STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345463	A. BUILDING ______ B. WING ______	C 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF HENDERSONVILLE	**400 THOMPSON STREET HENDERSONVILLE, NC 28792**

(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 07/15/24 through 07/19/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# L8V711.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 07/15/24 through 07/19/24. Event ID# L8V711. The following intakes were investigated: NC00218683, NC00218607, NC00218122, NC00208503, NC00203235, NC00202466, NC00204190, and NC00219525. 6 of the 27 complaint allegations resulted in deficiency.	F 000		
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 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.	F 578		8/11/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/08/2024

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 578	Continued From page 1 (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: The facility failed to ensure the physician's order for an advanced directive matched the medical orders for scope of treatment (MOST) form signed by the resident's family for 1 of 18 residents (Resident #270) reviewed for advanced directives. The findings included: Resident #270 was admitted to the facility on 7/12/24. Review of the brief interview for mental status (BIMS) interview dated 7/15/24 revealed that Resident #270 was moderately cognitively impaired.	F 578	It is the practice of the facility to allow patients□ the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Corrective Action Resident #270 advance directive reviewed by Director of Nursing and received physician order for Do Not Resuscitate and updated in system on 7/16/2024. Like Residents Director of Nursing completed audit of all residents□ code status and Medical Orders for Scope of Treatment (MOST)form to ensure they match on 7/24/2024 with no further issues found	

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F 578	Continued From page 2	F 578		

Review of the baseline care plan dated 7/15/24 revealed resident #270 was documented as a full code (lifesaving efforts such as Cardiopulmonary Resuscitation (CPR) were to be conducted).

Review of the physician's orders dated 7/12/2024 revealed an order for the resident to be a full code.

Review of the MOST form dated 7/12/24 revealed (section A) do not resuscitate (DNR) (lifesaving efforts such as CPR are not to be conducted) with (section B) limited interventions to use medical treatment, intravenous (IV) fluid and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider the use of less invasive airway support such as BIPAP or CPAP. Also provide comfort measures. Transfer to hospital if indicated. Avoid intensive care. (section C) Antibiotics if indicated. (section D) IV fluids if indicated and no feeding tube. (section E) Signed by Resident #270's family.

An interview with the Assistant Director of Nursing (ADON) on 7/16/24 at 1:26 PM revealed that the facility received situation, background, assessment, recommendation (SBAR) report (a communication framework that nurses used to share important information about a patient's condition with other health care team members) from the hospital which included code status as full code. The ADON entered the order for Resident #270's code status of full code into the electronic health record. It was expressed to the family and Resident #270 upon arrival to the facility that they could change Resident #270's code status if they wanted from full code to DNR. The family of Resident #270 decided to change her code status from full code to DNR with limited

during audit.
Systemic Changes
Director of Nursing and/or designee re-educated licensed nurses on code status/MOST form procedures and ensuring they match on 8/7/2024. Staff received re-education prior to working next shift.
Monitoring
Director of Nursing and/or designee to review MOST form and physician's order on new admissions for accuracy and coordination five times weekly for 4 weeks, three times weekly for 4 weeks and then one time weekly for 4 weeks. Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate.
Completion Date: 8/11/2024

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F 578	Continued From page 3 interventions upon Resident #270's admission. The facility interdisciplinary team (IDT) reviewed all new residents code status the following business day to ensure accuracy in the event the families or residents made changes upon admission. Resident #270 was admitted on Friday 7/12/24 so her code status and the MOST form should have been reviewed Monday 7/15/24 to ensure they matched but it must have been overlooked. When asked what would have happened if Resident #270 had an emergency that required her code status, the ADON stated that staff were trained to check in the physical chart for the MOST form for the most up to date code status for new residents before providing medical intervention. An interview with the Director of Nursing (DON) on 7/16/24 at 1:46 PM revealed that if residents were DNR the facility would confirm that with the resident or family and ensure the code status orders and MOST/ DNR forms match. The MOST form was filled out at admission and reviewed with the physician. She stated her expectation was that code status ordered in the electronic health record should match the MOST form for the resident. An interview with the Executive Director on 7/19/24 at 10:57 AM revealed that her expectation was the order for the code status should match the MOST form signed by the family.	F 578		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		8/11/24

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F 641 Continued From page 4
resident's status.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of falls, functional limitation in range of motion, anticoagulant (blood thinner) use, weight loss, colostomy status, and bowel incontinence for 5 of 18 sampled residents (Residents #44, #17, #2, #7, and #13).

Findings included:

1. Resident #44 was admitted to the facility on 04/01/23 with diagnoses that included abnormal gait and muscle weakness.

An incident/accident report dated 05/17/24 revealed Resident #44 had a witnessed fall from her wheelchair to the floor. Upon nurse assessment, Resident #44 had a small topical abrasion to the left elbow, passive range of motion was within normal limits and she voiced no complaints of pain. Approximately 2 hours later, Resident #44 complained of left hip pain, the on-call provider was notified and orders were obtained for a STAT (immediate) left hip x-ray.

Review of left hip x-ray results dated 05/18/24 revealed Resident #44 had an acute (sudden in onset) intertrochanteric femoral (hip) fracture with mild displacement.

The significant change Minimum Data Set (MDS) assessment dated 05/22/24 revealed Resident #44 had an intertrochanteric fracture of left femur. Further review revealed that Resident #44 did not fall any time in the last month or 2 to 6 months

F 641

It is the practice of the facility to accurately reflect the residents� status.
Corrective Action
Resident #44 Minimum Data Set was updated on 8/6/2024 to accurately reflect the falls.
Resident #17 MDS was updated on 7/19/2024 to accurately reflect the anticoagulant use and impairment of upper extremities.
Resident #13 MDS was updated on 7/19/2024 to reflect weight loss of 10% or more.
Resident #7 MDS was updated on 7/19/2024 to reflect bowel incontinence.
Resident #2 MDS was updated on 7/19/2024 to reflect having an appliance, including a colostomy.
Like Residents
All residents have the potential to be affected.
Systemic Changes
MDS Coordinator re-educated on 7/19/2024 on importance of accurate assessments to reflect residents' needs, including falls, anticoagulant use, appliances, bowel continence/incontinence, and weight loss on 7/19/2024.
Monitoring
Regional MDS Coordinator and/or designee to complete 5 MDS assessment audits weekly x 4 weeks, 3 audits weekly x 4 weeks and 1 weekly x 4 weeks to ensure that MDS reflects accurate falls, anticoagulant use, appliance use, bowel

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F 641	Continued From page 5 prior to admission or reentry and did not have any fracture related to a fall in the 6 months prior to admission or reentry. The facility's MDS Coordinator was unavailable for interview during the investigation. During a telephone interview on 07/19/24 at 3:28 PM with the Director of Nursing (DON) present, the Corporate MDS Consultant revealed Resident #44's significant change MDS assessment dated 05/22/24 should have accurately reflected she had a fall with fracture in the last month. The MDS Consultant explained the facility's MDS Coordinator was currently out due to health problems and he felt the coding inaccuracies were likely due to an oversight. During an interview on 07/19/24 at 4:10 PM, the Administrator stated she expected for MDS assessments to be completed accurately. 2. Resident #17 was admitted to the facility on 05/14/20 with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the right dominant side and right hand contracture. A physician's order dated 02/27/24 for Resident #17 read, Xarelto (anticoagulant medication) 20 milligrams (mg) every evening related to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of the May 2024 Medication Administration Record for Resident #17 revealed Xarelto 20 mg was initialed as administered every evening per physician order.	F 641	continence/incontinence, and weight loss. Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate. Completion: 8/11/2024	

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The annual Minimum Data Set (MDS) assessment dated 05/24/24 revealed Resident #17 was not taking anticoagulant medication and he had no impairment of his upper extremities.

