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	345302	A. BUILDING _____ B. WING _____	C 07/30/2024

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VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/07/24 through 7/30/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #74AT11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/07/24 through 07/30/24. Event ID#74AT11. The following intakes were investigated NC00217241, NC00217849, NC00217876, NC00218035, NC00218675, NC00218438, and NC00218757. Nine of the 18 complaint allegations resulted in deficiency. The survey team entered the facility on 07/07/24 to conduct a recertification survey and complaint investigation. The survey team was onsite from 07/07/24 through 07/10/24. After management review, immediate jeopardy was identified for F690 and substandard quality of care was identified for F584, and the facility was notified of this on 07/20/24. The team went back to the facility on 07/30/24 to validate the facility's credible allegation for IJ removal. Therefore, the exit date was changed to 07/30/24. Event ID#74AT11. Immediate Jeopardy was identified at: CFR 483.25 at tag F690 at a scope and severity (K) The tags F584 and F690 constituted Substandard Quality of Care.	F 000		

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

Electronically Signed | 08/09/2024

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F 000	Continued From page 1 Immediate Jeopardy began on 05/03/24 and was removed on 07/26/24. An extended survey was conducted.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		8/20/24

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and interviews with residents and staff, the facility failed to treat residents in a dignified manner when staff did not allow Resident #51, Resident # 77 and Resident # 8 to leave their rooms due to the facility running out of oxygen tanks for 3 days. Resident # 51 stated she was very upset because she was unable to leave her room to go to church or do any of her daily routine and it made her feel very depressed. She stated that she felt like a "caged animal" having to stay in her room and felt anxiety over it. Resident #77 stated he had to stay in his room for all those days and was very bored and upset and did not feel it was right for the facility to not have portable tanks so he could do his daily business. Resident #8 stated he had to stay in his room for all those days and was very bored and upset and did not feel it was right for the facility to not have portable tanks so he could do his daily business. In addition, the facility failed to treat Resident #34 in a dignified manner by standing over them while assisting with eating. The reasonable person concept was applied to this example as individuals have expectations of being treated with dignity while dining. This deficient practice affected 4 of 4 residents reviewed for dignity. The findings included:	F 550	F550 Resident Rights Immediate action taken to ensure that this alleged deficiency does not recur; 1. A inventory of the facility oxygen supply was completed and has been maintained on a bi-weekly basis. Automatic oxygen deliveries are scheduled bi-weekly. The inventory count of portable oxygen tanks was completed by the Central Supply Coordinator on 7-8-2024. Resident #51 has been discharged from the facility. 2. Residents #77 and 8 were interviewed that there are no concerns regarding lack of oxygen availability. The Director of Nursing completed an inservice with NA #3 and the other Certified Nursing Assistants that were scheduled on 7-8-2024. 3. Residents #77 and 8 were interviewed that there are no concerns regarding lack of oxygen availability. The Director of Nursing completed an inservice with NA #3 and the other Certified Nursing Assistants that were scheduled on 7-8-2024. 4. Immediate taken for Resident# 34 involved Certified Nursing Assistant #3 receiving reeducation from the Director of	

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F 550	Continued From page 3 1. Resident #51 was admitted to the facility on 10/13/23 with the following diagnoses: chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD). Resident #51 had a physician order 3/17/24 stating the resident should be administered oxygen at 3 liters per minute via nasal cannula continuously. The Quarterly Minimum Data Set (MDS) dated 4/13/24 revealed that Resident #51 was cognitively intact. She used a walker or a wheelchair for mobility. She did show signs of shortness of breath with exertion, when sitting and lying flat. She was on oxygen therapy. On 7/08/24 at 3:13 PM an interview with Resident #51 stated about one month ago, on a Friday, she needed a new portable oxygen tank and one of the staff took her to the oxygen tank room to get a new tank. Resident # 51 could not remember who the staff was. The staff person went into the room to get a tank and came out saying there wasn't any. She stated the facility was out of the portable tanks until Tuesday at 3pm. Resident #51 stated that this had never happened before. She stated she was very upset because she was unable to leave her room to go to church or do any of her daily routine and it made her feel very depressed. She stated that she felt like a "caged animal" having to stay in her room for so many days. She also stated she had anxiety over it. On 7/08/24 at 11:30 AM an interview with Nurse #3 was conducted. Nurse #3 stated that she started working at the facility 6 weeks ago. Nurse #3 stated that she was alerted by a resident on	F 550	Nursing on the proper process for providing assisted feeding. This was completed on 7-8-2024. The facility recognizes that all residents requiring oxygen could be potentially affected by this alleged deficiency. Measures put into place to ensure that this alleged deficiency does not recur includes the following: An audit of all resident's requiring feeding assistance was completed on 7-11-2024 by the Speech Language Pathologist. This list was reviewed by the Interdisciplinary Team to review and update the resident list to assist the direct care staff with identifying residents requiring assistance. All resident care plans were reviewed and updated by the Minimum Data Set Coordinator on 7-10-2024 to reflect all residents that require special assistance. Inservices were held with the direct line nursing staff by the Director of Nursing /designee on 7-30-24 to review and communicate the availability of oxygen and the expectations of proper feeding techniques for all residents requiring feeding assistance which includes how to maintain dignity while assisting with feeding. A Interdisciplinary meeting was held with nursing and therapy to review the process for providing assistance to residents with special feeding needs. The facility is to have therapy services involved with any identified resident requiring 1:1 feeding assistance. The Director of Nursing/Designee will assure that nursing coverage is provided to the dining room so that observations can be made to ensure that Certified Nursing Assistants	

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F 550	Continued From page 4 her first day working at the facility that the facility had run out of portable oxygen for about 5 days. Nurse #3 checked the room which holds the portable oxygen tanks and found there were no portable oxygen tanks. She remembers that later that same day there was a delivery of portable oxygen tanks. Nurse #3 stated that this was the only time she knew that the facility ran out of portable tanks. Nurse #3 remembers that Resident #51was upset that day. Nurse #3 stated that Resident #51 needed to always be on oxygen, so she had to stay in her room using the concentrator. On 7/8/24 at 3:29 PM an interview was held with central supply staff. She stated that she took over the position at the end of March. She keeps an inventory of all office supplies and facility supplies. She has a list hanging in her office to write down supplies needed. The portable oxygen tanks are kept in a room off the 100 hall. There is an order placed with vendor every other Tuesday to get more tanks. The staff person stated the facility has never run out of portable oxygen tanks. She stated that the facility did have a power outage and the staff did use more of the portable tanks, but they did not run out. She stated that she has slips for all the deliveries. The delivery receipts were reviewed and showed that 40 tanks were delivered on 4/9/24, 40 tanks delivered on 4/23/24, 110 tanks delivered on 5/7/24, 110 tanks delivered on 5/10/24, 129 tanks delivered on 6/4/24, 78 tanks delivered on 6/18/24 and 119 tanks delivered on 7/2/24 On 7/10/24 at 2:45 PM an interview was conducted with the Director of Nursing (DON). The DON stated that central supply usually orders the oxygen for the facility and had the tank	F 550	are following the expectations with proper feeding procedures. Monitoring will be completed by the following: The Central Supply Coordinator will maintain a list of oxygen dependent residents. This list will be updated upon new admissions, readmissions and any new oxygen orders that are written for current residents. Oxygen deliveries will be changed to weekly as needed by 8-20-24. Oxygen dependent residents and residents requiring assistance with meals will be interviewed during Department Manager rounds and the results will be reported daily during the management stand down meetings. Residents that are unable to communicate any concerns will have observations completed by the Director of Nursing/Designees to ensure that standards of maintaining proper feeding techniques and resident dignity assistance is being provided. The Central Supply Coordinator maintains a current inventory listing and oversees the ordering based on the facility utilization rate. Oxygen deliveries are reconciled with the needed replacement oxygen tanks. Delivery tickets and inventory is maintained to support and ensure the available supply. The Central Supply Coordinator will be responsible for completing a monthly report and presenting the report to the monthly Quality Assurance and Process Improvement Committee x 3 months. Completion date: 8-20-2024	

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delivery on a schedule and if for some reason the facility runs out before the next scheduled delivery, central supply can call for more tanks to be delivered. The DON states that if staff notices that they need more tanks they can text the central supply staff and sometimes the central supply staff work on the weekends. The DON's understanding was that the facility did not run out of tanks, but only had 2 tanks left. The residents could use their concentrators and still have oxygen needed, but daily activity would be disrupted.

On 7/10/24 at 4:54 PM an interview was held with the Administrator. The administrator stated that central supply handles and maintains the portable oxygen tanks. Central supply orders them and returns the empty tanks. Central supply staff keep a log and check to see how many tanks the facility had. The administrator is not aware of the facility running out of portable tanks. The administrator stated she had recently spoken to central supply about making an extra order of tanks to ensure the facility doesn't run out. The administrator stated that there would be no reason to run out of tanks for 3 or 4 days because the staff at the facility can call and get them delivered.

2. Resident #77 was admitted to the facility on 4/1/24 with diagnoses of acute and chronic respiratory failure with hypoxia (lack of enough oxygen in the tissues to sustain bodily functions) and pulmonary fibrosis (chronic lung disease causing scarring of the lungs making it difficult to breath).

Resident #77 had a physician order dated 4/17/24 stating to administer oxygen at 6 liter per minute

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via nasal cannula continuously and monitor for shortness of breath or oxygen saturation less than 90%.

The Admission Minimum Data Set (MDS) dated 4/8/24 revealed that Resident #77 was cognitively intact. He was independent with his mobility. He did show signs of shortness of breath with exertion, when sitting and lying flat. He was on oxygen therapy.

On 7/9/24 at 12:30 PM an interview was conducted with Resident #77. Resident #77 stated that he needs to be on continuous oxygen. He stated about 5 weeks ago the facility ran out of portable oxygen tanks. He stated that it was a Friday when the facility ran out of tanks and the facility did not get more until Tuesday. Resident #77 had to stay in his room for all those days and was very bored and upset and did not feel it was right for the facility to not have portable tanks so he could do his daily business.

On 7/08/24 at 11:30 AM an interview with nurse #3 was conducted. Nurse #3 stated that she started working at the facility 6 weeks ago. Nurse #3 stated that she was alerted by a resident on her first day working at the facility that the facility had run out of portable oxygen for about 5 days. Nurse #3 checked the room which holds the portable oxygen tanks and found there were no portable oxygen tanks. She remembers that later that same day there was a delivery of portable oxygen tanks. Nurse #3 stated that this was the only time she knew that the facility ran out of portable tanks. Nurse #3 remembered that Resident #77 were upset that day as well. Nurse #3 stated that he needs to always be on oxygen continuously, so he had to stay in his room using

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the concentrator.

On 7/8/24 at 3:29 PM an interview was held with central supply staff. She stated that she took over the position at the end of March. She keeps an inventory of all office supplies and facility supplies. She has a list hanging in her office to write down supplies needed. The portable oxygen tanks are kept in a room off the 100 hall. There is an order placed with vendor every other Tuesday to get more tanks. The staff person stated the facility has never run out of portable oxygen tanks. She stated that the facility did have a power outage and the staff did use more of the portable tanks, but they did not run out. She stated that she has slips for all the deliveries. The delivery receipts were reviewed and showed that 40 tanks were delivered on 4/9/24, 40 tanks delivered on 4/23/24, 110 tanks delivered on 5/7/24, 110 tanks delivered on 5/10/24, 129 tanks delivered on 6/4/24, 78 tanks delivered on 6/18/24 and 119 tanks delivered on 7/2/24.

On 7/10/24 at 2:45 PM an interview was conducted with the Director of Nursing (DON). The DON stated that central supply usually orders the oxygen for the facility and had the tank delivery on a schedule and if for some reason the facility runs out before the next scheduled delivery, central supply can call for more tanks to be delivered. The DON states that if staff notices that they need more tanks they can text the central supply staff and sometimes the central supply staff work on the weekends. The DON's understanding was that the facility did not run out of tanks, but only had 2 tanks left. The residents could use their concentrators and still have oxygen needed, but daily activity would be disrupted.

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On 7/10/24 at 4:54 PM an interview was held with the Administrator. The administrator stated that central supply handles and maintains the portable oxygen tanks. Central supply orders them and returns the empty tanks. Central supply staff keep a log and check to see how many tanks the facility had. The administrator is not aware of the facility running out of portable tanks. The administrator stated she had recently spoken to central supply about making an extra order of tanks to ensure the facility doesn't run out. The administrator stated that there would be no reason to run out of tanks for 3 or 4 days because the staff at the facility can call and get them delivered.

3. Resident #8 was admitted to the facility on 3/8/24 with the diagnosis of chronic obstructive pulmonary disease. He had a physician order 4/10/24 for oxygen at 2 liter per minute via nasal cannula as needed for shortness of breath.

The quarterly MDS dated 4/4/24 revealed that Resident #8 was cognitively intact and used a wheelchair for mobility. He did not have shortness of breath.

On 7/08/24 at 11:30 AM an interview with nurse #3 was conducted. Nurse #3 stated that she started working at the facility 6 weeks ago. Nurse #3 stated that she was alerted by a resident on her first day working at the facility that the facility had run out of portable oxygen for about 5 days. Nurse #3 checked the room which holds the portable oxygen tanks and found there were no portable oxygen tanks. She remembers that later that same day there was a delivery of portable oxygen tanks. Nurse #3 stated that this was the

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only time she knew that the facility ran out of portable tanks.

On 7/9/24 at 12:30 PM an interview was conducted with Resident #8. Resident #8 shared a room with Resident #77 and stated he was also affected by the facility running out of oxygen tanks. Resident #8 stated that he needed to be on oxygen. He stated that about 5 weeks ago the facility ran out of portable oxygen tanks. He stated that it was a Friday when the facility ran out of tanks and the facility did not get more until Tuesday. Resident #8 had to stay in his room for all those days and was very bored and upset and did not feel it was right for the facility to not have portable tanks so he could do his daily business.

