facility on 12/22/2023 with diagnoses of stroke, mood disorder, and diabetes.

A review of Resident #47's most recent quarterly Minimum Data Set (MDS) assessment dated 2/13/2024 indicated he was cognitively intact.

Resident #47's Care Plan dated 2/10/2024 indicated he did not have cognitive issues or behaviors.

An interview was conducted on 3/21/2024 at 10:25 am with Resident #47, who was the roommate of Resident #241. Resident #47 stated Resident #241 pushed Resident #38 into their room on the evening of 2/13/2024 and they were watching television together. Resident #241 then wheeled Resident #38 into the bathroom and shut the door, and he knew that wasn't right. Resident #47 stated he put on his call light and Nurse Aide (NA) #1 answered. He stated he told Nurse Aide #1 that Resident #241 and Resident #38 were in the bathroom and Nurse Aide #1

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went to get the Nurse.

On 3/21/2024 at 5:03 pm Nurse Aide (NA) #1 was interviewed by phone and stated she answered Resident #47's (roommate for Resident #241) call light and he told her he thought his roommate, Resident #241, was trying to have sex with "that lady" (Resident #38) in the next room. Nurse Aide #1 stated she went to the next resident room and there was a resident in the room and then she checked the bathroom and there were no other residents in the bathroom, so she dismissed the allegation and did not look any further for the two residents. Nurse Aide #1 stated she might have told Nurse #2 about Resident #47's allegation but she was not sure if she told someone.

During an interview with Resident #38 on 3/21/2024 at 6:28 pm she stated she could not remember what happened when she was found in the bathroom with Resident #241 on 2/13/2024. She stated she thought it was something unpleasant and she felt violated but was unable to verbalize any details of the incident and she did not remember if the incident happened in the facility or somewhere else.

On 2/13/2024, during the facility's investigation into the allegation of sexual abuse, the Director of Nursing interviewed Resident #241's roommate, Resident #47, and he stated Resident #241 pushed Resident #38 into his bathroom and shut the door. Resident #47 stated when Nurse Aide #1 entered the room to answer his call light he mouthed the words that Resident #241 and Resident #38 were in the bathroom.

The facility provided a copy of the statement

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Resident #241 gave on 2/13/2024 and he stated Resident #38 was complaining about her brief rubbing against her because it was too tight, and she could not break the tape on the brief, so he tore the tape and pushed the brief down for her. Resident #241 also stated during the statement that he did not touch her he just pushed the brief down.

A phone interview was conducted 3/22/2024 at 1:03 pm with Resident #241 and he stated the facility had accused him of doing something to Resident #38. He stated they were friends and they held hands, and he bought her candy. He stated he went into the bathroom with Resident #38 because she needed to use the toilet and she could not remove her brief without assistance.

Nurse #1 was interviewed by phone on 3/22/2024 at 9:33 am, she stated she worked for an agency staffing company, and she was Resident #241's nurse on 2/13/2024 on the 7:00 pm to 7:00 am shift. Nurse #1 stated she went into Resident #241's room at approximately 9:30 pm to give him his evening medications. She stated when she did not see Resident #241 in his room she went to the bathroom door, which was closed, and when she opened it, Resident #38 was sitting in her wheelchair, her brief was on the floor beside her wheelchair, her pants were pulled down to the floor, and her shirt was pulled up to just below her breasts. Nurse #1 stated Resident #241 was standing with his hands in front of his abdomen, he was fully clothed, and he told Nurse #1, Resident #38 was changing her brief and she was doing a good job. Nurse #1 stated she called for Nurse #2 to help her separate the residents.

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Nurse # 2 was interviewed by phone on 3/22/2024 at 9:15 am and she stated Nurse #1 called her to Nurse #2's unit and stated Resident #241 was with Resident #38 in his bathroom and she needed her assistance. She stated Resident #241 was standing at the door to the bathroom when she arrived at the room and did not want to let her in, and he stated he was helping Resident #38 change her brief. Nurse #2 stated Nurse #1 took Resident #241 out of the room and she assisted Resident #38 with dressing, and she spoke with Resident #38 after assisting Resident #241 out of the bathroom and Resident #38 told her Resident #241 stimulated her and touched her "boobs." Nurse #2 further stated Resident #38 said Resident #241 did not hurt her, but it was not pleasurable, or painful. Nurse #2 stated Resident #38 did not act like she was upset and did not appear to be trying to get away from Resident #241 when she entered the bathroom.

Review of Resident #38's Nurse's Progress notes revealed a note by the Director of Nursing (DON) on 2/13/2024 at 11:19 pm which stated she was notified by Nurse #2 of Resident #38 being discovered in Resident #241's bathroom and Resident #38 stated Resident #241 had touched her breasts and stimulated her. The DON's Progress Note further revealed the residents were separated; Resident #38's Responsible Party was notified of the situation; and an investigation was initiated. The DON's Progress Note also stated Resident #38 denied pain, stated she felt safe; and exhibited no distress.

During a review of the facility's investigation after the incident the Director of Nursing and Social Worker interviewed Resident #38 and a written

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statement indicated Resident #38 stated she remembered she was not hurt or scared; it felt good; and she felt like he (Resident #241) was playing a game, and she was being taken advantage of.

On 3/21/2024 at 1:34 pm the Director of Nursing (DON) was interviewed, and she stated she received a phone call from the Nurse #2 on 2/13/2024 at 9:30 pm. She stated during the phone call Nurse #1 told her Resident #38 was found in Resident #241's bathroom with Resident #241. When Resident #38 was found with Resident #241 she was undressed from the waist down, and Resident #241 stated he was helping her go to the bathroom. She stated she and the Social Worker began an investigation immediately and Resident #38 was calm and did not appear to be in distress. The DON stated they interviewed Nurse #1, Nurse #2, Nurse Aide #1, and Resident #47 after they interviewed Resident #38 and Resident #241. She stated Nurse #1 put Resident #241 on 1:1 observation and separated him from Resident #38. The DON stated Resident #47 requested a room change and he was moved to another room that evening.

A Progress Note written by the Physician's Assistant (PA) on 2/14/2024 stated Resident #38 was seen due to an allegation of sexual assault by a male resident. The Progress Note stated staff reported Resident #38 was found with her pants and brief pulled down and a male resident grabbed her breast. The Progress Note further stated Resident #38 was severely cognitively impaired, had a history of bipolar disorder and suffered from post-traumatic stress disorder and her recall of events is limited. The PA's Progress Note stated a physical assessment was

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performed and no bruising, bleeding or other abnormal findings were found from the physical exam; no pain was reported; and the resident did not appear to be in acute distress.

The Physician's Assistant (PA) was interviewed on 3/21/2024 at 11:59 am and she stated she was on call when Resident #38 was found in the bathroom with Resident #241 when her brief was off, and her pants were pulled down. The PA stated she saw Resident #38 the next day and she could recall some things but could not specify what had happened. The PA stated Resident #38 could remember a man in the bathroom. She stated she denied pain and her physical exam was normal.

On 3/19/2024 at 4:30 pm a phone interview was conducted with the Family Member of Resident #38, and he stated the Administrator called him on the evening of 2/13/2024 and reported she was found Resident #38 in male resident's bathroom partially unclothed. He stated the facility had separated Resident #241 from Resident #38 and protected her from any further incidents. He stated Resident #38 was severely cognitively impaired and did not talk about the incident after it happened.

On 3/22/2024 at 12:32 pm the Administrator was interviewed, and she stated the facility had completed a plan of correction for the allegation of sexual abuse on 2/13/2024 when Resident #38 was found sitting in her wheelchair with Resident #241, in his bathroom, with her shirt pulled up to below her breasts, her brief on the floor beside her wheelchair, and her pants pulled down to her ankles. She stated the Director of Nursing (DON) and Social Worker (SW) began interviewing the

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staff and residents involved. She stated Nurse #1 and Nurse #2 put Resident #241 on 1:1 observation and at Resident #47's request, they transferred him to another room. The Administrator further stated she and the DON began education about the facility's Abuse Prohibition and Reporting Policy on 2/13/2024 with all staff including the nursing department, dietary department, maintenance department, housekeeping department, therapy department and administration staff. She stated they educated all staff on the kinds of abuse, signs of abuse, and what to do if the staff suspect or have abuse reported to them. The Administrator stated they had continued to educate all new staff and they had taken the results of their monitoring to their monthly Quality Assurance Meetings.

The Administrator was notified of the immediate jeopardy on 03/22/2024 at 7:55 pm.

The facility provided the following credible allegation of immediate jeopardy removal for Resident #38:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On February 13, 2024, nurse #1 entered resident #241's room. Nurse #1 observed resident #38 in resident #241's bathroom with her pants down to her ankles with her brief off sitting in her wheelchair with resident #38 standing beside resident #241. Nurse #1 called for nurse #2. Nurse #1 immediately removed resident #241, who is cognitively intact, from resident #241's bathroom and stayed with him in the dayroom 1:1 while nurse # 2 remained with resident #38.

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Nurse #2 assessed, dressed, and interviewed resident #38, who is severely cognitively impaired with a diagnosis of Dementia/Alzheimer's. Nurse #2 then removed resident #38 and returned her to her room. Nurse #2 notified the Director of Nursing (DON) of incident with resident #38 and resident #241. DON notified Administrator of incident with resident #38 and resident #241. The administrator notified social worker and treatment nurse and requested their assistance with incident in the building. On 2/13/2024, upon notification by phone of incident, the Director of Nursing (DON) and treatment nurse drove to the facility to meet with Resident #38, who was severely cognitively impaired, with a diagnosis of Dementia/Alzheimer and was assessed by the DON and treatment nurse for any injury on the residents' body as a result of the alleged abuse and incontinent care was provided for resident #38. The assessment revealed that resident #38 had no obvious bruising or redness on her body or genitals. 0n 2/14/2024 the psych provider was notified of incident with resident #38. On 2/20/2024 the psych provider visited with resident #38.

On 2/13/2024, upon notification by phone of incident, the Administrator drove to the facility, it was determined that there was suspected abuse, notified police and adult protective services and submitted initial allegation report to State Survey Agency at 10:59 pm. The Administrator and DON notified Resident #38's responsible party and the on-call provider of the alleged abuse. The Administrator and police conducted an interview of resident #241, nurse #1, and nurse #2 regarding alleged abuse.

Upon notification by phone the social worker

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drove to the facility to meet Resident #38 and conduct interview for alleged abuse. On 02/13/2024, the Social Worker and Director of Nursing interviewed resident #38 regarding alleged abuse. On 2/13/2024 at 10:00 pm resident #241's roommate was moved from room 101B to 108B. Resident #241 was then taken back to his room by nurse remaining 1:1 until he discharged on 2/14/24.

On 02/14/2024, the Administrator concluded alleged abuse investigation and based on investigation findings, unsubstantiated the alleged abuse of resident #38. On 02/14/2024 at 1:59 am, the Administrator submitted an investigation report to the State Survey Agency. Resident # 241 was discharged from the facility on 02/14/2024.

On 2/13/2024, social worker completed 100% interviews of alert and oriented residents for sexual abuse. On 02/13/2024 the treatment nurse completed 100% skin checks of cognitively impaired residents for signs of abuse. Findings included: No other residents affected by alleged abuse.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 02/13/2024 the Director of Nursing began in-service of all full-time, part-time, and PRN (as needed) staff, administration, housekeeping, dietary, nursing, therapy and maintenance (including agency) on the abuse prohibition/reporting policy. This training will include all current staff including agency. This

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training included: Residents' right to be free from abuse, Abuse Types, screening of residents for red flags indicative of potential perpetrator behavior, identifying what constitutes abuse, recognizing signs of abuse, understanding behavioral symptoms of residents that may increase their risk of abuse and/or of being victimized, what to do if abuse is observed or suspected, and assuring resident safety. Staff were also educated to have heightened awareness, understanding and identifying resident #38 behaviors that placed her at an increased risk of abuse and monitoring, prohibiting and preventing abuse for resident #38. Staff were also asked if they were aware of any abuse occurring to any resident in the facility. No staff were aware of any other alleged abuse occurring in the facility. The Director of Nursing will ensure that any of the above-identified staff (all staff including agency) who do not complete the in-service training by 02/13/2024 will not be allowed to work until the training is completed. The Director of Nursing will ensure this training will be included in new hire orientation for any newly hired staff.

Alleged date of IJ removal was 02/15/24.

The facility provided evidence of correction of action accomplished for Resident #38 on 03/22/24. The facility provided documentation of Resident #241 being put on 1:1 observation immediately after the incident was discovered and continued until he was discharged from the facility on 2/14/24. The facility began an investigation by interviewing all staff involved on 2/13/2024. The facility also provided documentation of assessment of Resident #38 by Nurse #2 on 3/13/2024 and by the Nurse

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F 600	Continued From page 27 Practitioner on 3/14/2024. The facility provided evidence of actions accomplished for all other residents by providing skin assessments of all residents that were cognitively impaired and could not answer a questionnaire. They also provided documentation of questionnaires completed with any residents that were able to answer questions regarding any allegations of abuse and no issues were reported. The facility provided in-service education for all staff, for all departments, including agency and contracted staff regarding their abuse and neglect policy. The facility provided documentation of their monitoring, review of the monitoring, and their monthly Quality Assurance Committee meeting which included the review monitoring and in-servicing of all employees. The IJ removal date of 02/15/24 was validated.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes	F 607		

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F 607	Continued From page 28 occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, and Physician's Assistant interviews the facility failed to immediately report an allegation of sexual abuse to the administrator for 1 of 3 residents reviewed for sexual abuse (Resident #38). A severely cognitively impaired female resident (Resident #38) was taken by a resident (Resident #241), a cognitively intact male resident, into the bathroom in his room. Resident #241's roommate, a cognitively intact male resident (Resident #47), used his call light to alert Nurse Aide (NA) #1 about Resident #241 and Resident #38. NA #1 did not report the allegation about Resident #241 and Resident #38 to a nurse. During this time when NA #1 did not report the allegation to a nurse, Resident #241 was in the bathroom with Resident #38. It was not until a nurse, who was coming to administer evening medications to Resident #241, discovered Resident #38 with her pants down, brief off, and shirt pulled up to below her breasts, as Resident #241 was standing in the bathroom with her. Findings included:	F 607	Past noncompliance: no plan of correction required.	