The activities of daily living Care Area Assessment (CAA) associated with the annual MDS assessment dated 05/24/24 revealed in part, Resident #17 had a right hand contracture and received anticoagulant medication daily.

During a telephone interview on 07/19/24 at 3:28 PM with the Director of Nursing (DON) present, the Corporate MDS Consultant revealed Resident #17's annual MDS assessment dated 05/24/24 should have reflected that he had upper extremity impairment due to right hand contracture and that he received anticoagulant medication during the MDS assessment period. The Corporate MDS Consultant explained the facility's MDS Coordinator was currently out due to health problems and he felt the coding inaccuracies were likely due to an oversight.

During an interview on 07/19/24 at 4:10 PM, the Administrator stated she expected for MDS assessments to be completed accurately.
3. Resident #13 was admitted to the facility 01/23/24 with diagnoses including malnutrition and muscle weakness.

Resident #13's weights for the past 6 months were as follows:

01/29/24 137 pounds
02/26/24 124 pounds
03/0424 131 pounds
04/01/24 118.2 pounds

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F 641	Continued From page 7 05/01/24 114.8 pounds 06/01/24 113.8 pounds Review of Resident #13's weights from January 2024, through June 2024, reflected a 20.39% weight loss over the last 6 months. Review of Resident #13's quarterly Minimum Data Set (MDS) assessment dated 06/25/24 revealed she was severely cognitively impaired and did not reflect that she had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The facility's MDS Coordinator was unavailable for interview during the investigation. In a telephone interview with the Corporate MDS Coordinator on 07/19/24 at 3:35 PM he confirmed Resident #13's quarterly MDS dated 06/25/24 should have been coded to reflect a 10% weight loss over the past 6 months. He explained the facility's MDS Coordinator had recently been having a number of health problems and he felt that contributed to the error in MDS coding. An interview with the Administrator on 07/19/24 at 4:05 PM revealed she expected MDS assessments to be coded correctly. 4. Resident #7 was admitted to the facility 03/27/24 with diagnoses including anemia and malnutrition. Review of Resident #7's admission MDS assessment dated 04/17/24 revealed she was moderately cognitively impaired and bowel continence was not rated.	F 641		

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The facility's MDS Coordinator was unavailable for interview during the investigation.

In a telephone interview with the Corporate MDS Coordinator on 07/19/24 at 3:35 PM he confirmed Resident #7's admission MDS dated 04/17/24 should have been coded to reflect she was incontinent of bowel. He explained the facility's MDS Coordinator had recently been having a number of health problems and he felt that contributed to the error in MDS coding.

An interview with the Administrator on 07/19/24 at 4:05 PM revealed she expected MDS assessments to be coded correctly.

5. Resident #2 was admitted to the facility 04/17/13 with diagnoses including malnutrition.

Review of Resident #2's colostomy (a surgically created opening from the colon through the abdomen) care plan last revised 02/15/24 revealed she removed her colostomy pouch and wafer frequently and interventions included providing colostomy care as ordered and as needed and assessing the skin around the stoma site for signs of irritation with each wafer change.

Resident #2 had a Physician order dated 05/06/24 to change her colostomy bag and wafer every 2 days and as needed.

Review of Resident #2's quarterly MDS assessment dated 05/29/24 revealed she was not coded as having an appliance, including a colostomy.

The facility's MDS Coordinator was unavailable for interview during the investigation.

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F 641	Continued From page 9 In a telephone interview with the Corporate MDS Coordinator on 07/19/24 at 3:35 PM he confirmed Resident #2's quarterly MDS dated 05/29/24 should have been coded to reflect Resident #2 had a colostomy. He explained the facility's MDS Coordinator had recently been having a number of health problems and he felt that contributed to the error in MDS coding. An interview with the Administrator on 07/19/24 at 4:05 PM revealed she expected MDS assessments to be coded correctly.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with staff, the facility failed to provide oral hygiene assistance for a dependent resident with visibly dirty dentures and teeth for 1 of 11 residents reviewed for activities of daily living (Resident #64). Findings included: Resident #64 was admitted to the facility on 06/11/24 with diagnoses including dementia and seizure disorder. The admission Minimum Data Set assessment dated 06/17/24 revealed Resident #64's cognition was severely impaired and setup assistance was	F 677	It is the practice of the facility to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Corrective Action Resident #63 had dentures soaked by director of nursing on 7/18/2024. Nurse aide #3 re-educated on oral hygiene on 7/18/2024. Like Residents Director of Nursing reviewed all residents that were dependent for oral hygiene with no further issues, at that time. Systemic Changes	8/11/24

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F 677

Continued From page 10
needed with oral hygiene.

The activities of daily living care plan last reviewed on 06/18/24 revealed Resident #64 required assistance to maintain or attain the highest level of functioning. Interventions included to assist with activities of daily living care as needed.

Observations on 07/15/24 at 2:20 PM and 07/16/24 at 3:27 PM revealed Resident #64's upper denture and lower teeth appeared dirty with a visible white colored buildup of debris on several of the front upper and lower teeth.

An observation and interview was conducted on 07/18/24 at 11:35 AM with the Director of Nursing (DON). Resident #64 removed his lower plate and upper denture and gave them to the DON. A white colored buildup was observed on several of the teeth and gums of the upper denture and lower plate. The DON stated she was not sure when Resident #64 last received assistance with oral hygiene, but both the upper denture and lower plate needed to be cleaned and she placed them in a denture cup to soak. It was shared with the DON previous observations were made and there had been no change in the appearance of Resident #64's teeth that continued to appear dirty with a white colored buildup.

An interview was conducted on 07/18/24 at 12:03 PM with NA #3. NA #3 revealed she was not aware Resident #64 had dentures and usually was not on her assignment. She stated Resident #64 needed setup assistance and confirmed she had not provided assistance for oral hygiene on 7/16/24 or 07/18/24. When asked why setup assistance for oral hygiene was not provided NA

F 677

Director of Nursing and/or designee re-educated all clinical staff on proper oral hygiene on dependent residents on 7/19/2024, prior to working shift.
Monitoring
Director of Nursing and/or designee to complete 5 random observations of dependent residents for oral hygiene weekly x 4 weeks, 3 random audits weekly x 4 weeks and then 1 weekly x 4weeks.
Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate.
Completion Date: 8/11/2024

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F 677	Continued From page 11 #3 reiterated, she was not aware Resident #64 had dentures. A follow-up observation and interview was conducted on 07/18/24 at 3:52 PM with the DON. The DON stated oral care was done in morning when getting residents up and dentures were soaked overnight. Resident #64 showed his upper and lower teeth that appeared clean with no visible white colored buildup of debris. During an interview on 07/19/24 at 4:46 PM the Administrator revealed NA staff were expected to provide assistance with oral hygiene daily and as needed when teeth were visibly dirty.	F 677		
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 observation, record review and Responsible Party, Physician Assistant, resident and staff interviews, the facility failed to include a resident's transfer status in the comprehensive care plan for staff to safely transfer a resident from the wheelchair to bed resulting in the resident falling to the floor (Resident #44) and failed to transfer a dependent resident from the bed to the wheelchair using a mechanical lift and two-person assistance as indicated on the care	F 689	It is the practice of the facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action On 5/17/224, Nurse aide #1 attempted to transfer resident #44 from motorized wheelchair to bed by herself; during transfer, nurse aide #1 was unable to complete transfer and resident #44	7/19/24

