STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MBNX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. Event ID# MBNX11. The following Intake Numbers: NC00201952, NC00202185, NC00203540, NC00204985, NC00205927, NC00207068, NC00210762, NC00210946, NC00211281, NC00212124, NC00212747, NC00213089, NC00213100, NC00214590, NC00214698, NC00214664, NC00214827, NC00214889, NC00214883, NC00215067, NC00215186, and NC00215216 were investigated. 17 of the 70 complaint allegations resulted in deficiency. Additional investigation was conducted from 4/1/2024 - 4/5/2024 resulting in a revised statement of deficiencies. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.35 at tag F726 at a scope and severity	F 000		

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

Electronically Signed | 03/01/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 (J) The tags F600 and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/08/24 and was removed on 4/5/24. An extended survey was conducted.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews, the facility failed to assess the ability of a resident to self-administer medications for 1 of 1 sampled resident observed with medication at the bedside (Resident #97). Findings included: Resident #97 was admitted to the facility on 3/30/23 with diagnoses that included bilateral primary osteoarthritis of hip, muscle weakness, lymphedema, and overactive bladder. The quarterly Minimum Data Set (MDS) dated 12/8/23 revealed the Resident #97 had intact cognition. Review of Resident #97's medical record revealed no documentation that Resident #97 was assessed for self-administration of medications.	F 554	F554 Self Administration Corrective action for the residents found to be affected by the deficient practice. Resident #97 still resides in the facility. An immediate sweep of resident rooms was conducted to ensure there were no additional medications at bedside unless the self-administer medications policy/procedure had been implemented by Director of Nursing on 2/9/24. Immediately for resident #97 a self-administration assessment was completed, a physician order for self-administration obtained and the care plan was updated to reflect this change done by Director of Nursing on 2/9/24. Corrective action for other residents having the potential to be affected by the same deficient practice.	4/30/24

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F 554	Continued From page 2 Further review of Resident #97's medical record revealed no care plan for self-administration of medications. Review of physician's orders for Resident #97 revealed no order for self-administration of medications. Review of Resident #97's Medication Administration Record (MAR) for January 2024 revealed an order for: Nystatin Powder 100000 UNIT/GM, apply to groin topically every shift for fungal infection for 14 days. Cleanse with normal saline solution (NSS) pat dry, apply nystatin powder, and leave open to air dry. The order started on 1/12/24 and was completed on 1/26/24. During an interview and observation on 2/6/24 at 9:59 AM, Resident #97 was sitting up on the side of the bed, with nystatin topical medication on the bedside table. Resident #97 explained to surveyor that she had an itchy rash near her groin, and she was prescribed nystatin topical on 1/12/24 and had been using the nystatin. An observation of Resident #97's room was conducted on 2/6/24 at 4:29 PM. Nystatin was on the bedside table. An observation of Resident #97's room was conducted on 2/7/24 at 8:24 AM. Nystatin was on the bedside table. On 2/7/24 at 1:45 PM an interview was conducted with Nurse #12 who occasionally medicated Resident #97. Nurse #12 explained that for a resident to have medication in their room they	F 554	All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted. Systemic Changes made to ensure that the deficient practice will not recur. All Staff were educated by Assistant Director of Nursing on the requirements of F554; specifically, the licensed nursing staff/licensed agency staff on the importance of completing the self-administration assessment if applicable before any resident self-administers medication, this includes leaving medications at bedside for residents to take at a later time. On-going monitoring of items in resident rooms by all staff to make sure items are secured in resident locked cabinet if applicable or in the medication cart. Plans to monitor its performance to make sure that the solutions are sustained. The DON or designee will monitor all new admissions for self-administration assessment completion if appropriate. An environmental rounding tool was implemented, it includes checking the residents□ rooms for any medications that should be secure. The DON or designee will conduct this audit at random weekly x 4 weeks, then bi-weekly x 2, then monthly x 1. All findings of concern will be immediately addressed and reported to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review monthly x 3 months or until substantial compliance is achieved.	

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F 554	Continued From page 3 would have to have an order to be able to self-medicate and as far as she knew she did not have a resident that was allowed to self-medicate. Accompanied Nurse #12 to Resident #97's room to find the nystatin on the bedside table. Resident #97 informed Nurse #12 that she was allowed to have the medication at bedside. An interview conducted on 2/7/24 at 1:57 PM with Nurse #12 revealed that Resident #97 did not have an order to self-medicate. Nurse #12 removed the nystatin from Resident #97's room. An interview conducted on 2/7/24 at 2:18 PM with Director of Nursing (DON) revealed that for a resident to self-administer medication they had to be assessed and care planned for it, and must have a lock box to keep medication in. Interview further revealed that Resident #97 is cognitively intact and would be able to self-administer. The DON found the order for Resident #97 for nystatin, but Resident #97 did not have an order to self-administer. An interview conducted with the Administrator and Corporate Nurse Consultant on 2/8/24 at 11:58 AM revealed that Resident #97 should have been assessed for capability and cognitive intactness to self-administer medication. They indicated that medication should not be at bedside if there is no order and no lock box.	F 554	Date of compliance: 4/30/24	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to	F 578		4/30/24

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F 578	Continued From page 4 formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the	F 578	F578 DNR	

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F 578	Continued From page 5 facility failed to maintain accurate advance directive information (code status) throughout both the electronic medical record and paper chart for 2 of 32 residents reviewed for advance directives (Resident #100 and Resident #73). The findings included: 1. Resident #100 was admitted to the facility on 7/14/23. Resident #100's Care Plan included an area of focus which read: "The resident/surrogate has exercised the right to self-determination. The resident/surrogate has decided after informed decision making to be 'Do Not Resuscitate' (Date Initiated: 7/24/23)." The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 1/18/24. A review of the MDS assessment revealed Resident #100 had moderately impaired cognition. The resident was receiving Hospice services. A review of Resident #100's electronic medical record (EMR) was conducted on 2/6/24. The banner at the top of Resident #100's EMR page indicated the resident had an advance directive which read, "DNR" (Do Not Resuscitate). However, a review of the resident's paper medical record revealed a signed form dated 7/14/23 indicated the resident was a "Full Code." No other advance directive form was placed in the resident's paper chart. An interview was conducted on 2/7/24 at 9:11 AM with Nurse #13. Nurse #13 identified herself as an Agency Nurse (temporary staff member) who	F 578	Corrective action for the residents found to be affected by the deficient practice. Resident #100 still resides in the facility. Code status was updated on all accounts on 2/9/24 by the Director of Nursing. Resident # 73 still resides in the facility. Code status was updated on all accounts on 2/9/24 by the Director of Nursing. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 2/9/24 an audit was initiated by the Administrator to review all resident□s charts for code status to ensure all information is accurate throughout the residents□ electronic and paper medical record. Systemic Changes made to ensure that the deficient practice will not recur. On 2/9/24 the Administrator and the Director of Nursing initiated education for all licensed nurses and agency nurses, social workers and MDS nurses on the requirement of completing correct code status in the medical record for electronic and paper charts in a timely manner. Education was completed on 2/26/24. Any newly hired licensed nurses, social workers or MDS staff will be educated by the Assistant Director of Nursing on the requirement of completing correct code status in the medical record specified by the state and approved CMS by the Administrator and/or the Director of Nursing during new hire orientation. The Administrator, the Director of Nursing and Social Workers will review all new	

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F 578	Continued From page 6 was working as a hall nurse. Upon inquiry, Nurse #13 was asked where she would locate a resident's advance directive to identify his/her code status in the event this was needed. The nurse reported she could access this information from either the resident's EMR or paper chart. When asked, the nurse stated both the EMR and the paper chart should contain the same information related to a resident's advance directive. An interview was conducted on 2/7/24 at 9:15 AM with Nurse #14. Nurse #14 identified herself as an Agency Nurse who was assigned to work on Resident #100's hall. When asked where information on a resident's advance directive could be located, Nurse #14 reported she could either check the resident's Medication Administration Record (MAR) in his/her EMR or look in the resident's paper chart, whichever would be the quickest to access. Upon request, the nurse reviewed Resident #100's EMR and confirmed it indicated the resident was "DNR". Nurse #14 then reviewed the resident's paper chart and reported the only advance directive information she saw in the chart was for a "Full Code" status signed and dated 7/14/23. Nurse #14 stated she would need to look into this discrepancy further. An interview was conducted with the Unit Coordinator and Assistant Director of Nursing (ADON) on 2/7/24 at 9:32 AM. During the interview, the Unit Coordinator was asked where nursing staff could locate a resident's advance directive. The Unit Coordinator reported this information should be available both in the computer (the EMR) and in his/her paper chart. When asked who was responsible for keeping the	F 578	admits and residents with significant changes 5 days a week for 4 weeks to ensure code status is completed and updated promptly. The licensed nursing staff and agency nurses, social workers and MDS nurses have been informed by the Administrator of their responsibility of ensuring correct code status are completed in a timely manner specified by the state and approved by CMS. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator, the Director of Nursing and Social Workers will review all new admissions and residents with significant changes for correct code status during daily standup meetings for 4 weeks and then weekly for 2 months and then monthly thereafter until 6 consecutive months of compliance is maintained. The Administrator will report any findings of non-compliance to the Quality Assurance and Performance Improvement Committee monthly for 3 months or until substantial compliance is achieved. Date of compliance: 4/30/24	

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F 578	Continued From page 7	F 578		

advance directives up to date and accurate (in both the EMR and paper chart), the ADON stated, "It's all of our responsibility."

An interview was conducted on 2/7/24 at 9:41 AM with the facility's Administrator. During the interview, the Administrator stated she had been informed there was a discrepancy related to the advance directive between Resident #100's EMR and paper chart. When asked, the Administrator agreed both sources of this information needed to be consistent and accurate.

2. Resident #73 was admitted to the facility on 1/6/24.

Resident #73's electronic medical record (EMR) revealed a physician's order dated 1/6/24 that read "full code."

Review of Resident #73's paper medical record located at the nurse's station revealed Resident #73 had two advanced directives forms, a signed Do Not Resuscitate (DNR) form dated 1/6/24 and a signed Full Code form dated 1/6/24.

Resident #73's Care Plan dated 1/12/24 revealed Resident #73 elected to be a Full Code and would receive Cardiopulmonary Resuscitation (CPR) if code occurred.

Resident #73's admission Minimum Data Set (MDS) dated 1/13/24 revealed Resident #73 was moderately cognitively impaired.

Resident #73's EMR showed a communication banner on the top of Resident #73's opened EMR and his code status read "full code."

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F 578	Continued From page 8	F 578		

An interview was conducted with Nurse #4 on 2/7/24 at 9:20 AM. During the interview, Nurse #4 indicated he would check the hard chart (paper medical record) and computer (EMR) for code status, but he usually checked the hard chart (paper medical record) first, as it was faster. Nurse #4 checked Resident #73's advanced directives section of the paper medical record. Nurse #4 located the DNR form and behind the DNR form was a written Full Code form. Nurse #4 took the DNR form out of the binder and tore/ripped the paper and threw it in the waste basket and said, "thank you for noticing," and he would check with his supervisor.

An interview was conducted with the Unit Coordinator and Assistant Director of Nursing (ADON) on 2/7/24 at 9:32 AM. During the interview, the Unit Coordinator was asked where nursing staff could locate a resident's advance directive. The Unit Coordinator reported this information should be both in the computer (the EMR) and in his/her paper medical record. When asked who was responsible for keeping the advance directives up to date and accurate (in both the EMR and paper chart), the ADON stated, "It's all of our responsibility." ADON and Unit Coordinator were made aware of discrepancy related to the advance directive between Resident #73's paper medical record and EMR.

An interview was conducted on 2/7/24 at 9:41 AM with the Administrator. During the interview, the Administrator stated she had been informed there was a discrepancy related to the advance directive between Resident #73's paper medical record and EMR. When asked, the Administrator agreed both sources of this information needed to be consistent and accurate.

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		4/30/24

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F 580	Continued From page 10 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interviews, family interview, physician interview and record review, the facility failed to notify the responsible person (RP) and physician of facility acquired pressure wounds (Resident # 181), facility acquired non-pressure wound (Resident #5) and a resident pulling out the urinary catheter reviewed for 3 of 6 residents reviewed for change of condition notification. The findings included: 1. Resident #181 was admitted on 2/3/23, readmitted on 3/23/23 and discharged home on 5/1/23. The diagnoses included diabetes, dementia, hypertension, dysphagia, chronic kidney failure, osteoarthritis, and Alzheimer's disease. The readmission Minimum Data Set (MDS) dated 3/23/23, revealed Resident #181 was severely cognitively impaired and was coded as not having wounds or pressure ulcers. Review of the head-to-toe skin assessment dated 4/24/23 done by Nurse #20, identified and documented a new deep tissue injury to right heel and 3 open areas to the buttocks. The wound nurse was notified. There was no documentation	F 580	F580 Notify of Changes Corrective action for the residents found to be affected by the deficient practice. Resident # 181 no longer resides in the facility. Resident # 2 no longer resides in the facility. Resident #5 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to suffer a serious adverse outcome because of the failure to address/communicate/report/document the identification/condition/status/size/appearance of a change in condition in a timely manner. Systemic Changes made to ensure that the deficient practice will not recur. On 04/19/24 a daily review of the 24-hour summary is being completed by the Director of Nursing and/or Designee to	

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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 580	Continued From page 11 on the head-to-toe skin assessment that the physician or RP were notified. Review of the April 2023 Treatment Administration Record (TAR) dated 4/24/23 revealed an order for wound care to right heel. Review of the weekly pressure ulcer record completed by Nurse #1(Wound Nurse) dated 5/1/23 documented, the onset of right heal wound acquired in the facility. The measurements included 5.0 centimeters x 6.5 centimeters x 0.0 centimeter, suspected deep tissue injury, wound edges dark red purple. The form documented the resident was notified and not the responsible person. An interview was conducted 2/5/24 at 3:25 PM, the Nurse #1 stated the process was for the aides and nursing to inform him of any observations of wound or skin changes. The nurse stated he was only informed about the breakdown on the resident's right heel on 4/24/23, there was no mention of the open areas on the resident's buttocks. The nurse stated he did not communicate with the physician or family regarding the wound observation or the treatment. Nurse #1 stated he was responsible for notifying responsible person and physician. A telephone interview was conducted on 2/5/24 at 2:15 PM, the family member stated her mother had no pressure ulcers when she was admitted. The family member stated she was unaware of the pressure ulcers on her mother's buttocks, mid cheek area and right heel until the resident arrived home on 5/1/23. She stated she saw a dressing on the resident's buttocks and when she removed it there were large wounds on both	F 580	ensure that timely notification of change of condition occurs. The Assistant Director of Nursing/designee was notified on 4/19/24 by the Licensed Nursing Home Administrator (LNHA) to educate all nursing staff on the notification of change of condition. This education was also added to the general orientation for nursing staff upon hire. On 4/19/24 the Director of Nursing/designee will meet daily x 1 month to discuss and review the 24-hour summary to ensure that timely notification of change of condition occurs and then meet 5 days a week x 2 months. Plans to monitor its performance to make sure that the solutions are sustained. A summary report of the notification of change of condition occurs will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Nursing (DON) for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 4/30/24	

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cheeks that were draining. The right heel had an open area as well. The facility did not inform her when the pressure ulcer developed.

An interview was conducted on 2/8/24 at 8:26 AM, the Director of Nursing, reviewed the weekly pressure ulcer record dated 5/1/23, the form documented the person notified was the resident and not the responsible person. The Director of Nursing stated the wound nurse should have notified the responsible person and the physician of the development of the new wound.

A telephone interview was conducted on 2/8/24 at 12:34 PM, the Physician Assistant #3 stated she did not recall any discussion with nursing about Resident #181 having any open areas on the buttocks. The Physician Assistant #3 stated the process was the wound care nurse would notify the physician about the changes in skin condition and a discussion would have been held regarding the treatment plan.

2. Resident #2 was admitted on 3/5/24. The diagnoses included diabetes, dementia, chronic kidney failure, urinary retention, benign prostate hyperplasia (increase in size of the prostate gland. Symptoms may include frequent urination, trouble starting to urinate, weak stream, inability to urinate, or loss of bladder control), and Alzheimer's disease.

The admission Minimum Data Set (MDS) dated 3/7/24, revealed Resident #2 was severely cognitively impaired and was coded as having a urinary catheter.

Review of the nursing note dated 3/9/24 written by Nurse #8 documented Resident #2 returned

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from the hospital at 2:30 pm. There were no new orders or changes with medications. At 7:00 PM Resident #2 was found standing at the sink in his room with his urinary catheter pulled out on the floor. The nurses were unable to reinsert the urinary catheter. The on-call physician was called and stated if the resident did not void within the next 8 hours, then to call physician back to obtain further instructions.
Review of the nursing note dated 3/9/24, facility 24-hour report dated 3/9/24, and Nurse #8's telephone log dated 3/9/24, did not have any information about contacting the responsible person(s) and the resident pulling out the catheter.
A telephone interview was conducted on 3/21/24 at 11:25 AM. Nurse #8 stated Resident #2 returned from the hospital on 3/9/24 with a catheter. She was called to the room by an aide, whom she could not recall the name of the aide. She was told by the aide the resident was walking to the sink and pulled the catheter out. When she arrived at the room there was urine on the floor, and she was unsuccessful in re-inserting the catheter. She further stated she called the on-call physician who stated to monitor the resident, if resident does not void within the next 8 hours, then to call physician back to obtain further instructions. Nurse #8 stated she did not speak directly to any family member and could not recall which family member she called. She stated she had forgotten to document who she called.
A care plan meeting held on 3/10/24, revealed Resident #2 had an activities of daily living self-care performance deficit related to deconditioning secondary to acute cystitis with hematuria with urinary retention status post catheter placement with recurrent urinary tract infections caused by chronic moderate dementia.

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The resident had a history of urinary tract infection and benign prostate hyperplasia with urinary retention. The Resident pulled the indwelling catheter out after admission and staff were unable to reinsert it. The goal indicated the resident's urinary tract infection will resolve without complications. The approaches included Resident #2 needs extensive/total assistance with incontinence care due to being legally blind. Check at least every 2 hours for incontinence. Resident #2's current level of function with activities of daily living would improve. Follow up with urology as ordered.

A telephone interview was conducted on 3/20/24 at 9:02AM. Family Member #3 stated during her visit 3/10/24, she observed Resident #2 without the catheter in place. She stated she asked Nurse #8 why the catheter was not in place, the nurse stated Resident #2 had pulled out the catheter and staff tried to put the catheter back in place but could not and the doctor told her to wait 8 hours and call back if there was a problem. Family Member #3 asked why had the family not been notified and if there was a protocol for nursing to notify the family when there was a change of condition. Family Member #3 stated she informed the responsible parties via a chat of the situation and neither responsible person was aware of what happened.

A telephone interview was conducted on 3/20/24 at 2:41 PM with the Responsible Person #1 who stated Resident #2 had a history of urinary retention and atrophy. He had an infection eight times and when he got infections, he would retain more fluid resulting in the insertion of a catheter. He explained Resident #2 has dementia and doesn't realize he has a sensation to void all the

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time, so he pulls on the catheter if he's not closely monitored. He stated the resident wore mitts when he was in the hospital or was closely monitored to prevent him from pulling on the catheter. Responsible Person #1 stated he was not contacted by the facility about Resident #2 pulling out the catheter on 3/9/24, he was informed through family chat on 3/10/24, following a visit from another family member.

A telephone interview was conducted on 3/21/24 at 10:45 AM, Responsible Person #2 stated she was at the hospital on 3/9/24 when Resident #2 was discharged with a catheter. She reported a care plan meeting was held on 3/10/24. When Family Member #3 visited on 3/10/24 in the evening, Resident #2 did not have the catheter in place. Family Member #3 spoke with nursing staff about why Resident #2 did not have the catheter and asked why had the responsible person(s) had not been contacted about Resident #2 pulling the catheter out. She stated after the family member #3 contacted her and sent a family text about her observation and concern, she contacted the facility to speak with the nurse and facility administrator to find out what happened. The Responsible Person #2 stated she was upset the facility had not informed anyone in the family of the situation, which could have resulted in Resident #2 developing an infection with the catheter being out for an extended period.