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A review of the facility's Abuse, Neglect and Exploitation Policy dated 10/20/2020 stated the facility's staff will report all alleged violations to the Administrator within specified timeframes: immediately if the events that caused the allegation involve abuse.

Resident #241 was admitted to the facility on 2/1/2024 with diagnoses of Parkinson's disease and weakness.

An admission Minimum Data Set (MDS) assessment dated 2/7/2024 indicated Resident #241 was cognitively intact, had not had behaviors, and required moderate assistance with walking and used a wheelchair and walker for ambulation.

Resident #38 was admitted to the facility on 10/13/2023. Resident #38's cumulative diagnoses included: dementia, schizoaffective disorder, bipolar disorder, and posttraumatic stress disorder.

A quarterly Minimum Data Set (MDS) assessment dated 1/19/2024 indicated Resident #38 was severely cognitively impaired and she required moderate assistance for transfers and toileting, she did not have any behaviors, and she was occasionally incontinent of bowel and bladder. The MDS assessment further indicated Resident #38 could roll herself in her wheelchair for 150 feet without assistance.

Resident #47 was admitted to the facility on 12/22/2023 with diagnoses of stroke, mood disorder, and diabetes.

A review of Resident #47's most recent quarterly

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Minimum Data Set (MDS) assessment indicated he was cognitively intact.

On 2/13/2024, during the facility's investigation into the allegation of sexual abuse, the Director of Nursing interviewed Resident #241's roommate, Resident #47, and he stated Resident #241 pushed Resident #38 into his bathroom and shut the door. Resident #47 stated when Nurse Aide #1 entered the room to answer his call light he mouthed the words that Resident #241 and Resident #38 were in the bathroom, and he stated Nurse Aide #1 got Nurse #1.

An interview was conducted on 3/21/2024 at 10:25 am with Resident #47, who was the roommate of Resident #241. Resident #47 stated Resident #241 pushed Resident #38 into their room on the evening of 2/13/2024 and they were watching television together. Resident #241 then wheeled Resident #38 into the bathroom and shut the door, and he knew that wasn't right. Resident #47 stated he put on his call light and Nurse Aide (NA) #1 answered. Resident #47 told Nurse Aide (NA) #1 that Resident #241 and Resident #38 were in the bathroom and Nurse Aide #1 went to get the Nurse.

On 3/21/2024 at 5:03 pm Nurse Aide (NA) #1 was interviewed by phone and stated she answered Resident #47's (roommate for Resident #241) call light and he told her he thought his roommate, Resident #241, was trying to have sex with "that lady" (Resident #38) in the next room. Nurse Aide #1 stated she went to the next resident room and there was a resident in the room and then she checked the bathroom and there were no other residents in the bathroom, so she dismissed the allegation and did not look any

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further for the two residents. Nurse Aide #1 stated she might have told Nurse #2 about Resident #47's allegation but she was not sure if she told someone.

A phone interview was conducted with Nurse #1 on 3/22/2024 at 9:10 am and she stated no one reported to her there was an allegation by Resident #241's roommate (Resident #47) that Resident #241 pushed Resident #38 into his bathroom, and he thought they were going to have sex. She stated she found Resident #38 in the bathroom with Resident #241 when she went to Resident #241's room to give him his evening medication. Nurse #1 stated Resident #38 was sitting in her wheelchair beside the commode with her brief on the floor beside her wheelchair and her pants pulled down to the floor, and her shirt pulled up to just below her breasts. She further stated Resident #241 was standing with his hands around his abdomen, he was fully clothed, and he stated Resident #38 was changing her brief and was doing a good job.

Nurse #2 was interviewed by phone on 3/22/2024 at 9:15 am and she stated she was called to Resident #241's room by Nurse #1 and Nurse #1 told her she found Resident #241 and Resident #38 in Resident #241's bathroom and her pants were pulled down, her brief was on the floor, and her shirt was pulled up to just below her breasts. She stated when she arrived at Resident #241's room Resident #38 was sitting in her wheelchair in front of the commode with her pants below her knees, her brief on the floor, and her shirt pulled up to just below her breasts. Nurse #2 was interviewed by phone again on 3/22/2024 at 9:56 am and she stated Nurse Aide #1 did not notify her of Resident #47's allegation, she was notified

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of the incident by Nurse #1 after she found Resident #241 and Resident #38 in the bathroom together. Nurse #2 stated if Nurse Aide #1 told her about the allegation she would have investigated immediately.

The written statements gathered by the Social Worker and the Director of Nursing on 2/13/2024 indicated Nurse Aide #1 stated between 9:00 pm and 9:15 pm the roommate, Resident #47, put his call light on and when she answered the call light, he stated Resident #241 was in bed with the lady in the next room and he was being fresh (inappropriate) with her. The written statement by Nurse #2 stated she was called by Nurse #1 for assistance and when she entered the room at 9:25 pm with Nurse #1 Resident #38 was sitting in her wheelchair with her pants down to her ankles, her shirt pulled up to just below her breasts, and her brief on the floor beside the wheelchair.

On 3/21/2024 at 1:34 pm the Director of Nursing (DON) was interviewed, and she stated she received a phone call from Nurse #2 on 2/13/2024 at 9:30 pm. The DON stated during the phone call Nurse #1 told her Resident #38 was found in Resident #241's bathroom with Resident #241. The DON stated Nurse #2 reported Resident #38 was found undressed from the waist down, and Resident #241 was helping her to go to the bathroom. The DON stated she was not aware Nurse Aide #1 had not reported to Nurse #1 or Nurse #2 that Resident #47, Resident #241's roommate had reported an allegation of abuse and Nurse Aide #1 had not reported it to either Nurse #1 or Nurse #2. The DON stated Nurse Aide #1 should have reported the allegation to the Nurse #1 immediately.

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On 3/22/2024 at 12:32 pm the Administrator was interviewed, and she stated the facility had completed a plan of correction for the reporting of the allegation of sexual abuse that occurred on 2/13/2024 when Resident #38 was found sitting in her wheelchair with Resident #241, in his bathroom, with her shirt pulled up to below her breasts, her brief in the floor beside her wheelchair and her pants pulled down to her ankles. The Administrator stated Nurse Aide #1 should have immediately reported the allegation to a Nurse and the Nurse would report to the Director of Nursing or her.

The Administrator was notified of Immediate Jeopardy on 3/22/2024 at 11:25 am.

On 3/22/2024 at 11:25 am the Administrator stated the facility had completed a plan of correction regarding reporting of abuse on 2/13/2024:

Corrective action for resident(s) affected by the allegation of deficient practice:
On February 13, 2024, between 9:00 pm and 9:15 pm Resident #241's roommate, Resident #47, notified Nurse Aide #1 that Resident #241 was in the bed with the lady in the next room and he was being fresh (inappropriate) with her. Nurse Aide #1 stated she checked the next room and its adjoining bathroom and there was only one resident in the next room.
On February 13, 2024, Nurse #1 entered Resident #241's room to give him his medications at 9:30 pm and Nurse #1 observed resident #38 in Resident #241's bathroom with her pants down to her ankles with her brief off sitting in her wheelchair with Resident #241standing beside

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Resident #38. Nurse #1 called Nurse #2 for assistance and Nurse #2 immediately removed Resident #241, who was cognitively intact, and stayed with him to ensure Resident #38's and other resident's safety. Nurse #2 stayed with Resident #38, a severely cognitively impaired resident, and assessed her for injuries, dressed her, and interviewed her. Nurse #2 notified the Director of Nursing of the incident, and the Director of Nursing notified the Administrator. The Administrator notified the Social Worker and the Treatment Nurse and requested their assistance with the incident.
On 2/13/2024 the Administrator notified the police, notified Adult Protective Services, and submitted an initial allegation report to the State Survey Agency at 11:59 pm. The Administrator and DON notified Resident #38's responsible party and the on-call provider of the alleged abuse. The Administrator and the Police conducted an interview with Resident #38, Nurse #1, and Nurse #2 regarding the alleged abuse. The Social Worker and Administrator interviewed Resident #38 and Resident #47 for alleged abuse on 2/12/2024. Resident #38 was returned to her room; Resident #47 was moved to another room and Resident #241 was returned to his room and remained on 1:1 with nursing staff until he discharged on 2/14/2024.
On 2/14/2024 the Administrator concluded the investigation of allegation of abuse and based on investigation finding the allegation was unsubstantiated for the allegation of abuse of Resident #38. On 2/14/2024 at 1:59 am the administrator submitted the investigation report to the State Survey Agency.

Corrective action for residents with the potential to be affected by the deficient practice:

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On 2/13/2024 the Social Worker completed interviews with 100% alert and oriented residents for sexual abuse. On 2/13/2024 the Treatment Nurse completed skin assessments for 100% of residents with cognitive impairments for any signs of abuse. Findings included no other residents were affected by the alleged abuse.

Measure/systemic changes to prevent reoccurrence of alleged deficient practice:
On 2/13/2024 the Director of Nursing began in-service education of all full-time, part-time, and prn (as needed) staff, administration, housekeeping, dietary, nursing, therapy, and maintenance (including agency) on the abuse prohibition/reporting policy. The training will include all current staff including agency. This training included: abuse types, reporting abuse allegations immediately to the nurse/Director of Nursing/ Administrator, what to do if abuse is observed or suspected, assuring residents safety, zero tolerance of retaliation of reporting allegations of abuse, along with notification of local law enforcement, Adult Protective Services, and State Survey Agency. Staff were also asked if they were aware of any abuse occurring to any residents in the facility and what to do if observed or suspected. No staff were aware of any other alleged abuse occurring in the facility. The Director of Nursing will ensure that any of the above identified staff (all staff including agency) who does not complete the in-service training by 2/14/2024 will not be allowed to work until the training had been completed. This training will be included in new hire orientation for any newly hired staff.

Monitoring procedure to ensure the plan of correction is effective and that specific deficiency

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cited remains corrected and/or in compliance with regulatory requirements:
Beginning the week of 2/14/2024, the Administrator or designee will monitor the abuse process to ensure residents are free from abuse and any abuse identified reported and addressed according to facility policy using the QA Tool for recognizing and reporting abuse. The Administrator or designee will interview 5 staff members to monitor if staff know the procedure for reporting alleged abuse and when and who to report to. The monitoring will be completed for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the monthly Quality Assurance Committee by the Administrator or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored, and on-going auditing program reviewed at month Quality Assurance Meeting.

Immediate jeopardy removal date is 2/15/24.

Date of Compliance is 2/15/24.

Review of the Plan of Correction with compliance date of 2/15/2024:

The facility provided documentation of interviews with staff who cared for Resident #38, Resident #241, and Resident #47 when Resident #47 reported an allegation of abuse to Nurse Aide #1 which she did not report. The Director of Nursing was notified, and the Director of Nursing notified the Administrator of the allegation of abuse and an investigation began on the evening of 2/13/2024. The Social Worker interviewed Resident #38 and all other residents that were cognitively intact regarding any abuse allegations on 2/13/2024 and there were no further

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F 607	Continued From page 37 allegations of abuse. The Wound Nurse completed skin assessments on all residents that were cognitively impaired, and no signs of abuse were identified on 2/13/2024. The Director of Nursing began in-service education on 2/13/2024 regarding the reporting of all types of abuse to the nurse/Director of Nursing/ Administrator; what to do if abuse is observed or suspected; assuring residents safety; zero tolerance of retaliation of reporting allegations of abuse, along with notification of local law enforcement, Adult Protective Services, and State Survey Agency. The facility also interviewed all staff to ensure they were not aware of any abuse that had occurred in the facility on 2/13/2024. The facility included the training in the orientation packet for all newly hired staff as of 2/13/2024. On 2/14/2024 the facility's Administrator began monitoring through interviews of 5 staff members a week for 4 weeks, then 5 staff members a month for 2 months to monitor through interviews if staff know the procedure for reporting alleged abuse and when and who to report to. The facility provided documentation of sign in sheets for education and staff were interviewed regarding their knowledge with no issues identified. The facility also provided documentation of the monitoring they had completed with no issues identified. The Plan of Correction compliance date of 2/15/24 was validated on 3/22/24.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		4/23/24

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F 641	Continued From page 38 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 4 residents reviewed for accidents (Resident #79). Findings included: Resident #79 was admitted to the facility on 6/23/2023 with diagnoses of agitation and a neurodegenerative disease. A Care Plan initiated on 7/6/2023 noted Resident #79 was at high risk for falls due to deconditioning and psychoactive medication use. The Care Plan was updated on 12/25/2023 for a fall without injury with interventions of repositioning on care rounds and neuro-checks for an unwitnessed fall. During a review of Resident #79's medical record, Fall Reports were found for a fall without injury on 11/15/2023 and a fall without injury on 12/26/2023. A quarterly Minimum Data Set (MDS) assessment dated 1/9/2024 indicated Resident #79 was severely cognitively impaired and had not had a fall since his last MDS assessment dated 10/1/2023. The Minimum Data Set (MDS) Coordinator was interviewed on 3/21/2024 at 3:15 pm and stated the falls on 11/15/2023 and 12/26/2023 were not recorded on the quarterly Minimum Data Set Assessment (MDS) dated 1/9/2024. The MDS Coordinator stated she must have missed the falls that causeed the MDS to be coded incorrectly.	F 641	F641 Resident #79 minimum data set (MDS) assessment was modified on 3/25/24. The Administrator and MDS nurses audited all in house residents with falls for the past 30 days for accuracy of the MDS assessment. Any resident who was incorrectly coded for falls was modified by the MDS and completed by 4/10/24. The Administrator educated the MDS nurses on accuracy of assessments for residents who had falls on 4/1/24. The Interdisciplinary team will audit 5 days a week for any resident who has a fall and ensure that eh MDS is reflective of the fall during the look back period. These audits will be conducted x 2 months. Any newly hired "MDS coordinator" will be provided with orientation on their position including but not limited to the accuracy of MDS completion ensuring compliance. The MDS nurse will bring the audit results to the Quality Assurance Performance Improvement committee x 2 consecutive meetings. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 4/23/24	

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F 641	Continued From page 39 On 3/21/2024 at 3:20 pm the Administrator was interviewed and stated the administrative team, which included all department heads, meets each morning to go through each fall that has occurred since the last meeting and the MDS Coordinator is a part of the meeting each morning. She stated since the meeting is to notify the team of any falls the MDS Coordinator should have coded the MDS assessment correctly.	F 641		
F 660 SS=J	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.	F 660		4/23/24

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

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F 660	Continued From page 41 needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, resident, facility staff, and shelter staff interview the facility failed to develop and implement an effective discharge planning process to ensure discharge needs and goals were identified with the resident and the interdisciplinary team (IDT) as active participants in the discharge plan in order to prepare the resident for an effective transition to post-discharge care for a resident who was a planned discharge. On 2/14/24 Resident #241 was discharged without the facility verifying his discharge location and if his care needs were able to be met. In addition, the resident was discharged without adaptive equipment required for ambulation (rolling walker). Resident #241 indicated he was dropped off at a homeless shelter where he continued to reside and felt "unsafe" and was "fearful. These failures created a high likelihood of harm for Resident #241. This deficient practice affected 1 of 4 residents reviewed for discharge. Immediate jeopardy began on 02/14/24 when the facility initiated a planned discharge of a resident without verifying the discharge location and ensuring the resident's needs were able to be met. The immediate jeopardy was removed on 03/24/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of	F 660	F660 Resident #241 was discharged on 2/14/24. The facility Administrator made multiple attempts to contact resident #241 by phone with the phone number provided on 3/23/24. The voicemail box was full, and a message could not be left. The administrator sent a text message notifying me of the attempt to reach and voicemail being full, inquiring if resident was ok and if he had any current care need that I could help with and requested a return call. As of 3/24/2024 at 1:50 pm the Administrator has not received any follow up text or phone call from resident #241. If resident#241 contacts administrator the administrator will inquire as to care needs of resident and attempt to provide assistance with current care needs. Residents discharged from the facility have potential to be affected by the same deficient practice. On 3/22/24 the Director of Nursing reviewed the last 30 days of planned discharges to community for development of a discharge plan that included: adaptive equipment, ensuring basic needs (food,	

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compliance at a lower scope and severity of a D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective.