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F 689	Continued From page 12 plan (Resident #8) for 2 of 3 residents reviewed for accidents and mobility. On the evening of 05/17/24, Nurse Aide #1 attempted to independently transfer Resident #44 to the bed resulting in Resident #44 falling to the floor onto her left side. Upon initial nurse assessment, Resident #44 complained of no pain and had a small topical abrasion to the left elbow with no other obvious injuries identified. Later that same evening, Resident #44 complained of hip pain, the on-call provider was notified and new orders for a STAT (immediate) x-ray was obtained. Early in the morning of 05/18/24, x-rays revealed Resident #44 had an acute (sudden in onset) left intertrochanteric fracture (type of hip fracture that occurs between the two bony points of the thighbone where the muscles of the thigh and hip attach) with mild displacement (when the bone breaks in two or more parts and moves so that the two ends do not line up straight) with varus (occurs when the broken bones are turned toward the center of the body) angulation. Resident #44 was admitted to the hospital on 05/18/24 for evaluation and treatment, underwent surgical repair for the hip fracture and returned to the facility on 05/20/24. Findings included: 1. Resident #44 was admitted to the facility on 04/01/23 with diagnoses that included right foot pathological fracture, muscle weakness, abnormal posture, right and left hip contractures, and age-related physical debility. A Physical Therapy (PT) evaluation and plan of treatment dated 04/03/23 revealed in part, Resident #44 reported she had not walked or stood for at least a year and was unable. She	F 689	sustained fall. Based on previous evaluations by therapy, resident #44 should have been a 2 person assist with mechanical lift for transfers. Resident # 44 was assessed by therapy, upon return from the hospital, for proper transfer status on 5/21/24. Care plan/Kardex updated to 2-person assist with mechanical lift for transfers on 5/21/2024. Nurse aide #1 was provided 1:1 education on resident transfers on 5/18/2024. On 7/19/2024, nurse aide #2 transferred resident #8 via stand/pivot transfer and care plan/Kardex indicated that resident requires 2-person assist with mechanical lift for transfers. Therapy assessment completed on resident #8 on 7/19/2024 that determined resident was appropriate for stand/pivot transfer. Care plan/Kardex updated to stand/pivot transfer needs on 7/19/2024. Nurse aide #2 provided corrective action on proper transfer techniques and review care plan/Kardex prior to transfers. Resident #8 Like Residents Director of Nursing completed an audit of all residents to determine transfer status, based on previous performance and therapy evaluations, was reflected on care plan and accurate to current needs on 5/20/2024 with Director of Rehab, Executive Director, and Activities Director. Care plans/Kardex updated to current needs, as needed. Systemic Changes Director of Nursing and/or Staff development coordinator educated nurses and nurse aides on mechanical lift safety	

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required total dependence with transfer to bed from wheelchair due to both lower extremity weakness and non-weight bearing on the right leg due to fracture. She was unable to complete sit-to-stand as she could not stand but was able to complete wheelchair to bed transfer with PT assistance. She was able to assist with upper extremities but very little with lower extremities. Resident #44 was maximum assistance with bed mobility tasks due to inability to move her legs on her own but did use her upper extremities to help as able.

An Activity of Daily Living (ADL) care plan, initiated on 04/19/23, revealed Resident #44 had an ADL self-care performance deficit related to inability to move bilateral legs, needs assistance. There were no interventions regarding transfer status until the care plan was revised on 05/21/24 which noted Resident #44 required total staff assistance with transfers.

The annual Minimum Data Set (MDS) dated 02/29/24 assessed Resident #44 with intact cognition. Resident #44 required partial to moderate staff assistance for sit-to-stand and chair/bed-to-chair transfers.

An incident/accident report dated 05/17/24 completed by Nurse #3 revealed around 8:00 PM, she was notified by Nurse Aide (NA) #1 that Resident #44 had fallen out of her motorized wheelchair onto the floor. NA #1 reported that as she was turning down the covers on Resident #44's bed, Resident #44 was sitting toward the edge of the seat of the motorized wheelchair when she (Resident #44) accidentally hit the hand control causing it to jerk backwards and Resident #44 fell forward onto the floor. Upon

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and transfer status on care plan/Kardex on 5/19/2024, prior to next shift. Director of Rehab educated that resident transfer status is assessed upon admission, readmission and change of condition through BMAT (Bedside Mobility Assessment Tool) completed by nursing or therapy evaluation on 5/20/2024.
Director of Nursing, Director of Therapy and/or designee re-educated nurses and nurse aides on mechanical lift safety, reviewing transfer status on care plan/Kardex prior to care and proper transfer techniques on 7/19/2024, prior to next shift.
Monitoring
Interdisciplinary team to review new admissions transfer status during morning meeting 5 times weekly for 4 weeks; 3 times weekly for 4 weeks; 1 time weekly for 4 weeks. Random mechanical lift transfer observations completed by Director of Nursing and/or designee during rounds of facility 5 times weekly for 4 weeks; 3 times weekly for 4 weeks; 1 time weekly for 4 weeks. Executive director to perform 5 random interviews of residents about transfer needs being met times 4 weeks; 3 interviews weekly times 4 weeks and 1 interview weekly for 4 weeks.
Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate.
Completion Date: 7/19/2024

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F 689	Continued From page 14 assessment, Nurse #3 noted Resident #44's passive range of motion was within normal limits and Resident #44 voiced no complaints of pain. The only injury identified at the time of Nurse #3's assessment was a small topical abrasion to the left elbow and a bandaid was applied. Around 10:00 PM, Resident #44 complained of left hip pain, as needed Tylenol was administered and ice applied to her left hip. The on-call provider was notified and provided orders for a 2-view STAT x-ray of the left hip. Radiology results dated 05/18/24 revealed in part, Resident #44 had an acute left intertrochanteric fracture with mild displacement with varus angulation. A physician's order dated 05/18/24 read, send to Emergency Room (ER) due to left femoral fracture with displacement. Review of hospital records dated 05/20/24 revealed on 05/18/24 Resident #44 "who is paralyzed from the legs down" presented to the ER for evaluation of left hip pain after being dropped by staff while being transferred between surfaces. X-rays obtained revealed she had an acute minimally displaced left intertrochanteric fracture. On 05/18/24, Resident #44 underwent a successful cephalomedullary intertrochanteric nailing (surgical procedure to treat displaced intertrochanteric femur fractures) and was discharged back to the facility on 05/20/24. During an interview on 07/17/24 at 3:15 PM and follow-up interviews on 07/18/24 at 8:55 AM and 07/18/24 at 4:18 PM, Resident #44 revealed NA #1 had dropped her to the floor while trying to transfer her from the motorized wheelchair to her	F 689		