On 7/8/24 at 3:29 PM an interview was held with central supply staff. She stated that she took over the position at the end of March. She keeps an inventory of all office supplies and facility supplies. She has a list hanging in her office to write down supplies needed. The portable oxygen tanks are kept in a room off the 100 hall. There is an order placed with vendor every other Tuesday to get more tanks. The staff person stated the facility has never run out of portable oxygen tanks. She stated that the facility did have a power outage and the staff did use more of the portable tanks, but they did not run out. She stated that she has slips for all the deliveries. The delivery receipts were reviewed and showed that 40 tanks were delivered on 4/9/24, 40 tanks delivered on 4/23/24, 110 tanks delivered on 5/7/24, 110 tanks delivered on 5/10/24, 129 tanks delivered on 6/4/24, 78 tanks delivered on 6/18/24 and 119 tanks delivered on 7/2/24.

On 7/10/24 at 2:45 PM an interview was

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conducted with the Director of Nursing (DON). The DON stated that central supply usually orders the oxygen for the facility and had the tank delivery on a schedule and if for some reason the facility runs out before the next scheduled delivery, central supply can call for more tanks to be delivered. The DON states that if staff notices that they need more tanks they can text the central supply staff and sometimes the central supply staff work on the weekends. The DON's understanding was that the facility did not run out of tanks, but only had 2 tanks left. The residents could use their concentrators and still have oxygen needed, but daily activity would be disrupted.

On 7/10/24 at 4:54 PM an interview was held with the Administrator. The administrator stated that central supply handles and maintains the portable oxygen tanks. Central supply orders them and returns the empty tanks. Central supply staff keep a log and check to see how many tanks the facility had. The administrator is not aware of the facility running out of portable tanks. The administrator stated she had recently spoken to central supply about making an extra order of tanks to ensure the facility doesn't run out. The administrator stated that there would be no reason to run out of tanks for 3 or 4 days because the staff at the facility can call and get them delivered.

4. Resident # 34 was re-admitted to the facility on 2/26/24 with diagnoses including dementia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.

The Minimum Data Set (MDS) quarterly assessment dated 4/11/24 revealed Resident #34

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was cognitively impaired and required substantial/ maximum assistance with eating.

Review of Resident #34's care plan dated 1/26/21 and last reviewed 4/16/24 revealed she had a care plan in place for needing assistance with activities of daily living (ADLs) due to cerebral vascular accident (CVA/stroke) and impaired cognition. The care plan interventions included to assist with eating. She had an additional care plan in place for nutritional problems or potential nutritional problems related to the need for mechanically altered pureed foods and nectar thickened liquids, poor dentition, and impaired cognition. The care plan interventions included to provide feeding assistance when she did not feed herself, and that sometimes she needed staff to provide total assistance with meal.

A continuous dining observation was performed on 7/8/24 from 12:22 PM through 12:44 PM.
At 12:22PM Resident #34 was observed in the dining room. She was sitting in a specialty wheelchair. The chair was pushed up to the dining table. There were 3 other residents seated at the table. The meal tray for Resident #34 was positioned in front of her on the table. NA #3 was observed to be standing beside Resident #34 while she was feeding her.

At 12:26 PM an observation of the dining room revealed there were multiple empty extra chairs located throughout the dining room

At 12:28 PM NA #3 was observed briefly to sit on her knees on the floor beside Resident #34 as she continued to feed her.
At 12:29 PM NA #3 was observed to stand again as she continued to feed Resident #34.

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VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

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F 550	Continued From page 12	F 550		

At 12:35 PM NA #3 covered the meal plate with the lid. She kneeled beside Resident #34 to give her fluids from a cup and then stood again. NA #3 proceeded to feed resident #34 the ice cream and pudding that was on her meal tray while standing. The NA #3 remained standing for the remainder of the time while feeding Resident #34.

At 12:44 PM The NA #3 stopped feeding Resident #34 and she was assisted from the dining room by another staff member.

An interview was conducted on 7/8/24 at 12:56 PM with NA #3. She said that there was usually an extra empty chair located at the table for her to sit in while providing feeding assistance. NA #3 said that today the table had been full with 4 residents seated at the table. She said she could have pulled an empty chair over to the table to sit in. NA #3 said since she had already been at Resident #34's table she had not wanted her to be delayed in eating and thought it would be okay to feed her standing up. NA #3 said she had never been told she could not or should not stand to feed a resident. NA #3 said it would make her feel a little bit inferior if someone stood over her while assisting her with eating.

An interview was conducted on 7/9/24 at 11:23 AM with Nurse # 3. She said Resident #34 did not feed herself and was dependent on staff to eat. Nurse #3 said NA #3 should have sat beside Resident #34 when she was feeding her. She said you should be at eye level with residents and not hover or stand over them while providing feeding assistance. Nurse #3 said it was a dignity issue if an NA stood while feeding a resident.

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F 550	Continued From page 13 An interview was conducted on 7/10/24 at 1:55 PM with the Director of Nursing (DON). She said NA #3 should have sat beside Resident #34 while providing feeding assistance. The DON stated it would make her feel rushed if someone was standing while assisting her with eating. An interview was conducted on 7/10/24 at 4:55 PM with the Administrator. She said staff should sit while feeding a resident during meals. The Administrator said this was a dignity issue and that the staff member should be at eye level with the resident when providing meal assistance. The Administrator stated she felt the outcomes from feeding and meal consumption were improved with that approach. She said this also provided a better view of the residents chewing process to ensure safety and swallowing of food.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items	F 553		8/20/24

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F 553	Continued From page 14 included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with resident and staff, the facility failed to invite residents and/or their resident representative to participate and provide input in care planning for 2 of 4 residents reviewed for care planning (Resident #27 and Resident #37). The findings included: 1. Resident #27 was admitted to the facility on 3/16/21. A review of Resident #27's medical record revealed her last care plan meeting was held on 3/14/24. Resident #27's care plan was last revised on 5/16/24. The quarterly Minimum Data Set (MDS) assessment dated 5/18/24 indicated Resident #27 was cognitively intact.	F 553	F553 Right to Participate in Planning Care Immediate action taken to address the allegations included: The Social Worker immediately scheduled a care plan with the resident #27 and #37. A care plan was had on 7-31-24 for resident #27. A care plan was also held on 7-31-24 for resident #37. In-services were provided to Social Worker and Administrative assistant on importance of care plans and care plans being done in a timely manner. An audit was completed on all residents in the facility to ensure no other care plans where missed. The facility acknowledges that all residents have the potential to be affected by this alleged deficient practice. Measures put into place includes: In-services were provided to Social	

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F 553	Continued From page 15 An interview with Resident #27 on 7/7/24 at 10:38 AM revealed she had not been to a care plan meeting recently. An interview with the Social Worker (SW) on 7/9/24 at 8:21 AM revealed she was responsible for scheduling the care plan meetings. The SW stated that when she started working at the facility in June 2024, she was given a list of residents whose care plan meetings needed to be done because a staff member had quit doing them before she came onboard. The SW stated that she scheduled the care plan meetings right after the MDS was updated and it looked like Resident #27 should have had a care plan meeting done around May 2024 or June 2024 since her last care plan meeting was done on 3/14/24. The SW shared that the late care plan meetings would take time to get done. An interview with the Administrator on 7/10/24 at 5:07 PM revealed that there was a week in May 2024 when they had to reschedule some of the care plan meetings due to a state survey at the facility. 2. Resident #37 was admitted to the facility on 1/10/20. A review of Resident #37's medical record revealed his last care plan meeting was held on 3/26/24. The quarterly Minimum Data Set (MDS) assessment dated 6/10/24 indicated Resident #37 was cognitively intact. Resident #37's care plan was last revised on	F 553	Worker and Administrative assistant on importance of care plans and care plans being done in a timely manner. Included in this in-service an overview of insuring that residents and family members are invited to the care plans. The in-service was provided by the Minimum Data Set Coordinator/ Director of Nursing. This in-service was held on 7-11-2024. Care plans are scheduled by the due dates of the Minimum Data Set , (MDS), evaluations are due. Weekly review of all care plan scheduled are reviewed during the weekly clinical morning meeting. The Social Worker will review the MDS calendar to determine when care plans need to be scheduled to make sure they are in a timely manner, as needed or as requested. The Social Worker will let the administrator know if any issues arise with scheduling care plans so it can be immediately addressed. Monitoring will be conducted by morning meeting, and Social Work monitoring the MDS schedule. The Social Worker will present a monthly report during the Quality Assurance Process Improvement on the accumulative results from the prior month care plans. The Social Woker will conduct tracking of completed MDS's and care plans during the monthly Quality Assurance and Process Improvement meeting. These reports will be presented for 3 months. Date Certain: 8-20-24	

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F 553	Continued From page 16 6/10/24. An interview with Resident #37 on 7/7/24 at 10:28 AM revealed he had not been to a care plan meeting in a while. An interview with the Social Worker (SW) on 7/9/24 at 8:21 AM revealed she was responsible for scheduling the care plan meetings. The SW stated that when she started working at the facility in June 2024, she was given a list of residents whose care plan meetings needed to be done because a staff member had quit doing them before she came onboard. The SW stated that she scheduled the care plan meetings right after the MDS was updated and it looked like Resident #37 should have had a care plan meeting done around June 2024 since his last care plan meeting was done on 3/26/24. The SW shared that the late care plan meetings would take time to get done. An interview with the Administrator on 7/10/24 at 5:07 PM revealed that there was a week in May 2024 when they had to reschedule some of the care plan meetings due to a state survey at the facility.	F 553		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		8/20/24

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F 558	Continued From page 17 Based on observation, record review, and interviews with resident and staff, the facility failed to ensure a dependent resident could access a light switch located behind her bed for 1 of 1 resident reviewed for accommodation of needs (Resident #60). Resident #60 was admitted to the facility on 06/19/23. Review of Resident #60's medical records revealed she had moved to her current room on 08/07/23. The annual Minimum Data Set (MDS) dated 05/18/24 coded Resident #60 with intact cognition. The MDS indicated Resident #60 with impairment for both sides of her lower extremities and walking between locations inside the room for more than 10 feet did not occur during the assessment period. During an observation conducted on 07/07/24 at 10:50 AM, the switch for the light fixture behind Resident #60's bed on the wall approximately 5 feet from the floor and 6 feet from the bed was attached with a cord approximately 4 inches in length. Resident #60 was unable to reach the switch cord from the bed if needed. An interview was conducted with Resident #60 on 07/07/24 at 10:52 AM. She stated she had osteoarthritis and was non-ambulatory. She did not have any control of the light fixture behind her bed as she could hardly stand up to reach the broken switch cord on the wall from her bed. She had to rely on nursing staff to control the light fixture for her and it was very inconvenient. Resident #60 added the switch cord was broken	F 558	F558 Reasonable Accommodations Immediate action taken to address this alleged deficient practice: The Maintenance Director replaced the pull cord for the light fixture For resident #60. All residents have the potential to be affected by this practice. Measures put into place to ensure that this practice does not recur includes; The Maintenance Director will complete an overview educational session with the Direct care staff and licensed nursing staff by 8-19-24. An inservice was held with Department Managers by the Administrator on 7-11-2024. Information on how to Process Maintenance requests has been added to the new hire packet for The onboarding process for facility employees. An audit was completed by the Maintenance Director on 7/11/2024 for any overbed light requiring a replacement cord to ensure accessibility. Any Resident that needed a longer pull cord for accessing the overbed light had A longer cord placed for the resident□s use. Overbed light cords was added to Preventive maintenance logs to ensure that the Maintenance Department completes monthly checks on the overbed light cords. Monitoring will be completed by the Maintenance Director and Maintenance	

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F 558	Continued From page 18 since she moved into this room last August. She had never brought up her concern to any staff so far. However, she wanted the maintenance staff to fix the switch cord to accommodate her needs as soon as possible. Subsequent observation conducted on 07/08/24 at 11:12 AM revealed the switch cord for the light fixture behind Resident #60's bed remained inaccessible. During a joint observation conducted with Nurse Aide (NA) #5 and Nurse #5 on 07/09/24 at 12:07 PM, the switch cord for the light fixture behind Resident #60's bed remained inaccessible from her bed. Both nursing staff acknowledged that the switch cord needed to be fixed immediately. An interview was conducted with NA #5 on 07/09/24 at 12:18 PM. She stated that she worked in 300 halls frequently and had provided care for Resident #60 on a regular basis. She did not notice that the switch cord for the light fixture behind Resident #60's bed was broken and inaccessible from her bed. NA #5 explained Resident #60 never voiced accessibility concerns for the light fixture behind her bed when receiving care so far. She stated the light fixture behind Resident #60's bed should always be accessible. During an interview conducted with Nurse #5 on 07/09/24 at 12:20 PM, she confirmed she had provided care for Resident #60 frequently, but she did not notice that the switch cord for the light fixture behind Resident #60's bed was broken and inaccessible from her bed. She added Resident #60 was bed bound and it was important for her to have accessibility to the light fixture behind the bed all the time.	F 558	Assistant completing monthly rounds to ensure that overbed lights have pull Cords that ensure accessibility to the residents. Management rounds will also Be completed 5 times weekly and the results will be shared during the daily Standdown meetings. The Maintenance Director will compile a report of these Results and report monthly to the facility Quality Assurance and Process Improvement Committee for 3 months. Completion date: 8-20-24	