The findings included:

Resident #241 was admitted to the facility on 02/01/24 following a hospital stay for a surgical hernia repair. He admitted with diagnoses that included hernia repair, Parkinson's disease, chronic obstructive pulmonary disease, hypertension, right lower quadrant pain, major depressive disorder, muscle weakness, lack of coordination.

Resident #241's admission Minimum Data Set assessment dated 02/07/24 revealed he was cognitively intact. Resident #241 was coded as having the goal to discharge to the community. The assessment indicated no discharge planning was actively occurring. Resident #241 was coded as normally using a walker and wheelchair, required limited assistance with toileting hygiene, bathing, lower body dressing, personal hygiene, and picking up an object from the floor. He required supervision with rising from a seated position, moving from a chair to the bed and from the bed to a chair, toileting transfers, tub or shower transfer, walking 10 feet, walking 50 feet, and walking 150 feet. Resident #241 was coded as taking antidepressant medications.

Review of Resident's #241's care plan initiated on 02/01/24 and last reviewed on 02/13/24, revealed a care plan for "I wish to discharge to [assisted living facility] once able to do so". Interventions included evaluate and discuss with the

shelter, water) were met, location was identified, physician appointments and discharge was safe and orderly. There were no issues identified during this review, regulatory criteria were met for safe discharge of all 13 residents reviewed. There were no issues identified during this review, regulatory criteria were met for safe discharge of all 13 residents reviewed. On 3/22/24 the Director of Nursing reviewed the last 30 days of un-planned discharges to community for documentation to support the voluntary revocation of all services without clearance or proper notice to implement a safe and orderly discharge. There were no issues identified during this review, regulatory criteria were met for unplanned discharge of all 2 residents reviewed.

On 3/22/2024 the Administrator completed education with the interdisciplinary team. Education included: the discharge planning processes for facility initiated and resident initiated discharges; determining when safe discharge planning is attainable and/or unsafe discharge/against medical advice. Education also included understanding the regulatory requirements for the discharge planning processes, in the State Operations Manual for F660, to ensure the interdisciplinary team understands the intent of the regulation as follows and has discharge planning processes in place for residents prior to planned discharges. The discharge planning process will address each resident's discharge goals and needs

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F 660	Continued From page 43 resident/family/caregivers the prognosis for independent or assisted living. Identify, discuss, and address limitations, risks, benefits, and needs for maximum independence. Evaluate the resident's motivation to return to the community. Additional review of Resident #241's care plan revealed a care plan for "Resident is (specify high, Moderate, Low) risk for falls related to gait or balance problems". Interventions included Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair and for physical therapy to evaluate and treat as ordered or as needed. Review of resident's medications revealed he was taking the following medications: Carbidopa-Levodopa ER Oral Tablet Extended Release for the treatment of Parkinson's disease Spiriva Respimat Aerosol, solution for the treatment of chronic obstructive pulmonary disease (COPD) Albuterol Sulfate HFA Aerosol, solution for wheezing or shortness of breath Diclofenac Sodium External Gel for pain management Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour for the treatment of depression Mirapex Tablet for the treatment of Parkinson's disease Trazodone HCl Oral Tablet for the treatment of insomnia Propranolol HCl Oral Tablet for the treatment of hypertension Trilogy Ellipta Inhalation Aerosol Powder Breath Activated for the treatment of COPD Carbidopa-Levodopa ER Oral Tablet Extended Release for the treatment of Parkinson's disease Atorvastatin Calcium Oral Tablet for the treatment	F 660	including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan to ensure a safe discharge for those residents discharging from the facility. This will also include having knowledge of the discharge location, adaptive equipment as needed, ensuring basic needs (food, shelter, water) were met, location was identified, physician appointments, medications as needed, and discharge was safe and orderly. The Administrator will educate newly hired social workers and other newly hired IDT members in orientation. Education completed 3/22/24.administrator also notified the interdisciplinary team they will meet weekly to review residents with goals to discharge from the facility to identify and address resident goals for care, treatment, preferences, barriers to discharge such as: care giver support, education, resident interests in any referrals made to local contact agency, post discharge needs such as nursing and therapy services, medical equipment or modification to the home or activities of daily living assistance. The Administrator and IDT will review all discharges x 8 weeks to ensure a safe and orderly discharge process. The Administrator will be responsible for bringing the discharge process audits to the Quality Assurance Performance	

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F 660	Continued From page 44 of hyperlipidemia Baclofen Tablet for the treatment of muscle spasms Gabapentin Oral Capsule for the treatment of nerve pain On 02/13/24 Resident #241 was found in a bathroom with a female resident. The female resident was reportedly undressed from the waist down with her shirt pulled up to below her breasts. Review of Resident #241's progress notes revealed no notes or documentation related to discharge planning prior to 02/13/24 when the facility opened and began to complete a discharge summary. Review of Resident #241's discharge summary revealed it was created on 02/13/24 at 10:50 PM by the Social Worker. Resident #241's discharge summary indicated no transitional services or referrals were completed or recommended, and no durable medical equipment [wheelchair, walker, bedside commode, oxygen] was ordered. The discharge assessment indicated Resident #241 was independent with his activities of daily living and was cognitively intact. Physical therapy and occupational therapy referrals were completed but no home health services were recommended or ordered and there was no scheduled primary care physician appointment scheduled. The discharge summary did report a primary care physician of Doctor #1 with a provided phone number with instructions that read "please follow-up with your primary care physician 1-2 weeks post discharge from facility. If you have any immediate medical needs, call 911". The discharge assessment indicated that	F 660	Improvement committee x 2 consecutive meetings. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 4/23/24	

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Resident #241 discharged home, accompanied by "agency" and was ambulatory at the time of discharge and that no durable medical equipment (rolling walker) was ordered. The discharge assessment was completed on 02/14/24 and signed by the Social Worker, Nurse #8, Resident #241.

Review of Resident #241's functional abilities and goals assessment completed on 02/14/24 revealed Resident #241 required the use of a walker prior to his admission, required supervision or touching assistance with toilet hygiene, bathing, was dependent on others for lower body dressing, and needed supervision with walking 50 and 150 feet.

An interview with the Social Worker on 03/22/24 at 1:32 PM revealed Resident #241 had been admitted to the facility on 02/01/24 and subsequently discharged on 02/14/24. She stated on the morning of 02/14/24, Resident #241 approached her and told her he wanted to leave She reported she asked him if he would stay until she could make it safe, and he reported that he would not and that he was going to leave that day. The Social Worker reported Resident #241 had approached him with his belongings packed. She proceeded to try and put as much post-discharge assistance in place as she could, as fast as possible but by the time she had contacted the Medical Director to notify him of the pending discharge and returned from trying to reach out to the physician, Resident #241 had already left the facility. She reported from the time Resident #241 reported he wanted to leave until the time he left, it was approximately 30 minutes or less. The Social Worker stated it was her understanding that Resident #241 had arranged

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for a ride share driver to pick him up from the facility. She stated she had no knowledge where Resident #241 had departed to and that he had previously mentioned he would go to stay with his spouse in a neighboring county and had assumed that was where he had gone. She reported she attempted to reach Resident #241 via telephone post discharge at the number in his medical record, but was unsuccessful. She also stated she could not recall if she coded the discharge as planned on the discharge summary. She reported she had processed the discharge as a planned discharge because she had been receiving pressure to ensure that all discharges were safe. She indicated that due to the hasty nature of Resident #241's discharge, it probably should have been treated more as an unplanned discharge against medical advice, instead of a planned, safe discharge. She also indicated there had been no active discharge planning prior to 02/13/24.

Review of a progress note completed by Nurse #8 dated 02/14/24 at 4:47 PM read "Resident has been discharged from facility, ambulating. [The] writer reviewed discharge summary and medications. No questions asked. Medications on cart were released to the resident and explained/educated and written on medicine card in detail the times to self-administer. No further questions. Transportation driver transported resident to destination."

An interview with Nurse #8 on 03/25/24 at 10:15 AM revealed she remembered the discharge for Resident #241 on 2/14/24 and reported it did not seem like it was rushed or hurried. Nurse #8 did not indicate who informed her the resident was going to discharge on that date (2/14/24). Nurse

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#8 stated that she was able to educate Resident #241 on his medications and when and how to take them. She reported he never mentioned to her that he was asked or being forced to leave and that she believed he mentioned that he was either going to go to a friend's house or to the shelter. She reported the process was not different from any other planned discharges she had been involved with in the past. Nurse #8 also stated that she coded that resident was transported to his destination on her discharge progress note by the transportation driver because Resident #241 had set up his own transportation at discharge and since it was not family, she coded it as a transportation driver. Nurse #8 reported she did not recognize the transportation driver.

Resident #241's discharge Minimum Data Set assessment dated 02/14/24 revealed he had a planned discharge from the facility back to the community with a return to the facility being unanticipated.

An interview was conducted with Resident #241 on 03/22/24 at 1:03 PM via telephone. Resident #241 reported he used to live at the facility and was currently living in a homeless shelter. He stated He reported he was accused of molesting female resident at the facility on 02/13/24 and the staff told him he had to leave after the incident. Resident #241 was unable to provide the staff member's name but was able to provide a physical description. The physical description did not pinpoint the staff member as it corresponded with multiple staff members. He described the staff member that told him he had to leave as a Caucasian female with dark hair, approximately 5'9 and weight approximately 180 pounds but he

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could not recall her name. Resident #241 reported he did not want to go to the shelter because he thought he would be going to an assisted living facility, but stated he was not given a choice. Resident #241 reported he could not go live with his spouse because they were estranged and he did not want her to have to see him deteriorate as his Parkinson's disease progressed. He indicated he had not set up his own transportation as he did not want to leave the facility. Resident #241 stated he had been at the homeless shelter since he was dropped off and that he had not seen his physician since he left the facility. He explicitly stated that he did not feel safe and explained that a week prior to this interview a fight occurred at the shelter where knives were being thrown and he was pushed hard into a wall. He reported he was fearful he would be injured or hurt. When Resident #241 was asked if he was in pain, he stated "I hurt from my ankles to the tips of ears." He indicated he was still at the shelter because he had nowhere else to go.

During a follow-up interview with Resident #241 on 03/22/24 at 5:21 PM, he reported prior to his admission to the hospital for hernia repair, he was living in a different shelter. He stated he was admitted to a local hospital for hernia repair, and then was moved to the facility for aftercare and therapy. He stated he believed the plan was for him to go to an assisted living facility "down the street" from the facility he was in when he finished his therapy, but they kicked him out before that could happen. Resident #241 reported on 2/14/24 he was transported in an "old ambulance type vehicle" driven by and African American man. Resident #241 also indicated that he was not included in his discharge planning and

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that it surprised him.

An interview with the Transportation Driver #1, who was the only transportation driver employed by the facility that matched the description provided by Resident #241 on 03/25/24 at 10:55 AM, revealed he had been at the facility since August 2022 and provided transportation in the facility's van for residents. He stated he remembered Resident #241 and stated he believed he had transported him to and from "a couple appointments" during his admission. Transportation Driver #1 reported he did not provide transportation services to Resident #241 at the time of his discharge (2/14/24).

An interview with the Case Manager, who worked at the homeless shelter where Resident #241 was currently residing at, was conducted on 03/22/24 at 2:00 PM. She reported Resident #241 had been at the shelter approximately 2 months. She stated he arrived there straight from the facility. The Case Manager reported when Resident #241 arrived, he (Resident #241) indicated he was unsure why the facility had dropped him off at the shelter. She continued, stating that another staff member (Shelter Staff #1) from the shelter observed a facility labeled transportation van drop Resident #241 off at the shelter with his belongings and "a whole bunch of medicine". She stated the shelter staff were helping Resident #241 with his medication management but stated they needed to find him a rolling walker as when he arrived, he did not have one and was having difficulty ambulating without a rolling walker. She also stated Resident #241 was able to continue to stay at the shelter for 120 days and then the shelter staff would have to reassess Resident #241 to determine if he would

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be allowed to stay longer. The Case Manger stated that Resident #241 was able to stay at the shelter through the day as he was paying a small amount of money while he was there. The Case Manager also reported Resident #241 was receiving some assistance with his activities of daily living from other residents such as tying his shoes and bathing as the shelter staff were unable to assist him. The Case Manager reported another resident at the shelter was able to provide Resident #241 with an extra rolling walker they had, and he was currently using it all the time when ambulating.