An interview was conducted on 3/21/24 at 8:00 AM, with the Director of Nursing revealed Nurse #8 had not documented that the responsible person(s) was notified of Resident #2 pulling out the catheter on 3/9/24 or the condition of the resident for the remaining of the evening.

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An interview on 3/21/24 at 12:00 PM, with the Administrator and Regional Nurse Consultant, revealed Nurse #8 had not documented any communication in the medical record or the facility communication forms that Resident #2's responsible person(s) had been informed of the resident pulling out the catheter. Both stated the nursing staff were in-serviced on the expectation of notification and documentation process of resident change of condition to the responsible person(s) in the month of February for a past citation in this area.

3. Resident #5 was re-admitted on 2/6/24. The significant change Minimum Data Set assessment, dated 3/5/24, revealed Resident #5 was severely cognitively impaired. The resident's diagnoses included pressure ulcers, diabetes mellitus, tube feeding and malnutrition.

Resident 5's plan of care, dated 3/5/24, reflected the risk for skin break down and actual pressure ulcers, with appropriate goals and interventions.

Record review revealed the 24 hours report, dated 3/20/24, indicated that the "daytime nurse documented" for Resident #5 the swollen right arm with blisters.

Record review of the Communication to Physician report, dated 3/20/24, indicated "swollen left arm with blisters" for Resident #5. The report was reviewed and signed by the Physician Assistant (PA #1) on 3/20/24.

Review of the wound evaluation and management summary for Resident #5, dated 3/20/24, revealed the new non - pressure wound of the right hand, 8.5 x 2.0 x 0.1 cm (centimeters) with 70 % (percent) granulation. The form documented that the wound condition and plan of care was discussed with the family member.

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Review of the physician's order and Treatment Administration Record (TAR) for Resident #5 for March 2024 revealed that beginning 3/20/24, the resident received Xeroform Gauze (wound treatment medication) to apply on the right hand wound and cover with dressing three times per week.

On 3/21/24 at 9:08 AM, during the phone interview, the family member indicated that on 3/20/24, she visited Resident #5 and was informed by the Wound Treatment Physician about the resident's new right hand wound. The family member was aware of the resident's two existing pressure ulcers and confirmed that the facility did not inform her when the new wound developed.

On 3/21/24 at 10:20 AM, during an interview, the PA #1 indicated that on 3/20/24 at 8:30 AM, she was notified via the Communication to Physician book about new right-hand blister for Resident #5. Upon assessment, the resident had her right hand swollen, with the skin opening. The PA #1 referred it to the wound treatment team. On 3/20/24, the PA #1 had a conversation with Resident 5's family member, who stated she did not know about the new right hand wound.

On 3/21/24 at 11:50 AM, during the phone interview, the Wound Treatment Physician, indicated that on 3/20/24, upon assessment of Resident #5, in addition to current pressure ulcers on the sacrum and the left hip, the resident presented the right-hand edema with non-pressure wound. The family member at bedside mentioned that the facility did not inform her about the new resident's wound.

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F 580	Continued From page 18 On 3/21/24 at 1:50 PM, during an interview, the Director of Nursing (DON) indicated that Nurse #5, who was assigned to Resident #5 on 3/19/24 and completed the Communication to Physician report about the new right hand wound, did not notify the family. The DON expected the staff to notify the responsible person of the development of the new wound. The DON mentioned that Nurse #5 was not available for interview.	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585		4/30/24

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to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by

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F 585	Continued From page 20 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and provide a written grievance summary for 1 of 1 sampled resident (Residents #280) reviewed for grievances. Findings included: Review of the Grievance /Complaint Filing policy (revised March 2023) revealed the Administrator was the chief grievance officer. The policy indicated upon receipt of a grievance and /or complaint, the grievance officer would review and	F 585	F585 Corrective action for the residents found to be affected by the deficient practice. Resident #280 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents could be affected by the alleged deficient practice. On 2/12/24 an audit was initiated by the Administrator to review all resident□s grievances for the	

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F 585	Continued From page 21 investigate the allegation. A written report related to the findings would be submitted to the Administrator within five (5) working days of receiving the grievance and /or complaint. It also indicated that the resident and /or family member would receive written and oral information about the resolution. Resident #280 was admitted on 6/2/23 with diagnoses that included congestive heart failure, chronic obstructive pulmonary disease, and diabetes mellitus type 2. Review of the resident's admission Minimum Data Set (MDS) assessment dated 6/8/23 revealed Resident #280 was assessed as cognitively intact. Review of the concern form dated 6/5/23 revealed the resident's family member had some concerns and a grievance report was filled out related to their concerns. There were no details on how these concerns were investigated. It just indicated investigation was completed and addressed by the Director of Nursing (DON). There were no details as to how the concerns were investigated and what the resolutions were. The grievance was incomplete and did not indicate if a resolution was reached, what the resolution was, if the individual who raised concerns was satisfied with the resolution and date of any follow up if needed. There was no signature or date of the staff completing the investigation. The form was signed by the Administrator on 6/5/23. Review of Resident #280's discharge-return not anticipated MDS assessment dated 6/16/23 revealed the resident was discharged to	F 585	last 60 days (about 2 months) to ensure all grievances have been addressed, resolved and written notice sent to the Resident or the Responsible party. Systemic Changes made to ensure that the deficient practice will not recur. The Administrator and/or Director of Nursing will review all grievances 5 days a week for 4 weeks to ensure they have been resolved and written notice sent to the resident or the Responsible Party to ensure satisfaction with resolution. Education for all staff on the grievance policy and procedure. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator and/or Director of Nursing will review all grievances 5 days a week for 4 weeks and then weekly for 2 months and then monthly thereafter until 6 consecutive months of compliance is maintained. The Administrator will report any findings of non-compliance to the Quality Assurance and Performance Improvement Committee monthly for 3 months or until substantial compliance is achieved. Date of compliance: 4/30/24	

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community.

During an interview on 2/9/24 at 10:12 AM, the guest service staff stated when any resident was newly admitted to the facility, she would introduce herself to the resident and resident family and ask them if they had any concerns or questions. The guest service staff indicated that she does not recollect many details but based on what she had documented the resident's family member had expressed some concerns. These concerns were documented in the grievance form dated 6/5/23. The guest staff stated she had reported these concerns to the Director of Nursing (DON). The guest service staff indicated a grievance form was filed when any resident or family expressed any concern, and this form was given to the respective department. She confirmed she had given the form to DON for further investigation.

During an interview on 2/9/24 at 9:07 AM, DON stated a copy of the grievance form would be given to the appropriate department for investigation and resolution and another copy would be given to the Administrator. When the investigation was completed and resolution reached, it would be documented in the form and would be given to the Administrator. The DON stated the Administrator was the chief grievance officer. The Administrator would replace the incomplete form with the detailed form which included the investigation and the resolution reached. The Administrator would then complete the grievance process by contacting the resident and or family regarding the resolution. The DON stated she was informed about the family concern related to poor customer service provided by the Nurse aide staff. The grievance was investigated, and the staff was terminated. The DON indicated

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F 585	Continued From page 23 she was not aware a grievance form was filed by any staff member. During an interview on 2/9/24 at 3:10 PM, the Administrator and Corporate Nurse consultant. The Administrator stated she was hired on 2/5/24 and was not the chief grievance officer at that time. The Corporate Nurse consultant stated that she was the interim Administrator for the past 2 months. She indicated she noticed that the previous Administrator was not following the grievance policy to ensure all grievances were promptly resolved. The Corporate Nurse consultant further indicated a performance improvement project (PIP) was put in place on 12/27/23. All staff were in-serviced on the Grievance process. When asked what the completion date was, she indicated it was an ongoing process and did not have any completion date. When the request was made for the audit/monitoring tools, she indicated there were no audit tools, just that all grievances were discussed during the morning meeting. Review of the PIP document revealed that the SMART goal / desired result was 100% written response to be given to residents/ families. When asked if the families were receiving a written response, the Corporate Nurse consultant stated she was not providing any written response to residents or their family members who had concerns or filed a grievance.	F 585		
F 600 SS=J	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,	F 600		4/30/24

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F 600	Continued From page 24 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 interviews, and a recorded 911 call, the facility failed to protect a resident's right to be free from neglect when they did not effectively respond to a medical emergency. This occurred for 1 of 1 resident reviewed for neglect. Resident #232 was found to have a critical low blood sugar of 28 and was unresponsive. Nurse #7 failed to complete a nursing clinical assessment, failed to initiate emergency procedures within the nursing home and with 911. Nurse #7 also delayed in activating 911, demonstrated no urgency with the 911 call, and did not relay accurate information of the situation to the rest of the nursing staff. Emergency medical services (EMS) were not called until 6:56 am. Resident #232 expired on 2/8/24. Immediate jeopardy began on 2/8/24 when nursing staff failed to immediately and effectively respond to a medical emergency and was removed on 4/5/24 when the facility implemented an credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity D (not actual harm with potential for more than minimal harm	F 600	F 600 Neglect Corrective action for the residents found to be affected by the deficient practice. Resident #232 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All facility insulin dependent diabetic residents that require insulin administration have the potential to be affected by this deficient practice. An immediate audit was completed by the Clinical Regional Director/Designee to verify all residents that are insulin dependent are following physician orders. This audit monitors if a nurse was potentially neglectful for not following physician orders for insulin dependent residents and for not following emergency medical management policies and procedures. The audit reviews if nurses were not following emergent hypoglycemic policies and procedures. This audit was completed on 4/3/24 by the Clinical Regional Director/Designee. No	

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F 600	Continued From page 25 that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. The findings included: This tag is cross referred to: F 684- Based on record review, staff interviews, and a recorded 911 call, the facility failed to implement emergency procedures including immediately calling 911, when a resident who was a known brittle diabetic was discovered to have a blood sugar of 28 and was unresponsive. Resident #232 was found to have a critical low blood sugar of 28. Nurse #7 failed to complete a nursing clinical assessment, failed to initiate emergency procedures within the nursing home and with 911. Nurse #7 also delayed in activating 911, demonstrated no urgency with the 911 call, and did not relay accurate information of the situation. Resident #232 expired on 2/8/24. This occurred for 1 of 1 resident reviewed for neglect. F 726- Based on record review, staff interviews, and a recorded 911 call, the facility failed to ensure nursing staff were trained and competent with responding to medical emergencies, activating emergency procedures within the nursing home and with emergency medical services for 1 of 1 resident (Resident #232) reviewed for neglect. Nursing staff failed to complete nursing clinical assessments (including vital signs), failed to immediately initiate emergency procedures within the nursing home and with 911 when a nurse asked for a glucagon injection. Nursing staff also delayed in activating 911, demonstrated no urgency with the 911 call, and did not relay accurate information of the situation to the 911 operator. Resident #232	F 600	adverse outcomes were identified in this audit. Systemic Changes made to ensure that the deficient practice will not recur. All licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated on Abuse and Neglect Policy. The policy describes Neglect as the failure of the facility, its employees or service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. All education was completed by DON/ADON designee by 4/04/2024. This education will include 1:1, and group training sessions. The administrator/designee will be the person who will ensure all licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated. Plans to monitor its performance to make sure that the solutions are sustained. To ensure ongoing compliance, the Administrator and/or designee will conduct daily audits on all insulin dependent diabetic residents that require insulin administration this audit began on 4/5/24 and will continue for one month, then 5 x times a week for 2 months. A summary report of compliance will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Nursing (DON) for review and revision monthly x 3 months or until substantial compliance is achieved.	

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F 600	Continued From page 26 expired on 2/8/24. The Administrator was notified of immediate jeopardy on 4/2/24 at 6:27pm. The facility provided a credible allegation of immediate jeopardy removal dated 4/5/24. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident #232 suffered related to this deficient practice. Nurse #7 and Nurse #10 failed to effectively respond to a medical emergency when resident #232 blood sugar was 28 and was unresponsive. EMS was not activated timely or effectively. All facility insulin dependent diabetic residents that require insulin administration have the potential to be affected by this deficient practice. An immediate audit was completed by the Clinical Regional Director/Designee to verify all resident's that are insulin dependent are following physician orders. Lastly, this audit will monitor if a nurse was potentially neglectful for not following physician orders for insulin dependent residents and for not following emergency medical management policies and procedures. Lastly, the audit reviewed if nurses were not following emergent hypoglycemic policies and procedures. This audit was completed on 4/3/24 by the Clinical Regional Director/Designee. No adverse outcomes were identified in this audit. Root cause analysis which was completed on 4/2/24 by the Regional Clinical Director/designee reveals that the nurse #7 did not recognize the hypoglycemic event as a medical emergency in a	F 600	Date of compliance: 4/30/24	

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F 600	Continued From page 27	F 600		

timely manner. She neglected to assess and intervene in a timely manner. Conclusion via the root cause analysis is that she was not competent in her skill set for managing emergency medical situations or competent in assessing and managing hypoglycemia. Therefore, the nurse was negligent in assessing and intervening when the resident was having a medical emergency.

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.
Nurse #7 has not worked in the facility since the date of this incident. Her agency was notified of the occurrence by the Administrator, and she was interviewed by the Administrator for her statement regarding her response to the medical emergency on 02/07/2024.

All licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated on Abuse and Neglect Policy. The policy describes Neglect as the failure of the facility, its employees or service provider to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. All education will be completed DON/ADON designee by 4/04/2024. This education will include 1:1, and group training sessions. The administrator/designee will be the person who will ensure all licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated.
Immediate jeopardy will be removed by 4/05/24.

The credible allegation was validated onsite on

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F 600	Continued From page 28 4/5/24 when staff interviews revealed that they had received recent education on Abuse and Neglect Policy. Facility documentation revealed staff were educated on Neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. In-service reports and sign-in sheets were used to verify this information. Audit tool dated 4/4/24 was reviewed. The tool identified residents who were insulin dependent, were receiving insulin per physician orders, if signs and symptoms of hypoglycemia were monitored by the nurses and emergency medical management policies and procedures were followed, any signs and symptoms of emergent hypoglycemia and if the nurse was negligent by not following physician orders or assess the resident to recognize a medical emergency. The review revealed no concerns. Immediate jeopardy removal date of 4/5/24 was validated.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		4/30/24

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F 609	Continued From page 29 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit an Initial Allegation Report to the State Agency, Adult Protective Services (APS), and the police within the required timeframe for 1 of 1 resident (Resident #232) reviewed for neglect. The facility was officially notified of neglect on 4/2/24 at 6:27 pm when an immediate jeopardy template was issued. The facility did not submit an initial report to the State Agency within the required timeframe following notification. Findings included: Review of the facility provided investigation, dated 2/8/24, regarding Resident #232, revealed no information regarding an initial report to the State Agency, no documentation of APS being notified, and no record of police notification. During a complaint investigation, the facility was officially notified of neglect on 4/2/24 at 6:27 pm	F 609	F609 Reporting of Alleged Violations Corrective action for the residents found to be affected by the deficient practice. The facility failed to submit and Initial Allegation Report to the State Agency, Adult Protective Services (APS), and the police withing the required timeframe of 1 of 1 resident (#232). The facility was officially notified of neglect on 4/2/24 at 6:27pm when an immediate jeopardy was issued. The facility submitted the Initial Allegation on 4/3/24 to the State Reporting Agency. The police were notified on 2/8/24 around 6:56am during a 911 call. APS was not notified on 4/3/24 because the resident #232 was deceased at that time. The Administrator stated the facility did interviews with the staff involved with the incident regarding Resident #232 and did not find any reason to label it as neglect, so an initial report was not done on 2/8/24 or 4/2/24. The	

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F 609	Continued From page 30 and an immediate jeopardy template was issued to the administrator. The immediate jeopardy template was signed by the administrator and the administrator was verbally informed of the information regarding the situation involving neglect. Review of the state agency records revealed the facility did not submit an initial report to the State Agency within the required timeframe following the notification of neglect. During an interview with the facility administrator on 4/3/24 at 4:37 pm she stated that she did not submit nor complete an initial allegation report to the State Agency regarding the neglect information provided on the template which she had received on 4/2/24. She stated the facility did interviews with the staff involved and did not find any reason to label it as neglect, so an initial report was not done on 2/8/24 or 4/2/24. She also stated she wasn't aware she needed to submit an initial report to the State Agency at that point since the neglect template had already been issued. The administrator further indicated she had not notified APS nor the police regarding the situation involving neglect.	F 609	Administrator also stated she wasn't aware she needed to submit an initial report to the State Agency at that point since the neglect template had already been issued on 4/2/24 by NC DHHS. The facility 5 day Investigation for Resident #232 concluded on 4/8/24 with a conclusion of being unsubstantiated. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice if there is an allegation of abuse reported that fits the criteria for the reporting circumstances and guidelines, and the facility fails to report timely to state reporting agency, APS, and police. The Administrator/Designee audited the past 3 months of reportable to the State Agency 4/19/24 to ensure timely reporting of any allegation of neglect/abuse was completed per the policy and procedure of the Abuse/Neglect reporting guidelines. No adverse findings noted. Systemic Changes made to ensure that the deficient practice will not recur. 100% mandatory Education was provided to the whole staff, by the Administrator/designee, regarding the Resident Abuse and Neglect Reporting policy and procedures, with emphasis on following the protocols of submitting an initial report to the state agency within the required timeframe following notification. Regional Clinical Director provided 1:1 education to the Administrator on 4/3/24 regarding timely reporting time frames once and allegation is identified and	

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F 609	Continued From page 31	F 609	reported to the Grievance officer. Entire staff education was completed on 4/5/24. Plans to monitor its performance to make sure that the solutions are sustained. To ensure ongoing compliance, the Administrator and/or designee will conduct compliance audits 3 x week x 12 weeks to ensure if there is an Initial Allegation Report to the State Agency, APS, and police, that it is completed within the required timeframe following the notification. The facility will continue to provide education on any areas of concern if necessary. The results of the audits will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Date of compliance: 4/30/24	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		4/30/24

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the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, residents and staff interviews, the facility failed to review, revise, and include the participation of residents/resident representatives after the completion of Minimum Data Set (MDS) assessments for 5 of 5 residents reviewed for care plan participation (Residents # 93, Resident #37, Resident # 53, Resident #104, and Resident #97).

Findings included:

1. Resident #93 was readmitted to the facility on 11/14/23 with diagnoses that included urinary tract infection, neuromuscular dysfunction of bladder and panic disorder.

A record review of the most recent quarterly Minimum Data Set (MDS) dated 1/19/24 revealed the resident was admitted on 11/18/22 and was assessed as cognitively intact. Assessment indicated the resident was dependent on staff for most of the Activities of Daily Living (ADL) care.

Review of the modification annual assessment

F657
Corrective action for the residents found to be affected by the deficient practice.
Resident # 93 was admitted to the facility on 8/22/23. The interdisciplinary team (IDT) held a care plan meeting on 2/27/24 with the resident to review his current comprehensive care plan.
Resident # 37 was admitted to the facility on 10/13/22 and readmitted on 11/12/23. The interdisciplinary team (IDT) held a care plan meeting on 2/27/24 with the resident to review her current comprehensive care plan.
Resident # 53 was admitted to the facility on 10/19/23. The interdisciplinary team (IDT) held a care plan meeting on 2/27/24 with the resident to review his current comprehensive care plan.
Resident # 104 was admitted to the facility on 8/29/23. The interdisciplinary team (IDT) held a care plan meeting on 2/27/24 with the resident to review his current comprehensive care plan.