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F 558	Continued From page 19 An interview was conducted with the Maintenance Director on 07/09/24 at 2:51 PM. He stated that he did not notice the switch cord for Resident #60's light fixture behind her bed was broken and acknowledged that it needed to be fixed as soon as possible. He performed weekly walk throughs for the facility to identify repair needs. Once a month, he would conduct a more detailed walk through that included the interior of residents' rooms and bathrooms. In most cases, he depended on the staff to report repair needs via work orders or verbal notifications. He checked the work order box outside of his office door at least twice daily to ensure all repair needs being addressed in a timely manner. He could not explain why he missed the switch cord for Resident #60 and acknowledged that it had to be fixed immediately. During an interview conducted on 07/09/24 at 4:31 PM, the Director of Nursing (DON) expected the staff to be more attentive to residents' living environment, and to report repair needs to the maintenance department in a timely manner to accommodate residents' needs. An interview was conducted on 07/10/24 at 5:06 PM with the Administrator. She expected nursing staff to pay attention to residents' homes and reported repair needs to the maintenance department in a timely manner. It was her expectation for all the dependent residents to have full accessibility and control of the light fixture behind the bed all the time.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		8/20/24

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F 561	Continued From page 20 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, and staff interviews, the facility put a resident that had been assessed to be a safe smoker on a supervised smoking schedule for 1 of 2 residents (Resident #83) reviewed for choices. The findings included: The facility's smoking policy dated 5/2024 stated	F 561	F561 Self-determination Immediate action to correct this allegation: Resident # 83 no longer residents at this facility. On 8-2-2024 a meeting was held with the current resident smoking group to discuss the current smoking times that are available. On 8-2-2024 the facility smoking policy was reviewed by the Administrative team and revised. The	

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F 561	Continued From page 21 on page 2 under designated smoking times that the facility had designated up to four (4) smoking times daily. Smoking times are posted near the designated smoking area lasting up to thirty (30) minutes. Designated smoking times are subject to change in response to inclement weather or other unforeseen events. Changes in the designated smoking times shall be communicated with residents who smoke. The policy also listed smoking rules and resident policy on violation enforcement. Resident #83 was admitted to the facility on 5/26/24. A smoking assessment was completed on Resident #83 on 5/29/24. The assessment found him to be a safe smoker. The quarterly Minimum Data Set (MDS) dated 6/2/24 revealed that Resident #83 was cognitively intact. He used a wheelchair for mobility and had full range of motion of both upper extremities and on one side of his lower extremity. Resident #83 had an admission care plan dated 6/10/24 that stated that Resident #83 was a smoker and needed to be supervised when smoking. The care plan had the following interventions: all smoking materials were kept at the nurses' station and the resident will ask staff to get the materials before going outside to smoke. The resident was informed of the facility smoking policy. The resident will need staff to accompany him to the designated smoking area and will need staff to stay until the resident had finished smoking. Staff were to ensure the resident was dressed appropriately to go outside to smoke.	F 561	facility smoking policy is noted to indicate that all individual smokers will be provided supervision. The facility recognizes that all residents that any resident who chooses to smoke has the potential to be affected by this alleged deficiency. Measures put into place to ensure that this alleged deficient practice does not recur includes: Smoking assessments were completed on 7-28-24 Unit Nurse Manager and on 8-12-24 to identify any resident that is determined to be a non -supervised smoker. Per the facility policy no residents were deemed a safe smoker. A smoking review was discussed with the current facility smokers with the policy and procedural review of the safe smoking expectations, the daily scheduled smoking times and the storage requirements of combustible smoking materials. Monitoring will be completed by the assigned smoking supervisor maintaining a smoking attendance list to ensure that all smokers are granted the opportunity to attend the provided smoking times. The smoking policy will be included for any resident requesting clarification of the facilities policies and procedures as it relates to smoking practices. Admissions will reflect the facility practice of refraining from admissions of individuals that choose to smoke. Monitoring will be completed by the assigned smoking employee verifying the smoking procedures and reporting to the Activity Director monthly. The Activity Director will present a report to the Quality Assurance and Process Improvement Committee for	

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F 561	Continued From page 22 On 7/7/24 at 10:55 AM an interview was held with Resident #83. He stated that the facility currently allowed residents to smoke 3 times a day, at 9:30 am, 1:30 pm and 4:00 pm. Resident #83 would like the facility to allow him or any other resident a fourth time to smoke. Resident #83 would like the fourth time to be after dinner. Resident #83 stated that he would like to have a cigarette after each meal. Resident #83 understood that the staff would first need to finish with dinner trays before supervising a fourth smoke session. On 7/10/24 at 10:04 AM an interview was held with Activity Aide. He stated that when he was working, he usually supervised the 3 smoking times, which are 9:30 am, 1:30 pm and 4:00 pm. He stated that since he had worked at the facility there had only been 3 times during a 24 hour period to smoke. The Activity Aide was aware that a few residents would like a fourth time to smoke after dinner. He stated that Resident #83 has made it known that he wishes for a fourth smoking break after dinner. Recently at a resident council meeting the fourth smoking time was discussed and the Administrative Assistant told the council that the facility was unable to do a fourth smoke session. The Activity Aide stated he didn't remember if there was a reason why a fourth smoke session could not happen. On 7/10/24 at 2:49 PM an interview was held with the Director Of Nursing (DON). She stated that the facility had conducted education to the staff on supervising residents with smoking and vaping. The DON stated she was not aware of any residents wanting another smoking time. She stated she could not think of a reason not to look into the facility having a fourth smoke break.	F 561	2 months. Completion date: 8-20-24	

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F 561	Continued From page 23 On 7/10/24 at 10:15 AM an interview was held with the Administrator. The smoking policy was reviewed, and she stated that the policy stated that smoking would be allowed up to 4 times a day which meant the facility could have smoking sessions up to 4 times but not necessarily. The Administrator is aware that a fourth smoke break had been requested by some residents. The Administrator stated the facility had considered a smoke session after dinner and it had been talked about at departmental meetings and at resident council, but currently the facility didn't know who would be available to supervise smoking after dinner.	F 561		
F 568 SS=C	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents, family member, and staff, the facility failed to provide quarterly statements for 4 of 4 residents reviewed for personal funds (Resident #27, Resident #60, Resident #20, and Resident	F 568	F568 Accounting and Records of Personal Funds: F568 Accounting and Records of Personal Funds:	8/20/24

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F 568	Continued From page 24 #52). The findings included: 1. Resident #27 was admitted to the facility on 3/16/21. The quarterly Minimum Data Set assessment dated 5/18/24 indicated Resident #27 was cognitively intact. A review of Resident #27's medical record indicated she was her own responsible party. An interview with Resident #27 on 7/7/24 at 10:37 AM revealed she had a personal funds account at the facility, but she did not get a statement about her current balance. A phone interview with Resident #27's family member on 7/10/24 at 1:43 PM revealed he did not get any statements in the mail about Resident #27's personal funds account. An interview with the Business Office Manager (BOM) on 7/10/24 at 10:55 AM revealed he did not issue statements on personal funds accounts unless the resident requested for one because there was no state-regulated law that he was supposed to give statements regularly, and that there was no requirement to do so. The BOM stated that the system generated a letter that was mailed directly to the residents monthly, but he was not sure if this was a statement about their personal funds account. A follow-up interview with the BOM on 7/10/24 at 2:12 PM revealed he looked into the facility's Resident Fund Management Service (RFMS)	F 568	Immediate action taken to address this alleged deficient practice: 1.Resident #27 received her personal fund statement on 7-10-2024 by the Social Work Director. 2. Resident #60 received her personal fund statement on 7-10-2024 by the Social Work Director. 3. Resident #20 received her personal fund statement on 7-10-2024 by the Social Work Director. 4. Resident #52 received her personal fund statement on 7-10-2024 by the Social Work Director. All residents have the potential to be affected by this alleged deficient practice. Measures put into place to ensure that this alleged deficiency does not recur includes the following: The Business Office Manager is no longer employed with this facility. A newly hired Business Office Manager was hired 7-10-2024. On 7-26-2024 education was provided by the Regional Business Office Manager. This education consisted of the overall process on how and when to provide the quarterly statements/ On 7-11-2024 The Administrator, Business Office Manager and the Chief Operating Operator reviewed the record keeping practices for the facilitys resident trust accounts. The facility policy and procedures were review for review of the process for ensuring resident□s personal funds are managed properly. The policy reviewed covered: 1. Resident funds will be deposited in a	

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F 568	Continued From page 25 which had switched to electronic about a year ago. The BOM stated that he found out that statements had not been sent quarterly and were only sent per request since switching electronically about a year ago. An interview with the Administrator on 7/10/24 at 5:07 PM revealed she was not aware that the quarterly statements were not being mailed to the residents with personal funds account. 2. Resident #60 was admitted to the facility on 6/19/23. The annual Minimum Data Set assessment dated 5/18/24 indicated Resident #60 was cognitively intact. An interview with Resident #60 on 7/10/24 at 6:07 PM revealed she had a personal funds account at the facility, but she did not get a statement about her current balance. An interview with the Business Office Manager (BOM) on 7/10/24 at 10:55 AM revealed he did not issue statements on personal funds accounts unless the resident requested for one because there was no state-regulated law that he was supposed to give statements regularly, and that there was no requirement to do so. The BOM stated that the system generated a letter that was mailed directly to the residents monthly, but he was not sure if this was a statement about their personal funds account. A follow-up interview with the BOM on 7/10/24 at 2:12 PM revealed he looked into the facility's Resident Fund Management Service (RFMS)	F 568	residents trust fund account that is separate from the facility s banking account. 2. The resident is provided with a confidential quarterly statement of fu-11nds on deposit with the facility and activity since the previous statement. 3. A resident petty cash fund is kept on-site to provide residents quick and on-going access to small amounts of cash (fifty dollars or less). The amount withdrawn from petty cash upon a resident s request will be debited from the resident s account within three banking days and a record of the transaction will appear on the resident s next quarterly statement. 4. Inquiries concerning the residents trust fund account and petty cash fund should be referred to the Administrator or to the Business Office Manager. 5. The primary purpose of our resident fund policies is to establish uniform guidelines to protect personal funds managed by our facility on behalf of its residents. 6. Our resident fund policies and procedures apply uniformly to residents without regard to race, color, creed, national origin, age, sex, religion, handicap, or payment source. 7. The objectives of our resident fund policies are to: 1. Provide a means to protect resident funds managed by the facility; 2. Provide for an individual and confidential accounting of funds received and disbursed on the resident s behalf; 3. Provide a means for the resident to	

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F 568	Continued From page 26 which had switched to electronic about a year ago. The BOM stated that he found out that statements had not been sent quarterly and were only sent per request since switching electronically about a year ago. An interview with the Administrator on 7/10/24 at 5:07 PM revealed she was not aware that the quarterly statements were not being mailed to the residents with personal funds account. 3. Resident #20 was admitted to the facility on 3/11/23. The quarterly Minimum Data Set assessment dated 6/19/24 indicated Resident #20 was cognitively intact. A review of Resident #20's medical record indicated she was her own responsible party. An interview with Resident #20 on 7/10/24 at 6:09 PM revealed she had a personal funds account at the facility, but she did not get a statement about her current balance. An interview with the Business Office Manager (BOM) on 7/10/24 at 10:55 AM revealed he did not issue statements on personal funds accounts unless the resident requested for one because there was no state-regulated law that he was supposed to give statements regularly, and that there was no requirement to do so. The BOM stated that the system generated a letter that was mailed directly to the residents monthly, but he was not sure if this was a statement about their personal funds account.	F 568	access his or her funds or to have a guardian or other legally appropriate representative do so; and 4. Establish uniform guidelines to follow in implementing policies and procedures to protect the residents funds. 8. The Administrator will inform all residents, prior to or upon admission, of the facility s policies and procedures governing the management of resident funds. 9. Residents are not obligated to deposit their funds with this facility. 10. Inquiries concerning resident funds should be referred to the Administrator and/or to the business office. The resident fund accounts will be reviewed for accuracy and completeness on a quarterly basis by the Business Office Manager by the 5th of the Quarterly month. The Business Office Manager will ensure that the individual resident accounts are distributed to the current residents by the 5th day of each month. Monitoring will be completed by the Business Office verifying each quarter that any RFMS account balances were generated, reviewed and distributed. This will be compared to the facility resident census for any current residents. Residents that are no longer here will have their statements mailed to them. The Business Office Manager will present a report to the monthly Quality Assurance and Process Improvement Committee for 3 months. Completion date: 8-20-2024	

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A follow-up interview with the BOM on 7/10/24 at 2:12 PM revealed he looked into the facility's Resident Fund Management Service (RFMS) which had switched to electronic about a year ago. The BOM stated that he found out that statements had not been sent quarterly and were only sent per request since switching electronically about a year ago.

An interview with the Administrator on 7/10/24 at 5:07 PM revealed she was not aware that the quarterly statements were not being mailed to the residents with personal funds account.

4. Resident #52 was admitted to the facility on 9/16/22.

The annual Minimum Data Set assessment dated 6/20/24 indicated Resident #52 was cognitively intact.

A review of Resident #52's medical record indicated he was his own responsible party.

An interview with Resident #52 on 7/10/24 at 6:12 PM revealed he had a personal funds account at the facility, but he did not get a statement about his current balance.

