STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-TOWN CENTER	6300 ROBERTA ROAD HARRISBURG, NC 28075

(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 06/16/24 through 06/25/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness, Event ID# E9U311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/16/24 through 06/19/24. Event ID #E9U311. The following intake was investigated NC00205579. 1 of 1 allegations resulted in no deficiency. Additional information was obtained from the facility on 6/25/2024 and the exit date was changed to 06/25/2024.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		7/18/24

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

Electronically Signed | 07/19/2024

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F 623	Continued From page 1 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F 623		

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F 623	Continued From page 2 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, Ombudsman, and	F 623	Corrective action for the residents found	

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F 623	Continued From page 3 Social Work interviews, the facility failed to provide a letter of transfer or discharge to residents (Resident #39) for 1 of 3 residents reviewed for transfer and discharge and failed to send a summary of discharge and transfer residents to the Ombudsman (Resident #47) for 1 of 2 residents reviewed for hospitalization. . The findings included: 1. Resident #39 was admitted to the facility 10/8/2021. Review of the medical record for Resident #39 revealed on 6/7/2024 she was transferred to the hospital for evaluation after experiencing shortness of breath. The medical record documented Resident #39 returned to the facility on 6/17/2024. Review of the medical record for Resident #39 revealed no letter of transfer or discharge was in the medical record. The Social Worker (SW) was interviewed on 6/19/2024 at 11:42 AM. The SW explained the facility had not been sending letters of transfer or discharge to residents who were sent to the hospital for treatment or discharged from the facility. The SW explained she was not aware the letters should be sent. The Senior Nurse Consultant was interviewed on 6/19/2024 at 12:33 PM and she reported it was policy to send a letter of transfer or discharge to any resident who was admitted to the hospital or was discharged from the facility. 2. Resident #47 was admitted to the facility 4/29/2024. Resident #47 was transferred to the hospital on 5/7/2024 and readmitted to the facility	F 623	to be affected by the deficient practice. On 6-19-24, a discharge log for the previous months (01-01-2024/5-13-20240 to include discharges and transfers from the facility was sent to the ombudsman that included all affected residents. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents being transferred or discharged from the facility has the potential to be affected. The notice of Transfer/Discharge form NC Medicaid □ 9050 will be given to each resident discharged or transferred from the facility by the Nurse and/or Social Worker. Discharge logs to be sent via fax to the Ombudsman monthly by the Social Worker. Residents being transferred to the hospital will have a transfer form completed and sent with them, as well as sent to Responsible Party (RP) via mail. Nursing staff re-educated to complete the transfer for at each discharge and send to RP. Systemic changes made to ensure that the deficient practice will not recur. The Social Worker will send the ombudsman via fax at the beginning of each month the prior months discharge / transfer logs to include the destination of	

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F 623	Continued From page 4 5/14/2024. Review of the hospital discharge note revealed Resident #47 was admitted for complications of post-hemorrhagic anemia. During a phone interview with the Ombudsman on 6/14/2024 at 8:39 AM, she reported the facility had not sent her a monthly report regarding the facility transfers or discharges for many months. The Ombudsman did not recall the last time she received a report from the facility. The Social Worker (SW) was interviewed on 6/19/2024 at 11:42 AM. When asked for the reports of resident transfer and discharge from the facility, the SW provided lists from January 2024 to May 2024 and reported she had just faxed the discharge and transfer lists to the Ombudsman from January 2024 to May 2024 on 6/19/2024. Resident #47 was noted to be included in the transfer list for May 2024. The SW explained she had not sent a transfer or discharge summary to the Ombudsman at all in 2024. The SW was unable to explain why the summary reports were not sent, other than to report she had "gotten behind" in tasks.	F 623	each resident. The Social Worker will maintain a copy of the faxed copy receipt to validate compliance. The Director of Health Services, Administrator and/or Clinical Competency Coordinator began educating the Nurses and Social Worker on 7/15/24 on providing the notice of discharge to planned and unplanned discharges and their responsibility, to provide the notice of transfer to the resident and/or RP, as well as mailing the notice and maintaining a copy of the notice and envelope for validation of mailing. Any nurse and/or social worker not educated by 7/19/24 will be educated prior to their next scheduled shift. This education has been added to the general orientation of all newly hired nurses and/or social workers. The Nurse, Social Worker or designee will provide a copy of the Transfer form upon discharge / transfer and a copy will be sent to the RP after transfer to the hospital via mail a copy of the letter and envelope mailed will be uploaded into the electronic medical record for validation of notification, and a hard copy will be maintained by the medical records director. For planned discharges the Nurse and/or social worker will provide a copy of the notice to the resident to be signed on or before planned discharge, attached to the signed Pruitt Discharge summary by the resident/representative and uploaded into Matix by medical records. Plans to monitor its performance to make	