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F 657	Continued From page 33 dated 11/21/23 revealed the resident was assessed as cognitively intact. Review of Resident #93's care plan revealed it was reviewed and revised on 11/21/23. There was no indication that resident participated in the care plan meeting or in the development of the care plan. During an interview on 2/5/24 at 1:29 PM, Resident #93 indicated he was not invited to any care plan meeting. The resident further indicated he had not participated in developing his care plan goals. Resident #93 stated that only therapy staff would notify him about his progress and if he had reached his therapy goal. During an interview on 2/7/24 at 11:46 AM, the Social Worker stated residents on short term rehab, were schedule a care plan meeting with the resident and /or resident's representatives and the meeting was conducted. The Social Worker indicated a note was later documented in the resident's record indicating when the care plan meeting was conducted, who attended the meeting and what was discussed. The Social Worker stated for residents who were on long-term care, the care plan meetings were conducted as needed and it was informal. The Social Worker stated that each department reviewed their own care plan goals related to the resident after they completed the MDS assessment and made changes accordingly. Unless there was a significant change and/or if a care plan meeting was indicated by staff, then a care plan meeting was scheduled. If not care plan meetings were not scheduled. The Social Worker stated Resident #93 was a long-term care resident and his last care plan meeting was	F 657	Resident # 97 was admitted to the facility on 3/30/23. The interdisciplinary team (IDT) held a care plan meeting on 2/27/24 with the resident to review her current comprehensive care plan. Corrective action for other residents having the potential to be affected by the same deficient practice. A new Social Worker began employment in February 2024. The Social Services department initiated the care plan review process to include resident and/or Responsible Party (RP) participation. As of 3/1/24, the Social Services department reviewed all residents for documentation of a comprehensive care plan meeting with the resident and/or Responsible Party (RP) and 72 of the 72 have been done. The Social Services department have completed and mailed care plan meeting letters to all residents and/or Responsible Party (RP) notifying them of a scheduled care plan meeting date and time and/or care plan already scheduled by 3/1/24. If by 3/1/24 the facility has not heard from the resident/Responsible Party (RP), the Social Services department will follow-up with a phone call to schedule a care plan meeting with the resident and/or Responsible Party (RP). Systemic Changes made to ensure that the deficient practice will not recur. The Administrator educated the Social Workers on Comprehensive Care plans this was completed on 2/26/24. The Social Services department will schedule the comprehensive care plan meeting for each resident as assigned quarterly,	

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F 657	Continued From page 34 conducted on 3/7/23. There were no care plan meetings after 3/7/23. During an interview on 2/8/24 at 8:34 AM, the Director of Nursing (DON) stated the Social Services were responsible for scheduling the care plan meeting. DON indicated the team discusses in the morning meeting if any resident needs a care plan meeting due to some change in condition, or if it was a quarterly or annual assessment coming up or if the resident or resident's representative had any concerns. Social Services would then schedule a care plan meeting with the resident and/or their representative. Care plan meetings were conducted 2 to 3 times a week and the residents were invited to attend their care plan meeting. DON indicated the care plan meeting were conducted within 48 hours of admission, after completion of admission care plan and then quarterly, or when there was a significant changes, or if any resident or representative, or staff, requests for a care plan meeting. She further stated she was not sure when the care plan for Resident #93 was reviewed/revised. During an interview on 2/8/24 at 9:08 AM, the MDS Nurse stated when any resident was due for a MDS assessment, the assessment was opened. The IDT team reviewed and completed their respective sections. The care plans were also reviewed. The care plans were closed within 14 days of completion of MDS assessment. The MDS Nurse indicated Social Worker was responsible for scheduling a care plan meeting with the residents and their representatives. She further indicated the Social Worker could run a report to see which assessments and care plans were completed and could schedule the meetings	F 657	annually and with a significant change and distribute the care plan letter invitation to the resident and /or Responsible Party (RP). The Social Worker will discuss the assigned care plans daily during Interdisciplinary Team (IDT) meeting. The Interdisciplinary Team (IDT) will review each care plan during care plan meeting with the resident and/or Responsible Party (RP). The Social Worker (SW) will review and document via a log all scheduled care plan meetings weekly x4 weeks and then monthly x 3 months ensuring care plans are conducted quarterly, annually and with a significant change with the resident and/or Responsible Party (RP). In-servicing was conducted on 2/21/24 with Interdisciplinary Team (IDT) by the Licensed Nursing Home Administrator on the care plan meeting process to include mailing care plan invitations letters quarterly, annually and with a significant change and including the resident and/or Responsible Party (RP) participation of the comprehensive care plan. Plans to monitor its performance to make sure that the solutions are sustained. Results of the monitoring/log will be presented by Social Worker (SW) to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and revision x 3 months or until substantial compliance is achieved. Date of compliance: 4/30/24	

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accordingly. The MDS Nurse stated Resident #93's care plan review start date was 6/28/23 and completion date was 1/19/24. The MDS Nurse indicated the resident's care plan should have been reviewed by the IDT team and closed within 14 days from the start date i.e. 6/28/23. The MDS Nurse stated the resident had a quarterly assessment on 10/28/23 and there should have been a care plan review or revision after 10/28/23.

2. Resident #37 was readmitted to the facility on 11/14/23 with diagnoses that included congestive heart failure, diabetes mellitus type 2 and pain in right shoulder. Review of the quarterly MDS assessment dated 11/18/23 revealed the resident was admitted to the facility on 10/13/22 and was assessed as cognitively intact. Assessment indicated the resident needed substantial / maximal assistance for most of her ADL care.

Review of Resident #37's care plan revealed it was reviewed and revised on 9/12/23. There was no indication that resident participated in the care plan meeting or development of the care plan.

Review of the Social Worker note dated 1/26/23 read in part "Care Plan meeting held with resident, SW (Social Worker) and nursing." Note indicated Resident #37 was to remain in long term care.

During an interview on 2/5/24 at 11:43 AM, Resident #37 indicated she was not invited to care plan meetings. Resident stated she does not recollect attending any care plan meeting.

During an interview on 2/7/24 at 11:46 AM, the Social Worker stated residents on short term

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rehab, were schedule a care plan meeting with the resident and /or resident's representatives and the meeting was conducted. The Social Worker indicated a note was later documented in the resident's record indicating when the care plan meeting was conducted, who attended the meeting and what was discussed. The Social Worker stated for residents who were on long-term care, the care plan meetings were conducted as needed and it was informal. The Social Worker stated that each department reviewed their own care plan goals related to the resident after they completed the MDS assessment and made changes accordingly. Unless there was a significant change and/or if a care plan meeting was indicated by staff, then a care plan meeting was scheduled. If not care plan meetings were not scheduled. The Social Worker stated Resident #37 was a long-term care resident and her last care plan meeting was conducted on 1/26/23. There were no care plan meetings conducted by the IDT team after 1/26/23.

During an interview on 2/8/24 at 8:34 AM, the Director of Nursing (DON) stated the Social Services were responsible for scheduling the care plan meeting. DON indicated the team discusses in the morning meeting if any resident needs a care plan meeting due to some change in condition, or if it was a quarterly or annual assessment coming up or if the resident or resident's representative had any concerns. Social Services would then schedule a care plan meeting with the resident and/or their representative. Care plan meetings were conducted 2 to 3 times a week and the residents were invited to attend their care plan meeting. DON indicated the care plan meeting were

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conducted within 48 hours of admission, after completion of admission care plan and then quarterly, or when there was a significant changes, or if any resident or representative, or staff, requests for a care plan meeting. She further stated she was not sure when the care plan was reviewed/revised.

During an interview on 2/8/24 at 9:08 AM, the MDS Nurse stated when any resident was due for a MDS assessment, the assessment was opened. The IDT team reviewed and completed their respective sections. The care plans were also reviewed by the IDT. The care plans were closed within 14 days of completion of MDS assessment. The MDS Nurse indicated Social Worker was responsible for scheduling a care plan meeting with the residents and their representatives. She further indicated the Social Worker could run a report to see which assessments and care plans were completed and could schedule the meetings accordingly. The MDS Nurse stated Resident # 37's care plan review start date was 7/7/23 and target completion date was 10/18/23. The care plan review was completed on 1/19/24. The MDS nurse indicated the resident's care plan should have been reviewed by the IDT team and closed within 14 days from the start date i.e. 7/7/23. The MDS nurse further indicated that the resident had an annual assessment on 9/13/23 and quarterly assessment on 11/18/23. MDS nurse stated the resident's care plan should have been reviewed and/or revised by the IDT team after completion of these assessments.

3. Resident #53 was readmitted on 12/11/23 with diagnoses that included diabetes mellitus type 2, end stage renal disease and dependent on renal

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dialysis. Review of the most recent quarterly MDS assessment dated 1/2/24 revealed the resident was admitted on 6/13/23. Assessment indicated the resident was moderately cognitively impaired and dependent on staff with ADL care.

Review of Resident #53's care plan revealed it was reviewed and revised on 9/12/23. There was no indication that the resident or resident's representatives participated in the care plan meeting or in development of the care plan.

During an interview on 2/5/24 10:46 AM, Resident #53 indicated he did not recollect being invited to a care plan meeting. He stated nobody had asked him involved him with his care plan goal development.

During an interview on 2/7/24 at 11:46 AM, the Social Worker stated residents on short term rehab, were schedule a care plan meeting with the resident and /or resident's representatives and the meeting was conducted. The Social Worker indicated a note was later documented in the resident's record indicating when the care plan meeting was conducted, who attended the meeting and what was discussed. The Social Worker stated for residents who were on long-term care, the care plan meetings were conducted as needed and it was informal. The Social Worker stated that each department reviewed their own care plan goals related to the resident after they completed the MDS assessment and made changes accordingly. Unless there was a significant change and/or if a care plan meeting was indicated by staff, then a care plan meeting was scheduled. If not care plan meetings were not scheduled. The Social Worker stated Resident #53 was a long-term

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care resident and based on the documentation the resident did not have any care plan meeting since he transitioned from short term rehab to long term care resident.

During an interview on 2/8/24 at 8:34 AM, the Director of Nursing (DON) stated the Social Services were responsible for scheduling the care plan meeting. DON indicated the team discusses in the morning meeting if any resident needs a care plan meeting due to some change in condition, or if it was a quarterly or annual assessment coming up or if the resident or resident's representative had any concerns. Social Services would then schedule a care plan meeting with the resident and/or their representative. Care plan meetings were conducted 2 to 3 times a week and the residents were invited to attend their care plan meeting. DON indicated the care plan meeting were conducted within 48 hours of admission, after completion of admission care plan and then quarterly, or when there was a significant changes, or if any resident or representative, or staff, requests for a care plan meeting. She further stated she was not sure when the care plan was reviewed.

During an interview on 2/8/24 at 9:08 AM, the MDS Nurse stated when any resident was due for a MDS assessment, the assessment was opened. The IDT team reviewed and completed their respective sections. The care plans were also reviewed. The care plans were closed within 14 days of completion of MDS assessment. The MDS Nurse indicated Social Worker was responsible for scheduling a care plan meeting with the residents and their representatives. She further indicated the Social Worker could run a

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report to see which assessments and care plans were completed and could schedule the meetings accordingly. The MDS Nurse stated Resident # 53's care plan review start date was 1/2/23 and target completion date was 1/16/24. The MDS Nurse indicated the resident's care plan should have been reviewed by the IDT team and closed within 14 days from the start date i.e. 1/2/23. The MDS Nurse further indicated that the resident had a significant change assessment on 8/14/23 and quarterly assessment on 10/2/23. MDS Nurse stated the last care plan review was on 6/19/23. The care plan needed to be reviewed and /or revised by IDT after the significant change assessment and quarterly assessment.

4. Resident #104 was readmitted on 2/5/24 with diagnoses that included acute respiratory failure with hypercapnia, cellulites of lower limb, and contrition of the lungs. Review of the quarterly MDS assessment dated 10/9/23 indicated the resident was admitted on 10/6/23. The resident was assessed as cognitively intact and needed substantial / maximal assistance with most of his ADL care.

Review of Resident #104's care plan revealed it was reviewed/revised on 11/22/23. There was no indication Resident #104 participated in the care plan meeting or development of the care plan.

During an interview on 02/05/24 10:46 AM, Resident #104 indicated he was not invited to any care plan meeting and had never participated in the care plan meeting.

During an interview on 2/7/24 at 11:46 AM, the Social Worker stated residents on short term rehab, were schedule a care plan meeting with

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the resident and /or resident's representatives and the meeting was conducted. The Social Worker indicated a note was later documented in the resident's record indicating when the care plan meeting was conducted, who attended the meeting and what was discussed. The Social Worker stated for residents who were on long-term care, the care plan meetings were conducted as needed and it was informal. The Social Worker stated that each department reviewed their own care plan goals related to the resident after they completed the MDS assessment and made changes accordingly. Unless there was a significant change and/or if a care plan meeting was indicated by staff, then a care plan meeting was scheduled. If not care plan meetings were not scheduled. The Social Worker stated Resident #104 was a long-term care resident and based on the documentation the resident did not have any care plan meeting.

During an interview on 2/8/24 at 8:34 AM, the Director of Nursing (DON) stated the Social Services were responsible for scheduling the care plan meeting. DON indicated the team discusses in the morning meeting if any resident needs a care plan meeting due to some change in condition, or if it was a quarterly or annual assessment coming up or if the resident or resident's representative had any concerns. Social Services would then schedule a care plan meeting with the resident and/or their representative. Care plan meetings were conducted 2 to 3 times a week and the residents were invited to attend their care plan meeting. DON indicated the care plan meeting were conducted within 48 hours of admission, after completion of admission care plan and then quarterly, or when there was a significant

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changes, or if any resident or representative, or staff, requests for a care plan meeting. She further stated she was not sure when the care plan was reviewed.

During an interview on 2/8/24 at 9:08 AM, the MDS Nurse stated when any resident was due for a MDS assessment, the assessment was opened. The IDT team reviewed and completed their respective sections. The care plans were also reviewed. The care plans were closed within 14 days of completion of MDS assessment. The MDS Nurse indicated Social Worker was responsible for scheduling a care plan meeting with the residents and their representatives. She further indicated the Social Worker could run a report to see which assessments and care plans were completed and could schedule the meetings accordingly. The MDS Nurse stated the resident's care plan was revised on 8/28/23.

During an interview on 2/8/24 at 12:03 PM, the Administrator stated the care plan meeting should be done by interdisciplinary team, with resident and/or resident's representatives at admission, quarterly, as needed based on their change in condition and annually. The Administrator further stated that the resident's care plan should be reviewed and closed within 14 days from the completion of the MDS assessment. The Administrator indicated the Social services were responsible for scheduling the care plan meetings. The residents and/or resident's representatives should be invited to the care plan meeting. A letter should be sent out and care plan meeting should be scheduled based on the convenience of the resident and/or resident's representative.
5. Resident #97 was admitted to the facility on

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3/30/23 with diagnoses that included bilateral primary osteoarthritis of hip.

The quarterly Minimum Data Set (MDS) dated 12/8/23 revealed the Resident #97 had intact cognition.

Review of Resident #93's care plan revealed it was reviewed 12/8/23. There was no indication that Resident #97 participated in the care plan meeting or development of the care plan.

An interview on 2/6/24 at 9:46 AM with Resident #97 revealed she had not attended or been invited to a care plan meeting.

During an interview on 2/8/24 at 11:29 AM, the MDS Coordinator revealed the SW was responsible for scheduling care plan meetings. The SW could run a report to see which assessments and care plans were completed to schedule the meeting. The MDS Coordinator indicated the last care plan quarterly review for Resident #97 were 9/7/23 and 12/8/23. Interview further revealed MDS Coordinator didn't see any care plan notes for Resident #97.

An interview on 2/7/24 at 11:46 AM, with the Social Worker (SW) revealed for residents in short-term rehab, she would schedule a care plan meeting with the families. She indicated she called the families, invited residents and a care plan meeting was conducted. A note was later documented in the resident's record indicating when the care plan meeting was conducted, who attended the meeting and what was discussed. The SW indicated for residents who were in long-term care, the meetings were conducted as

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F 657	Continued From page 44 needed and it was less formal. The SW indicated that each department reviewed their own care plan goals related to the resident after they completed the MDS and made changes accordingly. Unless there was a very significant change and the staff wanted to talk to the resident or resident family about the change in the condition and goals there were no team care plan meetings conducted. Interview further revealed Resident #97 was a long-term care resident and the SW could not find the date of her last care plan meeting. The SW indicated she had not invited residents, mailed out notifications or invitations to attend care-plan meetings.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.	F 660		4/30/24

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(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.
(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

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F 660	Continued From page 46 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 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, family, home health agency, physician, staff interviews, the facility failed to implement an effective discharge planning process that included ensuring the resident's caregiver and the home health agency were informed of the resident's medication orders, wounds, and the treatment that was required for the wounds. This was for 1 of 3 residents reviewed for discharge (Resident #181). The findings included: Resident #181 was admitted on 2/3/23, readmitted on 3/23/23 and discharged home on 5/1/23 via stretcher transport. The diagnoses included diabetes, dementia, hypertension, dysphagia, chronic kidney failure, osteoarthritis, and Alzheimer's disease. Review of the admission Minimum Data Set (MDS) dated 3/23/23 revealed Resident #181 was severely cognitively impaired . She required extensive assistance from staff with toileting, hygiene, bathing, dressing and transfers. The MDS further revealed Resident #181 was	F 660	F660 Corrective action for the residents found to be affected by the deficient practice. Resident #181 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All facility residents that have a planned discharge have the potential to be affected by this deficient practice if the Interdisciplinary team (IDT) fails to implement an effective discharge plan. A facility in-house audit of all discharges for the last 30 days was conducted on 2/26/24 by the Social Services Team and facility Administrator. Systemic Changes made to ensure that the deficient practice will not recur. All IDT members involved with the discharge planning process were in-service and educated on by the Administrator on 2/26/24 on proper policy and procedures on discharge planning,	

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F 660	Continued From page 47 planning to discharge back to the community. Review of Resident #181's care plan dated 3/23/23 indicated Resident #181's goal was to discharge home with family. Review of the April 2023 Treatment Administration Record (TAR) for Resident #181 revealed the resident received right heel wound care treatment to the right heel which was to wipe the right heel with skin prep 3 times a day, every shift for wound care for the whole month. The TAR had no documented treatment for the sacral wound. Review of physician discharge summary note dated 4/28/23, revealed a physical exam was completed on Resident #181. The note documented the skin was warm, dry, and not diaphoretic. Resident #181 had right foot pain, very tender with light palpation. The discharge summary note did not include a discussion, any orders or treatment of the facility acquired deep tissue injury to the right heel or the sacral wound. Review of the interdisciplinary discharge summary dated 4/28/23 revealed Resident #181 was planning to discharge home with family on 5/1/23 and a referral was made to a home health and hospice agency for physical/occupational therapy and nursing to provide a medication review. The discharge summary did not include Resident #181's list of medications or wound care instructions for her right heel or pressure wounds. Additionally, review of the interdisciplinary discharge summary section description of services provided, home health and hospice agency referral revealed the home health referral did not include an order for nursing to evaluate	F 660	which is resident specific for their appropriate discharge needs. The in-service education was completed on 2/26/24. Plans to monitor its performance to make sure that the solutions are sustained. The Social Services Team or Facility Administrator will audit all planned discharges 5x a week for 4 weeks to ensure a cohesive discharge plan that includes ensuring that the resident□s specific needs are being met for discharge. Post discharge, a member of the IDT will follow-up with the resident after planned discharge to ensure all follow-ups for home health, therapies, DME and PHP visits are in place and if they need any further assistance with their transition back into their home settings. This audit will continue 5 x a week for 4 weeks, then weekly for 2 months. The results of the audit and any concerns identified will be reported to our Quality Assurance Committee monthly for three months or until substantial compliance is achieved. Date of compliance: 4/30/24	

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and treat Resident # 181's right heel and sacral wounds.

A telephone interview was conducted on 2/5/24 at 2:15 PM, the family member of Resident #181 stated her mother had no pressure ulcers when she was readmitted. The family member further stated she was unaware of the pressure ulcers on her mother's buttocks, mid cheek area and right heel until the resident arrived home on 5/1/23. She stated she saw a dressing on the resident's buttocks and when she removed it there were large wounds on both cheeks that were draining. The right heel had an open area as well.

A telephone interview was conducted on 2/7/24 at 1:39 PM, the Social Work Assistant stated she initiated the discharge plan and summary on 4/28/23 for Resident #181. The interdisciplinary team was responsible for the completion of their designated section prior to the Resident's discharge date of 5/1/23. She further stated once all interdisciplinary team members complete the form a packet would be prepared and given to the nurse. The nurse would review the packet with the resident and/or responsible person, they would sign the document and be given a copy at the time of discharge with all medications, prescriptions, appointments, and service providers. The Social Work Assistant stated the summary was prepared on 4/28/23 and she did not know if a copy had been given to the resident or responsible person. The Social Work Assistant did not state who followed up with the completion of the packet since she left the facility after completing this form.