An interview with the Business Office Manager (BOM) on 7/10/24 at 10:55 AM revealed he did not issue statements on personal funds accounts unless the resident requested for one because there was no state-regulated law that he was supposed to give statements regularly, and that there was no requirement to do so. The BOM stated that the system generated a letter that was mailed directly to the residents monthly, but he

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F 568	Continued From page 28 was not sure if this was a statement about their personal funds account. A follow-up interview with the BOM on 7/10/24 at 2:12 PM revealed he looked into the facility's Resident Fund Management Service (RFMS) which had switched to electronic about a year ago. The BOM stated that he found out that statements had not been sent quarterly and were only sent per request since switching electronically about a year ago. An interview with the Administrator on 7/10/24 at 5:07 PM revealed she was not aware that the quarterly statements were not being mailed to the residents with personal funds account.	F 568		
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		8/20/24

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F 584	Continued From page 29 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with resident and staff the facility failed to maintain the wall and ceiling in sanitary condition at 1 of 2 nursing stations (nursing station #1). The facility failed to manage outside water drainage to prevent outside storm water from flooding into 1 of 4 hallways (Hallway #2), 1 of 1 dining room, and 2 of 2 resident rooms (room 216 and room 217). Furthermore, the facility failed to clean ceiling air vents located over the food prep and food service area that had a large amount of dark black substance visible on the outside of 3 of 6 vents. The facility also failed to maintain a footboard in good repair for 1 of 1 bed (Resident #37's bed) and failed to maintain a wheelchair in good repair for 1 of 1 resident (Resident #6) reviewed for a safe, clean,	F 584	F584 Environmental Services Immediate action taken to address the alleged deficiencies included: 1. The facility plumbing vendor was scheduled to come out to make repairs to the area at the Nursing station area. The Maintenance Director cleaned and treated the area to address the black substance. 2. A./ B. On 7-7-2024 and 7-8-2024 the Maintenance Director and Environmental Service Director extracted the water from the carpeted areas from room #216 and #217. Following the water extraction, the carpeted rooms were bonneted and sanitized by the Environmental Director. 3. On 7-17-2024, the Maintenance	

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F 584	Continued From page 30 comfortable and homelike environment. These deficient practices had the potential to affect all residents residing in the facility. Findings included: 1. An observation on 7/7/24 at 2:40 PM of the common area at nursing station #1 revealed an area on the wall and an area on the ceiling that had a dark black substance visible. The wallpaper was off the wall. Each area was approximately one foot in diameter. The dark black substance had a circular and dotted growth pattern with scattered small areas of gray colored fuzz. There was a brown/orange colored drip line that was moist and extended from the black substance on the ceiling down the wall. Subsequent observation on 7/8/24 at 3:30 PM revealed the conditions remained unchanged. An interview was conducted on 7/8/24 at 4:16 PM with the Maintenance Director. He stated he had been at the facility in his current role for a little over three months. He stated that the black substance on the wall and ceiling had been there since he had started and had not changed. He said he had checked the area previously and thought the area was glue because it had been tacky feeling and that it did not scrape off the wall. He was unsure why the wallpaper had been removed from that area. An interview and observation was completed on 7/8/24 at 4:34 PM of the black substance on the wall and ceiling with the Maintenance Director. He touched the black substance on the wall and ceiling with two of his fingers. When he brought his fingers away from the wall/ ceiling a black	F 584	Assistant cleaned and resurfaced the 3 of 6 vents observed in the Dietary Kitchen area. A inservice was held with the Maintenance Director and Maintenance Assistant to review the duties of the maintenance roles. 4. The footboard for resident #37 was repaired by the Maintenance Director on 7 -11-24. 5. The arm rest for resident #6 was replaced by the Maintenance Director on 7-11-2024. A skin audit for resident #6 was completed on 7-11-2024 by the Nurse Manager. There were no skin injuries noted. The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Measures put in to place to prevent the alleged deficiency from recurring includes the following: Education was provided to the Maintenance Director and Maintenance Assistant by the Administrator and Director of Nursing 8-5-24. Education was provided on : Infection Control and the proper procedures from addressing any suspected area of substance growth and the proper cleaning procedures for each. Addition topics were related to the Overall Maintenance Responsibilities for monitoring and addressing the vents, and filtering areas of the facility. A review of expectations for the daily facility rounds was completed with the Department Mangers to ensure that they were clear on the areas of focus that are to be monitored. The Maintenance Director scheduled and arranged for a plumbing	

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F 584	Continued From page 31 residue was visible on his fingers. He touched along the seam of the wall and ceiling and stated the area was moist/ wet. He acknowledged there was a visible drip line from the ceiling extending down the wall. He said he thought the black substance on the wall and ceiling was "mold". He stated he thought the area was "mold" because the area was moist and because of the way the black residue came off onto his fingers when he touched the area. A follow up observation on 7/9/24 10:05 AM of the area revealed the black substance had been cleaned off the ceiling and wall. A follow up interview was conducted with the Maintenance Director on 7/10/24 at 3:14 PM. He said he had cleaned the black substance off the wall and ceiling with a bleach wipe. He said he had looked in the ceiling above the area and that there were pipes that ran above the area but that he had not seen anything leaking. He said there had been condensation and moisture in that area and that he had called a plumbing company to come out and check the pipes in that area. An interview was conducted with the Administrator on 7/10/24 at 4:55 PM. She said she was unsure how long the black substance had been on the ceiling and wall. She stated she had not noticed the black substance on the wall and ceiling. She said if she had noticed the black substance on the wall and ceiling, she would have asked maintenance to check the area and clean it. 2. a. An observation on 7/7/24 at 1:41 PM revealed water flooded and pooled across the bathroom and room floor in rooms 216 and 217.	F 584	specialist to observe the area of moisture that was noted in this area. The plumbing specialist repaired the piping in the ceiling that was dripping onto the sheet rock. This was completed on 8-9-2024. The Maintenance Director removed the area of the sheetrock that was showing mositure and replaced the sheetrock. The area was prepped for painting and finishing. A facility tour was completed by the Maintenance Director and Maintenance Assistant on 8-7-24,8-8-24, and 8-9-24 to determine any other areas that were of concern. Maintneance will complete weekly rounds of all ceiling areas to watch for any recurring moisture issues. Monitoring will be completed by the Environmental Services Director completing daily rounding and end of shift audits to ensure that proper floor and carpeting cleaning has been completed properly. The Maintenance Director has added the maintenance of the kitchen vents to the preventative maintenance lists for continued observations and cleaning. The Department Managers will also monitor the vents and returns for their perspective room assignments and report during the stand down meeting. The Maintenance Director will compile a report and present the results to the Quality Assurance and Process Improvement Committee for 3 months. Completion date 8-20-24	

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A moisture mark that extended out from the wall approximately 3 feet was observed on the carpet in hallway #2 along the wall outside of room 217. The moisture mark on the carpet extended the length of approximately 8 feet of hallway #2 along the wall. The carpet was wet to touch.

Subsequent observation on 7/8/24 at 11:26 AM revealed the carpet in hallway #2 continued to have a moisture mark extending from the wall and was moist to touch. There was a damp/ wet smell present. There was no water observed on the floor in room 216 or 217.

2. b. An observation on 7/7/24 at 2:23 PM of the dining room revealed water on the floor in front of the entrance door. The carpet in front of the dining room entrance door had a water moisture mark extending approximately 6 feet out on the carpet. The carpet was wet to touch.

Subsequent observation on 7/8/24 at 12:08 PM revealed the carpet in front of the dining room remained wet to touch. A wet/ moist smell was noted.

An interview was conducted on 7/8/24 at 4:16 PM with the Maintenance Director. He stated he had been at the facility in his current role for a little over three months. He stated that since he had been at the facility the dining room had flooded 3-4 times. He stated it had flooded into rooms 216 and 217 one other time that he was aware of. He stated the flooding was from an issue with the drain located outside of the dining room at the exterior wall of rooms 216 and 217. He said the fooding occurred when it rained. The Maintenance Director stated he had tried things to correct the issue the other times that water had

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flooded from outside into the building, but that what he had tried had not fixed the issue with the drain. He said he thought that the drainpipe needed to be brought down to ground level so it would drain. He said there was gravel along the exterior building wall at rooms 216 and 217. The Maintenance Director stated he thought the flooding into the resident rooms and hallway had occurred because there was plastic under the gravel and water was getting under the plastic and going into the foundation. He said the gravel and plastic would need to be removed and the ground graded to prevent the rooms from flooding again.

A follow up interview was conducted with the Maintenance Director on 7/10/24 at 3:14 PM. He stated that they had cleaned the carpet that had been flooded a few times with the carpet cleaning machine. He said he had placed fans to blow and help the carpet dry.

An interview was conducted with the Administrator on 7/10/24 at 4:55 PM. She said she was aware that the dining room had flooded on Sunday during a storm. She said since Sunday she had heard comments that the flooding happened frequently but that she had not been aware before then that the flooding had happened frequently. She said the water coming into the building and resident rooms from the outside was being addressed by Maintenance.

3. An observation of the kitchen on 7/9/24 at 12:35 PM was completed with the Dietary Manager (DM) and revealed 3 out of 6 air vents located over the food preparation and service area had a large amount of black substance with a circular and dotted growth pattern visible on the

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outside of the vents.

An interview with Dietary Manager (DM) was conducted on 7/9/24 at 12:40 PM. She said she was not sure what the black substance on the vents was. She stated that the vents needing to be cleaned had been identified by the health department during the kitchen inspection in October of 2023. She said the health department did not say what the black substance on the vents was but that the vents needed to be cleaned or replaced. The DM said she had told maintenance about the vents needing to be cleaned or replaced when it had come up on the kitchen inspection in October. The DM said she had also mentioned that the vents needed to be cleaned or replaced to the new Maintenance Director. She said each time she had been told by Maintenance they would take care of the vents but that nothing had been done.

An interview was conducted with the Health Department Inspector on 7/9/24 at 2:33 PM. She said that the facility kitchen inspection was completed in October 2023 and that the inspection said the outside of the vents in the kitchen needed to be cleaned. She said this was a repeated issue from the facility's previous kitchen inspection.

An interview was conducted with the Maintenance Director on 7/10/24 at 3:14 PM. He stated he had not been aware that the kitchen vents needed to be cleaned. He said that the vents needing to be cleaned had not been mentioned to him. The Maintenance Director said he had been under the assumption that the kitchen staff were supposed to clean the stuff in the kitchen. He said he was not aware that the vents needed to be cleaned

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and that it had been an issue during the last kitchen inspection and had not been addressed. The Maintenance Director said the health department had come to the building yesterday and had looked at the vents in the kitchen. He said the health department inspector said the black substance on the kitchen vents could be "mold" and had told him to clean them with bleach water. He said the health department had said some of the vents also had dust that needed to be cleaned off. He stated that the kitchen vents would have to be cleaned after hours and that he had set up for the vents to be cleaned on Friday 7/12/24. The Maintenance Director said there had been a couple of spots on the bottom of the walls in two resident rooms (room 303 and room 304) that recently had to be replaced because of "mold". He said he had taken the baseboard off in rooms 303 and 304 because it had been peeling away from the wall. The Maintenance Director said that when he had removed the baseboard, he could see the "mold" behind it. He said had cut out the area and replaced it.

An interview was conducted on 7/10/24 at 4:55 PM with the Administrator. She stated she did not remember if the kitchen vents needing to be cleaned had been an issue during the facility's last kitchen inspection in October 2023. She said she did not remember if the kitchen vents needing to be cleaned had been brought up by the DM previously. The Administrator stated she was not sure why the kitchen vents had not been cleaned. She did not mention if there had been other areas located in the building that had to be repaired due to the growth of black substance. The Administrator stated that the health department had come to the facility yesterday

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(7/9/24) and they had mentioned that the kitchen vents needed to be cleaned. She said that maintenance was going to clean them.

4. During an interview with Resident #37 on 7/7/24 at 10:28 AM, his footboard was observed coming off his bed on one side when he backed into it with his wheelchair. Resident #37 stated that his footboard needed to be fixed because the screw had come loose. He stated that the footboard had been broken like this for two months, but he was not sure if the Maintenance Director knew about it.

A follow-up observation on 7/8/24 at 8:24 AM revealed Resident #37's footboard was missing a screw and was not attached tightly to the bed frame.

An interview with Nurse Aide (NA) #2 on 7/10/24 at 8:43 AM revealed she had known about Resident #37's broken footboard a couple of weeks ago, and had told Unit Manager #2 about it because she did not know where the work orders were located.

An interview with Unit Manager (UM) #2 on 7/10/24 at 10:16 AM revealed she did not know about Resident #37's footboard needing repair, and that she did not remember NA #2 telling her about the broken footboard. UM #2 stated that if she had known about it, she would have texted the Maintenance Director right away to get it taken care of. She also stated that she did not know that NA #2 did not know where the work orders were located.

An observation and interview with the Maintenance Director on 7/9/24 at 2:50 PM revealed staff should fill out a work order or tell

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him verbally if something needed to be repaired inside a resident's room. The Maintenance Director stated that he did a walk through once a month, but he did not know about Resident #37's broken footboard. He looked at Resident #37's footboard and when he moved it, the footboard came off the bed frame. He stated that he needed to replace the screw, but that he was not aware that it had been broken.

An interview with the Administrator on 7/10/24 at 5:07 PM revealed that all department managers did daily rounds, and each had room assignments where they should be looking for equipment that needed repair. The Administrator stated that they had to change Resident #37's foot board a number of times, and the common way to notify the Maintenance Director of needed repairs was verbally.

5. Resident #6 was admitted to the facility on 09/08/16.

The quarterly Minimum Data Set (MDS) assessment dated 04/27/24 coded Resident #6 with severe impairment in cognition. The MDS indicated she had impairment for one side of her upper and lower extremities and utilized a wheelchair as the main mobility device for locomotion.

Review of the weekly skin assessment from 05/01/24 through 07/08/24 revealed Resident #6's skin was intact without any issues.

During an observation conducted on 07/07/24 at 11:21 AM, Resident #6 was seen sitting in her wheelchair outside of her room in the hallway. The armrest for both sides of the wheelchair were observed with multiple spots that were torn,

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cracked, and ripped with sharp edges approximately 2.5 inches in diameter. Resident #6 was wearing a short sleeves shirt while sitting in the wheelchair with both arms contacting the broken armrests during the observation.