An interview with Shelter Staff #1 on 03/27/24 at 3:48 PM revealed he worked on the evening of 02/14/24 from 5:00 PM until 10:00 PM. He stated he did not see the vehicle that Resident #241 arrived in but that when Resident #241 arrived he had only a bag of medicine and the clothes on his back. Shelter Staff #1 stated that Resident #241 had no wheelchair or walker and that the shelter staff had to scramble to find him a walker because Resident #241 walked with a shuffled gait and the shelter staff were concerned he would fall and seriously injure himself. Shelter Staff #1 stated Resident #241 currently used the walker the shelter provided at all times when he was ambulating.

An interview with Shelter Coordinator on 03/26/24 at 8:23 AM revealed she had worked at the shelter for approximately 1 year. She reported she was familiar with Resident #241 and had processed his intake when he arrived (2/14/24). She reported when Resident #241 arrived, he had a box and a suitcase with only medications and clothing. She also stated he was confused when he arrived, stating he thought the plan was for

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him to go to an assisted living facility, but the facility had "dumped him here". The Shelter Coordinator continued, stating the shelter cannot provide the care that Resident #241 needed and indicated if "he was not such a nice guy, we would have had to discharge him due to not being able to take care of him." She did not provide information on the Resident #241's care needs. She stated that other residents at the shelter helped him when possible. She also provided information that Resident #241 was running out of medication and the Case Manager and Resident #241 had reached out to the facility (no specific facility staff member was identified) the previous week and requested assistance and were denied. The facility reported that since he no longer was a resident, they could not do anything to assist him. The Shelter Coordinator stated Resident #241 will most likely have to be sent to the hospital soon to get treatment and medication refills. She stated one medication he received was for tremors and when he runs out, it will become more difficult for him to care for himself.

An interview with the Director of Therapy on 03/22/24 at 2:23 PM revealed Resident #241 was mostly independent with his activities of daily living at the time of his discharge. She reported he was walking more than 300 feet with the use of a rolling walker. She indicated that Resident #241 would require the use of a rolling walker to ambulate long distances. She indicated Resident #241 needed the rolling walker in order to ambulate long distances safely. The Therapy Director reported therapy last provided services to him on 02/13/24, the day before he discharged. She stated she was not included in the discharge planning process. She reported she did not know whether Resident #241 wanted to leave or if he

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was told to leave. The Director of Therapy reported she had no knowledge of where Resident #241 discharged to and indicated she had no knowledge if he had a rolling walker when he discharged but stated that was the recommendation at the time of discharge from therapy.

An interview with Unit Manager #1 on 03/22/24 at 2:32 PM revealed she was assigned to be one on one with Resident #241 following an incident between him and another resident at the facility on 02-13-24. She reported the morning of 02/14/24, Resident #241 was quiet and reserved and stayed to himself. She reported prior to that day, Resident #241 was outgoing and friendly and spent most of his day out in the facility visiting with other residents. Unit Manager #1 reported he placed a few phone calls while she was providing 1:1 supervision, but she did not overhear what they were about. She also reported Resident #241 had mentioned to her once on 02/14/24 that he wanted to go home. She stated she could not recall if she observed Resident #241 packing his belongings. Unit Manager #1 reported around 3:00 PM or 4:00 PM, Resident #241 exited the facility via the front door and got into a vehicle and left. She reported she could not recall the type, color, make, or model of vehicle Resident #241 left in. Unit Manager #1 stated she did not know where Resident #241 discharged to.

An interview with the Former Medical Director on 03/24/24 at 3:12 PM revealed he only saw Resident #241 one time during his admission. He stated when he saw Resident #241, he was using a wheelchair as a walker, had a shuffling gait, was being treated for Parkinson's disease and

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surgical aftercare. He reported he was not involved in the discharge of Resident #241 and that he did not know what the discharge goal for Resident #241 was after he completed his therapy. The Former Medical Director stated that Resident #241 had a shuffling gait and that he would have needed a rolling walker to ambulate. He also reported there would be some concern with Resident #241's involuntary movements from his Parkinson's disease worsening should he not take his medications or if they were unable to be filled.

An interview with the Director of Nursing on 03/23/24 at 2:34 PM revealed she had returned to the facility on the evening of 02/13/24 after being informed of an incident between Resident #241 and another resident. She reported at that time, Resident #241 informed her he wanted to discharge immediately and requested some of his belongings that the facility had been storing for him in the medication room. The Director of Nursing reported she spoke with Resident #241 and encouraged him to stay since it was so late, and the weather was cold. She stated Resident #241 agreed to stay through the night but that he was adamant the following morning that he was going to discharge. The Director of Nursing reported Resident #241 discharged on his own accord on 02/14/24 and she had no knowledge of where he discharged to, if he had everything he needed, and whether where he was going was safe and could meet his needs. The Director of Nursing indicated she could not recall if she had contacted adult protective services and stated she did not call the Medical Director but thought the Administrator had notified him.

An initial interview with the Administrator on

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03/22/24 at 4:17 PM revealed she did not have a lot of information regarding Resident #241's discharge from the facility and that she felt they did what they could to make it as safe as possible. She reported her interdisciplinary team typically set up discharges and discharge planning began when residents stated they wanted to discharge. She reported she was not involved in the discharge process for Resident #241 and did not know where he went. She was unable to indicate what staff were involved with Resident #241's discharge process. The Administrator reported she was informed that Resident #241 voiced he wanted to discharge home and had planned to return to his spouse. She was unable to state who informed her or when she was informed. She stated it was her knowledge that he called a ride share company for transportation and left on his own accord. She was unable to explain where she received this knowledge from. The Administrator stated she did not believe the facility had transported Resident #241 to the homeless shelter as they did not provide discharge transportation services. She also reported that the facility's transportation van did not have any markings on it until 03/14/24 when they paid to have it wrapped in their facility's name. The Administrator reported there had been an incident between Resident #241 and another resident in the facility on the evening of 02/13/24 and that the police department had questioned him and notified him (Resident #241) that the other resident's family wanted to press charges and she wondered if that conversation may have scared him and made him want to leave to avoid the situation. Regarding Resident #241 being discharged without a rolling walker, she indicated that the facility routinely and provided equipment to discharging residents if there was an issue with

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backorders of equipment, or if needed equipment was not going to arrive before the scheduled discharge date. The Administrator reported she would have approved for Resident #241 to take a rolling walker with him had she been aware he needed one. She also reported that Resident #241 did not have a primary care physician and that he received a small income each month and stated he could utilize an urgent care physician if he needed and that he could also afford to pay for his own transportation.

During a follow-up interview with the Administrator on 03/23/24 at 2:04 PM, she reported during Resident #241's 48-hour baseline care plan meeting, he voiced his desire to eventually discharge to an assisted living facility when he was able to. The Administrator continued, stating that Resident #241 had participated with therapy. She reported after the incident between him and another resident (2/13/24), he was informed that he would have to remain on one-to-one supervision but insisted that at no time during Resident #241's admission was he told he had to leave. The Administrator stated the discharge summary was opened on 02/13/24 because Resident #241 indicated that he wanted to leave that night, so the Social Worker began to prepare him for discharge from the facility. She continued, stating the Social Worker was eventually able to convince Resident #241 to stay until they could set up a safe and orderly discharge and the facility staff were under the impression on 02/13/24 that Resident #241 had agreed to stay until a safe and orderly discharge could occur. The Administrator reported the facility should have processed the discharge as leaving against medical advice instead of a safe discharge. She reported she had educated the

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Social Worker on how to better code discharges on the discharge assessment in the future. The Administrator reported a safe discharge would include a resident being prepared to go home or to another facility, with education received on care needs and medications. A safe discharge would include her interdisciplinary team and would now include knowing exactly where a resident will be discharging to.

The Administrator and DON were notified of the Immediate Jeopardy on 03/22/24 at 5:22 PM.

The facility provided the following IJ removal plan:

F660
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to develop a discharge plan and implement a discharge plan to ensure resident #241's needs would be met. The facility did not ascertain how resident's needs would be met post discharge. The facility failed to ensure recommended adaptive equipment was available upon discharge. The facility did not follow up after discharge to see if resident #241's needs were being met. The facility failed to involve the IDT team in the discharge process. The Administrator made multiple attempts to contact resident #241 by phone with phone number provided by surveyor on 03/23/2024. The voicemail box was full and a message could not be left. The administrator sent a text message notifying of attempt to reach and voicemail being full, inquiring if resident was ok and if he had any current care need that I could help with and

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requested a return call. As of 3/24/2024 at 1:50 pm the Administrator has not received any follow up text or phone call from resident #241. In the event that resident #241 contacts administrator the administrator will inquire as to care needs of resident and attempt to provide assistance with current care needs.
Residents discharging from the facility have potential to be affected by the same deficient practice.

On 3/22/24 the Director of Nursing reviewed the last 30 days of planned discharges to community for development of a discharge plan that included: adaptive equipment, ensuring basic needs (food, shelter, water) were met, location was identified, physician appointments and discharge was safe and orderly. There were no issues identified during this review, regulatory criteria were met for safe discharge of all 13 residents reviewed. There were no issues identified during this review, regulatory criteria were met for safe discharge of all 13 residents reviewed. On 3/22/24 the Director of Nursing reviewed the last 30 days of un-planned discharges to community for documentation to support the voluntary revocation of all services without clearance or proper notice to implement a safe and orderly discharge. There were no issues identified during this review, regulatory criteria were met for unplanned discharge of all 2 residents reviewed. On 3/22/2024 the Administrator notified the interdisciplinary team of reviewing upcoming planned discharges daily in morning meetings to ensure the discharge planning process has been followed and resident care/ discharge needs are addressed prior to final discharge and to provide the medical director with information regarding upcoming discharges to

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ensure proper orders and discharge paperwork are implemented. The administrator also notified the interdisciplinary team they will meet weekly to review residents with goals to discharge from the facility to identify and address resident goals for care, treatment, preferences, barriers to discharge such as: care giver support, education, resident interests in any referrals made to local contact agency, post discharge needs such as nursing and therapy services, medical equipment or modification to the home or activities of daily living assistance.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 3/22/2024 the Administrator completed education with the interdisciplinary team. Education included: the discharge planning processes for facility initiated and resident initiated discharges; determining when safe discharge planning is attainable and/or unsafe discharge/against medical advice. Education also included understanding the regulatory requirements for the discharge planning processes, in the State Operations Manual for F 660, to ensure the interdisciplinary team understands the intent of the regulation as follows and has discharge planning processes in place for residents prior to planned discharges. The discharge planning process will address each resident's discharge goals and needs including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident and if applicable, the resident representative and the interdisciplinary team in developing the discharge plan to ensure a safe

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F 660	Continued From page 59 discharge for those residents discharging from the facility. This will also include having knowledge of the discharge location, adaptive equipment as needed, ensuring basic needs (food, shelter, water) were met, location was identified, physician appointments, medications as needed, and discharge was safe and orderly. The Administrator will educate newly hired social workers and other newly hired IDT members in orientation. Education completed 3/22/24. Effective 3/22/24 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for the alleged non-compliance. Alleged Date of IJ Removal: 3/24/2024 On 03/25/24, the credible allegation of Immediate Jeopardy removal was validated onsite by verification through facility staff interviews and record review. The interviewed staff across disciplines included nursing, administration, and therapy. The interviewed staff indicated they had received in-service training on discharge planning and processes and what constituted a safe and orderly discharge. The facility also reviewed previous discharges for the past 30 days to see if other residents had possibly been affected. The facility's alleged Immediate Jeopardy removal date of 03/24/24 was validated.	F 660		
F 684 SS=K	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	F 684		4/23/24

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F 684	Continued From page 60 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff, family, Emergency Medical Services (EMS) personnel, Infectious Disease Nurse Practitioner, facility Nurse Practitioner #2, and Medical Director interviews the facility failed to send Resident #244 to the Emergency Room (ER) as directed by the Infectious Disease office on 07/14/23 to have his intravenous (IV) access restored and to resume his previously prescribed IV antibiotics. Resident #244's peripherally inserted central catheter (PICC) line became dislodged on 07/11/23 and on 07/14/23 Nurse #10 was notified by the Infectious Disease office to send Resident #244 to the ER to have his PICC line reinserted so that he could resume his antibiotics as ordered and Nurse #10 failed to send him to the ER. Resident #244 was discharged from the facility on 07/24/23 and followed up at the Infectious Disease office on 07/26/23, had his IV access restored and his IV antibiotics resumed at an outpatient infusion center. This deficient practice affected 1 of 2 residents reviewed for significant medication errors. Immediate jeopardy began on 07/14/23 when the Infectious Disease office instructed the facility staff to send Resident #244 to the ER to have his PICC line replaced so that he could resume his IV antibiotics and the facility failed to do so. Immediate jeopardy was removed on 03/28/24 when the facility implemented a credible allegation of immediate jeopardy removal. The	F 684	F684 Resident #244 was discharged from the facility on 7/24/23. Seen in the office on 7/26/23 and his access was restored. On 03/27/2024, the Director of Nursing assessed all current residents receiving IV antibiotics for: IV access placement/ patency/function, and orders for administration of IV antibiotic therapy course, to ensure residents are receiving their antibiotics as ordered by the physician, and do not require a higher level of care to meet resident current needs. On 03/27/2024, the Director of Nursing educated licensed nurses on directing residents to a higher level of care, if the needs of the resident cannot be met in the facility to avoid serious harm or impairment. 03/27/2024, the Director of Nursing educated licenses nurses (to include agency) on following facility provider orders (to include consulting physicians and notification of facility provider/consulting physicians within the realm of practice) and documenting any barriers to IV antibiotic administration. On 03/27/2024, the Director of Nursing educated all certified nursing assistants on reporting changes in resident baseline, new acute observations; to include observed IV issues. On 03/27/2024, the	

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F 684	Continued From page 61 facility will remain out of compliance at lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring system are in place. The finding included: Review of Resident #244's discharge summary from the local hospital dated 06/29/23 read in part, chronic left humeral fracture from a motor vehicle accident in 2018 with fixation with hardware and recurrent infection/osteomyelitis due to methicillin sensitive staphylococcus aureus (MSSA) status post recent left arm amputation 2 weeks ago. The discharge summary further indicated severe thoracic spinal stenosis with cord flattening, posterior disc bulging, vertebral abnormal marrow signal intensity possible osteomyelitis. Infectious disease on board and antibiotics were switched to daptomycin and ciprofloxacin to complete 8 weeks of antibiotic regimen. Resident #244's discharge medications included: Daptomycin (antibiotic) 500 milligrams (mg) intravenously (IV) daily and Ciprofloxacin (antibiotic) 750 mg by mouth twice daily. Both were to be given for a total of 8 weeks and were to be discontinued on 08/19/23. Resident #244 was admitted to the facility on 06/29/23 and was discharged on 07/24/23. Resident #244's diagnoses included thoracic osteomyelitis with spinal stenosis and left upper extremity amputation. Review of physician orders dated 06/30/23 read, Ciprofloxacin 750 mg by mouth twice a day until 08/19/23. Daptomycin 500 mg IV every day until 08/19/23.	F 684	Director of Nursing reviewed all current residents receiving IV antibiotics for: IV access placement/ patency/ function, and orders for administration of IV antibiotic therapy course; to ensure residents are receiving their antibiotics as ordered by the physician, and do not require a higher level of care to meet resident current needs. The Director of Nursing will educate newly hired licensed nurses and agency nurses. Education completed 3/27/24. The Director of Nursing or designee will review all residents receiving IV medications to ensure IV access and medication delivery according to orders. This audit will be conducted twice weekly x 2 months, then one-time weekly x month. The Director of Nursing will bring the IV medication audits to the Quality Assurance Performance Improvement Committee x 3 consecutive months. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 4/23/24	

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Review of the Medication Administration Record (MAR) dated July 2023 revealed that Resident #244's Ciprofloxacin was administered as prescribed during his time in the facility. The MAR further revealed that the Daptomycin was not given from 07/11/23 through 07/24/23.