An interview was conducted on 2/8/24 at 8:26 AM, in conjunction with a record review with the

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Director of Nursing, revealed all interdisciplinary team members had not completed the Resident #181's discharge summary. The discharge process would be initiated by the Social Worker who would prepare the packet to include medication list/prescriptions, wound care instructions and other support services and give the packet to the discharging nurse to be reviewed with the resident and/or responsible person at the time of discharge. The discharge nurse would obtain a signature from the resident and or responsible person and a copy would be given to them, and the second copy kept on file. The Director of Nursing stated the facility did not have a complete packet for Resident #181 or documentation that the packet had been reviewed or given to the resident or responsible person at the time of discharge. The Director of Nursing stated the current discharge plan was not followed.

An interview was conducted on 2/8/24 at 11:12 AM in conjunction with a record review with Nurse #6, the nurse reviewed her nursing note dated 5/1/23, which documented Resident #181 was discharged. Nurse #6 indicated she did not include the condition of the resident at the time of discharge. Nurse #6 stated the discharge process was the receipt of the discharge paperwork from the Social Worker, which included the discharge summary, list or medication and wound care instructions. She would document in the record the medication list and wound care instructions were reviewed with the resident and/or responsible person. A signed copy of the discharge paperwork would be sent home with the resident and/or responsible person. Nurse # 6 stated she did not recall reviewing the paperwork with the resident or responsible person and

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F 660	Continued From page 50 sending the paperwork home with the resident. A telephone interview was conducted on 2/8/24 at 12:34 PM, the Physician Assistant #3 stated she did not recall any discussion with nursing about Resident #181 having any open areas on the buttocks. The Physician Assistant #3 stated the process was the wound care nurse would notify the physician about the changes in skin condition and a discussion would have been held regarding the treatment plan. This would have been included in the discharge summary note. A telephone interview was conducted on 2/9/24 at 1:19PM with the home health and hospice agency nurse, confirmed a referral for Resident #181 was received on 4/28/23 for physical/occupational therapy, and nursing services, however, there was no information communicated about pressure wounds. Home health services began on 5/2/23 and there were no medication orders/list, treatment instructions for the wound summary paperwork sent with the resident or to the responsible person. The hospice nurse observed stage II bilateral wounds on the sacral area and an unstageable wound to the right heel on 5/2/23. The hospice nurse communicated with the facility nurse the following day to obtain the facility discharge summary information.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course	F 661		4/30/24

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F 661	Continued From page 51 of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to complete a recapitulation of stay for 1 of 4 closed records reviewed for planned discharge to the community(Resident #181). The findings included: Resident #181 was readmitted to the facility on 3/23/23. The admission Minimum Data Set(MDS) dated 3/23/23. Resident #181 was coded severely impaired with cognition. Resident #181 was discharged to the community	F 661	F661 Corrective action for the residents found to be affected by the deficient practice. Resident #181 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Administrator initiated 100% audit on all residents within the facility on 2/26/24 to ensure a discharge plan summary was in place. There were no other negative	

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F 661	Continued From page 52 on 5/1/23 and review of the closed record revealed the facility failed to complete a recapitulation of the resident's stay. A telephone interview was conducted on 2/7/24 at 1:39 PM, the Social Worker Assistant stated the discharge plans were discussed with the resident and responsible person on admission for Resident #181 to return to the community. She initiated the discharge plan and summary form on 4/28/23, a few days prior to discharge on 5/1/23. The Social Worker assistant stated she did not know if the other interdisciplinary team members completed the recapitulation of stay. An interview was conducted on 2/8/24 at 9:15 AM, in conjunction with record review of the discharge summary with the Social Work Director. The Social Work Director stated she was off at the time of the resident's discharge; however, the assistant social worker prepared the discharge plan summary form in her absence. She confirmed the only information in the facility system was the form completed on 4/28/23, and all the interdisciplinary sections were not completed to recapitulate Resident #181's stay which would have included the resident's medication list/prescriptions wound care instructions. Each of the interdisciplinary team members were responsible for completing their sections two days prior to the scheduled discharge. An interview was conducted on 2/8/24 at 8:26 AM, in conjunction with a record review with the Director of Nursing (DON). Review of the discharge summary revealed the physician saw the resident on 4/28/23 and completed a discharge summary note recapitulation the	F 661	outcomes identified. Systemic Changes made to ensure that the deficient practice will not recur. The Social Services department was educated by the Administrator on 2/26/24 on Discharge plan summaries in accordance with CMS guidelines. A recapitulation of the residents stay is required and must be completed by the IDT before the resident discharges from the facility. Plans to monitor its performance to make sure that the solutions are sustained. The administrator or designee will review each discharge daily x 5 days a week for 4 weeks to ensure that a discharge summary has been completed. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for 3 months for further or until substantial compliance is achieved. Date of compliance: 4/30/24	

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F 661	Continued From page 53 resident's stay but did not include any information about the identified wounds on the heel or sacral wounds or previous treatment or instructions provided to the wound. The Director of Nursing reviewed the medical record and revealed the discharge process was not completed by the interdisciplinary team because they did complete the recapitulation of Resident #181's stay at the time of discharge. The DON indicated the team should have met two days before the scheduled discharge to ensure all interdisciplinary documentation was completed before the paperwork was sent to the social worker.	F 661		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to provide an on-going activity program that met the individual interest and needs for 1 of 2 cognitively impaired residents reviewed for activities (Residents #74). The findings included: Resident #74 was admitted to the facility on 1/30/21. The diagnoses included cognitive	F 679	F679 Corrective action for the residents found to be affected by the deficient practice. Resident #74 still resides in house. The Activity Care plan for resident #74 was updated on 2/28/24. Corrective action for other residents having the potential to be affected by the same deficient practice.	4/30/24

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F 679	Continued From page 54 impairment and dementia. Resident #74 was coded on the annual Minimum Data Set(MDS) dated 6/23/23 as having moderately impaired cognition and he needed assistance with activities. The MDS also coded Resident #74's activity interest as very important to participate in favorite activities to include music and news and current events. The resident was coded for total assistance with transfers and locomotion. The annual activity assessment dated 6/22/23 revealed Resident #74's preference with interest in listening to music, news, and current events. A focus area on the care plan dated 6/22/23 revealed Resident #74 had little, or no activity involvement related to physical limitations. The goal included Resident #74 would choose his own leisure activities. The intervention included staff would offer music and change the television channel if necessary. Record review revealed there were no activity notes available after the 6/22/23 assessment for Resident #45. There were no documented notes or participation records for Resident #74. Review of the last documented activity note dated 6/22/2023, revealed Resident #74 was alert and could choose his own leisure time activity. Resident #74 enjoyed old school music, television, and game shows. The activity calendar for 2/5/24 was reviewed for independent activities. A continuous observation was done on 2/5/24 from 10:00 AM to 2:30 PM of staff interaction and activities throughout the day	F 679	All residents have the potential to be affected by the alleged deficient practice. The Administrator initiated 100% audit on all residents within the facility on 2/26/24 to ensure cognitively impaired residents are having their needs met with activities. There were no other negative outcomes identified. Systemic Changes made to ensure that the deficient practice will not recur. The Activity department was educated by the Administrator on 2/26/24 on the importance to ensure all cognitively impaired residents needs are being met by the activity department in accordance with CMS guidelines, required documentation and participation/attendance records being kept up to date. The Administrator or designee will monitor these areas 5x a week for 4 weeks and then weekly for 4 weeks then monthly thereafter. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator and/or designee will monitor these areas 5x a week for 4 weeks and then weekly for 4 weeks then monthly thereafter. The Administrator will present an analysis of this review to the Quality Assurance Performance Improvement Committee monthly until 3 consecutive months of compliance is sustained then quarterly. Date of compliance: 4/30/24	

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per the activity calendar. Resident #74 remained in bed during these time frames. There were no alternate activities or one-to-one activities available during the day.

Review of the activity calendar on 2/5/24 offered the following activities at 10:00 AM room visits, name that song at 11:00 AM, and 2:30 PM movies and manicures. Staff were observed passing by the Resident #74's room and did not stop to offer the resident assistance to participate in the scheduled activity.

Observation of the activity on 2/5/24 at 10:00 AM revealed the scheduled activity was room visits.Resident #74 was overheard and observed in the room yelling out for staff to come and assist with remote. The resident had difficulty operating the remote. During this time the Activity Director was observed in the activity room with a small group of residents. There were no room visits done. The nurse aides were in other rooms providing care.

Observation on 2/5/24 at 11:00 AM, revealed nine residents participated in the Name that Song activity. Resident #74 was in his room in silence. There was no television or radio on.

An interview and observation were conducted on 2/5/24 at 2:30 PM. Resident #74 was in bed calling out for someone to come talk to him. The television was playing, and the remote control was across the room on a counter. Resident #74 stated he had not seen the activities person and staff did not get him out of bed to go to anything.

Review of the activity calendar on 2/6/24 offered the following activities at 10:00 AM room visits,

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painting that song at 11:00 AM, and 2:00 PM resident council meeting with black history facts. Staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity.

An interview and observation were conducted on 2/06/24 at 10:57 AM. Resident #74 stated he enjoyed religious services, sports, gospel music and food events. Resident #74 further stated he had limited physical mobility and was unable to go to activities himself. Resident #74 reported he was not provided with in-room activities, offered, or assisted to an activity. The resident stated he would go to activities if staff would take him.The remote control was across the room on a counter out of reach of the resident.

An interview was conducted on 2/7/23 at 10:00 AM. Nurse Aide #4 stated the nurse aides should offer the resident the opportunity to get up and go to the activities of the day. The nurse aide stated if the nurse aides were providing care, they were unable to take residents to activities at the start of the activities and maybe only able to take the residents toward the end of the activity. The Nurse Aide #4 stated she had not seen the activity person working with the resident.

An observation and interview were conducted on 2/8/24 at 2:16 PM. Resident #74 was observed in bed with television on low volume and the remote control was across the room on the counter. There were no other stimulatory items in the room or within reach of the resident. Nurse Aide #5 stated staff would have to assist the resident with the use of the remote control. Nurse Aide #5 further stated she had not seen Resident #74 involved in group activities or provided with

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one-to-one activities by the activity staff. Nurse Aide #5 further stated Resident #74 would yell out if he needed something or assistance. Nurse Aide #5 indicated the aides try to assist with getting residents to activities, but if they were providing care to other residents, they were unable take residents to activities.

An interview was conducted on 2/7/24 at 3:00 PM, Nurse#12 stated Resident #74 stayed in bed most of the time and she had not seen any direct activities provided to the resident. Nurse #12 stated she could not recall if the activity person provided 1:1 for the resident. The nursing staff had been very busy and had difficulty getting residents to activities when the workload was heavy.

An interview was conducted on 2/8/24 at 12:00 PM, in conjunction with the record with the Activity Director (AD). She stated she was aware Resident #74 enjoyed music, news and games per her assessment done June 2023. She indicated per assessment and care plan at the time, the resident had not participated in any group activities, and she did not have any documentation of one-to-one activities activity provided to Resident #74. The Activity Director reviewed the record and acknowledged there had been no documented activity for Resident #74 since 6/22/23. The Activity Director stated she was the only person providing activities throughout the facility and the expectation was for the aides to assist and bring residents to the activities. The Activity Director stated she had spoken up about her limited ability to transport residents, provide one to one room visits and perform the daily activities to the Director of Nursing and former Administrator and have been

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SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

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F 679	Continued From page 58 told several times they were working on hiring additional staff and getting the facility staff to assist with transport. An interview was conducted on 2/7/24 at 2:45 PM. The Director of Nursing stated the staff should be encouraging/offering and assisting residents to preferred activities of interest daily. The facility staff should assist residents to activities as much as possible. An interview was conducted on 2/9/24 at 7:30 AM. The Administrator stated the resident's care plan and notes should reflect resident's individual preference and response to the activity. The residents who are not involved in group activities should be provided with one-to-one activities activity. The facility was challenged with staffing for the activities program.	F 679		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and a recorded 911 call, the facility failed to implement emergency procedures, when a resident who was a known brittle diabetic was discovered to have a blood sugar of 28 and was unresponsive. Nurse	F 684	F684 Corrective action for the residents found to be affected by the deficient practice. Resident #232 no longer resides in the facility.	4/30/24

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F 684	Continued From page 59 #7 failed to complete a nursing clinical assessment, failed to initiate emergency procedures within the nursing home and with 911. Nurse #7 also delayed in activating 911, demonstrated no urgency with the 911 call, and did not relay accurate information of the situation. Resident #232 expired on 2/8/24. This occurred for 1 of 1 resident reviewed for neglect (Resident #232). Immediate jeopardy began on 2/8/24 when the facility failed to immediately and effectively respond to a medical emergency. The immediate jeopardy was removed on 4/5/24 when the facility implemented an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity D (not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and all staff have been in-serviced. The findings included: Resident #232 was admitted to the facility on 1/23/24 with diagnoses including diabetes mellitus, long term use of insulin, cerebral infarction (stroke), and kidney transplant recipient. Review of his 5-day Minimum Data Set (MDS) assessment, dated 1/27/24, revealed he was cognitively intact and required limited assistance with activities of daily living. Resident #232 received insulin injections and tube feedings. A physician order dated 1/23/24 was nothing by mouth (NPO) diet, allow ice chips after oral care. Review of Resident #232's initial plan of care, dated 1/24/24, indicated he was a full code.	F 684	Corrective action for other residents having the potential to be affected by the same deficient practice. All facility insulin dependent diabetic residents have the potential to be affected by this deficient practice. An audit will be completed by the Clinical Regional Director/Designee to verify all residents that are insulin dependent are receiving insulin per the MD orders and are being monitored for any signs of symptoms of acute emergent hypoglycemia. This audit was completed on 4/3/24. If any adverse events are noted in this audit, it will be corrected immediately by DON/designee. Systemic Changes made to ensure that the deficient practice will not recur. All licensed nurses, certified nursing assistants, agency/contract staff, and all newly hired licensed nurses will be educated on the policies and procedures of responding to a medical emergency, and on how to manage Emergent Hypoglycemic events. This will also include how to manage the initiation of a medical code for initiation of CPR, calling 911 to report a medical emergency, and that EMS assistance is needed emergently. This information for education is defined in the Hypoglycemic policy and the Medical Emergency policy. Medical Emergency education will include if calling a “code blue” is necessary that all available staff report to resident in distress. Education will also include specifics for managing emergent Hypoglycemic events and will provide criteria for managing emergent Hypoglycemia secondary to insulin	

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F 684	Continued From page 60 A physician order dated 1/26/24 was continuous enteral feed Nutren 1.5 per PEG (percutaneous endoscopic gastrostomy) via Pump. Rate 70 ml (milliliters)/hour with water flush 60ml every hour for 20 hours per day from 2 PM to 10 AM (disconnect 10 AM - 2 PM). A physician order dated 2/7/24 was insulin regular human injection solution pen-injector 100 units/milliliter (ml)- Inject 28 units subcutaneously every 6 hours-Hold for blood glucose less than 120. There were no standing or physician orders for hypoglycemia. A review of Resident #232's Medication Administration Record revealed that he received 28 units of regular insulin at the following times: 2/7/24 at 6:00 pm with blood sugar of 202 and on 2/8/24 at 12:00 am with a blood sugar of 136. An initial nurse's note dated 2/8/24 at 8:02 am revealed Nurse #7 had written during the med pass at 9:58 pm Resident #232's blood sugar was 68 and she spoke with the resident, and they agreed to hold insulin. At 12:48 am she checked Resident #232's blood sugar and it was 136. Nurse #7 administered the insulin as ordered as it stated hold for blood glucose less than 120. She stayed on the hall for over an hour to monitor patient. Nurse #7 rechecked his blood sugar around 2:00 am and it was 156. She wrote that she finished rounds and sat down to chart and her last round was completed around 4:00 am. Nurse #7 wrote that she took a lunch break from 5:09 am to 5:40 am. She began her last round at 5:43 am and when she approached Resident #232's room, she noticed that he was not responding so she checked his blood sugar level,	F 684	therapy. The education will have emphasis of blood glucose ranges that would indicate a severe hypoglycemic event and that may or may not present with symptoms and how to assess and intervene quickly. Furthermore, for further clarification, the policy will also describe the need to follow Physicians orders, to determine when Hypoglycemia would result in a medical emergency for each resident that is insulin dependent per the physician's specific baseline blood glucose orders. The policy for Emergency medical management indicates what pertinent information needs to be given to 911 upon making an emergency call. The education will be in person. All education will be initiated by DON/ADON designee on 4/3/2024 and continue daily prior to start of shift. All new hires will receive this education in orientation prior to the start of their first shift going forward from 4/4/2024. The administrator/designee will be the person who will ensure all licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated. Plans to monitor its performance to make sure that the solutions are sustained. To ensure ongoing compliance, the Administrator and/or designee will conduct daily audits on all insulin dependent diabetic residents that require insulin administration this audit began on 4/5/24 and will continue for one month, then 5 x times a week for 2 months.	

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F 684	Continued From page 61 and it was 28. Nurse #7 asked a nurse aide to bring her a glucagon shot (an emergency medicine used to treat severe low blood sugar). The nurse aide brought her glucagon gel, which she administered under Resident #232's tongue. When she rechecked his blood sugar, it was 45. Nurse #7 documented she was unable to locate a glucagon shot on the medication cart, so she ran to nursing station #2 and asked the charge nurse (Nurse #10) for a glucagon shot. Nurse #7 wrote that the charge nurse told her that she could not send a resident out for low blood glucose. She wrote that she was calling 911 as she was getting the glucagon shot and administering it to Resident #232. She was instructed by the 911 Operator to move the resident from the bed to the floor, a nonrebreather mask was placed on resident and chest compressions began. Nurse #7 also wrote that she asked the charge nurse to assist her, and the charge nurse stated he couldn't help her because "it would break my back", so she proceeded to get the resident on the floor alone. She concluded her note by writing that more nurses came to assist, EMS (emergency medical services) arrived and took over care for an additional 5 minutes before EMS stopped compressions. This note was struck through in the medical record. An amended nurse's note dated 2/8/24 at 9:24 am revealed Nurse #7 had written during the med pass at 9:58 pm Resident #232's blood sugar was 68 and she spoke with the resident, and they agreed to hold insulin. At 12:48 am she checked Resident #232's blood sugar and it was 136. Nurse #7 administered the insulin as ordered as it stated hold for blood glucose less than 120. She stayed on the hall for over an hour to monitor patient. Nurse #7 rechecked his blood sugar	F 684	A summary report of compliance will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Nursing (DON) for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 4/30/24	

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around 2:00 am and it was 156. She wrote that she finished rounds and sat down to chart and her last round was completed around 4:00 am. Nurse #7 wrote that she took a lunch break from 5:09 am to 5:40 am. She began her last round at 5:43 am and when she approached Resident #232's room, she noticed that he was not responding so she checked his blood sugar level, and it was 28. Nurse #7 asked a nurse aide to bring her a glucagon shot (an emergency medicine used to treat severe low blood sugar). The nurse aide brought her glucagon gel, which she administered under Resident #232's tongue. When she rechecked his blood sugar, it was 45. Nurse #7 documented she was unable to locate a glucagon shot on the medication cart, so she ran to nursing station #2 and asked the charge nurse (Nurse #10) for a glucagon shot. She wrote that she was calling 911 as she was getting the glucagon shot and administering it to Resident #232. She was instructed by the 911 Operator to move the resident from the bed to the floor, a nonrebreather mask was placed on resident and chest compressions began. She concluded her note by writing that more nurses came to assist, EMS (emergency medical services) arrived and took over care for an additional 5 minutes before EMS stopped compressions.

During a recorded 911 phone call that began on 2/8/24 at 6:56 am the following conversation occurred between the 911 Operator and Nurse #7: The time stamps entered below document the time elapsed in minutes and seconds from the time the call was initiated at 6:56 am. The phone call lasted 9 minutes and 15 seconds.