An interview was conducted with Resident #6 on 07/07/24 at 11:24 AM. She could not recall how long the armrests for her wheelchair had been in disrepair. She stated she wore a short sleeve shirt most of the time, and the broken armrests had caused skin irritation at times.

During a subsequent observation conducted on 07/08/24 at 11:41 AM, Resident #6 was seen sitting in her wheelchair wearing a short sleeve shirt pedaling in the hallway. The armrests remained in disrepair.

A joint observation was conducted on 07/09/24 at 12:24 PM with Nurse Aide (NA) #5 and Nurse #5. Resident #6 was seen sitting in her wheelchair wearing a short sleeve shirt in the activity room in 400 halls. The armrests remained in disrepair.

An interview was conducted with Nurse Aide (NA) #5 on 07/09/24 at 12:26 PM. She stated she had provided care for Resident #6 in the past few months, but she did not notice the armrests were in disrepair. She added Resident #6 wore a short sleeve shirt frequently and explained the broken portion of the armrests were covered by Resident #6's arms most of the time to make it harder to identify repair needs.

During an interview conducted with Nurse #5 on 07/09/24 at 12:28 PM. She stated she had provided care for Resident #6 in the past few months, but she did not notice the armrests for

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the wheelchair were broken. She acknowledged that it needed to be fixed immediately as it could cause skin irritation. She added the rehab department was responsible for checking the wheelchair routinely and fixing it as needed.

An interview was conducted with the Rehab Director on 07/09/24 at 12:34 PM. She stated Resident #6 was under rehab department's caseload, she was responsible to check her wheelchair at least once per month. She could not explain why she missed Resident #6's wheelchair during the monthly audit. For residents who were not under rehab department's caseload, the maintenance department was responsible to check the wheelchair to ensure they were in good repair. She added the rehab department also depended on nursing staff to report repair needs. She acknowledged that the armrests for Resident #6's wheelchair were in disrepair, and it needed to be fixed immediately.

During an interview conducted on 07/09/24 at 2:51 PM, the Maintenance Director stated the maintenance department did not check repair needs for wheelchairs on a regular basis. Nursing staff or rehab staff would notify him whenever they identified repair needs for wheelchairs. He did not know Resident #6's wheelchair armrests were broken and acknowledged that they should be fixed immediately.

An interview was conducted with the Director of Nursing (DON) on 07/09/24 at 4:31 PM. She expected the staff to be more attentive to resident's mobility devices, and to report all the repair needs to the maintenance department or rehab department in a timely manner. It was her expectation for all the mobility devices to be in

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F 584	Continued From page 40 good repair at all the times. During an interview conducted on 07/10/24 at 5:06 PM, the Administrator expected the staff to pay attention to the condition of residents' mobility devices and report repair needs in a timely manner. It was her expectation for residents' mobility devices to be in good repair while in the facility.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		8/20/24

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F 609	Continued From page 41 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to submit an Initial Allegation Report to the State Agency for 1 of 1 resident reviewed for neglect (Resident #238). The findings included: The facility's policy "Abuse Investigations," dated 2017 indicated all reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management. The facility's policy "Reporting Abuse to State Agencies and Other Entities/Individuals," dated 2017 indicated: Should a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse be reported, the facility Administrator or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident, including law enforcement officials. During a complaint investigation survey on 4/22/24 through 5/22/24, the facility was cited for neglect for Resident #238 when Nurse Aide (NA) #18 neglected to provide incontinence care to Resident #238. Review of the state agency records revealed the facility did not submit an initial report to the State Agency following the notification of neglect through the CMS-2567. An interview with the Administrator on 7/10/24 at	F 609	F609 Reporting Alleged Violations Immediate action taken to address the allegations included: The Administrator completed the official reporting of the State generated allegation to the nurse aide registry on 7-10-24 with the reporting completed on 7-15-24. The facility could not substantiate neglect on behalf of Certified Nurse Aide #18. The facility acknowledges that all residents have the potential to be affected by this alleged deficient practice. Measures put into place includes: Inservices were provided to all staff on the Abuse, Neglect Prevention Policy and Procedure, Reporting expectations and Process of conducting a thorough investigation. This inservice was provided on 8-6-2024 by the Director of Nursing and unit Nurse Manager. The Administrator and Director of Nursing received inservice training on 7-11-2024 on reporting guidelines. Daily review of any allegations will be reviewed immediately with an investigation initiated. Education will be provided during the oboarding process for all new and rehired staff. This education will be provided by the facility Social Worker and Human Resource Director. The Director of Nursing will review the 24 hour report to determine if any incidents require a reportable investigation and initiate a	

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F 609	Continued From page 42 5:07 PM revealed that she was not made aware of neglect while the surveyors were onsite during the complaint investigation survey which ended on 5/22/24. The Administrator stated she found out about neglect on Resident #238 which involved NA #18 when she received the CMS-2567. The Administrator explained that NA #18 was uncomfortable with taking care of Resident #238 and requested to be re-assigned and spoke with the nurse. The nurse was aware that NA #18 was uncomfortable and had agreed to provide personal care for Resident #238. The Administrator stated that she did not file an initial report on NA #18 for neglect to the State Agency because she felt like she thoroughly investigated the issue, and she did not know that NA #18 was neglectful of Resident #238. According to the CMS-2567 from 5/22/24, the Administrator was notified of neglect when she was notified of immediate jeopardy on 5/11/24 at 10:37 AM.	F 609	report immediately. The Social Worker will review all expressed grievances upon intake and will discuss with the facility Interdisciplinary Team members Monitoring will be conducted by the daily review of 24 hour reports, departmental rounding feedback and the review of resident grievances. The Social Worker will present a monthly report during the Quality Assurance Process Improvement on the accumulative results from the prior months grievances and prompted reportables. The Administrator will conduct tracking and trending of completed reportables during the monthly Quality Assurance and Process Improvement meeting along with an overview of the occurrences. These reports will be presented for 3 months. Date Certain: 8-20-24	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		8/20/24

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F 644	Continued From page 43 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a Preadmission Screening and Resident Review (PASRR) application for a resident with a new psychiatric diagnosis for 1 of 3 residents (Resident #41) reviewed for PASRR. The findings included: When Resident #41 was admitted to the facility he came with a level 1 PASRR number dated 12/8/2020. Resident #41 was admitted to the facility on 9/14/23 with the following diagnoses: delusional disorder, dementia with other behavioral disturbances and psychosis not due to a substance or known physiological condition. Resident #41 was prescribed the following medications: On 10/18/23 he was prescribed Risperidone (an anti-psychotic medication) 3 milligrams (mg) given twice a day for mood related to delusional disorder and on 10/26/23 Resident #41 was prescribed Trazodone (an anti-depressant medication) 50mg given at bedtime for insomnia and depression related to delusional disorder. The quarterly Minimum Data Set (MDS) assessment dated 6/13/24 showed Resident #41	F 644	F561 Self-determination F644 Coordination of PASARR and Assessments Immediate action taken to address the allegations included: The Social Worker, Administrator, and Administrator assistant immediately signed up for PASRR training (North Carolina NCLIFTSS: PASRR Provider Training) which was held on July 18, 2024. A new PASRR was applied for by the facility Social Worker on 8/2/24 for resident #41. The facility recognizes that any resident that receives a new diagnoses and that may require a Level II PASRR has the potential to be affected by this alleged deficient practice. Measures put into place to ensure that this alleged deficient practice does not recur includes: In services were provided to the Social Worker and Administrative assistant on the importance of PASRR being done promptly on all admissions by the Administrator. This inservice was completed on 8-5-2024. An audit was completed on 7-11-24, by the Social Worker, on recent admissions to the facility to ensure no other PASRR needed submission. Monitoring will be completed by:	

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F 644	Continued From page 44 was cognitively intact and no behaviors were exhibited. A physician order dated 6/18/24 revealed behavioral monitoring every shift for paranoia, confabulation (creating false or distorted memories about oneself or the world), exit seeking and depression. The medical record revealed a PASRR application was not completed to determine if a level II PASRR referral (the purpose of the Level II screening is to assure that individuals with serious mental illness entering or residing in Medicaid certified nursing facilities receive appropriate placement and services) was needed due to new psychiatric diagnoses. On 7/09/24 at 9:33 AM an interview was conducted with the Social Worker (SW). She stated she was new to working at the facility and the previous SW was doing the PASRR applications. She stated that a new application for PASRR for Resident #41 had not been done when he was admitted from the hospital with psychiatric diagnoses. On 7/09/24 at 11:54 AM an interview was held with the Administrative Assistant. She stated that she knew a level I PASRR was completed for Resident #41. She did not know that the level I PASRR was dated 12/8/2020, almost 3 years before Resident #41 entered the facility. The Administrative Assistant stated she had not asked the hospital to complete a new PASRR application prior to admission. She also stated that the facility had not completed a new PASRR application for Resident #41.	F 644	The Social Worker or designee will review all admissions to ensure PASRRs have been done for admission. The Social Worker will let the administrator know if any issues arise so it can be immediately addressed. Monitoring will be conducted by morning meeting, and Social Work monitoring any admissions. The Social Worker will present a monthly report during the Quality Assurance Process Improvement on the accumulative results from the prior month of new admission PASRRs. The Social Woker will conduct tracking of completed PASRRs during the monthly Quality Assurance and Process Improvement meeting. These reports will be presented for 3 months. Completion date: 8-20-24	

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F 644	Continued From page 45 On 7/10/24 at 4:59 PM an interview was conducted with the Administrator. The Administrator stated she knew Resident #41, and he was admitted from the hospital with dementia. The Administrator stated that if he did not have a level II PASRR then he should have. The Administrator said a new PASRR application was needed for a new psychiatric diagnosis or if one was being treated for a qualifying diagnosis. The Administrator did not think Resident #41 had a new diagnosis.	F 644		
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, observation, and staff interviews, the facility failed to provide nail care and meal assistance to a resident dependent on staff. This occurred for 1 of 3 residents (Resident #45) reviewed for activities of daily living (ADL) care. The findings included: Resident # 45 was admitted to the facility on 1/16/24 with diagnoses including dementia, lack of coordination, and sequelae of cerebral infarction (stroke). The Minimum Data Set (MDS) quarterly assessment dated 6/17/24 revealed Resident #45 had severe cognitive impairment and required substantial/ maximum assistance with eating and	F 677	F677 ADL Care Provided for Dependent Residents Immediate action taken to correct the alleged deficient practice; Resident #45 received nail care on 7-9-2024. The Director of Nursing directed each unit charge nurse to oversee their Certified Nursing Assistants to provide nail care to all residents assigned to their units. This was initiated on 7-9-2024. The facility recognizes that all residents that are dependent on staff for nail care have the potential to be affected by this alleged deficient practice. Measures put into place to ensure that his	8/20/24

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F 677	Continued From page 46 personal hygiene. He had no behaviors or rejection of care documented. Review of Resident #45's care plan last reviewed on 6/18/24 revealed he had a care plan in place for ADL self-care performance deficit related to dementia. The care plan interventions included to check nail length and trim and clean on bath day and as necessary. Further care plan interventions included for staff to provide assistance with bathing, personal hygiene, and eating. A continuous dining observation was conducted on 7/8/24 from 12:20 PM- 1:00 PM and revealed the following: At 12:20 PM Resident #45 was observed sitting at a table in the dining room eating with his hands. His fingernails were long with a dark substance visible under all his nails. His thumb nail was noted to extend over the edge of his fingertip by approximately half an inch. He had his meal tray sitting in front of him on the table. His tray included a plate with the meal being served, an empty clear cup with handles, silverware, a single serve cup of ice cream, and a nutritional milk shake in a carton. The carton and ice cream cup were unopened. Resident #45 was observed attempting to open the milk shake carton but was unable to do so. After attempting to open the carton he sat it on top of his plate. He was observed dipping his fingers into his food and licking the food off of his fingers. He was further observed to scoop food up from his plate with his fingers and place it into his mouth. Nurse Aide (NA) #3 was observed feeding a resident at the table behind Resident #45. Hospitality Aide #1 was also observed assisting with the meal activities in the dining room. Resident #45 was	F 677	alleged deficient practice does not recur includes the following: An audit was completed on 7-9-2024 by the assigned Certified Nursing Assistant of all dependent residents that require assistance with all activities of daily living including nail care. Any resident that required nail care had the nail care provided by the assigned Certified Nursing Assistants for the resident identified. A resident list will maintained by the Rehabilitation Director of all residents requiring feeding assistance during meal times. This list will be made available to the direct care staff by keeping the list of names in a binder. This binder will be kept in the dining room as a resource for the direct care staff. Inservices were provided to the certified and licensed nursing staff on the expectations of completing nail care during showers and as needed. Education was provided to the nursing and Certified Nursing Assistants on the expectations of providing proper assistance to the residents requiring assistance in opening food containers and providing feeding assistance. This education will be completed by the Director of Nursing /Designee by 8-19-2024. The direct care staff that are not available on or before 8-20-2024 will not be scheduled until the education has been completed. Monitoring will be completed by the Department Managers completing daily rounds and reporting their observations during the daily stand down meetings to the clinical team. The Director of	