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F 623	Continued From page 5	F 623	sure that the solutions are sustained. Administrator will report the analysis of the Notice of Transfer /Discharge has been signed by the resident/representative, a copy given at the time of discharge and uploaded into Matrix, monthly until three months of sustained compliance is maintained then quarterly thereafter. The Administrator will present the analysis of faxed confirmation of discharge logs sent to the Ombudsman, monthly until three months of sustained compliance is maintained then quarterly thereafter. The Director of Health Services/designee will monitor the transfer notices being sent to the hospital and representative weekly for three weeks, then three time monthly for three months then monthly. The Director of Health Services will present the findings of the transfer forms to the hospital with the resident and mailed to the RP monthly until three months of sustained compliance is maintained then quarterly thereafter. Date of compliance: July 18,2024	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		7/18/24

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F 641	Continued From page 6 Based on observations, record review and staff interview the facility failed to accurately code the significant change in status Minimum Data Set (MDS) assessments for 1 of 5 residents reviewed for MDS accuracy (Resident #47). Findings included: Resident # 47 was readmitted to the facility on 05/13/24 with diagnoses that included cognitive communication deficit and cerebral vascular accident (CVA). Review of a form titled "Observation Detail List Report" dated 05/14/24 at 10:40 PM revealed Resident #47 had moderate difficulty hearing and the speaker had to increase volume and speak distinctly. Resident #47 was recorded to use bilateral hearing aids. A review of the most recent Minimum Data Set (MDS) significant change assessment dated 05/18/24 revealed Resident # 47 was cognitively intact. The MDS assessment was not coded to reflect Resident #47 had a moderate ability to hear at section B0200 and he utilized hearing Aid or other hearing appliance used to hear at section B0300 as required by the RAI manual (Resident Assessment Instrument). An observation of Resident #47 on 06/16/24 at 11:35AM revealed Resident #47 seated in his room with bilateral hearing aids in place. An interview with Nurse #2 conducted on 06/18/24 at 11:08 AM revealed Resident #47 had always worn bilateral hearing aids and he needed them to be able to hear adequately.	F 641	Corrective action for the residents found to be affected by the deficient practice. Resident # 47 was assessed for hearing aid need and usage. Significant change assessment done 7-8-24 for the resident # 47 and coded on B0300. Resident # 47 Care Plan for hearing aid usage was updated on 6-25-24. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. On 7-12-24, a facility audit was done by nursing staff to identify residents that wear hearing aids. The audit identified five residents with current hearing aid usage. Five of five residents MDS assessment were accurately coded. All five residents have orders placed in their perspective records to assist with placing the hearing aid on in the morning and removing at night. Systemic changes made to ensure that the deficient practice will not recur. The Case Mix Director (CMD) and Case Mix Coordinator (CMC) were educated by the Administrator on 7/15/24 regarding accuracy of MDS□s. This education has been added to the general orientation of all newly hired CMD□s and CMC□s. The admitting nurse completing the observation check form, will follow-up with	

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F 641	Continued From page 7 An interview conducted with MDS Nurse #1 and MDS Nurse #2 on 06/19/24 at 2:29 PM revealed Residents were coded as they were assessed during the MDS assessment look back review period. The Area Vice President was interviewed on 06/19/24 at 4:29 PM. She revealed that MDS coding was to be accurate and reflect each resident's conditions.	F 641	a narrative note for resident who are hard of hearing, and or in need of a hearing aid, a sign off order for morning and night assistance and the resident□s preference of charging at bedside, or on nurse cart. This will be verified during the 72-hour meeting with the resident and family. The residents Care plan will be updated as changes arise by the case mix director and/or case mix coordinator to include identification on the resident profile for the Certified Nursing Assistants to view. The Director of Health Services and/or Nurse Manager began educating the nurses on 7/15/24 for compliance with hearing aid documentation. Nurses not educated by 7/18/2024 will receive education prior to their next scheduled shift. The Director of Nursing, Clinical Competency Coordinator and /or Nurse Manager began education to the Certified Nursing Assistants on 7/15/24 regarding viewing the resident profile for application of hearing aids. Certified Nursing Assistants not educated by 7/18/24 will be educated prior to their next scheduled shift. Residents with hearing aids will have their MDS validated for accuracy by the Interdisciplinary Team prior to transmission. The Director of Nursing will maintain an audit for compliance with MDS accuracy. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services and/or	