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F 689	Continued From page 15 bed. Resident #44 could not recall the date but stated she was seated in her motorized wheelchair in-between the door of the room and wall of the bathroom door approximately 6 feet from the foot of her bed when NA #1 had come into the room to assist her with getting into bed for the night. Resident #44 recalled when NA #1 stated she was going to transfer her to the bed, Resident #44 told NA #1 that she needed to move closer to the bed because she too heavy and too far away for NA #1 to lift her but NA #1 told her "no, I can lift you." Resident #44 stated she never hit the hand control on the motorized wheelchair causing her to fall forward onto the floor. She explained NA #1 stood in front of the motorized wheelchair, put her arms underneath Resident #44's arms, and lifted her up. She stated NA #1 took 2 steps backwards toward the bed while lifting Resident #44 and was then dropped to the floor landing on her left side. Resident #44 did not recall having any immediate pain but stated she did have pain later and was sent out to the hospital due to a fracture. During a telephone interview on 07/19/24 at 2:28 PM, Resident #44's Responsible Party (RP) revealed on the evening of 05/17/24 she was notified that while being transferred, Resident #44 hit the hand control on the motorized wheelchair causing her to fall out onto the floor and her (RP) immediate response was to ask why the motorized wheelchair was left on if staff were transferring her out of it. Then early the next morning (05/18/24) she received a call that Resident #44 was in pain, x-rays were obtained and she was being sent out to the hospital. When the RP arrived at the hospital, she asked Resident #44 how she had hit the hand control on the motorized wheelchair and Resident #44	F 689		

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F 689	Continued From page 16 stated she didn't. Resident #44 told the RP that the NA had dropped her when trying to transfer her without using a mechanical lift. The RP stated she immediately called and spoke with the Administrator who confirmed that when they interviewed the NA, she admitted attempting to transfer Resident #44 without assistance or using a mechanical lift. During a telephone interview on 07/18/24 at 12:05 PM, NA #1 revealed she typically worked 7:00 PM to 7:00 AM and confirmed she was assigned to provide care to Resident #44 the evening of 05/17/24 when Resident #44 fell. NA #1 stated that night (05/17/24) was the first time she had attempted to transfer Resident #44 because she was usually already in bed when she started her shift at 7:00 PM. She explained when she checked the Kardex (NA reference guide that summarizes a resident's needs) there was nothing listed regarding Resident #44's transfer status and she did not think to ask anyone about Resident #44's transfer status or for assistance because at first, she thought she would be able to transfer Resident #44 herself. NA #1 recalled Resident #44 was facing the bed while seated in her motorized wheelchair in-between the door of the room and wall of the bathroom, when she (NA #1) put her arms underneath Resident #44's arms, started to lift her up and quickly realized she wouldn't be able to lift her so she sat Resident #44 back down on the seat of the motorized wheelchair. NA #1 could not recall for certain if she or Resident #44 hit the hand control on the motorized wheelchair but stated it jerked backwards and then Resident #44 fell forward onto the floor landing on her left side. NA #1 stated she only lifted Resident #44 up from the seat but not away from the wheelchair and did not	F 689		

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F 689	Continued From page 17 drop Resident #44 to the floor. When asked why she thought Resident #44 would state that NA #1 had dropped her while trying to lift and move her to the bed, NA #1 provided no response. NA #1 stated when Resident #44 fell to the floor, she made sure Resident #44 was ok, told her not to move and then left the room to inform Nurse #3 what happened. During a telephone interview on 07/18/24 at 11:57 PM, Nurse #3 confirmed she was notified by NA #1 that Resident #44 had fallen to the floor and she immediately went to the room to assess Resident #44. When she entered the room, she recalled Resident #44 was lying on her left side on the floor in front of her motorized wheelchair with her head toward the bed. Nurse #3 stated upon assessment, Resident #44 had no obvious or visible signs of fracture and she displayed no non-verbal indicators of pain such as grimacing nor voiced any complaints of pain when she (Nurse #3) lifted her legs up and outward to assess her range of motion. Nurse #3 stated she and NA #1 assisted Resident #44 up off the floor and into bed. Later that evening, Nurse #3 stated Resident #44 started complaining of pain, she notified the on-call provider, obtained orders for an x-ray and when the results revealed a hip fracture, Resident #44 was sent out to the hospital. Nurse #3 recalled when she initially assessed Resident #44, she had asked her what happened and all Resident #44 would state was "that lady did it" or "that lady dropped me." Nurse #3 could not recall for certain Resident #44's exact wording but stated that Resident #44 was a reliable historian and did imply the fall was NA #1's fault. Nurse #3 stated when she talked with NA #1 about the incident, NA #1 gave two different versions of what happened. NA #1 first	F 689		

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F 689	Continued From page 18 stated that Resident #44 was sitting on the edge of the motorized wheelchair and while NA #1 was getting the bed ready, Resident #44 accidentally hit the hand control of the motorized wheelchair causing it to go backwards and Resident #44 fell forward onto the floor. Then later when Nurse #3 asked NA #1 to write a statement, NA #1 revealed she had tried to lift Resident #44 from the motorized wheelchair to transfer her to the bed but couldn't and accidentally hit the hand control of the motorized wheelchair causing Resident #44 to fall out of the motorized wheelchair onto the floor. Nurse #3 stated based on how Resident #44 was lying on the floor when she first entered the room, NA #1's description of what happened didn't seem plausible as she would have expected for Resident #44 to have landed on her knees or stomach and not on her side if she had fell forward out of the motorized wheelchair. Nurse #3 recalled when she asked NA #1 why she tried to transfer Resident #44 independently, NA #1 stated she was not aware of Resident #44's transfer status or that she required a two-person assist. Nurse #3 stated even though she was certain she had told NA #1 of Resident #44's transfer status, NA #1 never asked anyone what level of assistance Resident #44 required before attempting to transfer her independently which she (Nurse #3) felt ultimately caused Resident #44 to fall to the floor. During an interview on 07/18/24 at 4:28 PM, the Rehab Director revealed when a resident admitted to the facility, upon initial assessment therapy specified the specific type of mechanical lift to be used if that was determined to be the safest way to transfer, otherwise, they would indicate "2-person total assist" which she explained could be 2 staff members providing	F 689		

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F 689	Continued From page 19 physical assistance without the use of a mechanical lift. The Rehab Director stated Resident #44 was unable to use her lower extremities or stand on her own but could bear weight on her legs with maximum staff assistance which she described as the person assisting performed 100 percent of the work. The Rehab Director stated when Resident #44 was first admitted, she was evaluated by PT on 04/03/23 as a 2-person total assist unless the staff member was trained with using a sliding board and then one-person could assist. The Rehab Director stated with therapy, Resident #44 transitioned to a sit-to-stand mechanical lift with 2-person assist that was still her current baseline. During interviews on 07/18/24 at 11:26 AM and 07/19/24 at 10:46 AM, the Director of Nursing (DON) stated it was the facility's policy to always have 2 staff members when transferring residents using a mechanical lift. The DON recalled Resident #44 stating that NA #1 was going to transfer her to the bed but she accidentally hit the hand control of the motorized wheelchair and fell to the floor. She stated Resident #44 had not mentioned anything about a mechanical lift being in the room. The DON stated when she talked with NA #1 about what happened, NA #1's stories did not remain consistent. At first, NA #1 stated Resident #44 was on the edge of the seat of the motorized wheelchair, Resident #44 hit the hand control which caused it to jerk backwards and Resident #44 fell forward onto the floor. Then later, NA #1 stated she had tried to independently transfer her without a mechanical lift but realized she couldn't and when she sat Resident #44 back into the seat of the motorized wheelchair somehow the hand control was accidentally hit which caused Resident #44 to fall forward onto	F 689		

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the floor. The DON stated when she and Nurse #3 discussed the incident, they didn't find NA #1's story plausible based on how Resident #44 was observed on the floor by Nurse #3. The DON stated through their investigation, they determined the fall was the result of NA #1 transferring Resident #44 without 2-person assist and staff education regarding safe transfers and residents transfer status was initiated.