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F 677	Continued From page 47 not approached by any of the staff members in the dining room to provide assistance with the items on his tray or to provide meal assistance. At 12:42 PM Hospitality Aide #1 approached Resident #45 and asked him "was it good?" She said, "here use your spoon" and handed him the spoon on his tray. The hospitality aide brought Resident #45 a cup of tea and left the table. Resident #45 was observed to place the spoon down and started eating with his hands. At 12:49 PM NA #3 approached Resident #45 and handed him his spoon again and verbally cued him to use the spoon. NA #3 left the table. Resident #45 was observed to put down his spoon and started eating with his hands again. He was observed trying to lift the top off the ice cream cup but was unsuccessful. At 12:53 PM NA #3 approached Resident #45 again at the table and poured his tea into the cup with handles but did not open the milk shake carton, ice cream cup, or assist him with his meal. The milk shake carton remained sitting on the top of his plate. At 12:59 PM NA #3 opened the milk shake carton and ice cream cup. At 1:00 PM the dining observation of Resident #45 ended. He was still seated at the table in the dining room, drinking his milk shake. He had eaten approximately 75 % of his meal. An interview was conducted with NA #3 on 7/8/24 at 12:59 PM. NA #3 said she was Resident #45's assigned NA today. NA #3 said she usually provided meal setup for Resident #45. She said	F 677	Nursing/Unit Nurse Manager will complete audits on 3 dependent residents 3x week for 4 weeks, then 2 x a week for 4 weeks then 1 time a week for 4 weeks to ensure the dependent residents nails are clean and trimmed. The Director of Nursing will present a report of the ADL results to the facility Quality Assurance and Process Improvement Committee monthly for 3 months. Completion date: 8-20-2024	

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F 677	Continued From page 48	F 677		

meal setup included cutting up food if needed, opening condiments, and cartons that were on the meal tray. NA #3 said it was not unusual for Resident #45 to eat with his hands and that he ate with his hands often. She said that he used his silverware when staff cued him but went back and used his hands once staff were not with him to provide cues. NA #3 said Resident #45 held the spoon but thought he ate with his hands because it was easier for him. NA #3 confirmed Resident #45's fingernails were long with a brown substance visible underneath the nails. NA #3 shared the condition of Resident #45's fingernails was unhygienic, especially when he ate with his hands. NA #3 said Resident #45 was unable to open cartons and that she should have opened the milk shake carton and ice cream cup for Resident #45 but that it got missed.
A follow up interview was conducted with NA #3 on 7/8/24 at 5:49 PM. NA #3 said resident nails should be checked every shift for cleanliness and trimmed during showers. She said nails should also be checked every shift between showers and trimmed if needed. NA #3 said that checking for nail cleanliness was important for Resident #45 because he ate with his hands. NA #3 said Resident #45's nail care had been missed and that his nails needed to be trimmed and cleaned.

An interview was conducted on 7/9/24 at 11:33 AM with Nurse #3. She said resident nails should be checked during showers and that they should be trimmed and cleaned if needed. She said if a resident ate with their hands staff were supposed to check that their nails were cleaned and trimmed before meals, but added residents should not be eating with their hands. She said NA #3 should assist residents with their meals and provide feeding assistance and cueing for

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F 677	Continued From page 49	F 677		

meals. She said staff working in the dining room should open cartons on the meal tray and provide tray setup for the residents. She did not say how much meal assistance Resident #45 needed.

An interview was conducted with Occupational Therapy Assistant (OTA) #1 on 7/9/24 at 4:14 PM. She stated Resident #45 had received occupational therapy services and that the services had ended on 7/4/24. She said occupational therapy had worked with him on feeding because he liked to eat with his hands. OTA #1 said Resident #45 needed supervision, spoon loaded, and cues for eating. She said he needed supervision and encouragement to keep using his utensils. OTA #1 said Resident #45 needed someone to keep cueing him to use his spoon but that once he was cued, he would usually use his spoon if someone was there to supervise and re-cue him if needed.

An interview was conducted on 7/10/24 at 1:55 PM with the Director of Nursing (DON). The DON said the staff in the dining room should have opened Resident #45's drink cartons and should have sat with him and cued him to use his spoon or provided feeding assistance if needed. She said that NA's checked nails during showers and trimmed them if needed. The DON said that NA's should be checking under nails for cleanliness daily and before meals, especially for Resident #45 since he used his hands to eat.

An interview was conducted with the Administrator on 7/10/24 at 4:55 PM. She said staff in the dining room should have assisted Resident #45 with his meals. She said staff should have sat with him to assist with the meal, provided cues, and opened the items on his tray.

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F 677	Continued From page 50 The Administrator said nail care should occur as needed. The Administrator said a resident's nails should be trimmed and checked for cleanliness	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and Nurse Practitioner (NP) interviews the facility failed to apply a hand splint to a resident (Resident #43) for management of a contracture. This deficient practice occurred for 1of 3 residents reviewed for positioning and mobility. Findings included: Resident # 43 was re-admitted to the facility on 12/16/23 with diagnosis including hemiplegia and hemiparesis following cerebral infarction (stroke)	F 688	F688 Increase/Prevent Decrease in ROM/Mobility The immediate action taken to address this alleged deficiency involved the Occupational Therapist discontinued the splint order for resident #43. The Occupational Therapist Reevaluated Resident #43 for continued splint management. Resident #43 was added to the Occupational Therapy caseload on 7-10-2024.	8/20/24

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F 688	Continued From page 51 affecting right dominant side and contracture of muscle. The annual minimum data set (MDS) assessment dated 5/11/24 revealed Resident #43 was cognitively impaired. He was not documented for behaviors or rejection of care. The MDS assessment revealed he was dependent for activities of daily living (ADL). Review of Resident #43's electronic medical record revealed he had a care plan which was last reviewed on 5/30/24 for impaired physical mobility. The care plan interventions included wearing right hand-based splint 4-6 hours a day on by 9:00 AM off by 2:00 PM for contracture management and prevention. Review of Resident #43's active physician orders for July 2024 revealed an order dated 2/6/24 that read: Effective 7/1/23 clarification: patient to wear right hand-based splint 4-6 hours a day, every day-on-day shift, on by 9am, off by 2pm for contracture management and prevention. The order was not present on Resident #43's July 2024 medication administration record (MAR) or treatment administration record (TAR). An observation of Resident #43 and his room was completed on 7/7/24 at 2:05 PM. He was observed resting in bed. His right hand was noted to be tight with his 3rd, 4th, and 5th digits drawn inward toward his palm. He did not have a splint in place on his right hand. There was not a splint visible in his room. Additional observations were completed of Resident #43 and his room	F 688	The facility recognizes that all residents that are dependent on splints for contracture prevention could potentially be affected by this alleged deficient practice. Measures put into place to ensure that this deficiency does not recur includes: An audit was completed by the Director of Rehabilitation Services/Designee on 7-10-2024 for all current residents that require hand splints to ensure that the splint orders were written and correct. The Director of Rehabilitation will complete an educational session with all evaluating therapist on expectations for initiating orders for trial splints needed by any resident referred for splints and the process for discontinuing any splint when appropriate. This education will be completed by 8-19-2024. The Director of Rehabilitation completed an audit on 7-9-2024 to ensure that all residents with orders for splints had these splints available. All residents splints were available. The Director of Rehabilitation/Designee will complete education to all direct care staff and licensed nursing staff by 8-19-2024. Any direct care staff, licensed nursing staff, or agency staff that have not completed this education by 8-19-2024 will be removed from the schedule until the education has been completed. Monitoring will be completed by the Director of Rehabilitation completing weekly audits on splint management weekly x 4 weeks and then monthly x 2	

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F 688	Continued From page 52 -on 7/8/24 at 9:16 AM he was observed, and he did not have a splint on his right hand. There was not a splint that was visible in his room. -on 7/8/24 at 11:53 AM he was observed and did not have a splint on his right hand An interview was conducted with Occupational Therapy Assistant (OTA) #1 on 7/9/24 at 9:50 AM. She stated that occupational therapy (OT) had been working with Resident #43 for splint management and that he needed the splint due to a contracture of his right hand. She stated Resident #43's right hand splint was supposed to be worn daily. She looked at Resident #43's therapy record and stated Resident #43 had started OT services on 6/11/24 and had been seen by OT three times a week but that he had been discharged from occupational therapy services on 7/3/24. OTA #1 stated she was not aware that Resident #43 had been discharged from OT on 7/3/24 until today. She explained that Resident #43's original splint had been lost and that OT had ordered a new splint. OTA #1 stated that they had been using the new splint for a couple of weeks and stated he had been tolerating the new splint. OTA #1 stated that Resident #43 did not have a splint in his room because his splint was kept in the therapy closet. She stated the splint was kept in the therapy closet because OT applied/ removed the splint as part of his therapy. OTA #1 stated she had still applied Resident #43's splint on the days he was not scheduled for therapy but that it would not be documented because he was not on therapy caseload those days. OTA #1 stated that she had worked on 7/4/24 and 7/5/24 and had applied Resident #43's right hand splint on those days. She stated she did not work on Saturday 7/6/24 or Sunday 7/7/24 but that the OTA who worked on	F 688	months. The Rehabilitation Director will complete a report of these findings and present to the monthly Quality Assurance and Process Improvement Committee for 3 months. Completion date: 8-20-24	

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F 688	Continued From page 53	F 688		

Saturday would have known to apply the splint for Resident #43 on Saturday. OTA #1 could not say how the OTA who worked on Saturday would have known to apply the splint since he had been discharged from OT service and was no longer on case load. OTA #1 stated she had not applied Resident #43's splint on Monday 7/8/24. She explained that Resident #43 would not have had his splint applied on Sunday 7/7/24 because there had not been a therapist scheduled for Sunday. OTA #1 explained that therapy typically educated nursing on a resident's splint and turned the management of the splint over to nursing before a resident was discharged from therapy. OTA #1 stated that Resident #43's splint had not been turned over to nursing to manage yet and that nursing had not yet been educated on Resident #43's splint. She stated this had not been done because she had not known Resident #43 was going to be discharged from OT on 7/3/24.

A telephone interview was conducted on 7/11/24 at 5:36 PM with OTA #3. She stated she had worked on Saturday 7/6/24. OTA #3 stated she did not work with Resident #43 on Saturday and did not apply his splint. OTA #3 stated Resident #43 was not on her schedule to see on Saturday. OTA #3 stated she did not apply splints for residents when they were not on her schedule or on the days she did not see a resident. OTA #3 stated she had not been aware Resident #43 had splint that needed to be applied because he had not been on her schedule.

An interview was conducted on 7/9/24 at 10:00 AM with Nurse #4. She stated she was Resident #43's assigned nurse today. Nurse #4 stated that Resident #43 had a right-hand contracture. She stated that Resident #43 did not have a splint for

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F 688	Continued From page 54 his right hand that nursing applied. A telephone interview was conducted on 7/10/24 with Nurse #2. She stated she had worked the 7AM- 7PM day shift on Sunday 7/7/24 and had been Resident #43's assigned nurse. Nurse #2 stated that Resident #43 did not have a splint for his right hand that he was supposed to wear that she knew of. An interview was conducted with the Nurse Practitioner (NP) #1 on 7/10/24 at 9:58 AM. NP #1 stated that Resident #43 should have had his right-hand splint on every day to help prevent further contracture. She stated if therapy had discharged Resident #43 then they should have turned his splint management over to nursing and educated nursing on applying his splint. An interview was conducted with the Director of Nursing (DON) on 7/10/24 at 1:55 PM. The DON stated Resident #43 should have had his splint applied to prevent his right-hand contracture from worsening. She did not say why it had not been applied or why the order did not show up on the MAR or TAR. An interview was conducted with the Administrator on 7/10/24 at 4:55 PM. She stated Resident #43 should have had his splint in place and that the splint was needed to prevent issues with his contracture.	F 688		
F 689 SS=D	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	F 689		8/20/24

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F 689	Continued From page 55 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, observation, and staff interviews, the facility failed to safely transfer a resident from bed to wheelchair using a total mechanical lift when staff did not lock the wheels of the lift prior to lifting Resident #69 from bed and lowering to his wheelchair. This deficient practice had the potential to cause an injury during transfers using a total mechanical lift for 1 of 6 residents reviewed for accidents (Resident #69). The findings included: Resident #69 was admitted to the facility on 10/1/23 with diagnoses that included hemiplegia (paralysis that affects one side of the body) and hemiparesis (muscle weakness) following cerebral infarction (stroke) affecting left non-dominant side. Resident #69's care plan dated 11/13/23 indicated he needed extensive/dependent assistance with activities of daily living due to left hemiparesis, and poor posture/positioning. Interventions included Resident #69 needed a total mechanical lift for transfers. The quarterly Minimum Data Set assessment dated 4/8/24 indicated Resident #69 was cognitively intact, had range of motion impairment on one side of both upper and lower extremities, and was dependent for chair/bed-to-chair	F 689	F689 Free of Accident Hazards/Supervision/Devices The immediate action taken to correct this alleged deficient practice includes; A Immediate education and training on how to use a total lift for transfers was provided to Nurse #1 by the Director of Nursing on 7-7-2024. The facility recognizes that all residents that are dependent on a total lift transfer has the potential to be affected by this alleged deficient practice. Measures put into place to ensure that this alleged deficient practice does not recur includes: A individual sling/lift pad was obtained for resident #69. The Director of Rehabilitation completed an inventory and audit. 7-9-2024, of the available slings/lift pads for the different needs for the residents requiring lift assistance for transfers. A list was completed of all resident that require lift assistance, the type of lift, the type of lift pad/sling needed. The C N A's were taught to recognize the necessary lift pad as it pertains to the sizes assigned and as indicated on the resident's list. These size allotments are determined by weight. Each resident that requires transfers by lifts will have a personal lift pad assigned.	