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F 641	Continued From page 8	F 641	Nurse Managers will review residents with hearing aids to validate, physician order, accuracy of MDS, care plan and placement of hearing aid weekly for four weeks then monthly thereafter. The Director of Health Services will present the analysis of the hearing aid audit to the Quality Assurance and Performance Improvement Committee meetings monthly until three months of sustained compliance is maintained then quarterly thereafter. Date of compliance: 7-18-24	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff, and physician interviews, the facility failed to provide care in a safe manner when a resident fell out of bed during incontinence care for 1 of 3 residents reviewed for accidents (Resident #11). Resident #11 sustained a laceration to the right side of his forehead requiring 6 sutures and a C-1 (cervical vertebra #1) fracture that required long-term use of a cervical collar for neck support. Resident #11 did not experience any neurological changes.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 9	F 689		

The findings included:

Resident #11 was admitted to the facility 11/6/2019 with diagnoses including Parkinson' disease.
A quarterly Minimum Data Set (MDS) assessment dated 2/6/2024 documented Resident #11 was severely cognitively impaired, and he required substantial to maximum assistance for bed mobility and incontinence care.

A review of the medications for Resident #11 revealed an order dated 11/19/2019 for aspirin 81 milligrams daily.

A nursing note dated 2/15/2024 written by Nurse #1 documented the nurse was called to Resident #11's room by Nursing Assistant (NA) #1 and Resident #11 was on the floor between his bed and the wall and there was a large amount of blood noted. The note documented Resident #11 was turned over to his back and he had a laceration to the right side of his head, and pressure was applied to stop the bleeding. The note documented the facility nurse supervisor was notified, and Emergency Medical Services (EMS) was called. The note documented NA #1 reported she was providing incontinence care to Resident #11, and he slipped off the bed. EMS arrived at the facility and Resident #11 was transported to the hospital for evaluation.

Hospital records dated 2/15/2024 documented Resident #11 was evaluated in the emergency room for injuries sustained after he had rolled out of bed. The note documented Resident #11 had a laceration to his right forehead and the CT of his

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head revealed a scalp contusion without fracture. A CT of his neck revealed nondisplaced fractures of the bilateral C1 posterior arch at the foramen, transverse area (fracture of the first vertebra of the spine). The note documented neurosurgery was consulted and a neck collar was used to provide stabilization to the neck. The note documented Resident #11 was at his neurological baseline. Resident #11 was hospitalized from 2/15/2024 until 2/17/2024.

The hospital discharge note dated 2/17/2024 documented Resident #11 had received 6 sutures to the right forehead laceration, and he was to continue wearing the neck collar until his follow up with the neurologist. The discharge note documented Resident #11 was at his baseline and did not have neurological deficits related to the vertebral fracture. The neck collar was the only new order for Resident #11.

Care plans for Resident #11 were reviewed and the fall care plan dated 2/16/2024 documented that due to the recent fall of Resident #11, he would require 2-person assistance for all activities of daily living, including bed mobility and incontinence care. The care plan documented the use of the neck collar, fall mats, bed in the low position, and frequent observations for safety.

A statement written by NA #1 dated 2/17/2024 documented she was providing Resident #11 with incontinence care and had him turned onto his left side, when he kicked out his leg and rolled out of the bed. The note documented NA #1 yelled for the nurse to come to the room.

A follow-up neurologist note dated 4/16/2024 documented Resident #11 was not having pain

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after the injury and C-1 fracture. The note documented a follow up CT scan of the spine had been completed on 4/4/2024 indicated the spinal alignment was within normal limits and stable. The note indicated a repeat CT scan would be completed 6 weeks later and the plan would be to wean Resident #11 from the neck collar use.

The most recent significant change MDS assessment dated 5/10/2024 assessed Resident #1 to be severely cognitively impaired and to require substantial to maximum assistance with incontinence care.

A CT scan of the cervical spine completed on 6/6/2024 indicated the spinal alignment was stable.

Resident #11 was observed on 6/16/2024 at 11:32 AM sitting up in a geri-chair. Resident #11 was wearing a neck collar, and his feet were elevated. Resident #11's bed was noted to have a scoop mattress in place, fall mats were on the floor, and the bed was in a low position.

The facility physician (MD) was interviewed on 6/18/2024 at 10:14 AM. The MD reported Resident #11 had a very serious accident when he rolled out of the bed during incontinence care, and he could have been more seriously injured. The MD reported he was contacted immediately after the accident.