Review of the admission Minimum Data Set (MDS) dated 07/06/23 revealed that Resident #244 was cognitively intact with no rejection of care. The MDS further indicated he received IV medications and 7 days of antibiotic during the assessment reference period.

A nurses note dated 07/11/23 at 7:24 PM read in part, nurse entered room to check on resident and his PICC line. Resident was digging in closet and nurse asked what was wrong and he stated his PICC line came out and PICC line noted on bedside table. This nurse requested resident to allow nurse to place pressure dressing on site and resident refused and stated it was fine. Nurse attempted to educate resident on need for pressure dressing and resident started cussing and threatening nurse. Resident told this nurse not to return to his room for any reason. No obvious signs of bleeding noted at the PICC line site with tip intact. The note was written by Nurse #3.

Review of a physician order dated 07/12/23 read pulled IV out, unable to place new line. PICC line to be put in place by third party. Medication to be held until PICC line inserted. The order was entered by Nurse #4. The order was a verbal order from the Medical Director (MD).

Review of a care plan initiated on 06/30/23 read,

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"I have osteomyelitis/discitis of the vertebra and am receiving IV antibiotic therapy, unless otherwise specified this event will be resolved as of 08/22/23." The goal read, "The resident will be free from complications related to infection through the review date." The interventions included, administer antibiotics as per MD order, follow facility policy and procedures for line listing summarizing and reporting infections, maintain universal precautions when providing care, monitor temperature/pulse as ordered, monitor and report signs of delirium."

Review of a document from a third-party company dated 07/13/23 at 1:00 PM read in part, large red area to the inner side of right arm, patient pulled out at least 2 lines already maybe more. Right cephalic vein (superficial vein in arm) with good blood return but the guide wire (used to insert catheter) only went up 8 centimeters. Right brachial vein (another superficial vein in arm) good blood return by would not thread guidewire. Not a candidate for future PICC or midline access. The form was signed by the technician that attempted to reinsert the PICC line.

Review of intraoffice communication from the Infectious Disease office dated 07/14/23 at 2:01 PM read, had a call today from {Unit Manager} stated that Resident #244's "picc line was out that had someone to come there and try to put it in and they could not get it in. I called back and down there and talked to the nurse with him today" {Nurse #10} "and she said she was not given any orders for IV antibiotics. She was giving him the cipro. I told her she needed to take him to the ER and get the PICC line put back in. I told her if PICC line had been out it was 2 days he has gone without his medication."

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The Unit Manager was interviewed on 03/20/24 at 3:45 PM, she stated that she had worked at the facility for 9 months. She stated she did not recall calling Infectious Disease regarding Resident #244 and did not recall having any involvement with the Resident #244 or the situation.

Review of intraoffice communication from the Infectious Disease office dated 07/17/23 read, I called the nursing home and spoke with {Nurse #11} "to see if they took him to the hospital to have PICC line put in. she said no they had someone to come out there. They could not get it in. Said his arm was too sore."

Nurse #11 was interviewed via phone on 03/20/24 at 3:05 PM. Nurse #1stated that she had received in report that Resident #244's PICC line was out, and he missed doses of his antibiotic. She stated that she had called the Infectious Disease office and made them aware that Resident #244's PICC line came out and that they tried to re-insert it and it was unsuccessful. She could not recall who gave her report that day or who she spoke to at the Infectious Disease office, but they did not give me any orders, or I would have put them in my notes. Nurse #11 stated she did recall speaking the facility NP or MD regarding Resident #244's PICC line or medication.

Resident #244's family was interviewed via phone on 03/20/24 at 4:41 PM. The family member stated that after Resident #244 was discharged from the facility he had followed up at the Infectious Disease office and continued his antibiotic treatment.

Nurse #10 was interviewed via phone on

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03/21/23 at 9:01 AM. She stated that it had been a while since she had worked at the facility. She stated that she really did not recall Resident #244, she remember that she came to work one day, and someone did not have an IV line so she could not administer the IV antibiotic. It rings a bell that maybe I called to have the line replaced but "it is odd that I did not make a note about it." Typically, I would have called the provider and told them that he did not have IV access and then carry out whatever orders they gave. If they would have told me to send Resident #244 to the hospital I would have done so because "it is unacceptable to skip an antibiotic."

A follow up interview was conducted with Nurse #10 on 03/21/24 at 3:38 PM. Nurse #10 confirmed that she did not receive a call with instructions to send Resident #244 to the ER. If she would have, she would put the order into the system, called Emergency Medical Services (EMS) and notified the management team. Finally, "I would have documented in the medical record the situation."

Nurse #6 was interviewed via phone on 03/22/24 at 10:43 AM, she stated that she had not worked at the facility for 6 months. She stated that she did not recall getting any orders from Infectious Disease or from the providers regarding Resident #244. She added that she was not able to give him his IV antibiotic because he did not have a PICC line in place. She stated she believed the staff tried to send him to the ER and when EMS came, they told them that the ER would not place a PICC line. She stated that EMS had called the ER, and the ER staff told them no they could not replace a PICC line. Nurse #6 stated that most of the time the pharmacy would come and replace

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the PICC line, and she believed they were contacted to come and replace the line.

An interview was conducted with EMS personnel on 03/26/24 at 3:15 PM and they had no record of any run reports for Resident #244 at the facility from 07/11/23 through 07/24/23.

The DON was interviewed on 03/20/24 at 5:07 PM who stated she recalled Resident #244 as he only had one arm and he pulled his PICC line out. She stated that he refused to have it reinserted as he wanted to go home. The DON stated that the Infection Disease office was notified on 07/17/24 that his line was out, and he had missed doses of the IV Daptomycin. When asked why she did not send Resident #244 to the Emergency Room (ER) for assistance in getting a PICC line or other line inserted for the antibiotic she replied, "if we cannot get a line the ER cannot get a line." The ER cannot put a PICC line in because they do not have access people over there to do it. The ATB was placed on hold pending an appointment with Infection Disease. The DON stated, "I do not when the appointment was it has been over a year ago." "He only had one arm and if we could not get a line the ER could not get a line." She added that she had no contact with Infectious Disease office during this time. The DON stated that with no IV access the IV antibiotic could not be administered.

The Infectious Disease Nurse Practitioner (NP) was interviewed via phone on 03/20/24 at 12;15 PM who stated that if Resident #244's PICC line was dislodged, or he did not have access and access was unable to be obtained then he should have been immediately sent to the ER so we could have restored his access. She explained

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that there were numerous other types of line access that they could have done for Resident #244 including a central line or tunneled PICC line in the groin. The NP stated, "it is not reasonable to not receive antibiotics for a portion of time due to access" issues. "It is prudent of any skilled nursing facility if the PICC line is out and attempts to reinsert failed, then he should have been directed to higher level of care, not say oh well and not give for 2 weeks." The NP added, "if the facility could not figure out how to work through the access issues we could have helped them." She added that Resident #244 "had thoracic spinal osteomyelitis with spinal stenosis and staphylococcus bacteremia and untreated could lead to loss of limb function and he was already a left upper extremity amputee." The NP stated that Resident #244 was seen in the office 2 days after discharging from the facility on 07/26/23 and his access was restored, and we resumed his IV antibiotic at an outpatient infusion center and extended the duration to make up for the missed doses at the facility.

The MD was interviewed via phone on 03/20/24 at 1:26 PM. He stated that he did not recall being made aware that his PICC line was out and that he had missed 14 doses of the IV antibiotic. The MD stated had he been aware that an attempt to reinsert the PICC line was unsuccessful, he would have directed the staff to send Resident #244 to the ER to have access regained. The MD stated, "it was very concerning that he missed 14 doses of antibiotic."

The facility NP #2 was interviewed via phone on 03/20/24 at 4:47 PM, she stated she recalled Resident #244 but stated she did not recall any issues with his PICC line or missing doses of his

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scheduled antibiotic. She explained that she was out of state on personal business during this time but had someone contacted her, she would have directed the staff to send Resident #244 to the ER.

The Administrator was notified of immediate jeopardy on 03/27/24.

The facility provided the following immediate jeopardy removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to send resident #244 to the hospital to have his intravenous access (IV) replaced, when his peripherally inserted central catheter became dislodged, as directed by the Infectious Disease provider on 07/14/2023. Resident #244 missed 14 doses of the IV antibiotics before being discharged from the facility, and then resuming his IV antibiotic course at a outpatient infusion center. There was a high likelihood of serious harm of impairment when resident #244 was not directed to a high level of care, and when attempts to restore his IV access were unsuccessful at the facility.

On 03/27/2024, the Director of Nursing assessed all current residents receiving IV antibiotics for: IV access placement/ patency/ function, and orders for administration of IV antibiotic therapy course, to ensure residents are receiving their antibiotics as ordered by the physician, and do not require a higher level of care to meet resident current needs.

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F 684	Continued From page 69 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 03/27/2024, the Director of Nursing educated licensed nurses on directing residents to a higher level of care, if the needs of the resident cannot be met in the facility to avoid serious harm or impairment. 03/27/2024, the Director of Nursing educated licenses nurses (to include agency) on following facility provider orders (to include consulting physicians and notification of facility provider/consulting physicians within the realm of practice) and documenting any barriers to IV antibiotic administration. On 03/27/2024, the Director of Nursing educated all certified nursing assistants on reporting changes in resident baseline, new acute observations; to include observed IV issues. On 03/27/2024, the Director of Nursing reviewed all current residents receiving IV antibiotics for: IV access placement/ patency/ function, and orders for administration of IV antibiotic therapy course; to ensure residents are receiving their antibiotics as ordered by the physician, and do not require a higher level of care to meet resident current needs. The Director of Nursing will educate newly hired licensed nurses and agency nurses. Education completed 3/27/24. Effective 3/28/24 the Director will be responsible for ensuring implementation of this immediate jeopardy removal for the alleged non-compliance. Alleged Date of IJ Removal: 3/28/24 On 03/28/24 an onsite credible allegation validation was conducted. The audit of all in	F 684		

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F 684	Continued From page 70 house residents on IV antibiotics was reviewed and revealed two residents. Those two residents' orders, administration record, dressings, and duration of medication were all verified, and no issues were identified. Interviews with all nursing staff revealed that they had been educated on identifying and reporting any changes in resident status or barriers to medication administration to the medical provider and carrying out any orders received and the ensuring that it was documented in the medical record. If the new orders entailed transferring the resident to a higher level of care the staff were able to verbalize the process for transferring a resident to the ER for treatment. The IJ removal date of 03/28/24 was validated.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident, roommate, staff, Wound Nurse Practitioner, and facility Nurse Practitioner interviews the facility failed to stop incontinent care when a resident (Resident #35) experienced pain and was crying and failed to report to the nurse so that her complaints of pain could be addressed for 1 of 1 resident reviewed for pain management. Resident #35 stated that during incontinent care and while being turned onto her side her pain was an 8 on a pain scale.	F 697	F697 Resident #35 was discharged from the facility on 3/22/24. The Regional Nurse Consultant, wound care nurse and unit manager conducted a 100% pain assessment audit on all residents who receive incontinent care and required turning by staff on 4/4/24 and 4/5/24. Any resident with issued identified, the physician was notified, and medication adjusted accordingly. The audit and adjustments were completed by	4/23/24

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F 697	Continued From page 71 The findings included: Resident #35 was admitted to the facility on 04/06/22 with diagnoses that included: diabetes melilites, chronic obstructive pulmonary disease, respiratory failure, a pressure ulcer to left lower leg, and a pressure ulcer to the right lower leg. Review of a pain care plan for Resident #35 revised on 01/26/24 read in part, "I am on pain medication therapy related to wound to lower extremities." The goal read, "The resident will be free of any discomfort or adverse side effects from pain medication through the review date," and the interventions included: administer analgesic (pain medication) as ordered, monitor/document as needed adverse reactions to pain medications, and review pain medication for effectiveness. Review of a physician's order dated 03/21/23 read, Hydrocodone/Acetaminophen (controlled pain medication) 5/325 milligrams (mg) by mouth every 6 hours as needed for pain. Tylenol Extra Strength 500 mg give two tables by mouth every 8 hours as needed for discomfort. Review of the annual Minimum Data Set (MDS) dated 01/22/24 revealed that Resident #35 was cognitively intact and had no rejection of care. Resident #35 reported pain occasionally on a pain scale of a 6. The MDS also indicated that Resident #35 had moisture associated skin dermatitis and had 2 venous ulcers. Resident #35 received opioid medication during the assessment reference period. Review of the MAR dated March 2024 revealed on 03/18/24 no as needed	F 697	4/5/24. The Director of Nursing initiated an in-service for all licensed nurses and certified nursing assistants (CNA) on pain management while turning or receiving incontinent care. This in-service included stopping care and getting resident assistance for pain management. This in-service was completed on 4/22/24. Any licensed nurse or CNA who did not complete this in-service by 4/22/24, will not be allowed to work until complete. The Director of Nursing added this to the new hire orientation on 4/12/24. The Director of Nursing or designee will audit 5 residents weekly x 2 months for incontinent care and/turning by staff for pain management. The Director of Nursing will be responsible for bringing the pain management audit to the Quality Assurance Performance Improvement committee x 2 consecutive meetings. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 4/23/24	

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	345011	A. BUILDING _____ B. WING _____	C 03/28/2024

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Hydrocodone/Acetaminophen or Tylenol Extra Strength were administered. The MAR also revealed Resident #35 had reported pain on a pain scale of 5-6 at least every day during the month of March except for 03/13/24 and 03/18/24. Some days there were multiple doses of the Hydrocodone/Acetaminophen administered.