During an interview on 07/19/24 at 11:15 AM, the Administrator revealed she spoke with Resident #44 when she returned from the hospital and Resident #44 stated the fall occurred when NA #1 was transferring her from the motorized wheelchair. She stated Resident #44 indicated "the poor girl was trying to transfer her but couldn't do it" and she (Resident #44) did not know what happened during the transfer to cause NA #1 to drop her. The Administrator stated that based on what NA #1 and Resident #44 both stated happened as well as how Resident #44 was observed on the floor by Nurse #3, they determined NA #1's account of what happened didn't seem plausible since Resident #44 had landed on her side and not on her hands or knees which was what they would have expected to happen if someone fell forward out of the wheelchair as NA #1 had stated. She stated she had staff assess the palms of Resident #44's hands and forehead to see if there were any carpet burns indicative of her falling forward out of the chair onto the floor but there was nothing. The Administrator stated she felt the incident scared NA #1 which led her not to disclose certain details about what happened and during the course of the investigation, it was determined that NA #1 did in fact attempt to lift Resident #44 out of the motorized wheelchair without the use of

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a mechanical lift or additional staff assistance. The Administrator stated she was not certain if the hand control of Resident #44's motorized wheelchair was hit by accident, if at all; however, she did not think the outcome would have been any different as NA #1 did not follow proper protocol for transferring a resident and if she was unsure of Resident #44's transfer status she should have asked someone.

During an interview on 07/18/24 at 11:30 AM, the Physician Assistant (PA) stated she was not at the facility on 05/17/24 when Resident #44 fell but she did examine her upon her return to the facility from the hospital. The PA stated she would expect for staff to follow PT recommendations regarding a resident's transfer status.
2. Resident #8 was admitted to the facility on 12/09/22 with diagnoses including multiple sclerosis and right foot drop.

The quarterly Minimum Data Set (MDS) assessment dated 05/03/24 revealed Resident #8 was cognitively intact and dependent on staff for transfers from the bed to the chair. There had been no falls since the previous assessment and Resident #8 used a wheelchair/scooter for mobility.

The activities of daily living care plan last reviewed on 05/30/24 identified Resident #8 as having a deficit in her ability to perform self-care. Her deficit was related to musculoskeletal impairment due to the diagnosis of multiple sclerosis. The goal was to maintain the current level of functioning through the review date. One of the interventions in place required staff use a total mechanical lift with 2-person assistance.

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During an interview on 07/15/24 at 11:08 AM Resident #8 revealed she needed staff assistance with transfers and used a powered wheelchair for mobility. She stated the nursing staff used different techniques to transfer her and sometimes one-person assistance was provided. She revealed nursing staff had physically lifted her from underneath her arms or used a mechanical lift with a sling. She revealed it hurt her left shoulder when staff physically lifted her under the arms. Resident #8 denied any falls had occurred while a resident at the facility.

Review of the Kardex updated on 07/19/24 revealed the guidance for transferring Resident #8 was to use the total mechanical lift with 2-person assistance.

During an observation and interview on 07/19/24 at 8:18 AM Resident #8 was in bed and stated someone would need to assist her out of bed but she preferred to wait at this time. Resident #8 stated some of the nursing staff continued to transfer her without the use of the mechanical lift and two-person assistance.

During an observation on 07/19/24 at 9:55 AM NA #2 exited the room with no mechanical lift. At 10:00 AM Resident #8 was observed out of the bed and sitting in her power wheelchair brushing her hair with no signs of distress or pain. Resident #8 revealed she was transferred by NA #2 without the use of a mechanical lift and was able to transfer without incident. A total mechanical lift was available on the hall where Resident #8's room was located.

An interview was conducted on 07/19/24 at 10:25 AM with NA #2. NA #2 confirmed she had

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LIFE CARE CENTER OF HENDERSONVILLE	**400 THOMPSON STREET HENDERSONVILLE, NC 28792**

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F 689	Continued From page 23 transferred Resident #8 from the bed to the wheelchair using one-person physical assistance. She did not ask for help and stated she felt safe transferring Resident #8 by herself because the resident could bear weight on one leg and was able to stand and pivot and she had used a gait belt during the transfer. She revealed a total mechanical lift was available and could be used to transfer the resident, but she was not directed to use it and stated it was more difficult to have two-person assist when transferring Resident #8. She did have access to Resident #8's care plan/Kardex and could review the level of assistance needed prior to transferring and stated she had not recently checked it. NA #2 revealed she worked as needed and recently started working on the floor as a NA. She stated if she noticed a change in the resident's ability to transfer, she would notify the nurse and there was a form to fill out and give to therapy or she would verbally tell the Rehab Director or other therapist. NA #2 confirmed she had not informed therapy or anyone Resident #8 was able bear weight and pivot with 1 person assistance using a gait belt to transfer from the bed to wheelchair. During an interview on 07/19/24 at 10:46 AM the Director of Nursing (DON) was made aware NA #2 transferred Resident #8 using one person assist and without the use of a total mechanical lift. The DON stated Resident #8 required two-person assistance using the total mechanical lift for transfers and she had spoken to the nursing staff about where to find transfer status and safety for residents using the Kardex. She stated NA #2 should not have transferred Resident #8 without using the total mechanical lift with 2-person assistance.	F 689		

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F 689	Continued From page 24 An interview was conducted on 07/19/24 at 11:06 AM with the Administrator. The Administrator confirmed Resident #8's care plan was to use the total mechanical lift with two-person assistance for transfers. The Administrator stated she expected NA #2 to check the care plan before providing care prior to transferring a resident.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Registered Dietitian, Physician Assistant, and staff interviews, the facility failed to follow a physicians order to administer the correct amount of a high protein, fiber fortified nutritional	F 692	It is the practice of the facility to ensure that residents are offered sufficient fluid intake to maintain proper hydration and health and offer a therapeutic diet when there is a nutritional problem and the	8/11/24

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F 692	Continued From page 25 supplement as recommended by the Registered Dietitian for 1 of 2 residents reviewed for tube feeding (Resident #15). Findings included: Resident #15 was admitted to the facility on 09/01/22 with multiple diagnoses that included dysphagia (difficulty swallowing) following cerebral infarction (stroke) and diabetes. The quarterly Minimum Data Set (MDS) assessment dated 05/31/24 revealed Resident #15 was severely impaired with cognitive skills for daily decision making and was dependent on staff assistance for all self-care tasks, bed mobility and transfers. Resident #15 received tube feeding while a resident and received 51% or more of total calories and 501 cubic centimeters (cc) or more of fluid intake via tube feeding. Review of Resident #15's comprehensive care plans, last reviewed/revised on 05/31/24, revealed a plan that addressed her nutritional needs related to tube feedings. Interventions included to provide total staff assistance with tube feeding and water flushes, see physician orders for current tube feeding orders, and the Registered Dietitian (RD) to make recommendations for changes to tube feeding as needed. A RD progress note dated 06/05/24 revealed in part, Resident #15's estimated oral intake was exceeding her estimated calorie and protein needs but was not meeting her estimated fluid needs as evidenced by recent laboratory results indicating poor hydration status. The RD recommended either 1) decreasing the fortified	F 692	health care provider orders a therapeutic diet. Corrective Action Resident #15 was reviewed by registered dietician for dietary needs and confirmed orders for tube feedings. Nurse #2 and Nurse #3 re-educated on following physician orders on 7/19/2024. Like Residents Director of Nursing reviewed tube feeding patients in the facility on 7/16/2024 with no further concerns. Systemic Changes Director of Nursing and/or designee re-educated licensed nurses on following physician's orders for nutrition/hydration needs on 8/7/2024, prior to working next shift. Monitoring Director of Nursing and/or designee to complete 5 random audits of tube feeding settings on residents□ receiving tube feedings weekly x 4 weeks; 3 times weekly x 4 weeks and then 1 time weekly x 4 weeks. Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate. Completion Date: 8/11/2024	