Nurse #1 was interviewed on 6/18/2024 at 10:42 AM by phone. Nurse #1 explained she had been in a room across from Resident #11's room on 2/16/2024 and she heard NA #1 calling out for help. Nurse #1 reported she went into Resident #11's room and he was on the floor between the

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bed and the wall on his stomach. Nurse #11 reported there was a large amount of blood under his head and she and NA #1 turned him over so she could assess the wound on his head. Nurse #1 explained she applied pressure to the laceration to stop the bleeding and called the nurse supervisor and EMS. Nurse #1 revealed they had not attempted to move Resident #11 until EMS arrived because they didn't know the extent of his injuries.

A phone interview was conducted with NA #1 on 6/18/2024 at 12:29 PM. NA #1 reported she had provided care to Resident #11 on 2/15/2024 and had been providing incontinence care. NA #1 explained she had provided care to Resident #11 before 2/15/2024 and he was a 1-person assistance with bed mobility and incontinence care. NA #1 reported she had Resident #11 on his side, and she was securing him with her arm when he kicked his leg and rolled out of the bed and fell onto the floor. NA #1 reported she went to the door of the room and yelled for help and Nurse #1 arrived to assess Resident #11. NA #1 reported that after the accident, Resident #11 required 2-person assistance for all activities of daily living.

An interview was conducted with the Occupational Therapist on 6/18/2024 at 2:36 PM. The Occupational Therapist explained prior to the accident on 2/15/2024, Resident #11 was safe to use 1 person assistance for bed mobility and care.

NA #2 was interviewed on 6/18/2024 at 4:31 PM. NA #2 explained after the accident on 2/15/2024, Resident #11 required 2 people for all activities of daily living.

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The facility submitted the following corrective action:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 2/15/24 at 8:45pm nursing assistant (NA) #1was providing resident care when a resident kicked his left leg out and started to roll off the bed. NA #1 attempted to catch the resident but was unable to. The NA #1 got the nurse and assisted with caring for him after the fall until EMS arrived.
A nursing note documented "at 8:45pm on 2/15/2024, the nurse was called to resident room per NA #1, upon arrival, resident noted laying on his right side on the floor with a large amount of blood present, once resident was turned onto his back, noted a large laceration to right side of head, ice and pressure applied to area, facility nurse supervisor notified, resident remains alert and responsive, ROM and neuro-checks are within resident baseline, V/S 196/84-98.4-70-16-93%, 9pm Medic called, Responsible Party called x5, no answer, at 9:05pm resident out to ER for evaluation, at 9:50pm resident Responsible Party returned call, notified of resident's incident and transfer to ER, CNA stated that while providing incontinent care, she was attempting to turn resident to left side, resident slipped off bed."

A root cause analysis was conducted on 2/16/2024. The facility reviewed the training of all staff including NA #1 who had received training on turning and positioning with observations, during general orientation and training, and

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re-educated on turning the resident toward you never away from you after the event. The Certified Nursing Assistant was found to use poor judgment during care of the resident and no longer worked for the facility.

The resident was returned to the facility on 2/17/24 with an open wound to scalp and a closed fracture of the 1st cervical vertebrae with neck collar intact.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected. Facility Administrator, Director of Health Services, Clinical Competency Coordinator and Nurse Managers reviewed bed mobility status for all residents in the facility to identify residents' level of assistance required during bed mobility. Of the 69 in-house, 1 resident required a change from 1 person assistance to two-person assistance, 68 residents maintained their current level of bed mobility assistance. The one resident requiring a change to two-person assistance care plan and resident profile was reviewed and updated.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Clinical Competency Coordinator and/ or Nurse Managers began education on 2/17/24 for the Certified Nursing Assistants regarding resident's plan of care to include neck collar, safety bolster cover (a overlay that goes onto the bed with elevated sides to identify the boundaries of the bed), turning and positioning in bed, and 2

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staff assist with activities of daily living in bed and transfers. This education continues with newly hired certified nursing assistants.

The Clinical Competency Coordinator and/or Nurse Managers began education 2/17/24 related to turning and repositioning a resident was provided through our Pruitt university online learning coordinator module and competencies reviewed with certified nursing assistants by the clinical competency. This education includes turning the resident toward you and asking for assistance from coworkers when two persons assist in required.

The Nursing Management Team and/or Administrator began observation of turning and repositioning a resident on 2/17/24. This is completed for 5 residents per week for 1 week, then 3 residents a week for 4 weeks, then 4 residents per month ongoing.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

The Nursing Management Team and/or Administrator began observation of turning and repositioning a resident on 2/17/24. This is completed for 5 residents per week for 1 week, then 3 residents a week for 4 weeks, then 4 residents per month ongoing.