An observation and interview were conducted with Resident #35 on 03/18/24 at 12:01 PM. Resident #35 was resting in bed on her back and had a very flat affect, her voice was very soft in tone almost a whisper. Resident #35 stated that two Nurse Aides (NA) had just given her a bed bath, the one with short hair was very nice and the one with long hair was very rough. Resident #35 was asked to describe what rough meant, she stated that the long-haired NA, identified as NA #2 was giving her a bed bath and she was washing with a rag that was very rough and then the short haired NA identified as NA #3 came in and they turned me onto my side and "I was in so much pain" from the wounds on my bottom. Resident #35 stated that she was crying and hollering out in pain and both NAs kept saying "we are sorry" but just kept on "wiping me." Resident #35 stated that she would rate her pain at 8 at the time, once the staff were done and got her back onto her back, she stated her pain was better than before "maybe down to a 5." She added that could not recall if this was the first time that NA #2 and NA #3 had taken care of her but stated they did put some cream on her sores on her bottom before they finished with her. She added that NA #2 and NA #3 were talking to each other about my wounds on my bottom but not to me directly.

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Resident #10 was admitted to the facility on 02/07/23.

Review of the quarterly MDS dated 01/19/24 revealed that Resident #10 was cognitively intact.

An interview with Resident #35's roommate (Resident #10) was conducted on 03/18/24 at 12:06 PM, she stated NA #2 came in and told Resident #35 she was going to give her a bed bath and got the basin and filled it with water and went to Resident #35's bedside to begin her bed bath. She stated she did pull the privacy curtain, but she heard the entire exchange of care being provided to her roommate. Resident #10 stated that she could hear NA #2 scrubbing Resident #35 and heard Resident #35 state to NA #2 that she was scrubbing her too hard. When NA #2 had completed washing the front of Resident #35 she went and got NA #3 to help turn her and wash her back side. Resident #10 stated that during the process both NA #2 and NA #3 were talking to themselves about how bad it was, and indicated they were referring to the size and color of Resident #35's sores on her bottom were but not talking to Resident #35. She stated the whole time NA #2 and NA #3 were washing her Resident #35 was crying and screaming saying it hurt. She did overhear NA #2 say to Resident #35 "I am sorry," and NA #3 apologized a couple of times, but they did not stop and get the nurse. She started that after NA #2 and NA #3 were finished and had left the room Resident #35 did calm down.

NA #2 was interviewed on 03/18/24 at 2:23 PM, she stated she had been coming to the facility for 4 days as agency staff. NA #2 confirmed she had given Resident #35 a bed bath earlier today. She

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stated that Resident #35 "was in pain and crying" especially when she rolled her over to her side. NA #2 stated, "She is raw in her peri area and on her back side." NA #3 came in and helped turn Resident #35 onto her side to help wash her back side. She stated Resident #35's wounds were not deep, and she had put cream (barrier cream) on them. NA #2 explained while washing Resident #35's other body parts she was fine and had no complaints of pain, but when she started washing her peri area and her back side, she began to cry but did not see real tears, but she was moaning and saying that it hurt. NA #2 stated she had not reported the interaction to the nurse and was not aware if Resident #35 had anything for pain or not. She added that everyone told me that her crying and fussing was her usual behavior and that was why she had not reported it to the nurse. NA #2 stated, "If you see it you will understand," referring to Resident #35's peri area and bottom.

NA #3 was interviewed on 03/18/24 at 2:56 PM who confirmed she assisted NA #2 with completing Resident #35's bed bath. She stated that when she entered the room Resident #35 was resting on her back, NA #2 had washed and dried her front side and they turned Resident #35 onto her side to wash her peri area and her back side. She stated when they turned Resident #35 over, she was moaning and saying ouch and at one point put her hands over her face. She stated she knew Resident #35 was hurting but she never asked us to stop and that was pretty normal behavior for her. NA #3 stated she had not let the nurse know that Resident #35 was hurting.

Nurse #9 was interviewed on 03/19/24 at 9:09 AM. She stated Resident #35 did complain a lot

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of pain with her wounds, and they definitely gave her something for pain prior to any wound treatment. Nurse #9 stated outside of wound care it was "hit or miss" if Resident #35 requested something for pain, she explained the resident may take the pain medication once a shift and then may not take it for a day or so. Nurse #9 stated Resident #35 has pain when she is moved and there were times where she would refuse to turn because it hurt so bad. Nurse #9 stated she has told Resident #35 that she can have her pain medication but that she still has to get changed and the pain medication is effective until we move her again. When Nurse #9 does assess Resident #35's pain she explained it was usually a headache or pain in her bottom and sometimes her pain was a 6 or 7. If she was resistive to care the NAs would come and get me but nothing was reported to her yesterday regarding Resident #35's pain during incontinent care. Nurse #9 also confirmed she had not given Resident #35 anything for pain on 03/18/24.

The facility NP was interviewed via phone on 03/19/24 at 4:57 PM, she stated the nurse had contacted her earlier on 03/19/24 and she was going to increase Resident #35's pain medication. She stated that recently "her usage had increased" and typically the pain medication was given with dressing changes. The NP explained the wounds on Resident #35's legs had been present for 5 years and were likely not going to heal. The NP stated although Resident #35 was starting to use her pain medication more frequently she did not think that she would need opioid medication with incontinent care. She added that she was increasing her Hydrocodone to 7.5 mg every 6 hours, but everything was a fine line especially respiratory depression which was a

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F 697	Continued From page 76 big concern for her. The Wound Nurse Practitioner (NP) was interviewed on 03/20/24 at 8:47 AM. She stated that Resident #35's bottom waxes and wanes, she will have spots that open and then get a little bigger. She stated she generally saw Resident #35 first thing in the morning, and she was usually more irritated from being wet throughout the night. and there were times she would not allow me to look at her bottom because she said it hurt to turn over. The Wound NP stated that when she first started seeing her, she recommend starting some pain medication prior to wound care and after noted an improvement in her participation. The Director of Nursing (DON) was interviewed on 03/21/24 at 10:28 AM, she stated that Resident #35 was verbal when she needed things. She stated the NP had increased Resident #35's pain medication to 7.5 mg on 03/19/24. If Resident #35 was in pain, then the staff should have given her pain medication and would expect the pain medication to be given ahead of the pain.	F 697		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		4/23/24

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F 757	Continued From page 77 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Physician interviews the facility failed to prevent a vaccine from being given more than once when it was ordered for a one-time dose for 1 of 5 residents (Resident #71) reviewed for unnecessary medications. Findings included: According to Arexvy.com, dosage and administration information indicated, "Administer a single dose (0.5 mL) of AREXVY as an intramuscular injection." Resident #71 was admitted to the facility on 3/8/2023 with diagnoses of stroke and chronic respiratory disease. An annual Minimum Data Set (MDS) assessment dated 1/11/2024 indicated Resident #71 was severely cognitively impaired. A Physician's Order dated 3/4/2024 indicated Resident #71 should receive Arexvy	F 757	F757 Resident #71 was assessed by the Nurse Practitioner on 3/22/24, and no adverse effects were identified. The Director of Nursing reviewed 100% of all in house residents on 4/1/24 for additional doses of RSV vaccine. No other residents were identified during this audit. The Director of Nursing initiated an in-service on 4/1/24 to all licensed nurses on immunization schedules. This in-service was completed on 4/22/24. Any licensed nurse who did not receive the in-service will not be allowed to work until this in-service has been completed. All new hired employees will be provided orientation/education on vaccines/immunizations and accuracy of giving them as requested to the resident and as per MD order. The Director of Nursing or designee will review all new admission RSV orders weekly x 3 months ensuring RSV immunizations have been documented	

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F 757	Continued From page 78 Intramuscular Suspension Vaccine 0.5 milliliters intramuscularly one time a day for RSV vaccination. During a review of Resident #71's electronic medical record a review was done of Medication Administration Record (MAR) for March 2024, and it indicated Resident #71 received three doses (on 3/4/2024, 3/7/2024, and 3/15/2024) of the vaccine Arexvy Intramuscular Suspension (RSV Vaccine). The MAR further indicated the vaccine should be given one time a day for RSV vaccine beginning on 3/4/2024. The MAR indicated the vaccine was discontinued on 3/19/2024. Nurse #14 was interviewed by phone on 3/21/2024 at 1:57 pm and she stated she gave Resident #71 the RSV vaccination on 3/4/2024 because it was ordered to be given that day. She stated she did not know why it was given again on the two other occasions. An interview was conducted on 3/21/2024 at 1:43pm with Nurse #3 who gave Resident #71 a dose of the RSV vaccine on 3/7/2024. She stated she documented giving the vaccination on 3/7/2024 and 3/15/2024, but she only gave the vaccination on 3/7/2024. She stated she must have documented it on 3/15/2024 by mistake. Nurse #3 indicated the order should have been transcribed into the electronic record as a one-time dose and not as a continuous once a day dose. During an interview with the Physician on 3/22/2024 at 9:00 am she stated Resident #71 should have received only one dose of the RSV vaccination but she would not have suffered any	F 757	and discontinued as ordered. The Director of Nursing will bring the RSV immunization audit to the Quality Assurance Performance Improvement committee x 3 consecutive meetings. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 4/23/24	

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F 757	Continued From page 79 ill effects from the extra dose. The Physician stated she was monitorred every shift by nursing and no side effects were reported. The Director of Nursing was interviewed on 3/22/2024 at 9:30 am and she stated the RSV vaccination was ordered by the physician as one dose, but the order was transcribed as one time a day. Since the Physician's Order was transcribed in the electronic record as once a day the nurses gave it more than one time. The Medication Administration Record should have been corrected in the electronic record so that after the first dose it would not have continued to indicate it needed to be given. On 3/22/2024 at 12:32 pm the Administrator was interviewed and stated Resident #71 should have received the RSV vacine as ordered by the physician and the electronic Medication Administration Record should have been correct to ensure the vaccine was not given in error.	F 757		
F 760 SS=K	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 record review, staff, family, Infectious Disease Nurse Practitioner, facility Nurse Practitioner #2, and Medical Director interviews the facility failed to prevent a significant medication error when staff failed to administer 14 ordered doses of intravenous (IV) antibiotic from 07/11/23 to 07/24/23 after the residents peripherally inserted central catheter (PICC line)	F 760	F760 Resident # 244 was discharged from the facility on 7/24/23. On 03/27/2024 the Director of Nursing reviewed all current residents receiving IV antibiotics for IV access placement/ patency/ function, orders for administration of IV antibiotic therapy	4/23/24

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F 760	Continued From page 80 was dislodged for 1 of 2 residents reviewed for significant medication error (Resident #244). Resident #244's infection if left untreated could lead to loss of limb function. Immediate jeopardy began on 07/14/23 when Resident #244's PICC line become dislodged, and the facility failed to direct him to higher level of care to ensure he received the IV antibiotic he required. Immediate jeopardy was removed on 03/28/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring system are in place. The findings included: Review of Resident #244's discharge summary from the local hospital dated 06/29/23 read in part, chronic left humeral fracture from a motor vehicle accident in 2018 with fixation with hardware and recurrent infection/osteomyelitis due to methicillin sensitive staphylococcus aureus (MSSA) status post recent left arm amputation 2 weeks ago. The discharge summary further indicated severe thoracic spinal stenosis with cord flattening, posterior disc bulging, vertebral abnormal marrow signal intensity possible osteomyelitis. Infectious disease on board and antibiotics were switched to daptomycin and ciprofloxacin to complete 8 weeks of antibiotic regimen. Resident #244's discharge medications included: Daptomycin (antibiotic) 500 milligrams (mg) intravenously (IV) daily and Ciprofloxacin (antibiotic) 750 mg by mouth twice daily. Both	F 760	course to ensure residents are receiving their antibiotics as ordered by the physician and do not require a higher level of care to meet resident current needs. On 03/27/2024 the Director of Nursing educated all licensed nurses on directing residents to a higher level of care if the needs of the resident cannot be met in the facility to avoid serious harm or impairment/ neglect of services needed. On 03/27/2024, the Director of Nursing educated all licenses nurses on following physician orders, notification of physician and documenting any barriers to IV antibiotic administration. On 03/27/2024 the Director of Nursing educated all certified nursing assistants on reporting changes in resident baseline, and any new acute observations to include observed IV issues. On 03/27/2024 the Director of Nursing educated all staff on heightened awareness of the definition of neglect, what constitutes neglect, and how to provide necessary care and services to the residents to ensure resident receive appropriate goods and services. On 03/27/2024, the Director of Nursing reviewed all current residents receiving IV antibiotics for IV access placement/patency/ function, orders for administration of IV antibiotic therapy course to ensure residents are receiving their antibiotics as ordered by the physician and do not require a higher level of care to meet resident current needs. The Director of Nursing will educate newly hired licensed nurses. Education completed 3/27/24.	