0-1:00-Nurse #7 was heard telling the 911 Operator the facility's address and that she had a

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resident with a blood sugar level that was 'trending down' and she was having trouble keeping it up. She did not state she had an emergency or ask the 911 Operator to send emergency services. She stated that resident was a full code.

1:10-1:16 -Nurse #7 was heard telling the 911 operator that she had just given a resident a glucagon shot.

1:17-1:30- Operator was heard asking Nurse #7 several times if the resident was breathing and if he was conscious. There was a 5 to 6 second pause before Nurse #7 stated that the resident was breathing but that he "wasn't coming to".

1:31-1:40- The Operator asked if the resident had seen a health care professional within the last 2 hours and Nurse #7 stated no. She also stated, "I'm not getting any blood".

1:43- Nurse #10 could be heard entering the room-unable to determine what he asked.

1:47- Nurse #7 was heard telling Nurse #10 that she was sending the resident out now.

1:50-1:57-The Operator asked Nurse #7 again if the resident was breathing. Nurse #7 paused for 2 to 3 seconds and stated "mm, yes he's breathing". The Operator then asked if the resident was breathing normally.

1:58-2:10- Nurse #7 can be heard asking Nurse #10 to bring her something. The Operator was heard asking Nurse #7 again if the resident was breathing normally. Nurse #7 is heard again saying "mmm ...no, he's completely out".

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F 684	Continued From page 64 2:11-2:27- Nurse #10 is heard in the background saying "hello, hello". The Operator said hello and then Nurse #7 was heard telling the Operator that it was the charge nurse. 2:28-3:01- The Operator told Nurse #7 that when she said go, she wanted Nurse #7 to count the number of times she saw rise and fall of the resident's chest. Nurse #7 then stated, "hold on". There was a 15 second pause (2:36-2:51) and the Operator said "hello" again. Nurse #7 then stated she was there and was trying to watch his chest and see. She stated it was "really faint". 3:02-3:17- The Operator stated again, when she said go, she wanted Nurse #7 to count the number of times the resident's chest rose. She asked Nurse #7 twice if she was ready before Nurse #7 stated yes. 3:18-3:33- Nurse #7 told the Operator that she saw his chest go up, but it wasn't "a real rise and fall". 3:34-3:49- The Operator told Nurse #7 that paramedics were on their way. She also asked if Nurse #7 was right by "him", and she stated yes. 3:50-4:02- The Operator told Nurse #7 to lay him flat on his back with nothing under his head. Nurse #7 responded that she needed to unhook his feeding tube because she couldn't lay him flat with it connected. 4:03-4:24- only background noises heard until Nurse #7 stated at the 4:24 mark that the resident was flat on his back.	F 684		

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4:25-4:30- Nurse #7 is heard saying, "I told this man to bring me some oxygen".

4:31-5:11- The Operator was heard telling Nurse #7 to listen carefully and she was going to tell her how to do chest compressions. Nurse #7 is heard saying "so, we are about to run a code". The Operator asked if the resident was on the floor and Nurse #7 stated, no. The Operator then stated that the resident needed to be on the floor. Nurse #7 stated that there was no way to do that, and the resident was lying on the bed.

5:15- Nurse #7 told someone in the room that she was about to have to start a code.

5:26- Nurse #7 was heard telling someone in the room to get her *inaudible*

5:27-5:33- background noises only

5:34- Nurse #7 was heard telling someone in the room that the 911 Operator wanted resident to be on the floor.

5:35-5:42- Nurse #7 was heard telling someone in the room "yes, but it is very faint".

5:43-6:06- background noises only

6:07- Nurse #7 was heard telling the operator that they are about to get a board.

6:10-6:48- The Operator was heard telling Nurse #7 to stand close to the resident, making sure there is nothing under their head, and to use the sheet to pull him toward her and off the bed. Nurse #7 is heard telling someone again the resident was a full code.

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6:49-7:27- Nurse #7 is heard asking Nurse #10 to help her get the resident onto the floor. Nurse #10's response was inaudible. Nurse #7 is heard telling the operator that she, "asked that man to help me".
Nurse #7 is heard grunting and stated at the 7:27 mark that the resident was on the floor.

7:28-8:02- The Operator was heard explaining to Nurse #7 where she needed to put her hands to do chest compressions. She told her that she wanted her press down at least 2 inches into his chest and that they needed to be hard and fast. She then told her to count out loud so they could do them together.

8:03-8:21- The Operator was heard counting chest compressions. Nurse #7 was not heard saying anything. The Operator again stated that Nurse #7 needed to count out loud with her.

8:22- Someone in the background is heard yelling "full code."

8:22-8:41- Inaudible voices are heard in the background. Nurse #7 was heard yelling at 8:31, "I'm actively calling them. The 911 Operator is heard trying to get Nurse #7's attention and again told her that she needed to count out loud as she was doing the chest compressions.

8:42-8:57- background noises; the Operator said, "Hello, hello? I need for you to count out loud". Nurse #7 is not heard responding to the Operator.

8:58- Nurse #7 stated to the Operator that EMS had arrived; The Operator asked if they were with the resident and the Nurse #7 stated that they

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were there.

9:04-9:09- The Operator asked again if EMS was with the resident and Nurse #7 stated "yes, yes".

9:15 - The call ended abruptly 9 minutes and 15 seconds from the start.

A review of the EMS report dated 2/8/24 stated that they arrived on scene at 7:03 am and found Resident #232 on the floor with nursing home staff performing CPR. The report further stated that during initial airway management, resident was found to have "rigor in jaw and confirmed in bilateral upper extremities. All further resuscitation efforts were discontinued. Staff on scene were unable to determine when patient was last seen conscious and alert. Staff in room states that patient was administered buccal oral glucose approximately one hour prior to EMS arrival but staff could not confirm that patient was breathing or alive at that point." The report further stated that resident was pronounced expired at 7:07 pm.

Several attempts to speak with EMS personnel on 4/2/24 and 4/3/24 who responded to the facility were unsuccessful.

During an interview with Nurse #7 (agency nurse) on 4/1/24 at 1:41 pm, she stated that she was assigned to the 100 hall (nursing station #1) and part of the 300 hall on 2/8/24. Nurse #7 said she worked both 2nd (3:00 pm-11:00 pm) and 3rd (11:00 pm-7:00 pm) shifts that day. She stated that she began her last medication pass at 5:43 am and as she approached Resident #232's room around 6:30 am, she noticed that he was not responding to her when she tried to wake him

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up. Nurse #7 stated she checked his blood glucose level, and it was 28. She stated that stepped out of the room and asked a nurse whose name she could not remember, to bring her a glucagon injection. Nurse #7 stated that a nurse returned to the room with glucose gel, and she told the nurse, no, that she needed the glucagon injection; not the glucose gel which the nurse then retrieved from the nurse's station and brought it to her. Nurse #7 explained she administered the glucagon gel to Resident #232 and the resident had lockjaw and she had a hard time opening his mouth enough to rub the gel on the inside of his cheek. The other nurse returned to the room with the injection and Nurse #7 stated that she administered the injection to Resident #232. She stated that she and other staff members got Resident #232 onto the floor as directed by 911 and began performing chest compressions. She stated she continued cardiopulmonary resuscitation efforts until EMS arrived. Nurse #7 stated that she stayed with Resident #232 the entire time.

A second interview was conducted with Nurse #7 on 4/2/24 at 10:23 am during which she stated a nurse aide brought her the glucose gel, not a nurse, as she had previously stated. She also stated that she did leave the resident alone to go to nursing station #2 and retrieve a glucagon injection since she did not know where to find it at her assigned station. Nurse #10 (charge nurse) was at nursing station #2 and gave her the glucagon injection. Nurse #7 did not recall if she asked Nurse #10 to call a code or not because she was dialing 911 from her cell phone while she was running back to the resident's room to give the injection. She said she was pretty sure she told the charge nurse who the shot was for and

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why. Nurse #7 stated that she did not remember checking to see if Resident #232's had a pulse at first because he was still breathing when she returned to the room and did not take time to do any vital signs because she was more concerned about getting his sugar up. The interview further revealed after Nurse #7 got Resident #232 on the floor, she felt for his pulse and could not feel one and she couldn't see him breathing at that point and she began chest compressions.

During an interview with Nurse Aide #3 on 4/3/24 at 8:24 am, he stated that he last saw Resident #232 several hours earlier in the shift when he asked Nurse Aide #3 to bring him some ice chips. He stated he does not remember what time that was and did not enter the resident's room again until he heard the overhead code being called near shift change. He stated that Nurse #7 asked him to go to the nurse's cart and bring her glucose gel. When asked to clarify, he stated he was certain Nurse #7 asked for the gel and not an injection. He stated that he retrieved the glucose gel, brought it back to Nurse #7 and then left to attend to another resident. He stated again that he was unsure of the time, but he remembered it being closer to 6:00 am.

A fourth attempt to speak to Nurse #7 on 4/3/23 following Nurse Aide #3's interview was unsuccessful.

During an interview with Nurse #8 on 4/1/24 at 5:05 pm, he stated that he heard the overhead code being called and responded to room. He stated he entered the room and Resident #232 was already on the floor and Nurse #7 was performing chest compressions. He stated that he relieved Nurse #7 doing chest compressions

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and EMS entered the room and took over. He stated he was unsure of the time, but it was during shift change.

During an interview with Nurse #24 on 4/2/24 at 7:31 am, she stated that she was speaking with another employee nearby when Nurse #7 came to the nurse's station asking for the glucagon shot. She stated she was on her cell phone but did not know what she was speaking to. She stated Nurse #7 did not state who she needed the shot for, what the current blood sugar was, or ask anyone to call a code.

During an interview with Nurse #10 (charge nurse) on 4/2/24 at 8:35 am, he stated that he saw Nurse #7 around 6:00 am at nursing station #1 when she began her last round. He stated she was on her cell phone when she came up to nursing station #2 asking for the glucagon injection which he gave her. He stated he was unsure of the time, but he remembered some first shift (7:00 AM to 3:00 PM) workers had arrived. Nurse #10 stated Nurse #7 didn't ask him to call a code or tell him who the shot was for or that Resident #232's blood sugar level was 28. Nurse #10 explained he came down the hall after a minute or two (he was unsure of how much time passed) and entered the room Nurse #7 was in to see what was going on. He stated he saw Nurse #7 on her cell phone telling someone that the resident was breathing but that he wasn't responding. Nurse #10 indicated he did not assess Resident #232 himself other than to do a sternal rub to see if he would wake up and the resident did not. That was when Nurse #7 told him she was on the phone with 911. He stated she said the resident was breathing and that she wanted to get him on the floor. Nurse #10 stated

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he told her Resident #232 was a large man and they would need another staff member to help get him on the floor. Nurse #10 explained he told Nurse #7 to put Resident #232 on some oxygen because he had found that oxygen helped a lot when he had a resident with low blood sugar. He stated he didn't recall her ever telling him what Resident #232's blood sugar level was. Nurse #10 stated he left the room to get a nonrebreather mask (non-rebreather masks are used for individuals who are still able to breathe on their own but require additional oxygen) with oxygen, to call a code over the loudspeaker and to grab someone else to help put the resident on the floor. Nurse #10 stated that they have a back board, but 911 always tells them to put the resident on the floor. When he returned to the room, Nurse #7 had the resident on the floor and was still on the phone with 911. Nurse #10 indicated he was told by Nurse #7 resident was still breathing when he left the room, so he applied the nonrebreather mask with oxygen, and added that it felt like the resident had "lockjaw" because it was hard to open his mouth very far. Nurse #10 did not recall if Resident #232 felt limp or stiff anywhere else and he did not assess the resident himself to see if he was still breathing before he applied the nonrebreather mask with oxygen. He stated Nurse #7 began doing chest compressions and he did not see Nurse #7 assess resident's pulse prior to beginning compressions. Then Nurse #8 came in to assist with chest compressions and EMS arrived almost immediately after that.

Review of the death certificate dated for 2/12/24 stated that Resident #232's cause of death was cerebral infarction (stroke).

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During an interview with the facility Medical Doctor on 4/1/24 at 12:47 pm, he stated that he felt like staff responded appropriately to the emergency. He stated he had no concerns regarding the care the staff provided or the time frame in which 911 was called.

During an interview with the interim Director of Nursing on 4/2/24 at 12:10 pm she stated that a resident found with a blood sugar of 28 was considered a critical level and was an emergency situation. She stated she would have expected the nurse to yell or scream for assistance-anything to get the attention of other staff to let them know she had an emergency and would have expected Nurse #7 to have done the same. She stated that Nurse #7 should have advised the charge nurse (Nurse #10) the gravity of the situation so he could have called a code immediately. She also stated she would have expected Nurse #7 to check vital signs immediately, even if she felt like the resident was still breathing. The DON indicated a blood sugar that low required a glucagon injection immediately. The DON indicated a blood sugar that low required a glucagon injection immediately.

During an interview with the Administrator and Nurse Consultant on 4/2/24 at 5:25 pm the Administrator stated that Nurse #7 had worked there several times but has not worked in the building since 2/8/24. The Administrator stated that she was in the building when the event occurred, and she had no concerns about how the code was conducted at that time and she did not feel like the facility neglected Resident #232. The interview further revealed EMS was already in the building as they had just transported

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another resident back from the hospital.

The Administrator was notified of immediate jeopardy on 4/2/24 at 6:27 PM.

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 a result of the noncompliance.
Resident #232 suffered related to this deficient practice. Nurse #7 and Nurse #10 failed to complete an assessment of the resident, failed to implement emergency procedures including immediately calling 911. Resident #232, who was a known brittle diabetic was discovered to have a blood sugar of 28 and was unresponsive.
All facility insulin dependent diabetic residents have the potential to be affected by this deficient practice. An audit will be completed by the Clinical Regional Director/Designee to verify all residents that are insulin dependent are receiving insulin per the MD orders and are being monitored for any signs of symptoms of acute emergent hypoglycemia. This audit will be completed on 4/3/24. If any adverse events are noted in this audit, it will be corrected immediately by DON/designee.
Root cause analysis which was conducted 4/2/24 by Regional Clinical Director/Designee reveals Nurse #7 did not recognize the hypoglycemic event as a medical emergency in a timely manner and failed to relay to EMS there was a Medical Emergency. Conclusion via the root cause analysis is that she was not competent in her skill set for managing emergency medical situations or competent in assessing and managing hypoglycemia.

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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.
All licensed nurses, certified nursing assistants, agency/contract staff, and all newly hired licensed nurses will be educated on the policies and procedures of responding to a medical emergency, and on how to manage Emergent Hypoglycemic events. This will also include how to manage the initiation of a medical code for initiation of CPR, calling 911 to report a medical emergency, and that EMS assistance is needed emergently. This information for education is defined in the Hypoglycemic policy and the Medical Emergency policy. Medical Emergency education will include if calling a "code blue" is necessary that all available staff report to resident in distress. Education will also include specifics for managing emergent Hypoglycemic events and will provide criteria for managing emergent Hypoglycemia secondary to insulin therapy. The education will have emphasis of blood glucose ranges that would indicate a severe hypoglycemic event and that may or may not present with symptoms and how to assess and intervene quickly. Furthermore, for further clarification, the policy will also describe the need to follow Physicians orders, to determine when Hypoglycemia would result in a medical emergency for each resident that is insulin dependent per the physician's specific baseline blood glucose orders. The policy for Emergency medical management indicates what pertinent information needs to be given to 911 upon making an emergency call. The education will be in person. All education will be initiated by DON/ADON designee on 4/3/2024 and continue daily prior to start of shift. All new hires will

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receive this education in orientation prior to the start of their first shift going forward from 4/4/2024. The administrator/designee will be the person who will ensure all licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated.
Immediate jeopardy will be removed by 4/05/24.

The credible allegation for removal of immediate jeopardy was validated onsite on 4/5/24. Audit tool dated 4/4/24 was reviewed. The tool identified residents who were insulin dependent, were receiving insulin per physician orders, if signs and symptoms of hypoglycemia were monitored by the nurses and emergency medical management policies and procedures were followed, any signs and symptoms of emergent hypoglycemia and if the nurse was negligent by not following physician orders or assess the resident to recognize a medical emergency. The review revealed no concerns. Nurse #7 was no longer working for the facility as indicated.
In-service education records which included sign-in sheets and interviews with staff confirmed education was provided on: Medical emergency management, Standard nursing practices, diabetic management, Management of hypoglycemia, Emergency Procedure - CPR (cardiopulmonary resuscitation), Adult CPR and AED, Acute condition changes - clinical protocol, pertinent information to be provided to 911 upon making an emergency call. The education related to policies and procedures of responding to a medical emergency and on how to manage Emergent Hypoglycemic events was added to orientation for new hires. The DON/ADON were responsible to ensure all nurses and certified nurse aides received this education prior to

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F 684	Continued From page 76 working on the floor.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff, family, and physician interviews, the facility failed to assess, document the pressure wound(s) identified and document the treatment provided for the identified wound(s) on the buttock for 1 of 3 residents reviewed for pressure ulcers (Resident #181). The findings: Resident #181 was readmitted to the facility on 3/23/23. The diagnoses included diabetes, dementia, hypertension, dysphagia, chronic kidney failure, osteoarthritis, and Alzheimer's disease. The admission Minimum Data Set (MDS) assessment, dated 3/23/23, revealed Resident	F 686	F686 Corrective action for the residents found to be affected by the deficient practice. Resident #181 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) initiated 100% body audits on all residents within the facility on 2/18/24. There were no new skin integrity issues identified. The Director of Nursing (DON) and/or Nurse Managers have reviewed the wound audit conducted on 2/18/24 □	4/30/24

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F 686	Continued From page 77 #181 was severely cognitively impaired. She required extensive two-person physical assistance with bed mobility, transfers, and activities of daily living. She was always incontinent of bowel and bladder and was not coded with wounds or pressure ulcers. Resident #181 was discharged to home on 5/1/23. Review of the nutritional care plan for Resident #181 dated 3/29/23 identified a focus area as Resident #181 was at nutritional risk related to diagnoses of diabetes, dementia, and dysphagia. Resident #181 noted in 4/2023 an area of skin impairment on the right heel. One of the interventions included the registered dietician was to evaluate nutritional needs and make diet change recommendations as needed. Review of the head-to-toe skin assessment for Resident #181 dated 4/24/23 done by Nurse #20, identified and documented a new deep tissue injury to the right heel and 3 open areas to the buttocks. Resident #181 wore protective boots to bilateral heels while in bed and the wound nurse was notified. A telephone interview was conducted on 2/8/24 at 11:44 AM, Nurse #20 stated she completed the weekly skin assessment for Resident #181 on 4/24/23. She explained she noticed that the resident had a deep tissue on the right heel and 3 open areas on her buttocks. She said she did not recall documenting a description of her observation, but she was certain she informed the wound nurse of her observation of all of the wounds.	F 686	2/20/24 and reviewed the documentation to ensure residents with skin impairments had an order for treatment to areas. The Director of Nursing (DON) and Nurse Managers reviewed residents with skin impairments identified on their 2/20/24 body audits to ensure the resident had a treatment order in place, physician notification, RP Notification and document of the condition/status/size/appearance of the wound. The Director of Nursing (DON) and/or Nurse Managers began educating the Nurses/agency nurses on 2/29/24 on weekly skin observations and documentation, physician notification, RP notification, initiates treatment per physician order for new / changes in skin integrity. The Assistant Director of Nursing was notified on 2/26/24 by the Licensed Nursing Home Administrator (LNHA) to add the skin observations and documentation education to the Nurse/agency nurse general orientation upon hire with emphasis that the nurse who identifies the skin integrity issue completes the wound documentation, physician notification, RP notification, initiates treatment per physician order for new / changes in skin integrity. On 2/29/24 the Director of Nursing (DON) and Nurse Managers educated the Certified Nursing Assistant (CNA)/ Agency CNA on daily skin checks during personal care. The Assistant Director of Nursing was notified on 2/26/24 by the Licensed Nursing Home Administrator (LNHA), to	