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F 692	Continued From page 26 nutritional supplement 1.5 tube feedings to 55 milliliters (ml)/hour (hr.) with water flushes of 20 ml/hr. for 22 hours from 8:00 PM to 6:00 AM or 2) change to fortified nutritional supplement 1.2 tube feedings at 70 ml/hr. with water flushes of 10 ml/hr. for 22 hours from 8:00 PM to 6:00 AM. A physician order dated 06/27/24 for Resident #15 read in part, fortified nutritional supplement 1.5 at 55 ml/hr. and add water flushes of 20 ml/hr. for 22 hours, from 8:00 PM to 6:00 AM two times a day. Review of Resident #15's July 2024 Medication Administration Record (MAR) revealed tube feedings were initialed as completed per physician order. An observation of Resident #15 on 07/15/24 at 11:37 AM revealed her tube feeding was running through the pump at 50 ml/hr. with water flushes at 20 ml/hr. The bottle of tube feeding was dated 07/15/24 at 6:00 PM. A second observation of Resident #15 on 07/16/24 at 8:16 AM revealed her tube feeding was running through the pump at 50 ml/hr. with water flushes at 20 ml/hr. The bottle of tube feeding was dated 07/16/24 at 11:00 PM and initialed by Nurse #2. An observation and interview was conducted with the Director of Nursing (DON) on 07/16/24 at 8:30 AM. The DON confirmed that Resident #15's tube feeding was set at 50 ml/hr. and should have been set at 55 ml/hr. The DON stated the physician order should be followed for the proper tube feeding settings and felt Nurse #2 likely just misread the order.	F 692		

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F 692	Continued From page 27 During a telephone interview on 07/16/24 at 4:51 PM, the RD revealed her recommendations for tube feedings depended on what the provider agreed with and/or what the resident could tolerate. The RD stated that since she didn't observe Resident #15's tube feeding settings at 50 ml/hr. or speak with Nurse #2, she could not state what her expectation was regarding why her recommendation for Resident #15 to receive tube feedings at 55 ml/hr. was not followed. Telephone attempts for an interview with Nurse #2 on 07/18/24 at 10:51 AM and 07/18/24 at 3:02 PM were unsuccessful. During an interview on 07/18/24 at 10:59 AM, the Physician Assistant stated that she would like for staff to follow the tube feeding orders recommended by the RD. During an interview on 07/18/24 at 5:09 PM, the Administrator stated she was not clinical and could not state what she would expect without first talking to Nurse #2 to see why Resident #15's tube feeding settings did not match the physician's order.	F 692		
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.	F 761		8/11/24

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F 761 Continued From page 28

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and interviews with staff the facility failed to date two open and in use bottles of medicated eye drops being stored at room temperature on 1 of 4 medication carts (Hall 400 med cart) and failed to date three in use multi-dose vials of tuberculin purified protein derivative (a diagnostic antigen used in testing for tuberculosis) and failed to remove expired medications and influenza vaccines from 2 of 2 medication room refrigerators (medication room for halls 200, 300, 400, 500, and 600) reviewed for medication storage and labeling.

Findings revealed:

a. Review of manufacturer's package insert for latanoprost eye drops read in part, "store unopened bottle(s) under refrigeration at 36 to 46°F. Once it was opened for use, it may be

F 761

It is the practice of the facility to label and store drugs and biologicals used in the facility to be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.
Corrective Action
The medicated eye drops that were labeled, the tuberculin purified protein derivative vials, and expired medications and influenza vaccines were disposed of 7/19/2024.
Like Residents
Director of Nursing reviewed medication carts and medication storage for any medication not labeled and/or expired. No further items identified during audit.
Systemic Changes
Director of Nursing and/or designee

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F 761	Continued From page 29	F 761		

stored at room temperature for 6 weeks."

An observation of the Hall 400 med cart and interview with Nurse #1 were conducted on 07/18/24 at 4:26 PM. Two opened bottles of latanoprost 0.005% were being stored at room temperature with no open date of when it was put in use. Nurse #1 stated latanoprost eye drops were kept in the refrigerator and should be dated when removed and could be left at room temperature in the med cart when in use. Nurse #1 was unsure how long the latanoprost eye drops were in use and revealed she had not administered them and usually was not assigned to administer medications from the Hall 400 med cart.

During an interview on 07/19/24 at 12:35 PM the Director of Nursing (DON) revealed latanoprost eye drops were stored in the refrigerator and should be dated when removed and placed on the medication cart for in use.

During an interview on 07/19/24 at 4:41 PM the Administrator revealed it was the expectation the nurse who removed the latanoprost eye drops from the refrigerator and placed it on the medication cart for use to date the bottle.

b. Review of manufacturer's package insert for tuberculin read in part, "this product should be stored between 36 and 46°F and vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."

An observation of the medication storage room for halls 200, 300, and 400 with the DON was conducted on 07/18/24 at 4:03 PM. Stored in the

re-educated licensed nurses on medication labeling and storage and expired medications on 8/7/2024, prior to working next shift.
Monitoring
Director of Nursing and/or designee to complete 5 random audits on medication carts weekly x 4 weeks; 3 times weekly x 4 weeks and 1 time weekly x 4 weeks.
Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate.
Completion Date: 8/11/2024

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F 761	Continued From page 30 refrigerator were two open vials of tuberculin purified protein derivative with no date of when they were put in use. The DON revealed she was unsure when the 2 vials were opened. An observation of the medication storage room for halls 500, and 600 with the DON was conducted on 07/19/24 at 12:37 PM. Stored in the refrigerator was one open vial of tuberculin purified protein derivative with no date of when it was put in use, four boxes containing 10 individual influenza vaccines with an expiration date 06/30/24 and five acetaminophen suppositories with the expiration date 06/24/24. The DON revealed either her or the Assistant Director of Nursing checked the refrigerators in the medication rooms for unlabeled and expired medications and the Infection Preventionist was responsible for checking the expiration dates on the influenza vaccines. During an interview on 07/19/24 at 3:47 PM the Infection Preventionist revealed she was not aware she was supposed to check the expiration dates for the influenza vaccines stored in the medication rooms. An interview was conducted on 07/19/24 at 4:41 PM with the Administrator. The Administrator revealed the nurses administered the tuberculin purified protein derivative and were responsible for dating the vial when accessed and put in use. She revealed it was her expectation the medication rooms were regularly checked and expired medications and vaccines were removed from the refrigerator.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		8/11/24

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F 803	Continued From page 31 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation of the meal service tray line, record review, and Registered Dietician and dietary staff interviews the facility failed to provide all food items as specified by the planned menu for residents receiving a pureed (foods that have a smooth consistency and don't have to be chewed) diet. This practice had the potential to affect 6 of 6 residents receiving a pureed diet. Findings included:	F 803	It is the practice of the facility to provide all food items as specified by the planned menu for residents receiving pureed diet. Corrective Action Executive Director re-educated Cook #1 on meeting residents□ needs and providing all food items to residents with a pureed diet on 7/17/2024. Like Residents Registered dietician reviewed all residents	