The Nursing Management and Interdisciplinary team met on 2/21/24 to discuss resident at risk for events and interventions applied. The Interdisciplinary team discussed the Nurse Managers observations of residents being turned and repositioned with the Interdisciplinary team

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F 689	Continued From page 16 on 2/21/24 to identify any areas requiring revision. The Interdisciplinary team did not identify any revisions to the observation review at that time (2/21/24). The plan of correction compliance was presented to the Quality Assurance Committee on March 12, 2024. The Administrator and or Director of Health Services presented the findings of the observation for turning and positioning to the Quality Assurance and Performance Committee meeting on March 12, 2024, and will continue to report findings monthly for further recommendations. Completion date: February 22, 2024 The facility corrective action plan of 2/22/2024 was validated on 6/18/2024 by reviewing the audits conducted, reviewing the education provided to nurses and NAs, observation of incontinence care and bed mobility for Resident #11, interviewing NAs and nurses, and reviewing the Quality Assurance and Performance Committee meeting notes.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		7/18/24

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F 695	Continued From page 17 by: Based on observations, record reviews, and staff and resident interviews, the facility failed to post precautionary and safety signs that indicated the use of oxygen for 5 of 5 residents reviewed for respiratory care (Resident #47, Resident #55, Resident # 26, Resident # 20, and Resident # 3). The findings included: 1. Resident # 47 was readmitted to the facility on 05/13/24 with diagnoses that included bacterial pneumonia, chronic systolic (congestive) heart failure and pneumonitis due to inhalation of food and vomit. A review of the most recent Minimum Data Set (MDS) significant change assessment dated 05/18/24 revealed Resident # 47 was cognitively intact. Review of Resident # 47's physician orders dated 06/13/24 revealed an order for continuous oxygen delivered at 2 liters per nasal cannula. An observation of Resident #47 on 06/16/24 at 11:35AM revealed Resident #47 seated in his room visiting with family. Resident #47 was observed with oxygen delivered at 2 liters via nasal cannula. There were no precautionary or safety signs to indicate that oxygen was in use noted in Resident #47's room, on his room door, or anywhere near his environment. A review of the care plan for Resident #47 updated 06/17/24 revealed in part that he had the potential respiratory declines and or declines related to chronic systolic congestive heart failure. The goal read in part to maintain	F 695	Corrective action for the residents found to be affected by the deficient practice. On 6/19/24, Resident # 55 had an oxygen sign posted outside their door by nursing administration. Corrective action for other residents having the potential to be affected by the same deficient practice. An audit of all resident rooms was conducted by nursing administration on 6/19/24 and identified nine residents that required oxygen signs to be placed outside the room door. Systemic changes made to ensure that the deficient practice will not recur. The Clinical Compliance Coordinator provided education for Nurses and Certified Nursing Assistants on 7/15/24, 7/16/24, 7/18/24 on Oxygen Safety and Storage including placing oxygen signs outside the resident□s door with oxygen. When there is a new order for oxygen use the nurse assigned to the resident will obtain oxygen signage for the resident□s room and place it on the outside door frame of the resident□s room. Any Nurse or Certified Nursing Assistant not educated after 7/18/24 will receive education related to oxygen safety and storage to include placing oxygen signs outside resident door prior to their next scheduled shift. This education has been added to the general orientation or all Nurses and Certified Nursing Assistants.	

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F 695	Continued From page 18 adequate air exchange with no respiratory distress. Interventions included assess for fluid excess such as shortness of breath and encourage self-care as tolerated. An interview with Nurse #2 conducted on 06/18/24 at 11:08 AM revealed that oxygen use signs were to be posted outside of each resident's room where oxygen was being utilized and the nurse was to obtain the sign from the oxygen supply room. Nurse #2 revealed she was not aware there was no oxygen safety sign posted outside of individual resident rooms. An interview with Nurse Assistant (NA) #1 on 06/18/24 11:43 AM revealed that she was not aware of the oxygen safety signs and did not pay attention to them. Nurse #1 was interviewed on 06/18/24 at 12:12 PM. Nurse #2 revealed all residents that used oxygen were supposed to have oxygen safety signs posted at the door to their rooms. Nurse #1 was not able to explain why Resident #47 did not have an oxygen safety sign on his door previously because Resident #47 always used oxygen at 2 liters nasal cannula. On 06/19/24 at 2: 57 during an interview conducted with the Director of Nursing revealed in part that it was her understanding if the facility posted no smoking signs on the facility entrance and exit doors that the oxygen safety signs were not required to be posted on individual rooms of residents using oxygen. The Area Vice President was interviewed on 06/19/24 at 4:29 PM. She revealed in part that it was her understanding that if the facility posted	F 695	The Director of Health Services and/or department managers are reviewing residents with oxygen signage outside of room doors three times per week for four weeks, then weekly for four weeks, then monthly thereafter. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Health Services will present the analysis of the oxygen audit to the Administrator at the Quality Assurance and Performance Improvement Committee meeting monthly until three months of sustained compliance is maintained then quarterly thereafter. Date of compliance: 7-18-24	

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no smoking signs on the entrance and exit doors of the facility that there was not a need to post oxygen safety signs on each individual resident rooms where oxygen was in use.