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F 686	Continued From page 78 Review of the April 2023 Treatment Administration Record (TAR) for Resident #181 revealed the resident received treatment to the right heel which was to wipe the heel with skin prep 3 times a day, every shift for wound care 4/24/23-4/30/23. The TAR had no documented treatment for the sacral wounds. Review of the weekly pressure ulcer record the Wound Nurse updated this record for Resident #181 dated 5/1/23 documented the onset date as 4/24/23 for the right heel wound acquired in the facility. The measurements included 5.0-centimeter x 6.5-centimeter x 0.0 centimeter, suspected deep tissue injury, wound edges dark red purple. The form was signed off as of 2/6/24. There was no documentation of an assessment of the 3 open areas identified on the buttocks on 4/24/23 by Nurse #20. A telephone interview was conducted on 2/5/24 at 2:15 PM, the family member of Resident #181 stated her mother had no pressure ulcers when she was readmitted. The family member stated she was aware that her mother had multiple health issues and was at the facility for rehab services. The family member did not state how many wounds she had but described what she observed when the resident arrived home. The family member further stated she was unaware of the pressure ulcers on her mother's buttocks, mid cheek area and right heel until the resident arrived home on 5/1/23. She stated she saw a dressing on the resident's buttocks and when she removed it there were large wounds on both cheeks that were draining. The right heel had an open area as well. The facility did not inform her when the pressure ulcers developed.	F 686	add the education to the general orientation of the Certified Nursing Assistant (CNA)/agency CNA. Any Certified Nursing Assistant (CNA)/agency CNA will not be allowed to work after 2/29/24 until they receive the education. Systemic Changes made to ensure that the deficient practice will not recur. On 2/26/24 the Director of Nursing (DON) notified the Wound Nurse and the Nurse Practitioner (NP) to meet weekly to discuss and review all residents with wounds. On 2/26/24 The Licensed Nursing Home Administrator (LNHA) notified the Director of Nursing (DON) and/or Nursing Leadership to review the weekly skin observations, to validate all areas identified have physician notification, RP notification, treatments orders are written, wound is monitored for changes weekly for four weeks then monthly thereafter. Plans to monitor its performance to make sure that the solutions are sustained. The facility wound manager report will be brought to the monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Health Services (DHS) for review and revision monthly x 3 months or until substantial compliance is achieved. Date of compliance: 4/30/24	

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An interview was conducted on 2/5/24 at 3:25 PM, the Nurse #1 (Wound Nurse) stated the process was for the Nursing Assistants and nurses to inform him of any observations of wound or skin changes. The nurse stated he was only informed about the breakdown on the Resident #181's right heel on 4/24/23, there was no mention of the open areas on the resident's buttocks. He explained the skin assessment done by Nurse #20 on 4/24/23, prior to his assessment, documented 3 open areas on the buttocks. Nurse #1 stated he had not seen Nurse #20's assessment and probably received his information regarding the heel wound in passing from an aide. Nurse #1 stated he observed the right heel which presented more as a deep tissue injury 4/24/23. He further stated he measured the area on the heel at 5.0-centimeter x 6.5 centimeter x 0.0 centimeter with no drainage and treatment was for skin prep 3 times a day. The nurse stated he did not communicate with the physician or family regarding the wound observation or the treatment for the heel. The Wound Nurse stated he did not provide any treatment to the resident's buttocks.

An interview was conducted on 2/8/24 at 8:26 AM in conjunction with a record review with the Director of Nursing (DON) reviewed the skin assessment for Resident #181 dated 4/24/23 completed by Nurse #20. The DON stated Nurse #20 documented an observation of a deep tissue injury to right heel and 3 open areas on the buttocks and the Wound Nurse was notified. Review of the weekly pressure ulcer form dated 5/1/23, documented measurements for the right heel 5.0-centimeter x 6.5-centimeter x 0 centimeter and there was no evidence of documentation of the identified area on the

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F 686	Continued From page 80 buttocks by Wound Nurse. The Director of Nursing stated the nursing staff was responsible for completing the weekly skin assessment and documenting change of skin condition, development of new pressure ulcers/deep tissue injury and report change of skin condition to the physician, family, and obtain treatment orders. The Director of Nursing acknowledged there was no documentation of the identified areas on the buttocks. The DON did not discuss the weekly wound treatment/meeting process. She acknowledged there was no documentation about all of Resident #181's wounds on the pressure ulcer form dated 5/1/23. An interview was conducted on 2/8/24 at 11:53 AM, the Registered Dietician (RD) stated she became aware of the right heel wound and 3 open areas on the buttocks for Resident #181 through her chart review. She stated the skin assessment dated 4/24/23 documented the resident had 3 open areas on her buttocks and a right heel wound. She made a recommendation to increase protein for wound healing. A telephone interview was conducted on 2/8/24 at 12:34 PM, Physician Assistant #3 stated she did not recall any discussion with nursing about Resident #181 having any open areas on the buttocks. The Physician Assistant #3 stated the process was the wound care nurse would notify the physician about the changes in skin condition and a discussion would have been held regarding the treatment plan.	F 686		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services	F 726		4/30/24

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F 726	Continued From page 81 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and a recorded 911 call, the facility failed to ensure nursing staff were trained and competent with responding to medical emergencies, activating emergency procedures within the nursing home and with emergency medical services for 1 of 1 resident (Resident #232) reviewed for neglect. Nursing staff failed to complete nursing clinical	F 726	F726 Corrective action for the residents found to be affected by the deficient practice. Resident #232 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice.	

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F 726	Continued From page 82 assessments (including vital signs), failed to immediately initiate emergency procedures within the nursing home and with 911 when a nurse asked for a glucagon injection. Nursing staff also delayed in activating 911, demonstrated no urgency with the 911 call, and did not relay accurate information of the situation to the 911 operator. Resident #232 expired on 2/8/24. Immediate jeopardy began on 2/8/24 when nursing staff failed to immediately and effectively respond to a medical emergency. The immediate jeopardy was removed on 4/5/24 when the facility implemented an acceptable credible allegation of compliance. The facility remains 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 complete education and ensure monitoring systems put into place for ensuring all staff are trained and competent before caring for residents in the facility. The findings included: An initial nurse's note dated 2/8/24 at 8:02 am revealed Nurse #7 had written during the med pass at 9:58 pm Resident #232's blood sugar was 68 and she spoke with the resident, and they agreed to hold insulin. At 12:48 am she checked Resident #232's blood sugar and it was 136. Nurse #7 administered the insulin as ordered as it stated hold for blood glucose less than 120. She stayed on the hall for over an hour to monitor patient. Nurse #7 rechecked his blood sugar around 2:00 am and it was 156. She wrote that she finished rounds and sat down to chart and her last round was completed around 4:00 am. Nurse #7 wrote that she took a lunch break from	F 726	All facility insulin dependent diabetic residents have the potential to be affected by this deficient practice if the nurse has not demonstrated or completed nursing competencies related to medical emergency management and signs and symptoms of emergent hypoglycemia upon hire, annually, and as needed. 100% audit completed by DON/ Designee on 4/4/24 to ensure all licensed nurses employed at the facility have current Nursing competencies in place for managing medical emergencies, to include management of emergent hypoglycemia in a medical emergency. This audit was completed on 4/4/24 by the Regional Clinical Director/Designee. No adverse outcomes were identified in this audit. All new licensed nurses and agency/contract nursing after 4/4/24, will have confirmation of competencies completed prior to working their scheduled shift at the facility. Nurse managers/ designee will be responsible for ensuring competencies are completed prior to working a scheduled shift, or if, competencies were not completed yet. This will be ongoing starting 4/4/2024. Nurse managers were notified by the Regional Clinical Director on 4/3/24 with this directive to achieve substantial compliance for licensed nursing competencies. Systemic Changes made to ensure that the deficient practice will not recur. All licensed nurses, nursing assistants, agency/contract staff, and all newly hired licensed nurses will be educated on the process of responding to a medical	

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F 726	Continued From page 83 5:09 am to 5:40 am. She began her last round at 5:43 am and when she approached Resident #232's room, she noticed that he was not responding so she checked his blood sugar level, and it was 28. Nurse #7 asked a nurse aide to bring her a glucagon shot (an emergency medicine used to treat severe low blood sugar). The nurse aide brought her glucagon gel, which she administered under Resident #232's tongue. When she rechecked his blood sugar, it was 45. Nurse #7 documented she was unable to locate a glucagon shot on the medication cart, so she ran to nursing station #2 and asked the charge nurse (Nurse #10) for a glucagon shot. Nurse #7 wrote that the charge nurse told her that she could not send a resident out for low blood glucose. She wrote that she was calling 911 as she was getting the glucagon shot and administering it to Resident #232. She was instructed by the 911 Operator to move the resident from the bed to the floor, a nonrebreather mask was placed on resident and chest compressions began. Nurse #7 also wrote that she asked Nurse #10 to assist her, and the charge nurse stated he couldn't help her because "it would break my back", so she proceeded to get the resident on the floor alone. She concluded her note by writing that more nurses came to assist, EMS (emergency medical services) arrived and took over care for an additional 5 minutes before EMS stopped compressions. This note was struck through in the medical record. An amended nurse's note dated 2/8/24 at 9:24 am revealed Nurse #7 had written during the med pass at 9:58 pm Resident #232's blood sugar was 68 and she spoke with the resident, and they agreed to hold insulin. At 12:48 am she checked Resident #232's blood sugar and it was 136.	F 726	emergency on how to manage Hypoglycemic events that are considered a medical emergency by nurse managers/ designee starting 4/3/24 and daily before start of initial shift. Going forward all new licensed nurses will have competencies completed upon hire and before the start of their shift. HR and DON/Designee were notified on 4/2/24 of this requirement that their competencies need to be completed prior to them taking a medication cart by the Administrator. Education on managing emergent Hypoglycemic events, as well as activating EMS immediately, will be completed by nurse managers/designee starting 4/3/2024. This will be done daily prior to first shift for all licensed nurses, nursing assistants, agency/ contract staff and all newly hired licensed nurses. This education will include the policy and procedures for emergency medical management. This policy and procedure guides licensed nursing staff to gather accurate medical information/assessments, in order for it to be reported to 911 accurately during the emergency call. 100% verification of Agency/contract staff Competency will be completed by DON/Designee prior to start of their initial shift. DON/Designee will be notified by the scheduler/ HR/ designee daily prior to any new agency/ contract staff working starting 04/04/2024. The education will be in person, 1:1 or in group setting. 100% education will be completed DON/ADON designee by 4/04/2024. The administrator/designee will be the person who will ensure all licensed nurses, certified nursing	

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Nurse #7 administered the insulin as ordered as it stated hold for blood glucose less than 120. She stayed on the hall for over an hour to monitor patient. Nurse #7 rechecked his blood sugar around 2:00 am and it was 156. She wrote that she finished rounds and sat down to chart and her last round was completed around 4:00 am. Nurse #7 wrote that she took a lunch break from 5:09 am to 5:40 am. She began her last round at 5:43 am and when she approached Resident #232's room, she noticed that he was not responding so she checked his blood sugar level, and it was 28. Nurse #7 asked a nurse aide to bring her a glucagon shot (an emergency medicine used to treat severe low blood sugar). The nurse aide brought her glucagon gel, which she administered under Resident #232's tongue. When she rechecked his blood sugar, it was 45. Nurse #7 documented she was unable to locate a glucagon shot on the medication cart, so she ran to nursing station #2 and asked the charge nurse (Nurse #10) for a glucagon shot. She wrote that she was calling 911 as she was getting the glucagon shot and administering it to Resident #232. She was instructed by the 911 Operator to move the resident from the bed to the floor, a nonrebreather mask was placed on resident and chest compressions began. She concluded her note by writing that more nurses came to assist, EMS (emergency medical services) arrived and took over care for an additional 5 minutes before EMS stopped compressions.

During a recorded 911 phone call that began on 2/8/24 at 6:56 am the following conversation occurred between the 911 Operator and Nurse #7: The time stamps entered below document the time elapsed in minutes and seconds from the time the call was initiated at 6:56 am. The phone

assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated.

Plans to monitor its performance to make sure that the solutions are sustained.
To ensure ongoing compliance, the Administrator and/or designee will conduct daily audits on staff competency this audit began on 4/5/24 and will continue for one month, then 5 x times a week for 2 months.
A summary report of compliance will be brought to the Monthly Quality Assurance Performance Improvement (QAPI) Committee meeting by the Director of Nursing (DON) for review and revision monthly x 3 months or until substantial compliance is achieved.

Date of compliance: 4/30/24

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F 726	Continued From page 85 call lasted 9 minutes and 15 seconds. 0-1:00-Nurse #7 was heard telling the 911 Operator the facility's address and that she had a resident with a blood sugar level that was 'trending down' and she was having trouble keeping it up. She did not state she had an emergency or ask the 911 Operator to send emergency services. She stated that resident was a full code. 1:10-1:16 -Nurse #7 was heard telling the 911 operator that she had just given a resident a glucagon shot. 1:17-1:30- Operator was heard asking Nurse #7 several times if the resident was breathing and if he was conscious. There was a 5 to 6 second pause before Nurse #7 stated that the resident was breathing but that he "wasn't coming to". 1:31-1:40- The Operator asked if the resident had seen a health care professional within the last 2 hours and Nurse #7 stated no. She also stated, "I'm not getting any blood". 1:43- Nurse #10 could be heard entering the room-unable to determine what he asked. 1:47- Nurse #7 was heard telling Nurse #10 that she was sending the resident out now. 1:50-1:57-The Operator asked Nurse #7 again if the resident was breathing. Nurse #7 paused for 2 to 3 seconds and stated "mm, yes he's breathing". The Operator then asked if the resident was breathing normally. 1:58-2:10- Nurse #7 can be heard asking Nurse #10 to bring her something. The Operator was heard asking Nurse #7 again if the resident was breathing normally. Nurse #7 is heard again saying, "mmm ...no, he's completely out". 2:11-2:27- Nurse #10 is heard in the background saying "hello, hello". The Operator said hello and then Nurse #7 was heard telling the Operator that	F 726		

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it was the charge nurse.
2:28-3:01- The Operator told Nurse #7 that when she said go, she wanted Nurse #7 to count the number of times she saw rise and fall of the resident's chest. Nurse #7 then stated, "hold on". There was a 15 second pause (2:36-2:51) and the Operator said "hello" again. Nurse #7 then stated she was there and was trying to watch his chest and see. She stated it was "really faint".
3:02-3:17- The Operator stated again, when she said go, she wanted Nurse #7 to count the number of times the resident's chest rose. She asked Nurse #7 twice if she was ready before Nurse #7 stated yes.
3:18-3:33- Nurse #7 told the Operator that she saw his chest go up, but it wasn't "a real rise and fall".
3:34-3:49- The Operator told Nurse #7 that paramedics were on their way. She also asked if Nurse #7 was right by "him", and she stated yes.
3:50-4:02- The Operator told Nurse #7 to lay him flat on his back with nothing under his head. Nurse #7 responded that she needed to unhook his feeding tube because she couldn't lay him flat with it connected.
4:03-4:24- only background noises heard until Nurse #7 stated at the 4:24 mark that the resident was flat on his back.
4:25-4:30- Nurse #7 is heard saying, "I told this man to bring me some oxygen".
4:31-5:11- The Operator was heard telling Nurse #7 to listen carefully and she was going to tell her how to do chest compressions. Nurse #7 is heard saying "so, we are about to run a code". The Operator asked if the resident was on the floor and Nurse #7 stated, no. The Operator then stated that the resident needed to be on the floor. Nurse #7 stated that there was no way to do that, and the resident was lying on the bed.

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F 726	Continued From page 87 5:15- Nurse #7 told someone in the room that she was about to have to start a code. 5:26- Nurse #7 was heard telling someone in the room to get her *inaudible* 5:27-5:33- background noises only 5:34- Nurse #7 was heard telling someone in the room that the 911 Operator wanted resident to be on the floor. 5:35-5:42- Nurse #7 was heard telling someone in the room "yes, but it is very faint". 5:43-6:06- background noises only 6:07- Nurse #7 was heard telling the operator that they are about to get a board. 6:10-6:48- The Operator was heard telling Nurse #7 to stand close to the resident, making sure there is nothing under their head, and to use the sheet to pull him toward her and off the bed. Nurse #7 is heard telling someone again the resident was a full code. 6:49-7:27- Nurse #7 is heard asking Nurse #10 to help her get the resident onto the floor. Nurse #10's response was inaudible. Nurse #7 is heard telling the operator that she, "asked that man to help me". Nurse #7 is heard grunting and stated at the 7:27 mark that the resident was on the floor. 7:28-8:02- The Operator was heard explaining to Nurse #7 where she needed to put her hands to do chest compressions. She told her that she wanted her press down at least 2 inches into his chest and that they needed to be hard and fast. She then told her to count out loud so they could do them together. 8:03-8:21- The Operator was heard counting chest compressions. Nurse #7 was not heard saying anything. The Operator again stated that Nurse #7 needed to count out loud with her. 8:22- Someone in the background is heard yelling "full code."	F 726		

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8:22-8:41- Inaudible voices are heard in the background. Nurse #7 was heard yelling at the 8:31 mark, "I'm actively calling them." The 911 Operator is heard trying to get Nurse #7's attention and again told her that she needed to count out loud as she was doing the chest compressions.
8:42-8:57- background noises; the Operator stated, "Hello, hello? I need for you to count out loud". Nurse #7 is not heard responding to the Operator.
8:58- Nurse #7 stated to the Operator that EMS had arrived; The Operator asked if they were with the resident and the Nurse #7 stated that they were there.
9:04-9:09- The Operator asked again if EMS was with the resident and Nurse #7 stated "yes, yes".
9:15 - The call ended abruptly 9 minutes and 15 seconds from the start.

A review of the EMS report dated 2/8/24 stated that they arrived on scene at 7:03 am and found Resident #232 on the floor with nursing home staff performing CPR. The report further stated that during initial airway management, resident was found to have "rigor in jaw and confirmed in bilateral upper extremities. All further resuscitation efforts were discontinued. Staff on scene were unable to determine when patient was last seen conscious and alert. Staff in room states that patient was administered buccal oral glucose approximately one hour prior to EMS arrival but staff could not confirm that patient was breathing or alive at that point." The report further stated that resident was pronounced expired at 7:07 pm.

During an interview with Nurse #7 (agency nurse) on 4/1/24 at 1:41 pm, she stated that she was

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assigned to the 100 hall (nursing station #1) and part of the 300 hall on 2/8/24. Nurse #7 said she worked both 2nd (3:00 pm-11:00 pm) and 3rd (11:00 pm-7:00 pm) shifts that day. She stated that she began her last medication pass at 5:43 am and as she approached Resident #232's room around 6:30 am, she noticed that he was not responding to her when she tried to wake him up. Nurse #7 stated she checked his blood glucose level, and it was 28. She stated that stepped out of the room and asked a nurse, whose name she could not remember, to bring her a glucagon injection. Nurse #7 stated that a nurse returned to the room with glucose gel, and she told the nurse, no, that she needed the glucagon injection; not the glucose gel Nurse #7 explained she administered the glucagon gel to Resident #232 and the resident had lockjaw and she had a hard time opening his mouth enough to rub the gel on the inside of his cheek. The other nurse returned to the room with the glucagon injection and Nurse #7 stated that she administered the injection to Resident #232. She stated that she and other staff members got Resident #232 onto the floor as directed by 911 and began performing chest compressions. She stated she continued cardiopulmonary resuscitation efforts until EMS arrived. Nurse #7 stated that she stayed with Resident #232 the entire time.

A second interview was conducted with Nurse #7 on 4/2/24 at 10:23 am during which she stated a nurse aide brought her the glucose gel, not a nurse, as she had previously stated. She also stated that she did leave the resident alone to go to nursing station #2 and retrieve a glucagon injection since she did not know where to find it at her assigned station. Nurse #10 (charge nurse)

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was at nursing station #2 and gave her the glucagon injection. Nurse #7 did not recall if she asked Nurse #10 to call a code or not because she was dialing 911 from her cell phone while she was running back to the resident's room to give the injection. She said she was pretty sure she told the charge nurse who the shot was for and why. Nurse #7 stated that she did not remember checking to see if Resident #232's had a pulse at first because he was still breathing when she returned to the room and did not take time to do any vital signs because she was more concerned about getting his sugar up. The interview further revealed after Nurse #7 got Resident #232 on the floor, she felt for his pulse and could not feel one and she couldn't see him breathing at that point and she began chest compressions.