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F 760	Continued From page 81 were to be given for a total of 8 weeks and were to be discontinued on 08/19/23. Resident #244 was admitted to the facility on 06/29/23 and was discharged on 07/24/23. Resident #244's diagnoses included thoracic osteomyelitis with spinal stenosis and left upper extremity amputation. Review of physician orders dated 06/30/23 read, Ciprofloxacin 750 mg by mouth twice a day until 08/19/23. Daptomycin 500 mg IV every day until 08/19/23. Review of the admission Minimum Data Set (MDS) dated 07/06/23 revealed that Resident #244 was cognitively intact with no rejection of care. The MDS further indicated he received IV medications and 7 days of antibiotic during the assessment reference period. Review of the Medication Administration Record dated July 2023 revealed that Resident #244 did not receive Daptomycin 500 mg IV from 07/11/23 through his discharge on 07/24/23. A nurses note dated 07/11/23 at 7:24 PM read in part, nurse entered room to check on resident and his PICC line. Resident was digging in closet and nurse asked what was wrong and he stated his PICC line came out and PICC line noted on bedside table. This nurse requested resident to allow nurse to place pressure dressing on site and resident refused and stated it was fine. Nurse attempted to educate resident on need for pressure dressing and resident started cussing and threatening nurse. Resident told this nurse not to return to his room for any reason. No obvious signs of bleeding noted at the PICC line	F 760	The Director of Nursing or designee will review all residents receiving IV medications to ensure IV access and medication delivery according to orders. This audit will be conducted twice weekly x 2 months, then one-time weekly x month. The Director of Nursing will bring the IV medication audits to the Quality Assurance Performance Improvement Committee x 3 consecutive months. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 4/23/24	

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F 760	Continued From page 82	F 760		

site with tip intact. The note was written by Nurse #3.

Review of a physician order dated 07/12/23 read pulled IV out, unable to place new line. PICC line to be put in place by third party. Medication to be held until PICC line inserted. The order was entered by Nurse #4. The order was a verbal order from the Medical Director (MD).

Review of a Medication Administration Note dated 07/11/23 at 8:26 PM by Nurse #3, Daptomycin 500 mg every 24 hours until 08/19/23 hold pending PICC replacement.

Review of a Medication Administration Note dated 07/12/23 at 9:48 PM read in part, placement of PICC line unsuccessful. The note was written by Nurse #5.

Review of a document from a third-party company dated 07/13/23 at 1:00 PM read in part, large red area to the inner side of right arm, patient pulled out at least 2 lines already maybe more. Right cephalic vein (superficial vein in arm) with good blood return but the guide wire (used to insert the catheter) only went up 8 centimeters. Right brachial vein (another superficial vein) good blood return by would not thread guidewire. Not a candidate for future PICC or midline access. The form was signed by the technician that attempted to reinsert the PICC line.

Review of a Medication Administration Note dated 07/13/23 at 7:58 PM read, attempts to replace PICC line this shift were unsuccessful. The note was written by Nurse #5.

Review of intraoffice communication from the

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Infectious Disease office dated 07/14/23 at 2:01 PM read, had a call today from {Unit Manager} stated that Resident #244's "picc line was out that had someone to come there and try to put it in and they could not get it in. I called back and down there and talked to the nurse with him today" {Nurse #10} "and she said she was not given any orders for IV antibiotics. She was giving him the cipro. I told her she needed to take him to the ER and get the PICC line put back in. I told her if PICC line had been out it was 2 days he has gone without his medication."

Review of a Medication Administration Note dated 07/14/23 at 7:50 PM read, PICC line to be replaced. The note was written by Nurse #2.

Review of a Medication Administration Note dated 07/15/23 at 9:52 PM read in part, Daptomycin 500 mg every 24 hours until 08/19/23, no access. The note was signed by Nurse #6.

Review of a Medication Administration Note dated 07/16/23 at 8:08 PM read in part, Daptomycin 500 mg every 24 hours until 08/19/23, held until PICC line placed. The note was signed by Nurse #7.

Review of intraoffice communication from the Infectious Disease office dated 07/17/23 read, I called the nursing home and spoke with {Nurse #11} "to see if they took him to the hospital to have PICC line put in. she said no they had someone to come out there. They could not get it in. Said his arm was too sore."

Review of a Medication Administration Note dated 07/17/23 at 8:36 PM read in part, Daptomycin 500 mg every 24 hours until 08/19/23, hold pending infectious disease appointment and PICC

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placement. The note was signed by Nurse #3.

Review of a nurses note dated 07/18/23 at 9:37 AM read in part, resident continues on therapy, IV antibiotic on hold due to unable to obtain line due to multiple attempts with resident pulling PICC lines out. On oral antibiotic to discharge home when complete. The note was signed by the Director of Nursing (DON).

Nurse #3 was interviewed on 03/20/24 at 3:21 PM who stated that she recalled Resident #244 had rolled over in bed and pulled his PICC line out. She stated she found it on his bedside table. Nurse #3 stated that Resident #244 would not allow the area to be dressed and began cursing at Nurse #3. She stated she had called and got an order for reinsertion and to hold the IV antibiotic pending reinsertion.

Resident #244's family was interviewed via phone on 03/20/24 at 4:41 PM. The family member stated that after Resident #244 was discharged from the facility he had followed up at the Infectious Disease office and continued his antibiotic treatment.

The DON was interviewed on 03/20/24 at 5:07 PM who stated she recalled Resident #244 as he only had one arm and he pulled his PICC line out. She stated that he refused to have it reinserted as he wanted to go home. The DON stated that the Infection Disease office was notified on 07/17/24 that his line was out, and he had missed doses of the IV Daptomycin. When asked why she did not send Resident #244 to the Emergency Room (ER) for assistance in getting a PICC line or other line inserted for the antibiotic she replied, "if we cannot get a line the ER cannot

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get a line." The ER cannot put a PICC line in because they do not have access people over there to do it. The ATB was placed on hold pending an appointment with Infection Disease. The DON stated, "I do not know when the appointment was it has been over a year ago." "He only had one arm and if we could not get a line the ER could not get a line." She added that she had no contact with Infectious Disease office during this time. The DON stated that with no IV access the IV antibiotic could not be administered.

Nurse #2 was interviewed via phone on 03/22/24 at 9:58 AM. Nurse #2 stated she worked all the units and did not recall Resident #244's name or situation, she stated "I see some of everyone."

Nurse #6 was interviewed via phone on 03/22/24 at 10:43 AM, she stated she no longer worked at the facility for the last 6 months. She stated she was not able to administer Resident #244's IV Daptomycin because he did not have a PICC line. She stated she thought they had called the pharmacy to request a new PICC line be placed but after that she did not recall working with Resident #244 again.

Nurse #7 was interviewed via phone on 03/22/24 at 11:00 AM. Nurse #7 stated that he did not work at the facility anymore and had been gone for approximately 2 months. He stated that he recalled Resident #244 was very particular about his PICC line dressing but did not recall much else about
Resident #244 or the situation. He stated if his PICC line was out we should have held the medication and notified the Medical Director (MD) for orders to have the line replaced.

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Nurse #4 was interviewed via phone on 03/24/24 at 12:50 PM who stated she had not worked at the facility for almost a year and did recall Resident #244 or anything about the situation.

An attempt to speak to Nurse #5 via phone was made on 03/24/24 at 3:38 PM and was unsuccessful.

The Infectious Disease Nurse Practitioner (NP) was interviewed via phone on 03/20/24 at 12;15 PM who stated that if Resident #244's PICC line was dislodged, or he did not have access and access was unable to be obtained then he should have been immediately sent to the ER so we could have restored his access. She explained that there were numerous other types of line access that they could have done for Resident #244 including a central line or tunneled PICC line in the groin. The NP stated, "it is not reasonable to not receive antibiotics for a portion of time due to access" issues. "It is prudent of any skilled nursing facility if the PICC line is out and attempts to reinsert failed, then he should have been directed to higher level of care, not say Oh well and not give for 2 weeks." The NP added, "if the facility could not figure out how to work through the access issues we could have helped them." She added that Resident #244 "had thoracic spinal osteomyelitis with spinal stenosis and staph bacteremia and untreated could lead to loss of limb function and he was already a left upper extremity amputee." The NP stated that Resident #244 was seen in the office 2 days after discharging from the facility on 07/26/23 and his access was restored, and we resumed his IV antibiotic at an outpatient infusion center and extended the duration to make up for the missed

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doses at the facility.

The MD was interviewed via phone on 03/20/24 at 1:26 PM. He stated that he did not recall being made aware that his PICC line was out and that he had missed 14 doses of the IV antibiotic. The MD stated had he been aware that an attempt to reinsert the PICC line was unsuccessful, he would have directed the staff to send Resident #244 to the ER to have access regained. The MD stated, "it was very concerning that he missed 14 doses of antibiotic."

The facility NP #2 was interviewed via phone on 03/20/24 at 4:47 PM, she stated she recalled Resident #244 but stated she did not recall any issues with his PICC line or missing doses of his scheduled antibiotic. She explained that she was out of state on personal business during this time but had someone contacted her, she would have directed the staff to send Resident #244 to the ER.

The Administrator was notified of the Immediate Jeopardy on 03/27/24 at 10:10 AM.

The facility provide the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to administer an intravenous (IV) antibiotic for 14 days after the residents peripherally inserted central catheter was dislodged in 07/11/2023 (Resident #244). Resident #244 was discharged on 07/24/2023 and was seen at the Infectious Disease office on

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07/26/2023, access was restored, and his IV antibiotic was resumed. There was a high likelihood that Resident #244 would lose the function of his one remaining upper extremity without having the IV antibiotics as ordered. On 03/27/2024 the Director of Nursing assessed all current residents receiving IV antibiotics for IV access placement/ patency/ function, orders for administration of IV antibiotic therapy course to ensure residents are receiving their antibiotics as ordered by the physician and do not require a higher level of care to meet resident current needs.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 03/27/2024 the Director of Nursing educated licensed nurses on directing residents to a higher level of care if the needs of the resident cannot be met in the facility to avoid serious harm or impairment. On 03/27/2024 the Director of Nursing educated medication aides on reporting to licensed nurses any observations of adversities to resident care that may indicate assessment by a licensed nurse to avoid serious harm or impairment. 03/27/2024 the Director of Nursing educated licenses nurses on following physician orders and notification of physician and documenting any barriers to medication administration. 03/27/2024 the Director of Nursing educated medication aides on following physician orders and notification to a licensed nurse any barriers to medication administration. On 03/27/2024 the Director of Nursing reviewed all current residents receiving IV antibiotics for IV access placement/ patency/ function, orders for

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F 760	Continued From page 89 administration of IV antibiotic therapy course to ensure residents are receiving their antibiotics as ordered by the physician and do not require a higher level of care to meet resident current needs. The Director of Nursing will educate newly hired licensed nurses and medication aides. Education completed 3/27/24. Effective 3/28/24 the Director will be responsible for ensuring implementation of this immediate jeopardy removal for the alleged non-compliance. Alleged Date of IJ Removal: 3/28/24 On 03/28/24 an onsite credible allegation validation was conducted. The audit of all in house residents on IV antibiotics was reviewed and revealed two residents. Those two residents' orders, administration record, dressings, and duration of medication were all verified, and no issues were identified. Interviews with all nursing staff revealed that they had been educated on identifying and reporting any changes in resident status or barriers to medication administration to the medical provider and carrying out any orders received and the ensuring that it was documented in the medical record. If the new orders entailed transferring the resident to a higher level of care the staff were able to verbalize the process for transferring a resident to the ER for treatment. The IJ removal date of 03/28/24 was validated.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		4/23/24

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F 761	Continued From page 90 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to label and date four liquid medications that had been opened in 1 of 3 medications carts (100-hall medication cart) observed for storage and labeling of medications. Findings included: During an observation of the 100-hall medication cart on 3/20/2024 at 10:24 am the following medications were found opened and were not dated: Pro-stat (a concentrated liquid protein) 15 milligrams per 1 fluid ounce was found opened and undated. The label indicated the medication	F 761	F761 Pro-stat, Chlorhexidine Gluconate, Valproic Acid, and Dextromethorphan/Guaifenesin that were opened and undated were removed from the medication□s carts on 3/20/24 were removed the same day by the Director of Nursing. All medication carts and medications rooms were audited on 4/5/24 by the Pharmacy consultant. Any medications found opened and undated were removed immediately. The Director of Nursing initiated an in-service to all licensed nurses and medication aides on dating medications	

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F 761	Continued From page 91 should be discarded 3 months after opening. A bottle of Chlorhexidine Gluconate 0.12% (an antiseptic mouthwash) was found open and undated. There were no instructions on the bottle regarding when it should be discarded after opening. Valproic Acid Oral Solution 250 milligrams in 5 milliliters (an antiseizure medication) was found opened and undated. There were no instructions on the bottle regarding when it should be discarded after opening. Dextromethorphan/Guaifenesin (an over-the-counter cough suppressant medication) 2 milligrams/200 milligrams in 10 milliliters liquid was found open and undated. There were no instructions on the label regarding when they should be discarded after opening. On 3/20/2024 at 10:42 am Nurse #8 was interviewed, and she stated she normally worked on the 100-hall. Nurse #8 stated all medications that were opened and stored in the medication carts should be labeled with the date they were opened. She stated she had an in-service education recently and understood the medications should be dated as soon as they were opened, and she did not know who had put the unlabeled medications in the medication cart. The Director of Nursing (DON) was interviewed on 3/21/2024 at 1:34 pm and stated the nursing staff had been educated on labeling and dating any medications that were opened and placed in the medication cart. She stated Nurse #8 should have ensured the medications were labeled with the date they were opened and discarded them if	F 761	when opened and if found to be opened with no date, to discard. This in-service was completed on 4/22/24. Any licensed nurse or medication aide who did not receive this in-service by 4/22/24 will not be allowed to work until the in-service has been completed. The Director of Nursing added this to the new hire orientation for all new hires on 4/12/24. The Director of Nursing or designee will conduct medication audits to include medication carts and medication rooms 3 times weekly for 4 weeks, then 1 time a week x 4 weeks. The pharmacy consultant will be reviewing medication carts "unannounced" ensuring deficient practice does not reoccur. The Director of Nursing will be responsible for bringing the medication cart and medication room audits to the Quality Assurance Performance Improvement committee for 2 consecutive meetings. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions and recommendations based on the audits to ensure continued compliance. Date of Compliance: 4/23/24	