2. Resident #55 was readmitted to the facility on 05/08/24 with diagnoses that included pneumonia, systolic congestive heart failure, acute cough, and chronic obstructive pulmonary disease (COPD).

Review of a significant change Minimum Data Set (MDS) assessment dated 06/04/24 revealed Resident #55 had no cognitive impairment.

Review of care plans for Resident #55 initiated 05/30/24 included in part Resident #55 had potential for inadequate air exchange and respiratory decline. With a goal that he would have effective respiratory rate, depth, and rhythm without unresolved shortness of breath. Interventions included to assess signs of ineffective breathing pattern, and to encourage rest periods.

A physician order dated 06/16/24 included oxygen at 2 liters via nasal cannula as needed for shortness of breath.

An interview with Nurse #2 conducted on 06/18/24 at 11:08 AM revealed that oxygen use signs were to be posted outside of each resident's room where oxygen was being utilized and the nurse was to obtain the sign from the oxygen supply room. Nurse #2 revealed she was not aware there was no oxygen safety sign posted outside of individual resident rooms.

An interview with Nurse Assistant (NA) #1 on

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06/18/24 11:43 AM revealed that she was not aware of the oxygen safety signs and did not pay attention to them.

A subsequent observation and interview with Resident #55 conducted on 06/17/24 at 10:05 AM revealed Resident #55 seated up in bed with oxygen 2 liters nasal cannula. Resident #55 revealed he only used oxygen when he became short of breath. There was a red oxygen safety sign posted on the door of Resident #55's room door.

An interview with Nurse #2 conducted on 06/18/24 at 11:08 AM revealed that oxygen use signs were to be posted outside of each resident's room where oxygen was being utilized and the nurse was to obtain the sign from the oxygen supply room. Nurse #2 revealed she was not aware there was no oxygen safety sign posted outside of individual resident rooms.

On 06/19/24 at 2: 57 during an interview conducted with the Director of Nursing revealed in part that it was her understanding if the facility posted no smoking signs on the facility entrance and exit doors that the oxygen safety signs were not required to be posted on individual rooms of residents using oxygen.

The Area Vice President was interviewed on 06/19/24 at 4:29 PM She revealed in part that it was her understanding that if the facility posted no smoking signs on the entrance and exit doors of the facility that there was not a need to post oxygen safety signs on each individual resident rooms where oxygen was in use.

3. Resident #26 was admitted to the facility on

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01/03/24 with diagnoses that included chronic obstructive pulmonary disease (COPD) with acute exacerbation, acute on chronic respiratory failure with hypoxia, and solitary pulmonary nodule.

A review of Resident #26's physician orders dated 06/04/24 revealed an order for continuous oxygen at 5 liters per minute (LPM) via nasal cannula.

Resident #26's Oxygen Use care plan dated 06/04/24 revealed that his oxygen use was related to COPD with acute exacerbation, and acute on chronic respiratory failure. Interventions included saturated oxygen monitoring, ample time to perform activities of daily living (ADL), and notifying his physician of any changes.

A review of Resident #26's Scheduled 5-day Minimum Data Set (MDS) assessment dated 06/08/24 rated Resident #26 as cognitively intact. He received oxygen therapy during the MDS assessment period.

An observation of Resident #26 on 06/16/24 at 11:22 AM found him sitting in his wheelchair, with his eyes closed and the tv on. Continuous oxygen was being delivered at 5 LPM via nasal cannula; however, there were no precautionary or safety signs to indicate that oxygen was in use posted in his room, on his door, or anywhere in his environment.

A subsequent observation of Resident #26 on 06/16/24 at 11:39 AM revealed him sitting up in his wheelchair, talking with visitors. No posted precautionary or safety signs to indicate that oxygen was in use were observed.

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An interview with Nurse #4 on 06/18/24 at 4:06 PM disclosed that oxygen in use signage was to be posted at admission, by the nurse. She stated she was not sure why no signs were posted on behalf of her residents. In addition, she reported that oxygen signs were moved with residents who changed rooms.

An interview with the Director of Nursing on 06/17/24 at 4:40 PM reported that nurses were responsible for posting oxygen signage outside of residents' rooms; and acknowledged that some resident rooms were "missed" when signage was to have been posted.