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F 803	Continued From page 32 During a continuous observation of the lunch meal tray line on 07/17/24 from 11:50 AM until 12:50 PM Cook #1 plated pureed chicken and dumplings and pureed beets using a 4-ounce serving utensil. No pureed bread was provided on pureed meal trays. Review of the menu revealed the following portions were to be served on 07/17/24 for the lunch meal: -pureed chicken and dumplings 4-ounce serving -pureed beets 4-ounce serving -1 serving of pureed bread mix Cook #1 was unable to be interviewed during the survey. An interview with the Dietary Manager on 07/17/24 at 1:05 PM revealed Cook #1 was responsible for following the menu and he was not sure why she had not prepared pureed bread. A telephone interview with the Registered Dietician (RD) on 07/17/24 at 1:26 PM revealed she expected dietary staff to follow the menu as planned and she was not sure why pureed bread had not been prepared. An interview with the Administrator on 07/19/24 at 4:16 PM revealed she expected menus to be followed as planned unless a substitution approved by the RD was provided.	F 803	with altered diets at facility with no further concerns, at that time. Systemic Changes Executive director re-educated dietary staff on providing all food items to residents with a pureed diet on 8/2/2024. Monitoring Executive director and/or designee to perform 5 random audits weekly of pureed diet trays x 4weeks; 3 times weekly for 4 weeks and 1 time weekly x 5 weeks. Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate. Completion Date: 8/11/2024	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink	F 806		8/11/24

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F 806	Continued From page 33 Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and resident interviews the facility failed to honor food preferences for 1 of 3 residents reviewed for food preferences (Resident #9). Findings included: Resident #9 was admitted to the facility 06/12/22 with diagnoses including anemia and malnutrition. Review of Resident #9's Physician orders revealed an order dated 06/08/24 for a regular diet. The quarterly Minimum Data Set (MDS) assessment dated 06/10/24 indicated Resident #9 was cognitively intact, required set-up or clean-up assistance with eating, and no weight loss or weight gain. Resident #9's nutrition care plan last revised on 06/18/24 revealed she had a potential nutritional problem related to coughing during meals. Interventions included providing and serving diet as ordered and assuring Resident #9 was out of bed for all meals. An interview with Resident #9 on 07/15/24 at	F 806	It is the practice of the facility to ensure that each resident receives and the facility provides food that accommodates resident allergies, intolerances and preferences. Corrective Action Resident #9 was provided yogurt on 7/18/2024 and tray card updated to reflect resident's preferences on 7/17/2024. Like Residents Registered dietician performed audit on tray cards and dietary preferences of facility on current residents and updated tray cards to reflect dietary preferences, as discrepancies were found. Systemic Changes Executive Director re-educated dietary staff on resident allergies, preferences and substitutes and providing food within these parameters on 8/2/2024. Monitoring Executive director and/or designee to perform 5 random audits weekly diet trays x 4weeks; 3 times weekly for 4 weeks and 1 time weekly x 5 weeks to ensure all items are present. Executive Director will review the results of audits for trends and will report findings	

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F 806	Continued From page 34 11:47 AM revealed she had asked dietary staff (the Dietary Manager and other dietary employees) multiple times for yogurt with each meal and had not received yogurt on her meal trays. Resident #9 was observed with her meal trays on 07/15/24 at 12:36 PM, 07/16/24 at 8:32 AM, and 07/17/24 at 8:20 AM. No yogurt was observed on her meal trays and no request for yogurt with all meals was observed on her meal ticket until 07/17/24. An interview with the Dietary Manager on 07/16/24 at 12:12 PM revealed he was aware Resident #9 had requested to receive yogurt on all her meal trays, yogurt was available from the kitchen, and he was not aware of any concerns that she had not been receiving yogurt per her preference. He stated he had not performed any audits of meal trays to ensure residents were receiving food per their preference since he began employment approximately one month ago. An interview with the Administrator on 07/19/24 at 4:16 PM revealed she expected residents' food preferences to be followed.	F 806	to the QAPI committee for further recommendations, as appropriate. It is the practice of the facility to ensure that each resident receives and the facility provides food that accommodates resident allergies, intolerances and preferences. Completion Date: 8/11/2024	
F 809 SS=D	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 regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.	F 809		8/11/24

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F 809	Continued From page 35 §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 and resident and staff interviews, the facility failed to offer and provide nighttime snacks for 3 of 4 sampled residents (Residents #2, #9 and #44). The findings included: During a resident council meeting on 07/17/24 at 3:05 PM, Resident #2, Resident #9 and Resident #44 all stated they were not offered nighttime snacks and when they did ask staff if there were any snacks available in the nourishment room, there wasn't much of a variety. The residents also stated they would enjoy receiving a healthy snack in the evenings because they usually ate dinner around 5:00 PM and sometimes they got hungry before breakfast was served the next morning around 8:45 AM to 9:00 AM. Observations of the 500/600 Hall nourishment room and activity nourishment room were conducted on 07/18/24 at 7:15 AM. The 500/600 Hall nourishment room revealed the only snacks available were a container of individually	F 809	It is the practice of the facility to offer and provide nighttime snacks to residents. Corrective Action Residents #2, #9 and #44 were offered snacks and reiterated that they can ask for snacks at any time on 7/19/2024. Like Residents All residents have the potential to be affected. Executive Director reviewed nourishment rooms and dietary storage for snack items and placement to ensure that they are readily available. Systemic Changes Executive director and/or designee re-educated dietary staff on providing snacks and restocking nourishment rooms with snacks routinely on 8/2/2024. Evening staff, including nurses, nurse aides, and/or hospitality aides, to offer snacks in the evening to residents that can't ask for themselves, on a daily basis. Monitoring Executive director and/or designee to perform random interviews with 5	

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F 809	Continued From page 36	F 809		

packaged peanut butter crackers and saltine crackers. The activity nourishment room revealed the only snacks available were two bags of saltine crackers.

During an interview on 07/18/24 at 3:32 PM, the Dietary Manager (DM) revealed evening snacks were available for residents upon request prior to dietary staff leaving for the day between 7:00 PM and 7:30 PM. The DM stated if a resident did not request a snack before dietary staff left for the day, they could choose from the snacks available in the nourishment rooms. The DM was unsure who was responsible for ensuring that the nourishment rooms were stocked with various snacks for the residents.

During a joint interview on 07/18/24 at 5:09 PM with the Administrator, the Corporate Consultant explained when she was the Interim Administrator last year, dietary staff used to bring out a tray of snacks labeled with resident's names before they left for the day and she was not sure if that was still being done.

During a joint interview on 07/18/24 at 5:09 PM with the Corporate Consultant, the Administrator stated since she had started her employment at the facility in April 2024, dietary staff had not brought out a tray of snacks for residents prior to them leaving for the day. The Administrator explained there were plenty of snacks available, such as crackers, chips and cookies, and all staff had access to the nourishment rooms to get snacks for residents when they requested.