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F 689	Continued From page 56 transfer. An observation was made on 7/7/24 at 1:50 PM of Resident #69 being transferred from bed to wheelchair using a total mechanical lift by Nurse #1 and Nurse Aide (NA) #1. Nurse #1 brought a green sling into the room, and it was placed underneath Resident #69 while in bed. NA #1 suggested that they crisscross the sling under Resident #69's thighs before securing it to the lift. Nurse #1 positioned the total mechanical lift so that the base was underneath Resident #69's bed frame. Nurse #1 asked NA #1 how to spread the lift's legs and NA #1 instructed Nurse #1 to move the lever from left to right. Nurse #1 moved the lever from left to right and this caused the lift's legs to spread wide. Both staff members secured the sling on the bottom loop onto the total mechanical lift. Without locking the wheels on the total mechanical lift, Nurse #1 proceeded to lift Resident #69 off the bed, moved the lift to where Resident #69 was positioned over his wheelchair and started lowering Resident #69 to his wheelchair without locking the wheels on the lift. While Nurse #1 lowered Resident #69 onto his wheelchair, the lift was observed to be unstable as it kept on moving while Resident #69 was being moved. An interview with Nurse #1 on 7/7/24 at 2:02 PM revealed he had never assisted before in lifting a resident with a total mechanical lift. He stated that he thought he had locked the wheels on the lift prior to moving Resident #69. He stated that he realized that he should have locked the wheels on the lift. An interview with the Rehabilitation Manager (RM) on 7/10/24 at 8:26 AM revealed that while	F 689	Each resident will have a reserve lift pad to allow for proper laundering and adequate turn around time. A list of residents requiring lift transfers will be made available to all staff. These lists will be maintained in the therapy communication books that will be kept at the nurses stations. An additional list will be kept in the clean linen room. Revisions to this list will be kept current by adding any changes related to changes in conditions and identified transfer needs of the residents. Skills competency and inservice education was initiated on 7-11-24 for all direct care staff. This education was provided by the Director of Rehabiliation and the Certified Occupational Therapy Assistant. Inervices provided education on the physical mechanics of operating the different type of lifts, safety practices and the importance of locking the brakes, a review of the different type of lifts and how to know which lift pads/slings are the correct fit for the residents. Observations were also completed of the direct staff memebers using the lifts with feedback to the staff member on proper procedures. This education will be provided to all newly hired direct care staff employees and agency/contract staff members. Any staff person that does not complete this lift and safety assessments and training before 8-19-2024 will not be allowed to work until the training is completeted. Monitoring will be accomplished by the	

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F 689	Continued From page 57 using a total mechanical lift, staff should make sure the lift's legs were spread out so that there was a wide base, and this would cause the lift to less likely tip over during the transfer. The RM stated that staff should make sure that the wheels on the lift were locked as locking the wheels would make it more stable, and prevent the lift from rolling out while the resident was being lifted or lowered with the lift. An interview with the Director of Nursing (DON) on 7/10/24 at 1:56 PM revealed staff should make sure that they were locking the wheels on the lift while using them on a resident.	F 689	Director of Nursing/Designee This will be proven by audits that will be conducted to observe a total lift transfer 3 times per week x 4 weeks, then 2 times a week x 4 weeks then once a week x 4 weeks to ensure that proper technique is being used during transfer with total lift. The Director of Nursing will present a report of these audits to the Quality Assurance and Process Improvement Committee monthly for 3 months. Completion date 8-20-24	
F 690 SS=K	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		8/20/24

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F 690	Continued From page 58 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with staff, Nurse Practitioner, Medical Director, and urology office staff the facility failed to follow up with the Urologist for Resident #49 who was hospitalized for obstructing ureteral stones (kidney stones that get stuck in tubes composed of smooth muscle that transport the urine from the kidneys to the bladder) with hydronephrosis (swelling of one or both kidneys due to urine build up), urinary tract infection (UTI), pyelonephritis (an infection of the kidneys) and (a serious condition in which the body responds improperly to an infection). The Resident had a stent (a small tube placed in the ureter that allows the urine to drain) placed for renal stone obstruction on 4/23/24 and returned to the facility on 4/26/24 with a urinary catheter. The discharge summary specified further assessment by Urology next week and also included an order for antibiotics for a UTI. Resident #49 experienced and was treated for two UTIs, urinary pain and a yeast infection due to the antibiotics while waiting to see the urologist. The second UTI diagnosed on 6/29/24 showed the growth of two organisms	F 690	F690 Bowel/Bladder Incontinence Catheter Immediate action taken to address this alleged deficient practice: 1. Resident #49 completed her Urology appointment on 7-12-2024. 2. An order for the Urinary catheter was obtained by the Unit Nurse Manager on 7-7-24. 3. Resident #11 is no longer a resident at this facility. The facility recognizes that all residents that have urinary catheters have the potential to be affected. Measures put into place to ensure that this alleged deficient practice does not recur: The Director of Nursing and Nurse Unit Manager completed an audit on 7-22-2024 of all residents with urinary catheters that required follow up medical appointments. This involved a review of	

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F 690	Continued From page 59 which had a greater resistance to antibiotics. The presence of the urinary catheter and the stent both increased the risk of bacterial growth, UTIs and sepsis. In addition, the facility failed to obtain physician orders for use of an indwelling catheter and failed to use a securement device to anchor urinary catheter tubing (Resident #80) and ensure the urine collection bag remained below the level of the resident's bladder (Resident #11). These deficient practices affected 3 of 4 residents reviewed for urinary catheter or urinary tract infection (Resident #49, Resident #80 and Resident #11). Immediate jeopardy began on 5/3/24 when the facility failed to not follow up with urology for Resident #49. Immediate jeopardy was removed on 7/26/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Example #2 and #3 were cited at a S/S of D. Findings included: 1. Review of nurses noted dated 4/22/24 revealed Resident #49's was complaining of stomach pain, nausea and chills. Resident #49 was noted to be shivering and had a temperature of 100.2 and oxygen saturation of 86%, resident placed on 2 liters via nasal canula. The doctor was notified and gave the order to send the resident to the emergency room (ER) for evaluation. Review of Resident #49's hospital discharge	F 690	resident orders received by the medical physician. Also included in this audit was a review of the physician orders and hospital discharge summaries. The Nurse Unit Manager verified that all residents did complete their follow up appointments by verbal confirmation with the physician's office and reviewing the resident's consult reports. The Director of Nursing/ Designee completed a 90-day review of urinary catheter orders for follow up appointments. There were no residents without scheduled appointments as ordered. On 7-20-24 the education that was provided to the Receptionist, Transportation Aide and Nursing staff included the requirement and expectation that no appointments will be cancelled or rescheduled without notification and approval of the cancellation by the Director of Nursing. The education that was provided was provided by the Director of Nursing / Designee in person and by telephone. All licensed nursing staff including staff that had not been in-serviced by 7-20-24 were not allowed to work until they completed this in-service. Inservices on obtaining urinary catheter orders on admission was delivered to the licensed nursing staff on 8-6-2024 by the Director of Nursing and Unit Nurse Manager. Inservice education was provided to all the Certified Nursing Assistants and the Licensed Nursing Staff on the positioning of the urinary bag below the bladder level and the placement of the securement device. Skills return	

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F 690	Continued From page 60 summary dated 4/26/24 revealed she had been hospitalized from 4/23/24 to 4/26/24 for obstructing ureteral stones with hydronephrosis, UTI, pyelonephritis due in part to obstructing ureteral stones, and sepsis. Diagnostics showed she had a 5millimeter (mm) stone in the juncture where the kidney meets the ureter and a 4 mm stone in the juncture where the ureter meets the bladder as well as multiple other non-obstructing stones in both kidneys. Urology was consulted during her hospitalization to provide intervention for her urinary obstruction. She was taken to the operating room on 4/23/24 by the urologist and a stent was placed in her left ureter. Her blood culture and urine cultures grew out the organism Klebsiella. Her discharge summary read in part, per infectious disease recommendations will treat with Ciprofloxacin (antibiotic) 500 milligrams (mg) twice daily with end of treatment on 5/2/24, return to the facility today, follow-up with urology next week, urinary catheter to stay in place and be further assessed by urology next week. Resident #49 was readmitted to the facility on 4/26/24 with diagnoses including renal and ureteral calculous (kidney stones) obstruction with hydronephrosis, urinary tract infection (UTI), acute pyelonephritis (sudden and severe inflammation of the kidney due to a bacterial infection), sepsis, chronic kidney disease, and encounter for surgical aftercare following surgery on the genitourinary system. Review of Resident #49's Medication Administration Record (MAR) for April 2024 and May 2024 revealed an order dated 4/26/24 that read: Ciprofloxacin 500 milligrams (mg) one tablet by mouth every 12 hours for infection until 5/2/24. The MAR revealed all doses of	F 690	demonstrations were completed with during these educational sessions to prove clinical staff's comprehension and recall of the information reviewed. To verify the phone education provided to the nurses, the Director of Nursing / Designee obtained verbal understanding from the nurse being educated. Newly hired Nurses, Receptionist, Transporters and Agency Nursing staff will receive this education during their onboarding process. This education will be provided by the Human Resource Director. The facility has re-educated the licensed nursing staff including agency on the process for following through with resident appointments, the possible complications of urinary catheters including UTIs and the seriousness of stents, resistance to antibiotics and sepsis. The education will be provided by the Director of Nursing/Designee in person and by phone and was completed by 7-23-2024. Any orders for appointments received by the Nurses, Monday through Friday and will be addressed by the Nurse communicating this to the Receptionist during the operational receptionist hours of 9:00 am and 5:00 PM. The resident assigned Nurse will bring a copy of the order to the Receptionist. If the Receptionist is out of work between 9 AM and 5 PM on a weekday the assigned Nurse will copy the order for the appointment and place the copy in the Transportation Aide's box. The Receptionist will log the appointment with the date received, the date the physicians' office was called and date of appointment.	

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F 690	Continued From page 61 Ciprofloxacin were documented as administered until 5/2/24. There was not a record of a urology appointment that had been scheduled for May 2024 in Resident #49's electronic medical record. Review of Resident #49's electronic medical record revealed there was an order dated 4/26/24 that read: follow up with urology next week. The order was discontinued by the Director of Nursing on 6/6/24. An interview was conducted on 7/12/24 at 11:27 AM with the Director of Nursing (DON). The DON said she had discontinued the order for Resident #49 from 4/26/24 that read follow up with urology next week. The DON said she had been removing old orders on all residents from the electronic computer system and had discontinued the order because it had been old. The DON said she did not check to see if Resident #49 had been to the urologist for follow up prior to discontinuing the order. The DON indicated she thought it had been an old order and had already been taken care of. A History and Physical (H&P) was completed on 5/2/24 by the Medical Director (MD). Under history of present illness, the note read in part: 70-year-old female seen at bedside for readmission H&P. Patient recently admitted to the hospital for sepsis and UTI secondary to obstructive stone in the left ureter. The patient underwent several days of IV antibiotics. After appropriate treatment, the patient was sent back to facility for continued rehabilitation. Under the section past surgical history, it read: recent left ureter stent placement. Under the note section	F 690	The appointment is to be logged on to the calendar by the Receptionist for the Transportation Aide once the appointment is made. Receptionist to make appointments for residents Monday through Friday. If the appointment cannot be made as ordered, the Receptionist will notify the Director of Nursing. After hours and weekends the residents', assigned Nurse will copy the order for the appointment and place the copy in the Transportation Aide's mailbox. To verify the phone education provided to the nurses, the Director of Nursing and Nurse Unit Manager obtained verbal understanding from the nurse being educated.Education was completed by 7-22-2024 for both the Receptionist and the Transportation Aide on the process required for the scheduling of residents requiring appointments. The Receptionist is responsible for scheduling the appointments. The process is, once an order for a appointment is received by the Nurse, this Nurse will notify the Receptionist of the necessary appointment. The Receptionist will be informed of appointment orders written on the weekend or after-hours by completing a check of the Transportation Aides mailboxes located at the Nurse's and Receptionist desks every morning Monday through Friday. The Receptionist will log the appointment with the date received, the date the physicians' office was called and date of appointment. The appointment is to be logged on to the calendar by the Receptionist for the Transportation Aide once the appointment	

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F 690	Continued From page 62 labeled physical exam there was not a genitourinary assessment/exam included. The note did not mention Resident #49 needing to follow up with the urologist or her indwelling urinary catheter. The significant change Minimum Data Set (MDS) assessment dated 5/2/24 revealed Resident #49 was cognitively intact. She was coded for an indwelling catheter. The MDS revealed she was also coded for receiving antibiotics and septicemia (disease caused by the spread of bacteria and their toxins in the blood stream). Review of Resident #49's care plan revised on 5/9/24 revealed she had a care plan in place for an indwelling catheter due to ureter obstruction, pyelonephritis, hydronephrosis, and UTI. The care plan goal was to not have any complications from the indwelling catheter, will not develop a UTI. The care plan interventions included: to follow up urology as recommended, monitor for signs/ symptoms of infection, and catheter care every shift. Further Review of Resident #49's electronic medical record revealed: A medical provider progress note dated 5/29/24 that read in part: Nurse reports that patient has bladder pain on and off. Urinalysis (UA) (a lab used test for an infection in the urine) with Culture and Sensitivity (C&S) (a report used to determine which antibiotic to use to treat an infection) ordered. Lab results showed Resident #49 had a UA completed on 5/30/24. The urine C&S report dated 6/1/24 showed the growth of the organism	F 690	is made. Receptionist to make appointments for residents Monday through Friday. If the appointment cannot be made as ordered, the Receptionist will notify the Director of Nursing. The education for this system will be provided by the Director of Nursing and Nurse Unit Manager. If an appointment is made with the Transportation Aide by the doctor's office personnel, the Transportation Aide will notify the Receptionist so that the Receptionist can log the appointment and notify nursing of the appointment that is needed. If the Receptionist is absent for some reason, the Transportation Aide will serve as a backup for logging the necessary follow up appointment and will notify nursing. This inservice was provided to the Receptionist, Transportation Aide, Human Resource Director and the licensed nursing staff. The Administrator provided this education to the Receptionist and Transportation Aide on 7-20-24. The Director of Nursing / Designee provided this education to the licensed nursing staff on 7-22-24, and 7-23-2024. The Human Resources Director received this education in person on 7-22-24 by the Administrator. For all of the above-mentioned education provided to the licensed nursing staff including agency staff the Director of Nursing is tracking the staff to determine which staff members still require the education on the scheduling process for making resident appointments. Licensed nursing staff that does not receive education by the 7-23-2024 will be	