During an interview with the Area Vice President on 06/19/24 at 3:44 PM, she stated the policy was to have No Smoking signs posted at the entrances to the facility, thus signage was not required to be posted at individual rooms of residents receiving oxygen.

4. Resident #20 was admitted to the facility on 05/06/24 with diagnoses that included chronic obstructive pulmonary disease (COPD) and heart failure.

A review of Resident #20's physician orders dated 05/06/24 revealed an order for oxygen at 3 liters per minute (LPM) via nasal cannula continuous.

Resident #20's care plan dated 05/06/24 exhibited potential for respiratory distress related to congestive heart failure (CHF), COPD, and atrial fibrillation, with interventions that included encouraging frequent rest periods, saturated oxygen (SaO2) monitoring, daily weights with variances reported, and reportable signs and symptoms.

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A review of Resident #20's 5-day Minimum Data Set (MDS) assessment dated 05/10/24 indicated Resident #20 was cognitively intact and received continuous oxygen therapy during the MDS assessment period.

An observation of Resident #20 on 06/16/24 at 11:34 AM revealed Resident #20 sitting in her wheelchair. She received 3 LPM of continuous oxygen via nasal cannula. However, no precautionary or safety signs were posted in her room, on her door, or anywhere in her environment.

An interview with Nurse #4 on 06/18/24 at 4:06 PM disclosed that oxygen in use signage was to be posted at admission, by the nurse. She stated she was not sure why no signs were posted on behalf of her residents. In addition, she reported that oxygen signs were moved with residents who changed rooms.

An interview with the Director of Nursing on 06/17/24 at 4:40 PM reported that nurses were responsible for posting oxygen signage outside of residents' rooms; and acknowledged that some resident rooms were "missed" when signage was to have been posted.

During an interview with the Area Vice President on 06/19/24 at 3:44 PM, she stated the policy was to have No Smoking signs posted at the entrances to the facility, thus signage was not required to be posted at individual rooms of residents receiving oxygen.

5. Resident #3 was admitted to the facility on 01/12/23. Her diagnoses included chronic

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obstructive pulmonary disease (COPD), pulmonary embolism without acute cor pulmonale, and acute respiratory failure with hypoxia.

A review of Resident #3's physician order dated 06/07/24 included oxygen at 2 liters per minute (LPM) via nasal cannula continuous due to malignant neoplasm of lower lobe, right bronchus or lung, and COPD.

A review of Resident #3's Quarterly Minimum Data Set (MDS) assessment dated 06/01/24 indicated she had mild cognitive impairment and received oxygen therapy during the MDS assessment period.

Resident #3's care plan dated 01/12/23 included potential for respiratory declines/distress related to COPD, congestive heart failure (CHF), and history of respiratory failure. Interventions included monitoring oxygen saturation every shift, encouraging frequent rest periods, assessing for changes in level of consciousness, monitoring lung sounds as needed, and reportable signs and symptoms.

An observation of Resident #3 on 06/16/24 at 11:32 am found her in bed, sleeping and receiving continuous oxygen via nasal cannula. There were no precautionary or safety signs to indicate that oxygen was in use in her room, on her door, or anywhere in her environment.

A subsequent observation of Resident #3 on 6/16/24 at 2:31 pm found her sitting in her wheelchair, outside of her room, coloring. Resident #3 received 2 LPM continuous oxygen via nasal cannula. No posted precautionary or

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F 695	Continued From page 25 safety signs to indicate that oxygen was in use were observed. An interview with Nurse #4 on 06/18/24 at 4:06 PM disclosed that oxygen in use signage was to be posted at admission, by the nurse. She stated she was not sure why no signs were posted on behalf of her residents. In addition, she reported that oxygen signs were moved with residents who changed rooms. An interview with the Director of Nursing on 06/17/24 at 4:40 PM reported that nurses were responsible for posting oxygen signage outside of residents' rooms; and acknowledged that some resident rooms were "missed" when signage was to have been posted. During an interview with the Area Vice President on 06/19/24 at 3:44 PM, she stated the policy was to have No Smoking signs posted at the entrances to the facility, thus signage was not required to be posted at individual rooms of residents receiving oxygen.	F 695		
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	F 812		7/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345515	A. BUILDING _____ B. WING _____	C 06/25/2024