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F 761	Continued From page 92 they were not labeled with the date they were opened. During an interview with the Administrator on 3/21/2024 at 3:29 pm she stated all medications should be labeled with the date they were opened before they were placed in the medication carts.	F 761		
F 867 SS=G	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		4/23/24

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development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity

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of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including

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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 867	Continued From page 95 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, resident, shelter staff, and facility staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 9/23/2021 Complaint Investigation Survey and the 3/8/2022 Complaint Investigation Survey During the 3/8/2022 Complaint Investigation Survey the facility was cited for Resident Rights (F550) and during the 9/23/2021 Complaint Investigation Survey the facility was cited for Discharge Planning Process (F660). These deficiencies were recited again on the current Recertification Survey and Complaint Investigation Survey of 3/28/2024. The continued failure of the facility to ensure compliance in the two previously deficient areas showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. Findings included: This tag is cross referenced to: F660-Based on record review, resident, facility staff, and shelter staff interview the facility failed to develop and implement an effective discharge planning process to ensure discharge needs and goals were identified with the resident and the interdisciplinary team (IDT) as active participants in the discharge plan in order to prepare the resident for an effective transition to post-discharge care for a resident who was a planned discharge. On 2/14/24 Resident #241	F 867	F867 The facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the 9/23/2021 Complaint Investigation Survey and the 3/8/2022 Complaint Investigation Survey During the 3/8/2022Complaint Investigation Survey the facility was cited for Resident Rights (F550) and during the9/23/2021 Complaint Investigation Survey the facility was cited for Discharge Planning Process(F660). These deficiencies were recited again on the current Recertification Survey and Complaint Investigation Survey of 3/28/2024.The continued failure of the facility to ensure compliance in the two previously deficient areas showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The Administrator initiated an in-service to all administrative staff on 3/29/24 regarding Quality Assurance Performance Improvement (QAPI) process including identifying and prioritizing quality deficiencies, systemically analyzing causes of quality deficiencies, developing, and implementing corrective action or performance improvement activities. This in-service included accuracy of audits, extending audits when appropriate, and	

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F 867	Continued From page 96 was discharged without the facility verifying his discharge location and if his care needs were able to be met. In addition, the resident was discharged without adaptive equipment required for ambulation (rolling walker). Resident #241 indicated he was dropped off at a homeless shelter where he continued to reside and felt "unsafe" and was "fearful". These failures created a high likelihood of harm for Resident #241. This deficient practice affected 1 of 4 residents reviewed for discharge. During a Complaint investigation survey of 9/23/2021 the facility failed to implement and communicate with Emergency Contact #1 or the Resident Representative (RP)/Emergency Contact #2, a discharge plan for a resident's transfer to a locked unit at another Skilled Nursing Facility. F550- Based on record review, resident, roommate, and staff interviews the facility failed to treat a resident in a dignified manner when two Nurse Aides (NAs) were talking about the residents' wounds in front of her but not to her and were rough during incontinent care and when the resident was screaming and crying in pain (Resident #35) and they did not stop the care. The resident stated the interactions with the NAs made her feel angry and upset that they treated her that way for 1 of 1 resident reviewed for pain. During the complaint investigation survey of 3/8/2022 the facility failed to treat a resident in a dignified manner when there was a delay in answering a resident's call light. During an interview with the Administrator on 3/22/2024 at 12:32 pm she stated the facility has	F 867	reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise, as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff worked util they received appropriate education. The QAPI committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: 4/23/24	

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F 867	Continued From page 97 a monthly Quality Assessment and Assurance (QAA) meeting with the department managers and the Physician; and the Pharmacist is available for the quarterly QAA meetings. She stated she understood the facility's QAA process had failed since they had repeated the two tags for Resident Rights and Discharge Planning Process and the facility would continue to strive to improve their processes.	F 867		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		

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F 883	Continued From page 98 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to included documentation in the medical record of education regarding the benefits and potential side effects of the Influenza and Pneumococcal immunization for 5 of 5 residents reviewed (Resident #10, Resident #21, Resident #34, Resident #35, and Resident #41.) The findings included: a. Resident #10 was admitted to the facility on	F 883	Past noncompliance: no plan of correction required.	

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02/07/23.

Review of the quarterly Minimum Data Set (MDS) dated 01/19/24 revealed Resident #10 was cognitively intact and received the Influenza immunization in the facility on 10/16/23 and Resident #10's Pneumococcal immunization was up to date.

A review of Resident #10's medical record revealed that there was no information in the medical record that the Resident or their legal representative was provided education regarding the benefits and potential side effects of the Influenza or Pneumococcal immunization.

b. Resident #21 was admitted to the facility on 09/24/18.

Review of the quarterly MDS dated 03/14/24 revealed that Resident #21 severely cognitively impaired and had received the Influenza immunization in the facility on 09/29/23 and his Pneumococcal immunization was up to date.

A review of Resident #21's medical record revealed that there was no information in the medical record that the Resident or his legal representative was provided education regarding the benefits and potential side effects of the Influenza or Pneumococcal immunization.

C. Resident #34 was admitted to the facility on 10/30/18.

Review of the quarterly MDS dated 01/16/24 revealed that Resident #34 was cognitively intact and had not received the Influenza immunization this year, she was offered and declined, and her

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F 883	Continued From page 100	F 883		

Pneumococcal Immunization was up to date.

A review of Resident #34's medical record revealed that there was no information in the medical record that the Resident or her legal representative was provided education regarding the benefits and potential side effects of the Influenza or Pneumococcal immunization.

D. Resident #35 was admitted to the facility on 04/06/22.

Review of the annual MDS dated 01/22/24 revealed that Resident #35 was cognitively intact and received the Influenza immunization in the facility on 09/29/23 and her Pneumococcal immunization was up to date.

A review of Resident #35's medical record revealed that there was no information in the medical record that the Resident or legal representative was provided education regarding the benefits and potential side effects of the Influenza or Pneumococcal immunization.

E. Resident #41 was admitted to the facility on 10/19/23.

Review of the quarterly MDS dated 01/25/24 revealed that Resident #41 was moderately cognitively impaired and received the Influenza immunization in the facility on 10/22/23 and her Pneumococcal immunization was up to date.

A review of Resident #41's medical record revealed that there was no information in the medical record that the Resident or her legal representative was provided education regarding the benefits and potential side effects of the

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Influenza or Pneumococcal immunization.

The Director of Nursing (DON) was interviewed on 03/21/24 at 9:34 AM. She explained the facility had participated in the Influenza and Pneumococcal immunization initiative with the quality improvement organization. They had recently looked at the immunization protocol and made some adjustments to it. The DON explained that when new admission came to the facility, they obtained their immunization history and pulled what information they could from the state database. Once they had the information, they got consent forms signed for whatever immunization was needed. Then the immunization would be ordered from the pharmacy and administered to the resident then documented in the medical record. The DON added during the review of the immunization program they realized that the consent forms that they were using did not have the risk and benefits on them, so we contacted the pharmacy and obtained new consent that had all the required information on them. Those were implemented in December 2023 starting with new admissions. Once the new consents were signed, they were uploaded into the resident's medical record.

The Administrator was interviewed on 03/21/24 at 4:45 PM. The Administrator explained that the facility had recently made changes to their Influenza and Pneumococcal immunization program. She stated they realized that the consent form that they were using did not include the risks and benefit education that was required. The Administrator stated that they pulled a new consent from the pharmacy and began getting them filled out and signed starting with new admissions. Once all the new consent forms were

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signed, they were uploaded into the system.

The facility submitted the following corrective action plan:

*The resident immunization consent form was updated to reflect education of the benefits and potential side effects of Influenza and Pneumococcal vaccine administration on 12/19/23 by the Administrator.

*All current residents in house medical records were audited for documentation of resident education of the benefits and potential side effects of the Influenza and Pneumococcal vaccine by the Medical Record Manager and DON on 12/19/23.

*The DON, Unit Manager, or Assistant Director of Nursing provided each resident who consented to vaccine administration and is able to make his/her own decision or the Responsibility Party the education of the benefits and potential side affects of the vaccine in which they consented to receive on 12/19/23.

*The Admissions Coordinator, Unit Manager, and Assistant Director of Nursing were in serviced by the DON on 12/19/23, that before offering the Influenza or Pneumococcal immunizations each resident or resident representative must receive education regarding the benefits and potential side effects of the immunization, and it must be documented in the resident's medical record.

*The DON or designee will audit all new admission and interview of resident or responsible party weekly x 12 weeks to ensure education of the benefits and potential side

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F 883	Continued From page 103 effects of the Influenza and Pneumococcal vaccine was provided and is documented in the resident's medical record. *The DON will be responsible for brining immunization education audit to the Quality Assurance performance Improvement Committee x 3 consecutive meeting starting on 12/19/23. The Quality Assurance Committee will determine the need for further education and monitoring. Date of Compliance: 12/20/23. The facility's corrective action plan was validated on 03/22/24. The initial audit of all in house residents' immunization records was reviewed. The education that was provided to the resident and or resident representative was also reviewed with no issues noted. The education included the potential risk and benefits of each immunization. Interviews with the Admission Coordinator and DON revealed that all new admissions were discussed in morning meeting and their immunization history was reviewed. Any needed or wanted immunizations were reviewed with the resident or resident representative that explained the potential risk and benefits of each immunization requested. The consent form was then uploaded into the resident's medical record. 13 weeks of audits were reviewed with each audit containing 5 new admission residents. All new admission residents or resident representatives had received the education of potential risk and benefits of each vaccination requested and that education was provided in the medical record. The completion date of 12/20/23 was validated.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii)	F 887		

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F 887	Continued From page 104 §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and	F 887		

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F 887	Continued From page 105 (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include documentation in the medical record of education regarding the benefits and potential side effects of the COVID-19 immunization for 3 of 5 (Resident #10, Resident #35, and Resident #41) residents reviewed for infection control. The findings included: a. Resident #10 was admitted to the facility on 02/07/23. Review of the quarterly Minimum Data Set (MDS) dated 01/19/24 indicated that Resident #10 was cognitively intact. Review of Resident #10's medical record revealed no information that the Resident or legal representative was provided information about	F 887	Past noncompliance: no plan of correction required.	

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the benefits and potential side effects of the COVID-19 immunization.

b. Resident #35 was admitted to the facility on 04/06/22.

Review of the annual MDS dated 01/22/24 indicated that Resident #35 was cognitively intact.

Review of Resident #35's medical record revealed no information that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization.

C. Resident #41 was admitted to the facility on 10/19/23.

Review of the quarterly MDS dated 01/25/24 indicated that Resident #41 was moderately cognitively impaired.

Review of Resident #41's medical record revealed no information that the Resident or legal representative was provided information about the benefits and potential side effects of the COVID-19 immunization.

The Director of Nursing (DON) was interviewed on 03/21/24 at 9:34 AM. She explained the facility had participated in the immunization initiative with the quality improvement organization. They had recently looked at the immunization protocol and made some adjustments to it. The DON explained that when new admission came to the facility, they obtained their immunization history and pulled what information they could from the state database. Once they had the information, they got consent forms signed for whatever

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immunization was needed. Then the immunization would be ordered from the pharmacy and administered to the resident then documented in the medical record. The DON added during the review of the immunization program they realized that the consent forms that they were using did not have the risk and benefits on them, so we contacted the pharmacy and obtained new consent that had all the required information on them. Those were implemented in December 2023 starting with new admissions. Once the new consents were signed, they were uploaded into the resident's medical record.

The Administrator was interviewed on 03/21/24 at 4:45 PM. The Administrator explained that the facility had recently made changes to their immunization program. She stated they realized that the consent form that they were using did not include the risks and benefit education that was required. The Administrator stated that they pulled a new consent from the pharmacy and began getting them filled out and signed starting with new admissions. Once all the new consent forms were signed, they were uploaded into the system.

The facility submitted the following corrective action plan:

*The resident immunization consent form was updated to reflect education of the benefits and potential side effects of the Covid-19 vaccine administration on 12/19/23 by the Administrator.

*All current residents in house medical records were audited for documentation of resident education of the benefits and potential side effects of the Covid-19 vaccine by the Medical

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Record Manager and DON on 12/19/23.

*The DON, Unit Manager, or Assistant Director of Nursing provided each resident who consented to vaccine administration and is able to make his/her own decision or the Responsibility Party the education of the benefits and potential side affects of the vaccine in which they consented to receive on 12/19/23.

*The Admissions Coordinator, Unit Manager, and Assistant Director of Nursing were in serviced by the DON on 12/19/23, that before offering the Covid-19 immunization each resident or resident representative must receive education regarding the benefits and potential side effects of the immunization, and it must be documented in the resident's medical record.

*The DON or designee will audit all new admission and interview of resident or responsible party weekly x 12 weeks to ensure education of the benefits and potential side effects of the Covid-19 vaccine was provided and is documented in the resident's medical record.

*The DON will be responsible for bringing immunization education audit to the Quality Assurance performance Improvement Committee x 3 consecutive meeting. The Quality Assurance Committee will determine the need for further education and monitoring starting on 12/19/23.

Date of Compliance: 12/20/23.

The facility's corrective action plan was validated on 03/22/24. The initial audit of all in house residents' immunization records was reviewed. The education that was provided to the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE ACRES CENTER FOR NURSING AND REHABILITATION	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

(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 887	Continued From page 109 and or resident representative was also reviewed with no issues noted. The education included the potential risk and benefits of each immunization. Interviews with the Admission Coordinator and DON revealed that all new admissions were discussed in morning meeting and their immunization history was reviewed. Any needed or wanted immunizations were reviewed with the resident or resident representative that explained the potential risk and benefits of each immunization requested. The consent form was then uploaded into the resident's medical record. 13 weeks of audits were reviewed with each audit containing 5 new admission residents. All new admission residents or resident representatives had received the education of potential risk and benefits of each vaccination requested and that education was provided in the medical record. The completion date of 12/20/23 was validated.	F 887		