A third interview was conducted with Nurse #7 on 4/2/24 at 10:23 am, during which she stated she doesn't know why the 911 operator had to talk her through how to check for breathing, how to check for a pulse, and how to do chest compressions other than to say it was all happening so fast. She stated that she was CPR trained and had been in several codes before, but she had only assisted, and all those patients survived. She stated she was unaware where glucagon injections were kept which is why she had to ask Nurse #10 to get it for her. Nurse #7 stated that she had been a nurse for 4 years and that she had to complete onboarding competencies with her agency, but she doesn't remember what all those were. She stated when she first arrived at the facility, she was oriented to the building only including the storage rooms, building layout, nursing stations, and did not receive any further orientation or individual competency training at the facility. She stated she did not receive training

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on where to locate emergency drugs, so she was unsure where to locate the glucagon injection.

During an interview with Nurse #10 (charge nurse) on 4/2/24 at 8:35 am, he stated that he saw Nurse #7 around 6:00 am at nursing station #1 when she began her last round. He stated she was on her cell phone when she came up to nursing station #2 asking for the glucagon injection which he gave her. He stated he was unsure of the time, but he remembered some first shift (7:00 AM to 3:00 PM) workers had arrived. Nurse #10 stated Nurse #7 didn't ask him to call a code or tell him who the shot was for or that Resident #232's blood sugar level was 28. Nurse #10 explained he came down the hall after a minute or two (he was unsure of how much time passed) and entered the room Nurse #7 was in to see what was going on. He stated he saw Nurse #7 on her cell phone telling someone that the resident was breathing but that he wasn't responding. Nurse #10 indicated he did not assess Resident #232 himself other than to do a sternal rub to see if he would wake up and the resident did not. That was when Nurse #7 told him she was on the phone with 911. He stated she said the resident was breathing and that she wanted to get him on the floor. Nurse #10 stated he told her Resident #232 was a large man and they would need another staff member to help get him on the floor. Nurse #10 explained he told Nurse #7 to put Resident #232 on some oxygen because he had found that oxygen helped a lot when he had a resident with low blood sugar. He stated he didn't recall her ever telling him what Resident #232's blood sugar level was. Nurse #10 stated he left the room to get a nonrebreather mask (non-rebreather masks are used for individuals who are still able to breathe on their

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SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

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own but require additional oxygen) with oxygen, to call a code over the loudspeaker and to grab someone else to help put the resident on the floor. Nurse #10 stated that they have a back board, but 911 always tells them to put the resident on the floor. When he returned to the room, Nurse #7 had the resident on the floor and was still on the phone with 911. Nurse #10 indicated he was told by Nurse #7 resident was still breathing when he left the room, so he applied the nonrebreather mask with oxygen, and added that it felt like the resident had "lockjaw" because it was hard to open his mouth very far. Nurse #10 did not recall if Resident #232 felt limp or stiff anywhere else and he did not assess the resident himself to see if he was still breathing before he applied the nonrebreather mask with oxygen. He stated Nurse #7 began doing chest compressions and he did not see Nurse #7 assess resident's pulse prior to beginning compressions. Then Nurse #8 came in to assist with chest compressions and EMS arrived almost immediately after that.

During an interview with the interim Director of Nursing on 4/2/24 at 12:10 pm she stated that a resident found with a blood sugar of 28 was considered a critical level and was an emergency situation. She stated she would have expected the nurse to yell or scream for assistance-anything to get the attention of other staff to let them know she had an emergency and would have expected Nurse #7 to have done the same. She stated that Nurse #7 should have advised the charge nurse (Nurse #10) the gravity of the situation so he could have called a code immediately. She also stated she would have expected Nurse #7 to check vital signs immediately, even if she felt like the resident was

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still breathing. The DON indicated a blood sugar that low required a glucagon injection immediately. She stated that the facility provided orientation to the building for all agency staff, but they do not do an individual competency check list like they do for their direct hire employees. She stated they rely on agencies to provide them with competent staff whom they have already done initial competency testing on such as initial assessments, emergency preparedness, abuse/neglect training.

During an interview with the Administrator and Nurse Consultant on 4/2/24 at 5:25 pm, they stated that the facility does not keep employee files or do individual competencies for agency staff. The Administrator stated that the facility confirms that the nurse has an active nursing license and a current CPR card only. The Administrator provided the surveyor a copy of Nurse #7's current CPR card during the interview. She stated they rely on agencies to complete individual competencies on their employees prior to assigning them to their buildings. The Administrator stated that Nurse #7 had worked there several times but has not worked in the building since 2/8/24.

The Administrator was notified of immediate jeopardy on 4/2/24 at 6:27 PM.

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 a result of the noncompliance.
Resident #232 suffered due to this deficient practice. The Nursing facility failed to confirm

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that Nurse #7 and Nurse #10 were competent in their nursing assessment skills, to properly respond efficiently to a medical emergent event. This was evidenced by Nurse #7 and Nurse #10; both failed to immediately assess and implement an effective emergency rapid response for a resident's acute change in condition. When resident #232 became unresponsive and had a blood glucose level of 28, Nurse #7 failed to effectively initiate a Code Blue within the facility and failed to report critical medical information regarding Resident #232 to the 911 operator.

All facility insulin dependent diabetic residents have the potential to be affected by this deficient practice if the nurse has not demonstrated or completed nursing competencies related to medical emergency management and signs and symptoms of emergent hypoglycemia upon hire, annually, and as needed. 100% audit completed by DON/ Designee on 4/4/24 to ensure all licensed nurses employed at the facility have current Nursing competencies in place for managing medical emergencies, to include management of emergent hypoglycemia in a medical emergency. This audit was completed on 4/4/24 by the Regional Clinical Director/Designee. No adverse outcomes were identified in this audit. All new licensed nurses and agency/contract nursing after 4/4/24, will have confirmation of competencies completed prior to working their scheduled shift at the facility. Nurse managers/ designee will be responsible for ensuring competencies are completed prior to working a scheduled shift, or if, competencies were not completed yet. This will be ongoing starting 4/4/2024. Nurse managers were notified by the Regional Clinical Director on 4/3/24 with this directive to achieve substantial compliance for licensed nursing competencies.

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Root cause analysis which was completed on 4/2/24 by the Regional Clinical Director/Designee reveals that the nurse #7 did not recognize the hypoglycemic event as a medical emergency in a timely manner. On 4/2/24, the Administrator called to interview the nursing agency that Nurse #7 was employed with. This was to inquire if the Agency was able to verify that Nurse #7 had nursing competencies completed upon her hire. The Agency stated to the Administrator on 4/2/24, that Nurse #7 had no nursing competencies completed in her file. The Nursing Home did not verify that the competency was completed prior to Nurse #7 working her scheduled shift.
Conclusion is that Nurse #7 did not have documented competencies completed by her hiring Nursing Agency employment, and the Nursing home failed to ensure competency prior to Nurse #7 working her shift.
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.
All licensed nurses, nursing assistants, agency/contract staff, and all newly hired licensed nurses will be educated on the process of responding to a medical emergency on how to manage Hypoglycemic events that are considered a medical emergency by nurse managers/ designee starting 4/3/24 and daily before start of initial shift. Going forward all new licensed nurses will have competencies completed upon hire and before the start of their shift. HR and DON/Designee were notified on 4/2/24 of this requirement that their competencies need to be completed prior to them taking a medication cart by the Administrator. Education on managing emergent Hypoglycemic events, as well as activating EMS immediately, will be

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completed by nurse managers/designee starting 4/3/2024. This will be done daily prior to first shift for all licensed nurses, nursing assistants, agency/ contract staff and all newly hired licensed nurses. This education will include the policy and procedures for emergency medical management. This policy and procedure guides licensed nursing staff to gather accurate medical information/assessments, in order for it to be reported to 911 accurately during the emergency call. 100% verification of Agency/contract staff Competency will be completed by DON/Designee prior to start of their initial shift. DON/Designee will be notified by the scheduler/ HR/ designee daily prior to any new agency/ contract staff working starting 04/04/2024. The education will be in person, 1:1 or in group setting. 100% education will be completed DON/ADON designee by 4/04/2024. The administrator/designee will be the person who will ensure all licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated.

Immediate jeopardy will be removed by 4/05/24. The credible allegation for removal of immediate jeopardy was validated onsite on 4/5/24. Audit tool dated 4/4/24 was reviewed. The tool identified residents who were insulin dependent, were receiving insulin per physician orders, if signs and symptoms of hypoglycemia were monitored by the nurses and emergency medical management policies and procedures were followed, any signs and symptoms of emergent hypoglycemia and if the nurse was negligent by not following physician orders or assess the resident to recognize a medical emergency. The review revealed no concerns. The review

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F 726	Continued From page 97 revealed no concerns. In-service education records which included sign-in sheets and interviews with nurses and certified nurse assistants confirmed education was provided on: Medical emergency management, Standard nursing practices, diabetic management, Management of hypoglycemia, Emergency Procedure - CPR (cardiopulmonary resuscitation), Adult CPR and AED, Acute condition changes - clinical protocol, pertinent information to be provided to 911 upon making an emergency call. The following nurse competency checklists completed by nurses were reviewed: 1) Diabetes skills checklist - glucose monitoring; 2) Change of conditions competency checklist, 3) Adult CPR and AED skill Testing checklist. Review revealed no concerns. The immediate jeopardy removal date of 4/5/25 was validated.	F 726		
F 761 SS=E	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 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	F 761		4/30/24

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F 761	Continued From page 98 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 observations and staff interviews, the facility failed to remove expired multi-dose pen injectors of insulin and expired tablets from the medication cart drawer for 2 of 7 medication administration carts (100 and 300 halls), failed to remove the expired medications, enteral feeding formula supplements and supply kit from the medication storage rooms (medication storge rooms #1 and #2). Findings included: 1.a. On 2/5/24 at 1:10 PM, an observation of the medication administration 300 hall cart with Nurse #17 revealed one opened insulin Lispro Kwik pen dated as opened on 1/4/24 and one Novolin Flex Pen (insulin) dated as opened on 1/4/24. The manufacturer's instructions were discard after 28 days, which would be on 2/1/24. On 2/5/24 at 1:15 PM, during an interview, Nurse #17 indicated that the nurses who worked on the medication carts, were responsible for discarding expired medications. She mentioned that per training, every nurse should check the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin pen injectors in her medication	F 761	F761 Corrective action for the residents found to be affected by the deficient practice. All residents had the potential to be affected. On 2/12/24 all 7 medication carts,2 treatment carts and 3 Medication rooms were checked/audited by the Director of Nursing and Nurse Managers. Any expired medications were removed and returned to the pharmacy per policy. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. On 2/12/24 all 7 medication carts, 2 treatment carts and 3 medication rooms were checked/audited by the Director of Nursing and Nurse Managers. Any expired medications were removed and returned to the pharmacy per policy. Systemic Changes made to ensure that the deficient practice will not recur. On 2/12/24 the Director of Nursing and the Nurse Managers educated the Licensed Nurses/agency nurse on Labeling/expired and pharmacy policy. All licensed nurses/ agency nurses were	

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F 761	Continued From page 99 administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift. 1.b. On 2/5/24 at 1:25 PM, an observation of the medication administration cart on the 100-300 (split) hall with Nurse #18 revealed one opened insulin Lispro Kwik pen dated as opened on 12/27/23. The manufacturer's instructions were discard after 28 days, which would be on 1/24/24 and one opened box of Famotidine, 10 milligram (mg), containing 66 tablets that expired in January 2024. On 2/5/24 at 1:30 PM, during an interview, Nurse #18 indicated that the nurses who worked on the medication carts were responsible for discarding expired medications. She mentioned that per training, every nurse should check the expiration date on medications. The nurse stated that she had not checked the expiration date on medications in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift. 2.a. On 2/5/24 at 2:40 PM, observation of the medication storage room #1 on 100/300 halls with Nurse #6 revealed there were two sealed multi-dose containers of Omeprazole Oral Suspension, 2 mg (milligram) in mL (milliliter), 100 ml, expired on 1/24/24 in the refrigerator. Additionally, there were two plastic bags of 0.9% (percent) Sodium Chloride, 1000 ml, expired on 1/14/24 and six sealed plastic containers of Perative 1.3 Cal (enteral feeding formula supplement), 1000 ml, expired on 2/1/24 in the	F 761	educated by 2/12/24. The licensed nurses/agency nurses will review their assigned medications rooms and medication carts for expired medications for 5 days a week for 4 weeks and then weekly for 4 weeks then monthly thereafter. The licensed nurse/ agency nurses review will be given to the Director of Nursing to validate the removal of all expired medications. The Consultant Pharmacist will review the medication carts and medication rooms for any expired medications. This audit will occur monthly. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Nursing and/or Nurse Managers will validate the License Nurse/agency nurses review of the Medication rooms and the Medication carts daily for 5 days a week for 4 weeks and then weekly for 4 weeks then monthly thereafter. The Consultant Pharmacist will review the medication rooms and medication carts for expired medications monthly. The Director of Nursing will present an analysis of their review to the Quality Assurance Performance Improvement committee monthly until 3 consecutive months of compliance is sustained then quarterly. Date of compliance: 4/30/24	

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F 761	Continued From page 100 cabinet. 2.b. On 2/5/24 at 2:55 PM, observation of the medication storage room #2 on 200/400/500 halls with Nurse #19 revealed there was one sealed multi-dose container of Omeprazole Oral Suspension, 2 mg in mL, 100 ml, expired on 11/30/23 in the refrigerator. There was one plastic bag of 0.9% Sodium Chloride, 1000 ml, expired on 1/19/24, one plastic bag of 0.45% Sodium Chloride, 1000 ml, expired in November 2023, one plastic bag of 0.9% Sodium Chloride, 250 ml, expired in August 2023 and one plastic pack of a Urine Sampling Kit, expired on 9/30/23 in the cabinet. On 2/5/24 at 3:25 PM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible to check all the medications in medication administration carts and medication storage rooms for expiration date and remove expired medications and supplies every shift. She expected that no expired items be left in the medication carts or medication storage rooms. On 2/6/24 at 10:30 AM, during an interview, the Administrator indicated she started to work in the facility on 2/5/24. Her expectation was that no expired items be left in the medication carts or medication storage rooms.	F 761		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at	F 809		4/30/24

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F 809	Continued From page 101 regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff, Regional Director of Dietary Operations, and Registered Dietitian (RD) interviews, and record review, the facility failed to have no greater than a 14-hour lapse between the provision of a substantial evening meal and breakfast the following day for residents served their meals on 4 of 8 meal carts (400 Hall Cart-1; 400 Hall Cart-2; 400 Hall Cart-3 and 500 Hall Cart) utilized for meal service. The findings included: A schedule of the Meal Delivery Times (Revised 8/12/21) was provided by the facility on 2/5/24. A review of this schedule indicated the meal cart delivery times allowed as much as 15 hours and 30 minutes to lapse between the last meal of the day and first meal of the following day. An interview was conducted on 2/7/24 at 3:32 PM	F 809	F809 Corrective action for the residents found to be affected by the deficient practice. On February 6, 2024, the schedule for Meals was changed to meet the minimum standard to be no greater than 14 hours between dinner and breakfast. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. On February 12, 2024, the Dietary Regional manager in-serviced all dietary staff that it is their responsibility to monitor the schedule of meals to ensure compliance. This in-service will be part of the orientation process for all newly hired dietary employees.	

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F 809	Continued From page 102 with the facility's Registered Dietitian (RD). During the interview, the RD was shown the facility's meal delivery schedule provided and asked what her thoughts were with regards to the time lapse between the evening meal and breakfast the following day. The RD stated, "That's not okay." The RD acknowledged that in addition to Resident Council approval, the facility would also need to offer a nourishing snack to everyone if greater than 14-hours elapsed between Dinner and Breakfast the next day. She reported that to her knowledge, the facility did not meet these requirements. The RD questioned whether the meal delivery schedule provided for review was the facility's current schedule. She telephoned the Regional Director of Dietary Operations and requested a current meal delivery schedule be provided. On 2/7/24 at 3:50 PM, the Regional Director of Dietary Operations provided a copy of the facility's current meal schedule and joined the interview conducted with the RD. The facility's current meal delivery schedule was different from the original schedule provided. A review of the facility's current Meal Schedule (not dated) indicated the meal cart delivery times were scheduled as follows: --The 400 Hall Cart-1 was scheduled to be delivered at 5:30 PM for Dinner and at 8:15 AM for Breakfast (indicative of a 14-hour and 45 minute time span between the two meals). --The 400 Hall Cart-2 was scheduled to be delivered at 5:40 PM for Dinner and at 8:25 AM for Breakfast (indicative of a 14-hour and 45 minute time span between the two meals). --The 400 Hall Cart-3 was scheduled to be delivered at 5:50 PM for Dinner and at 8:35 AM for Breakfast (indicative of a 14-hour and 45	F 809	Systemic Changes made to ensure that the deficient practice will not recur. On February 12, 2024, the Dietary Regional manager educated all dietary staff that it is their responsibility to monitor the schedule of meals to ensure compliance. This in-service will be part of the orientation process for all newly hired dietary employees. The Dietary Manager will monitor this schedule 5x a week for 4 weeks and then weekly for 4 weeks then monthly thereafter. The Dietary Manager will give these audits to the Administrator. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator will review all the daily audits 5x a week completed by the Dietary manager for 4 weeks and then weekly for 4 weeks and then monthly thereafter until 6 consecutive months of compliance is maintained. The Administrator will report any findings of non-compliance to the Quality Assurance and Performance Improvement Committee monthly for 3 months and then quarterly to ensure compliance is maintained. Date of compliance: 4/30/24	

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minute time span between the two meals).
--The meal cart for the 500 Hall was scheduled to be delivered at 6:00 PM for Dinner and at 8:05 AM for Breakfast (indicative of a 14-hour and 5 minute time span between the two meals).
--The 200 Hall Cart-1 was scheduled to be delivered at 6:10 PM for Dinner and at 7:50 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals).
--The 200 Hall Cart-2 was scheduled to be delivered at 6:15 PM for Dinner and at 7:55 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals).
--The meal cart for the 100 Hall was scheduled to be delivered at 6:25 PM for Dinner and at 7:30 AM for Breakfast (indicative of a 13-hour and 5 minute time span between the two meals).
--The meal cart for the 300 Hall was scheduled to be delivered at 6:30 PM for Dinner and at 7:40 AM for Breakfast (indicative of a 13-hour and 10 minute time span between the two meals).

A follow-up interview was conducted on 2/8/24 at 4:25 PM with the Regional Director of Dietary Operations. At that time, a review of the facility's current meal delivery schedule was discussed. Concerns regarding the time lapse of greater than 14-hours between Dinner and Breakfast the next day for 4 of the 8 meal carts was shared with the Director. Upon review, the Director stated he was not sure why the 400 Hall carts were served first for the Dinner meal when the same 400 Hall carts were served last for Breakfast the following day. The Regional Director of Dietary Operations reported the order of the meal carts being sent to the halls would need to be changed to ensure no more than 14 hours elapsed between the two meals.