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F 812	Continued From page 26 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 and staff interviews, the facility failed to remove a dented canned good item stored for use, seal open-to-air frozen food, ensure pans were dry before being stacked, and cover facial hair for 2 of 2 kitchen observations. These practices had the potential to affect food served to residents in the facility. The findings included: a. The kitchen was toured on 6/16/2024 at 10:55 with the Assistant Dietary Manager. The rack of canned goods was observed, and a can of spaghetti sauce was noted to have a large dent on the side of the can. The dent was approximately 3 inches long and dented approximately ½ inch into the can, and the paper label on the can was torn in the dent. The Assistant Dietary Manager explained dented cans should be removed from the rack and placed on the shelf labeled "dented cans". The Assistant Dietary Manager did not know why the can had not been removed. b. The freezer was observed with Cook #1 at 11:15 AM on 6/16/2024. The freezer was observed to have an open box of beef patties, an open box of cube steak, and an open box of fish nuggets. Inside each of the open boxes, the	F 812	Corrective action for the residents found to be affected by the deficient practice. No residents were directly affected by the deficient practice identified. 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 this deficiency. A 100% audit was completed by the Dietary Manager and Administrator on 6/27/24, of the walk-in freezer to ensure all open-to-air frozen food items were sealed: stockroom was inspected to ensure there were no dented cans remaining, beard guards were immediately donned by staff with facial hair, and pans were inspected to ensure there were none stacked wet. Systemic changes made to ensure that the deficient practice will not recur. The dietary manager was educated by the consultant dietitian on June 21, 2024, on	

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F 812	Continued From page 27 plastic bag containing the frozen food was open to air. Cook #1 explained when a box was opened from the freezer storage, the bags needed to be closed. Cook #1 reported he did not know why the open bags of food were not closed. c. The dry dish rack was observed with the Assistant Dietary Manager at 11:24 AM on 6/16/2024. Five steamer pans were noted to be stacked wet. The Assistant Dietary Manager explained the dishes were to be air dried before they were stacked for storage, and she did not know why the metal steamer pans were stacked wet. d. The kitchen was toured again on 6/17/2024 at 2:07 PM with the Dietary Manager (DM). The freezer was observed to have an open box cube steak with the bag inside the box open. The DM reported the plastic bags should have been closed. e. During the tour of the kitchen on 6/17/20024 at 2:07 PM, the DM and Dietary Aide #1 were noted to have uncovered facial hair. Dietary Aide #1 was observed to serve canned peaches without covering his facial hair and the DM reminded him to cover his facial hair. The DM explained he thought coverings for facial hair were required only when directly preparing food. The Registered Dietitian (RD) was interviewed on 6/19/2024 at 1:35 PM. The RD reported the dented can should have been removed from rack and the plastic bags in the freezer closed. The RD reported the steamer pans should be completely dry before stacking for storage. The Registered Dietician explained the DM had been	F 812	ensuring all open-to-air frozen food items were sealed, that a separate area in the stockroom is designated and labeled for dented cans, and that procedure for returning dented cans to the vendor is followed: Hair nets are to be worn by all dietary employees, and beard guards are to be worn by dietary partners with facial hair, and that pans are to be air dried completely before stacked. This education has been added to the general orientation for all newly hired Dietary Managers during their general orientation. Education was initiated by the dietary manager on 6-25-2024 to all dietary partners on ensuring all open-to-air frozen food items were sealed, that a separate area in the stockroom is designated and labeled for dented cans, and that procedure for returning dented cans to the vendor is followed: Haor nets are to be worn by all dietary employees, and beard guards are to be worn by dietary partners with facial hair, and that pans are to be air dried completely before stacked. All dietary partners not educated by 7/18/24 will be educated prior to their next scheduled shift. This education has been added to the general orientation of all newly hired dietary employees. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator and/or Infection Preventionist will audit the dietary department to ensuring all open-to-air frozen food items were sealed, and a	

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F 812	Continued From page 28 instructed to cover his facial hair when he was in the kitchen. Dietary Aide #1 was interviewed on 6/19/2024 at 2:21 PM. Dietary Aide #1 explained he was not aware he had to cover his facial hair when in the kitchen. The DM was interviewed on 6/19/2024 at 2:30 PM and he reported the kitchen staff should have removed the dented can and closed the bags of food in the freezer. The DM explained the RD had told the males in the kitchen with facial hair to cover their facial hair, but he thought it was only during food preparation. The DM explained the kitchen had limited drying space for dishes out of the dishwasher and he thought the kitchen staff had stacked the wet metal steamer pans too soon after washing.	F 812	separate area in the stockroom is designated and labeled for dented cans and the procedure is being followed for returning dented cans to the vendor: hair nets are worn by dietary partners and dietary partners with facial hair are wearing beard guards and that pans have been air dried prior to stacking. The Administrator will conduct this audit five days per week for two weeks, then weekly for four weeks, then monthly thereafter. The Administrator will present the analysis of the Dietary audit to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance are maintained then quarterly thereafter. Date of compliance: July 18,2024	