During a follow-up interview on 07/19/24 at 4:10 PM, the Administrator was unaware there were only few snacks available in the nourishment

residents to ensure that they are provided nutritional snacks weekly x 4 weeks, 3 times weekly times 4 weeks and 1 time weekly x 4 weeks.
Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate.
Completion Date: 8/11/2024

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F 809	Continued From page 37 rooms upon observation and stated dietary staff were responsible for ensuring the nourishment rooms remained stocked with various snacks for the residents.	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and 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 maintain a clean fan in the food preparation area of 1 of 1 kitchen; maintain clean walls and a clean ceiling in 1 of 1 walk-in cooler; label and date open food items, discard expired food, and discard food with signs of spoilage in 1 of 1 walk-in cooler; date milkshakes to identify their use-by date in 1of 1 walk-in cooler; date an opened food item in 1 of 1 walk-in freezer; discard expired food items in 1 of 1 kitchen; and	F 812	It is the practice of the facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Corrective Action The fans and walk in cooler were deep cleaned on 7/17/2024. All unlabeled and expired foods were disposed of on 7/17 and 7/18. Like Residents	8/11/24

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F 812	Continued From page 38 ensure food and beverage items were labeled and dated and date milkshakes to identify their use-by date in 2 of 2 nourishment rooms (activity room refrigerator and 500/600 hall). These practices had the potential to affect food served to the residents. Findings included: 1. An initial observation of the kitchen on 07/15/24 at 09:28 AM revealed a fan with gray debris to the front and back covers mounted on the wall near the walk-in cooler blowing toward the food preparation area. An additional observation of the kitchen on 07/16/24 at 12:12 PM revealed a fan with gray debris to the front and back covers mounted on the wall near the walk-in cooler blowing toward the food preparation area. An interview with the Dietary Manager on 07/16/24 at 12:12 PM revealed he expected the fan to be clean and free of debris. He explained he had only been employed at the facility around a month and he was not sure if there was a deep cleaning schedule or who was responsible for cleaning the fan. An interview with the Administrator on 07/19/24 at 4:16 PM revealed she expected all kitchen fans to be clean and free of debris. 2. An initial observation of the walk-in cooler on 07/15/24 at 09:29 AM revealed a thick build-up of gray debris near the ceiling light and on the wall of the entry door. An additional observation of the walk-in cooler on	F 812	All residents have the potential to be affected. Dietary manager completed review of food storage areas in the facility and any items found to be unlabeled, expired, showing signs of spoilage, or outside of manufacturer's guidelines for use were disposed of on 7/18/2024. Systemic Changes Executive Director and/or designee re-educated dietary staff on labeling and dating food, disposing of any items unlabeled, expired, showing signs of spoilage, or outside of manufacturer's guidelines for use and cleaning procedures on 8/2/2024. Monitoring Executive Director and/or designee to perform audits of food storage areas 5 times weekly x 4 weeks, 3 times weekly x 4 weeks and 1 time weekly x 4 weeks to review for any items that are unlabeled, expired, showing signs of spoilage, or outside of manufacturer's guidelines for use. Executive Director will review the results of audits for trends and will report findings to the QAPI committee for further recommendations, as appropriate. Completion Date: 8/11/2024	

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F 812	Continued From page 39 07/16/24 at 12:15 PM revealed a thick build-up of gray debris near the ceiling light and on the wall of the entry door. An interview with the Dietary Manager on 07/16/24 at 12:15 PM revealed he expected the cooler to be clean and free of debris. He explained he had only been employed at the facility around a month and he was not sure if there was a deep cleaning schedule or who was responsible for cleaning the cooler. An interview with the Administrator on 07/19/24 at 4:16 PM revealed she expected the walk-in cooler to be clean and free of debris. 3. An initial observation of the walk-in cooler on 07/15/24 at 09:30 AM revealed the following: (a). an opened and undated pack of sliced cheese (b). an opened and undated 5-pound container of cottage cheese (c). an opened and undated container of shredded cheese (d). 2 opened and undated loaves of bread which did not contain an expiration date (e). 3 heads of iceberg lettuce with brown discoloration (f). an unopened 32-ounce bag of collard greens with a best-by date of 07/10/24 (g). an opened and undated 5-pound bag of shredded carrots (h). a cardboard box of 12 fully thawed 4-ounce manufactured milkshakes with no label to indicate the date they were removed from the freezer or the expiration date An additional observation of the walk-in cooler on	F 812		

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F 812	Continued From page 40	F 812		

07/16/24 at 12:20 PM revealed 3 heads of iceberg lettuce with brown discoloration and 2 opened and undated loaves of bread which did not contain an expiration date sitting on a shelf.

An interview with the Dietary Manager on 07/16/24 at 12:20 PM revealed he expected all food items to be labeled and dated by the person placing the item in the cooler. He stated it was the responsibility of each dietary staff member to check for and discard any food with signs of spoilage or expired food. The Dietary Manager stated he was not sure of the shelf life of thawed manufactured milkshakes.

A follow-up interview with the Dietary Manager on 07/16/24 at 2:46 PM revealed thawed manufactured milkshakes were good for 14 days after being thawed and he expected dietary staff to date the milkshakes when they were removed from the freezer.

An interview with the Administrator on 07/19/24 at 4:16 PM revealed she expected all food items to be labeled and dated when placed in the cooler, food to be used or discarded on or by the best-by date, food with signs of spoilage to be discarded, and manufactured milkshakes to be used or discarded within 14 days of being thawed.

4. An initial observation of the walk-in freezer on 07/15/24 at 09:38 AM revealed an opened and undated bag of French fries.

An additional observation of the walk-in freezer on 07/16/24 at 12:22 PM revealed an opened and undated bag of French fries.

An interview with the Dietary Manager on

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F 812	Continued From page 41	F 812		

07/16/24 at 12:22 PM revealed he expected all opened food items to be labeled and dated by the person placing the item in the freezer.

An interview with the Administrator on 07/19/24 at 4:16 PM revealed she expected all opened food items to be dated when placed in the freezer.

5. An initial observation of a food preparation table on 07/15/24 at 09:40 AM revealed a bin of all-purpose flour with a use-by date of 12/28/23, a bin of breadcrumbs with a use-by date of 04/12/24, and a bin of sugar with a use-by date of 04/12/24.

An additional observation of a food preparation table on 07/16/24 at 12:25 PM revealed a bin of all-purpose flour with a use-by date of 12/28/23, a bin of breadcrumbs with a use-by date of 04/12/24, and a bin of sugar with a use-by date of 04/12/24.

An interview with the Dietary Manager on 07/16/24 at 12:25 PM revealed all dietary staff were responsible for checking for and discarding expired food items daily.

An interview with the Administrator on 07/19/24 at 4:16 PM revealed she expected all food items to be used or discarded by the use-by date.

6. (a) An observation of the activity room refrigerator on 07/18/24 at 7:15 AM revealed 7 fully thawed 4-ounce manufactured milkshakes with no label to indicate the date they were removed from the freezer or the expiration date.

(b). An observation of the 500/600 hall nourishment room refrigerator on 07/18/24 at

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F 812	Continued From page 42 07:25 AM revealed the following: -an opened and unlabeled 33.8-ounce bottle of water -an opened and unlabeled 6-ounce can of pineapple juice -an opened and unlabeled 20-ounce bottle of diet soda -an opened and unlabeled prepacked container of salad with a best-by date of 07/21/24 -an opened and unlabeled 16.9-ounce bottle of diet soda -an undated and unlabeled container of cake -1 fully thawed 4-ounce manufactured milkshake with no label to indicate when it was removed from the freezer or the expiration date An interview with the Dietary Manager on 07/18/24 at 7:45 AM revealed dietary aides were responsible each shift for ensuring all food and beverages were labeled and dated and discarding any items that were not labeled or dated. He stated dietary aides were also responsible for ensuring manufactured milkshakes were used or discarded 14 days after being thawed. An interview with the Administrator on 07/19/24 at 4:16 PM revealed she expected all food and beverage items in nourishment rooms to be labeled and dated and manufactured milkshakes to be used or discarded within 14 days of being thawed.	F 812		