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SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

(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 812	Continued From page 104	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff and the Regional Director of Dietary Operations interviews, and record reviews, the facility failed to: 1) Label, date, and discard expired food items stored in the refrigerator in 1 of 2 Nourishment Rooms (300 Hall Nourishment Room) observed; and 2) Maintain thermal pellets in good condition and without chipped edges for 6 of 60 pellets observed to be available for use as the meal service tray line was conducted. The findings included: 1. Accompanied by the facility's Dietary Manager, an observation was made of the 300 Hall	F 812	F812 Corrective action for the residents found to be affected by the deficient practice. On February 5, 2024, the following items were discarded by the Dietary Regional Manager from the nourishment room refrigerator a sandwich, fried chicken and a brown bag containing an unidentifiable food item. On February 5, 2024, six pellets were identified as being broken and thrown away. Corrective action for other residents having the potential to be affected by the same deficient practice.	4/30/24

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F 812	Continued From page 105 Nourishment Room on 2/5/24 at 9:32 AM. Observations made of the 300 Hall Nourishment Room identified the following items were stored in the refrigerator: --Two separate plastic containers, each containing one meat sandwich, were observed to be labeled with a resident's name and room number. Both containers were dated 1/19/24 (17 days prior to the observation). --One plastic take-out container labeled with a resident's name and room number was observed to contain 4 pieces of chicken. The container was labeled with a date of 1/29/24 (7 days prior to the observation). --One unlabeled brown paper bag was stored in the refrigerator. A food item was observed to be inside the brown paper bag and wrapped in white paper (also not labeled). Upon unwrapping the food item, the Dietary Manager identified this food item as a bacon, lettuce, and tomato (BLT) panini sandwich (a sandwich typically made with Italian bread). Upon inquiry, the Dietary Manager confirmed the sandwich was very hard to the touch and needed to be discarded. At the time of the 300 Hall Nourishment Room observation, the Dietary Manager was observed as she removed the expired items from the refrigerator. The Dietary Manager reported she needed to find out what she should do with the expired and unlabeled food items. When asked who was responsible for making sure all items in the refrigerator were within date and/or discarded if they were expired, the Dietary Manager stated she was not sure. An interview was conducted on 2/6/24 at 11:25 AM with the facility's Regional Director of Dietary Operations. During the interview, the Director	F 812	All residents have the potential to be affected by the same deficient practice. On February 5, 2024, the Dietary Regional manager in-serviced all dietary staff that it is their responsibility to monitor the nourishment rooms and chipped pellets to be discarded to ensure compliance. The in-service will be part of the orientation process for all newly hired dietary employees. Systemic Changes made to ensure that the deficient practice will not recur. On February 12, 2024, the Dietary Regional manager educated all dietary staff that it is their responsibility to monitor the nourishment rooms and chipped pellets to ensure compliance. This in-service will be part of the orientation process for all newly hired dietary employees. The Dietary Manager will monitor these areas daily 5x a week for 4 weeks and then weekly for 4 weeks then monthly thereafter. The Dietary Manager will give these audits to the Administrator. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator will review all the daily audits completed by the Dietary manager for 5x times a week for 4 weeks and then weekly for 4 weeks and then monthly thereafter until 6 consecutive months of compliance is maintained. The Administrator will report any findings of non-compliance to the Quality Assurance and Performance Improvement Committee monthly for 3 months and then quarterly to ensure compliance is maintained.	

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F 812	Continued From page 106	F 812	Date of compliance: 4/30/24	

was asked who was responsible to be sure the food brought in from the outside for a resident and stored in the nourishment refrigerator was labeled, kept within date, and discarded when it expired. He stated it was "our" (the Dietary Department's) responsibility. When asked how long perishable food brought from the outside could be kept before becoming expired, the Director reported that if a receipt was provided to show when the item was purchased, the facility could hold it in the refrigerator for 7 days. If the food item included a "use by date," the facility would use that date to determine whether the food was expired. He reported the Dietary staff monitored the Nourishment Room refrigerator temperatures daily to ensure they maintained an acceptable temperature of less than or equal to 40o Fahrenheit (F) and were responsible to ensure no unlabeled or expired food was kept.

Upon request, the Director provided a copy of the facility' entitled, "Food From Approved Source" (Original date 5/2014, Revised 9/2017, 10/2022). The Policy Statement read, "All food will be procured from sources approved or considered satisfactory by federal, state and local authorities." The Procedures read, in part: "4 [of 4]: Food may be brought into the facility by family, visitors, or other outside sources. The facility staff will assist with proper food storage and handling, as appropriate."

2. An observation was conducted of the facility's tray line on 2/7/24 at 11:42 AM as the lunch meal service began. This observation revealed the facility utilized a thermal pellet system to help maintain the temperatures of hot food. A thermal pellet (made of a high density plastic material) was placed on top of an insulated base. Each

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F 812	Continued From page 107	F 812		

individual plate of hot food was set on top of the thermal pellet before being covered and placed on an individual's meal tray and a cart for delivery to the resident's hall. During the observation, 6 thermal pellets (each with a large chip measuring approximately 2-3 inches long and 3/4 inches deep on the pellet's edge) were observed to have been placed among the pellets stacked near the tray line and ready for use. The chipped edges of the thermal pellets were observed to be jagged and sharp to the touch; the edge of the thermal pellet was partially exposed and could be touched when the pellet was placed between the insulated base and dinner plate, posing a potential risk of harm to a resident. All six (6) of the chipped thermal pellets observed were rejected and pulled off the tray line when either the facility's cook noticed the chip and/or when the cook was alerted to having used the chipped pellet after the food was plated. On 2/7/24 at 11:53 AM, the cook was asked if there were "a lot" of chipped pellets. She nodded to indicate 'yes.'

An interview was conducted on 2/7/24 at 12:12 PM with the Regional Director of Dietary Operations. At that time, the Director was asked to observe two remaining chipped pellets visible within the stack of thermal pellets ready for use on the tray line. When concern was expressed related to the outside edge of the pellet being exposed to touch and posing a potential hazard for residents, the Director stated these pellets would be pulled from use. During a follow-up interview conducted on 2/7/24 at 3:32 PM with the Regional Director of Dietary Operations, it was estimated there were 6 chipped pellets identified out of approximately 60 pellets used during the lunch tray line observation. He reported all chipped thermal pellets had been discarded.

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F 867 SS=E	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 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.	F 867		4/30/24

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F 867	Continued From page 109 §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 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	F 867		

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F 867	Continued From page 110 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 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 observations, record review, resident, and staff interviews, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification and complaint	F 867	F867 QAPI Corrective action for the residents found to be affected by the deficient practice. 1. Resident # 2 no longer resides in the	

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F 867	Continued From page 111 surveys dated 1/10/23, and 8/26/21 and for complaint investigation dated 8/18/23, 12/22/21, and 8/2/21 to achieve and sustain compliance. These were for recited deficiencies on the recent recertification and complaint investigation survey dated 2/9/24. The deficiencies were in the following areas: reporting of alleged violations, discharge planning process, treatment/services to prevent /heal pressure ulcers, label/ store drugs and biologicals, food procurement, store/prepare/serve - sanitary and resident records - identifiable information. The continued failure during federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: 1. F609-Based on record review and staff interviews, the facility failed to submit an Initial Allegation Report to the State Agency, Adult Protective Services (APS), and the police within the required timeframe for 1 of 1 resident (Resident #232) reviewed for neglect. The facility was officially notified of neglect on 4/2/24 at 6:27 pm when an immediate jeopardy template was issued. The facility did not submit an initial report to the State Agency within the required timeframe following notification. During a complaint investigation dated 12/22/21, the facility failed to report diversion of facility drugs to the State agency for the initial 24-hour report and the 5-day investigation report and failed to report to the local police department for a diversion of facility drugs by an employee.	F 867	facility. 2. Resident # 5 no longer resides in the facility. 3. Resident #181 no longer resides in the facility. 4. Resident #181 no longer resides in the facility. 5. All residents had the potential to be affected. On 2/12/24 all 7 medication carts,2 treatment carts and 3 Medication rooms were checked/audited by the Director of Nursing and Nurse Managers. Any expired medications were removed and returned to the pharmacy per policy. 6. On February 5, 2024, the following items were discarded by the Dietary Regional Manager from the nourishment room refrigerator a sandwich, fried chicken and a brown bag containing an unidentifiable food item. On February 5, 2024, six pellets were identified as being broken and thrown away. 7. Resident # 280 no longer resides in the facility. 8. Resident #232 no longer resides in the facility. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. The Administrator and the Director of Nursing educated the members of QAPI committee on the Quality Assurance and Performance Improvement policy/process emphasis on identifying areas that may lead to deficiency practice. Education was	

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F 867	Continued From page 112 2. F660 - Based on record review, family, home health agency, physician, staff interviews, the facility failed to implement an effective discharge planning process that included ensuring the resident's caregiver and the home health agency were informed of the resident's medication orders, wounds, and the treatment that was required for the wounds. This was for 1 of 3 residents reviewed for discharge (Resident #181). During a complaint investigation survey dated 8/18/23, the facility failed to implement an effective discharge plan that included ensuring a resident who required home health services was referred and accepted for services and that DME was ordered with arrangements coordinated for receipt of DME for 1 of 1 resident reviewed for discharge planning. 3. F 686 - Based on staff interviews, family interview, physician interview and record review, the facility failed to assess and document the pressure wound(s) identified on the buttock for 1 of 3 (Resident #181) residents reviewed for pressure ulcers. During a complaint investigation survey dated 8/2/21, for one of three sampled residents with pressure sores, the facility failed to thoroughly assess and initiate clear treatment orders when a resident was identified to have a pressure sore so that all nurses could follow through with an approved plan of care for the pressure sore. 4. F 761 - Based on observations and staff interviews, the facility failed to remove an expired multi-dose pen injectors of insulin and expired tablets from the medication cart drawer for 2 of 7 medication administration carts (100 and 300	F 867	completed on 2/29/24 and 4/19/24. The Administrator will lead Quality Assurance and Performance Improvement meeting with emphasis and focus on ensuring that any areas on non-compliance are addressed to prevent further deficient practices related to the following tags, Tag 580, Tag 609, Tag F660, Tag F686, Tag F761, Tag F812, and Tag F842. At least one member of the regional team that includes senior nurse consultant, or area vice president will attend QAPI meetings for 3 quarters. Systemic Changes made to ensure that the deficient practice will not recur. The Quality Assurance and Performance Improvement committee will continually monitor implemented procedures and monitor the plan of correction (POC) put in place for Tag 580, Tag 609, Tag F660, Tag F686, Tag F761, Tag F812, and Tag F842 monthly until 3 consecutive months of compliance is maintained then quarterly thereafter. The Quality Assurance and Performance Improvement committee will meet monthly to review the tracking and trending analysis of areas that led to repeat tag/deficiencies. The facility will develop a retrospective plan to examine facility standards and ensure no repeat citations. Plans to monitor its performance to make sure that the solutions are sustained. The administrator will lead the Quality Assurance and Performance Improvement meetings monthly with emphasis and focus on areas that have	

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F 867	Continued From page 113 halls), failed to remove the expired medications, enteral feeding formula supplements and supply kit from the medication storage rooms (medication storge rooms #1 and #2). During a previous recertification and complaint investigation survey dated 1/10/23, the facility failed to: 1) Discard expired medications, loose capsules from an opened stock bottle of medication and one unidentified tablet lying on the bottom of a medication (med) cart drawer; and 2) Store medications in accordance with the manufacturer's storage instructions. This was occurred observed for 2 of 3 medication carts observed (Station 2 A/B Med Cart and Station 1 Med Cart). During the recertification and complaint investigation survey dated 8/26/21, the facility failed to date opened medications in 2 of 6 medication administration carts (400 and 500 halls.) and failed to remove expired medications stored in 1 of 6 medication administration carts (500 hall.) 5. F812 - Based on observations, staff and the Regional Director of Dietary Operations interviews, and record reviews, the facility failed to: 1) Label, date, and discard expired food items stored in the refrigerator in 1 of 2 Nourishment Rooms (300 Hall Nourishment Room) observed; and 2) Maintain thermal pellets in good condition and without chipped edges for 6 of 60 pellets observed to be available for use as the meal service tray line was conducted. During a previous recertification and complaint investigation survey dated 1/10/23, the facility failed to keep food preparation areas, food	F 867	led to repeat deficiencies Tag 580, Tag 609, Tag F660, Tag F686, Tag F761, Tag F812, and Tag F842. This will ensure the facility is identifying areas on non-compliance and addressing them as needed to prevent further deficient practice. A member of the regional team that includes the senior nurse consultant or area vice president will attend QAPI meetings for the next 3 months and then quarterly to ensure the QAPI process is effective. The administrator will report to the Quality Assurance and Performance Improvement Committee any areas of non-compliance monthly for 3 months and then quarterly and/or needed for 3 quarters for further recommendations until compliance is sustained. Date of compliance: 4/30/24	

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F 867	Continued From page 114	F 867		

storage areas and food service equipment clean, free from debris, grease buildup, and/or dried spills from the dry ingredient bins during two kitchen observations. The facility failed to clean the floor and ceiling vents located over the food prep and food service area. This practice had the potential to affect food served to all residents.

6. F842 - Based on record review, staff and physician interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for pain medication administration for 1 of 1 resident (Resident #280) reviewed for pain management.

During a complaint investigation survey dated 8/2/21, the facility failed to assure the medical records were complete related to dressing changes for two of three sampled residents with dressing changes.

During an interview on 2/9/24 at 2:28 PM, the Administrator stated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. The Administrator stated if applicable the team would use the fish bone analysis (5 whys) to identify cause and performance improvement plan would be developed. Audit tools and monitoring system would be used. System changes and additional tasks would be put in place as needed to resolve the issue. Regarding the repeated deficiencies the Administrator stated she was recently hired on 2/5/24. The Administrator indicated that the old plan of correction would be revisited and analyzed to see where the failures and breakdowns happened. This would help analyze

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SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

(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 115 the cause of repeat deficiency. The Administrator indicated once the plan was put in place, audits and the monitoring phase would be completed. The repeated concerns would also be discussed in QA meeting and the QA committee would see how the approach can be changed if needed.	F 867		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345408	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/5/2024

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SOUTHPOINT REHABILITATION AND HEALTHCARE CEN	**6000 FAYETTEVILLE ROAD DURHAM, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 655	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to develop a baseline care plan within 48 hours of the resident's admission for 2 of 20 newly admitted residents reviewed (Resident #100 and Resident #381). The findings included: 1. Resident #100 was admitted to the facility on 7/14/23. Her cumulative diagnoses included cancer, asthma, cachexia (a wasting syndrome that leads to loss of skeletal muscle and fat), and dysphagia (difficulty swallowing).

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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F 655	Continued From Page 1

A review of Resident #100's electronic medical record (EMR) revealed a baseline care plan was completed by Nurse #16 (Dated 7/24/23) and reviewed/signed by the facility's Director of Nursing (DON) on 7/25/23 (11 days after the resident's admission to the facility).

An interview was conducted on 2/8/24 at 2:50 PM with Nurse #11. During the interview, this hall nurse was asked who was responsible to complete a newly admitted resident's baseline care plan. The nurse reported there was an "admitting nurse" who typically completed the baseline care plan.

An interview was conducted on 2/8/24 at 3:05 PM with the facility's Director of Nursing (DON). During the interview, she identified Nurse #16 as the nurse who assumed responsibility for completing baseline care plans for newly admitted residents. The DON stated that since Nurse #16 was a Licensed Practical Nurse (LPN), each baseline care plan needed to be reviewed and signed off on by a Registered Nurse (RN). She reported that either she (the DON) or another RN would sign off on the baseline care plans.

An interview was conducted on 2/8/24 at 3:30 PM with Nurse #16. During the interview, Nurse #16 reported it was her responsibility to complete the baseline care plans for newly admitted residents. However, the nurse reported that since she was an LPN, an RN needed to review and sign off on each baseline care plan. The nurse reported she would usually text the DON or ask another RN working in the facility to review and sign off on a baseline care plan after it was completed. The nurse reported that to her knowledge, she was the only staff member who completed baseline care plans. Nurse #16 added there was no other coverage for this task to be completed when she took time off, as she did during July of 2023 (when Resident #100's baseline care plan was due). Nurse #16 confirmed the baseline care plan was required to be completed within 48 hours of a resident's admission.

On 2/8/24 at 3:20 PM, the facility's Administrator was informed of the identified concern related to the facility's failure to complete baseline care plans within 48 hours of a resident's admission. The Administrator reported she had been made aware of this concern.

2. Resident #381 was initially admitted to the facility on 11/3/23. His cumulative diagnoses included a seizure disorder and malnutrition.

A review of Resident #381's electronic medical record (EMR) revealed a baseline care plan was completed by Nurse #16 (Dated 11/7/23) and reviewed/signed by a Registered Nurse (RN) on 11/7/23 (4 days after the resident's admission to the facility).

An interview was conducted on 2/8/24 at 2:50 PM with Nurse #11. During the interview, this hall nurse was asked who was responsible to complete a newly admitted resident's baseline care plan. The nurse reported there was an "admitting nurse" who typically completed the baseline care plan.

An interview was conducted on 2/8/24 at 3:05 PM with the facility's Director of Nursing (DON). During the

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F 655

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interview, she identified Nurse #16 as the nurse who assumed responsibility for completing baseline care plans for newly admitted residents. The DON stated that since Nurse #16 was a Licensed Practical Nurse (LPN), each baseline care plan needed to be reviewed and signed off on by a Registered Nurse (RN). She reported that either she (the DON) or another RN would sign off on the baseline care plans.

An interview was conducted on 2/8/24 at 3:30 PM with Nurse #16. During the interview, Nurse #16 reported it was her responsibility to complete the baseline care plans for newly admitted residents. However, the nurse reported that since she was an LPN, an RN needed to review and sign off on each baseline care plan. The nurse reported she would usually text the DON or ask another RN working in the facility to review and sign off on a baseline care plan after it was completed. The nurse reported that to her knowledge, she was the only staff member who completed baseline care plans. Nurse #16 added there was no other coverage for this task to be completed when she took time off. Nurse #16 confirmed the baseline care plan was required to be completed within 48 hours of a resident's admission.

On 2/8/24 at 3:20 PM, the facility's Administrator was informed of the identified concern related to the facility's failure to complete baseline care plans within 48 hours of a resident's admission. The Administrator reported she had been made aware of this concern.

F 842

Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR

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164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and physician interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for pain medication administration for 1 of 1 resident (Resident #280) reviewed for pain management.

Findings included:

Review of the physician orders 6/6/23 revealed, 5 / 325 milligrams (mg) hydrocodone / acetaminophen -1 tablet to be given twice a day by mouth for pain. (Hydrocodone / acetaminophen is a combination opioid medication which is a controlled substance).

Review of the Medication Administration Record (MAR) for June 2023 revealed 5 / 325 mg hydrocodone / acetaminophen 1 tablet to be given twice a day by mouth for pain was marked as administered on 6/10/23 at 9 AM and 9 PM by Nurse #23.

Review of the Control Substance Sheet (a declining inventory of a controlled substance medication dispensed for a resident) revealed the resident received the medication on 6/10/23 at 9 AM and did not receive it at 9 PM. The medication count for controlled substance was correct on the document and there was no discrepancy in the amount of controlled substance remaining when the resident was discharged.

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Review of the Treatment Administration Record (TAR) for June 2023 revealed the pain scale was marked as zero on 6/10/24 at 9 AM and 9 PM.

Review of the vital signs for June 2023 revealed the pain scale was marked as zero on 6/10/24.

During a telephone interview on 2/8/24 at 9:48 AM, Nurse #23 indicated she was an agency nurse and had not been working at the facility for more than 6 months. The nurse was unable to provide any information.

During an interview with the DON on 2/8/24 at 4:30 PM, she indicated the physician had initially ordered 5/325 mg hydrocodone / acetaminophen (controlled substance) as needed (PRN) and later discontinued it and changed it to scheduled. DON stated the Medication administration record (MAR) indicates the physician order "5 / 325 mg hydrocodone / acetaminophen- Give 1 tablet twice a day by mouth for pain" was marked as administered at 9 AM and 9 PM on 6/10/23. However, the Control substance sheet did not indicate a tablet of the medication was pulled from the inventory for administration to Resident #280 on 6/10/23 at 9 PM. The count of the medication on the control substance sheet was accurate all the way through. The DON indicated this only indicated the MAR was inaccurately documented as administered when the medication was not administered. DON further stated review of the TAR for 6/10/23 revealed a zero pain scale for 9 AM and 9 PM. DON stated Nurse #23 assigned to the resident on 6/10/23 and 6/11/23 was an agency nurse who no longer worked for the facility. DON further stated the physician orders should be followed and medication administration record should be accurately documented.

During a telephone interview on 2/9/24 at 9:16 AM, Physician Assistant (PA) #4 stated it was very essential that residents were administered medication as ordered and documented accurately in the record.

During an interview on 2/9/24 at 11:32 AM, the Corporate Nurse consultant stated Physician orders should be followed for all medications and should be documented accurately by all nurses.