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F 690	Continued From page 63 morganella morganii (bacteria) with a colony count of greater than 100,000 (cultures with greater than 100,000 colony count usually indicate infection). The organism was resistant to multiple antibiotics listed on the urine culture sensitivity report. An order entered by the Medical Director (MD) dated 5/30/24 read: Cephalexin (antibiotic) 500 mg tablet give one tablet by mouth three times a day for infection for 7 days. The order was discontinued on 6/3/24. Review of Resident #49's MAR for May 2024 and June 2024 revealed Cephalexin was given as ordered. A medical provider telehealth visit note dated 6/3/24 read in part: I gave an order to administer Ceftriaxone (antibiotic) 1 gram (gm) intramuscular once daily for 7 days. Patient was ordered Cephalexin prior, started 5/30/2024 until 6/6/2024. I discontinued cephalexin at this time. The note did not indicate why Cephalexin had been discontinued and a new antibiotic had been ordered. An order dated 6/3/24 for Ceftriaxone (antibiotic) 1 gm intramuscularly every 24 hours for infection for 7 days. Review of Resident #49's June 2024 MAR revealed Ceftriaxone was given as ordered. A medical provider progress note dated 6/4/24 read: "nurse reports patient complaining of pain 10/10 even after pain medication given. Patient states pain is in groin related to UTI. Order given for Pyridium (a medication used to treat urinary pain) 200 milligram (mg) three times daily as needed for two days." A review of Resident #49's active physician	F 690	removed from the schedule until the education has been completed. The DON will be responsible for ensuring that no nurse including agency will be allowed to work or accept a resident assignment until they have completed this education. The Human Resources Director will be responsible for providing this education to any new hires including licensed nursing staff, Receptionist, and Transportation Aides. The Human Resources Director was notified of this responsibility on 7/22/24. New agency staff will be educated on this process by the Director of Nursing / Designee prior to the beginning of their shift. Monitoring will be completed by The Director of Nursing (DON)/Unit Manager (UM) will check orders at standup meeting for new orders for any new admission and any readmissions. Orders will also be monitored following resident physician appointments. For all new admissions and readmissions a bedside observation will be completed within 48 hours of the admission/readmission. If a foley is observed without an accompanying order the Nurse Unit Manager will obtain the necessary order. All new admissions and readmissions will be monitored 3x week x 4 weeks, 2 x a week x 4 and then 1x weekly x 4. Results of the audits will be summarized and presented to the facility Quality Assurance and Process Improvement Committee for 3 months. Completion date: 8-20-24	

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orders revealed an order dated 6/4/24 given by the Medical Director (MD) that had been entered by the Minimum Data Assessment (MDS) Nurse that read: Urology consult/ follow up diagnosis pyelonephritis status post stent placement.

A progress note from NP #1 dated 6/27/24 read in part: Being seen today for follow up regarding urinary pain and not feeling well. Nurses report patient states she is not feeling well and having discomfort with urination. Patient reporting discomfort with urination, even though she has an indwelling urinary catheter. Under the section labeled assessment and plans it read: Dysuria: UA and C&S.

A progress note from NP #1 dated 6/29/24 read in part: Patient seen today for discomfort with urination and low-grade temp. Will start on antibiotics while awaiting lab results. Urinary tract infection: Previous 5/30/24 sensitivity noted to Ceftriaxone (Rocephin-antibiotic). Orders to give Ceftriaxone 1 gram (gm) give every 24 hours for 7 days intramuscular. Awaiting results from UA C&S. Follow up as soon as possible (ASAP) with urologist regarding indwelling placement status post left ureter stent placement.

An order to follow up with the urologist as soon as possible was not located in Resident #49's physician orders.

An order dated 6/29/24 that read: Ceftriaxone sodium solution reconstituted 1 gm inject 1 gm intramuscularly every 24 hours for infection related to urinary tract infection for 7 days. The order was discontinued on 7/5/24 the reason for discontinuation read due to sensitivity report shows resistance; antibiotic changed. Review of

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Resident #49's June 2024 and July 2024 MAR revealed Ceftriaxone had been given as ordered.

Lab results showed Resident #49 had a UA that was completed on 7/1/24. The urine C&S report dated 7/4/24 showed the growth of two different organisms, Provedencia Stuartii (bacteria) and Acinetobacter baumannii complex (bacteria) The two organisms were not sensitive to the same antibiotic. Both organisms were resistant to multiple antibiotics listed on the urine culture and sensitivity report.

An order dated 7/4/24 that read: Ciprofloxacin 250 mg tablet give one tablet by mouth twice daily related to UTI for 7 days.

An order dated 7/5/24 that read: Bactrim (an antibiotic) oral tablet 400-80 mg tablet give one tablet by mouth twice daily for 3 days related to UTI, do not give at the same time as Cipro.

A progress note from NP #1 dated 7/8/24 read in part: "Urine culture is not sensitive to Rocephin this has been discontinued. There are two bacteria isolation in urine culture: one is sensitive to Cipro (antibiotic); and the other sensitive to Bactrim (antibiotic); patient can take both safely."

A medical provider progress note dated 7/11/24 read: "Nursing reports resident with severe, yeast infection. Previously on antibiotic for UTI, Diflucan (a medication used to treat fungal infections) 150 mg one dose ordered."

An interview was conducted on 7/10/24 at 8:04 AM with the Transportation Aide. The Transportation Aide explained he primarily scheduled the facility resident appointments but

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that the receptionist helped schedule appointments if he was out on transport. The Transportation Aide said he had scheduled Resident #49's 5/17/24 urology appointment. He said 5/17/24 had been the date the urologist office had been able to get Resident #49 in to be seen. The Transportation Aide said he thought that Resident #49 had refused to go to the urology appointment that had been scheduled for her in May but was not sure. He stated Resident #49's urology appointment in June had been cancelled because another resident had an urgent appointment they needed to go to. The Transportation Aide stated he had been out on transport and that the Receptionist moved and rescheduled Resident #49's 6/14/24 appointment. He said Resident #49 had an upcoming urology appointment scheduled at the end of July on 7/31/24. He explained he looked at appointments when they needed to be moved and decided if appointments were okay to be moved. The Transportation Aide indicated the facility had a new DON and that now he discussed medical appointments that needed to be changed or moved with the DON to make sure it was clinically okay. He was unsure if the receptionist had spoken to anyone to make sure it was okay to move her appointment. He said the receptionist was currently out on medical leave.

The Receptionist was unavailable to be interviewed.

A telephone interview was conducted on 7/9/24 at 9:05 AM with the Urology Office Appointment Scheduler. The Scheduler stated that Resident #49's original urology appointment had been scheduled for 5/17/24. She said the office had received a call from the facility to cancel

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/reschedule the appointment, and that the appointment had been rescheduled to 6/14/24. She stated there was not a note as to why the appointment on 5/17/24 had been cancelled and moved. The Scheduler further stated the facility called again on 6/13/24 and had cancelled the appointment for 6/14/24 and rescheduled it for 7/31/24. She said there was a note attached to the appointment re-scheduled for 7/31/24 that said it was the only time and date they had available for a driver to take her. The Scheduler explained the turnaround time for appointments depended on the reason why someone needed to be seen. She said if the needed appointment was related to kidney stones or post-op the office would usually get them in within 2 weeks or sooner. If an initial hospital follow-up appointment had been cancelled the office would not re-schedule the appointment for a month out, she said the office would be able to get them in to be seen sooner.

A telephone interview was conducted on 7/9/24 at 10:51 AM with the Urology Office Clinical Coordinator Nurse. She reviewed Resident #49's notes and confirmed she was supposed to follow up with the urology office a week after her hospital discharge on 4/26/24. The Urology Office Clinical Coordinator Nurse indicated she thought the reason Resident #49 had not been seen was due to transportation issues with the facility. The Clinical Coordinator stated that if the physician had wanted to Resident #49 her for a follow-up in a week, then ideally Resident #49 should had been seen. She said typically at the one week follow up appointment the office would check to ensure the UTI causing her sepsis had resolved and schedule for surgery to bust the renal stone up. The Clinical Coordinator stated if the stent

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was in place, it would allow the urine to drain and keep the ureter from becoming blocked again. She said Resident #49 could become septic again if her ureter became blocked again. The Clinical Coordinator was unable to speak to if Resident #49 would have been able to pass the renal stones on her own without having the surgical procedure to break up the stones. She said if the plan was for Resident #49 to come back in a week for follow up, then at the follow up appointment they would have made sure her infection was resolving and set up for surgery to deal with the stones that had caused the urinary blockage and sepsis. She said that Resident #49 had a urology appointment scheduled for 7/31/24 and there was a note on the appointment that stated it was the only date and time the facility had a driver. The Clinical Coordinator explained that some patients kept urinary stents in place for months and some patients had to have them replaced quarterly if the stent was due to a chronic issue. She said a stent did not usually stay in place for a renal stone obstruction. The office was not aware Resident #49 had been treated with antibiotics for two additional UTIs since her hospitalization. She explained a urinary stent could cause urinary irritation and bacteria would accumulate around the device. The Clinical Coordinator stated the stent could cause the urine to have traces of blood in it and would cause the patient to feel uncomfortable because a urinary stent was not comfortable. She said the ureter was opened with the stent and the next step would be to bust up the stones. The Clinical Coordinator further explained after the stones were busted up, the old stent would be removed, and a new stent placed while in the operating room. The Clinical Coordinator stated that the new stent would remain in place for a certain

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amount of time, then it would be removed, and the ureter assessed for stricture. She could not say if or how long Resident #49's catheter would need to be in place or if the catheter would have been removed at the follow up appointment. She said kidney stones tended to hide infection and that with Resident #49 already having had urosepsis and having a catheter she was at a huge risk of further infection.

An interview was conducted on 7/10/24 at 8:15 AM with Resident #49. Resident #49 did not remember anyone coming to talk to her about a urology appointment in May and that she did not remember refusing to go a urology appointment in May. Resident #49 stated she did not remember being told by anyone in June that they needed to change/ reschedule her urology appointment. Resident #49 said she knew she had was supposed to go see the urologist after being in the hospital but was not sure why she had not been. Resident #49 thought she had been doing okay, until she had gotten another infection in her urine. Resident #49 stated she had pain in her bladder and stomach when she had the infections in her urine but said she did not currently have any discomfort. Resident #49 stated she did not have a urinary catheter before she had gone to the hospital and that she "would rather have it out than in" and if the catheter was able to be removed, she wanted it to be removed

An interview was conducted on 7/10/24 at 3:59 PM with the MDS Nurse. The MDS Nurse stated that Resident #49's indwelling catheter had been brought up during a clinical meeting. The MDS said she was unsure which meeting it had come up in, but that it was around the same date (6/4/24) that she had entered the order from the

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MD for Resident #49 to follow up with the urologist. The MDS Nurse said that she had heard Resident #49 had asked about her indwelling catheter and wanted to know when or if it would be able to come out. The MDS Nurse was unsure who had told her Resident #49 had asked about her indwelling catheter. The MDS nurse stated she had asked the Medical Director (MD) about Resident #49's indwelling catheter regarding if the plan was to keep the catheter in place long term, the diagnosis, and if it was necessary. She said the MD gave her the order to have Resident #49 follow up with urology for her indwelling catheter, pyelonephritis, and the urinary stent. The MDS Nurse had not been aware that when Resident #49 returned to the facility from the hospital on 4/26/24 she was supposed to follow up with urology in a week. She said it was after the MD had given her the order for the urology follow up on 6/4/24 that she realized that Resident #49 had not followed up with urology when she returned to facility as specified on the hospital discharge summary. The MDS Nurse stated the urology appointment for Resident #49 had been made for 6/14/24 but that she was not sure what had come of that appointment.

A telephone interview was conducted with NP #1 on 7/10/24 at 12:03 PM. NP #1 said when she saw Resident #49 on 6/29/24 and had placed in her progress note she needed to be seen by urology ASAP, she had also entered the order for a urology referral into the electronic computer system. NP #1 stated she had also verbally let the staff know. NP #1 was certain she had discussed Resident #49 needing to be seen by the urologist for follow up with Unit Manager (UM) #1 and the Director of Nursing (DON). NP #1

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indicated she had also told UM #3. NP #1 stated she had not given a time frame that Resident #49 needed to be seen, but that she expected that Resident #49 to be seen as soon as the urology office could get her in. NP #1 stated she had wanted Resident #49 to be seen ASAP for follow up of the stent and evaluation of the urinary catheter because Resident #49 had another UTI, and the current UTI had a greater resistance pattern to antibiotics. NP #1 was concerned if Resident #49 developed another UTI in between her completion of the antibiotic for her current UTI and her going to the urologist it could have a higher antibiotic resistance and required Resident #49 to go back to the hospital to be treated. NP #1 did not know that Resident #49 had missed her other urology appointments but that the appointments for follow up being scheduled a month later was too long. NP #1 stated she did not usually see the urology office being booked out and unable to fit someone in for an appointment.

An interview was conducted on 7/10/24 at 12:16 PM with Unit Manager (UM) #1. UM #1 did not remember the NP #1 speaking to her about Resident #49's indwelling catheter, urinary stent, UTTs, or needing to be seen by urology for follow up as soon as possible. UM #1 had not been aware of NP #1's note from 6/29/24 that specified Resident #49 needed to be seen by urology ASAP. UM #1 explained appointments listed on the hospital discharge summary were given to the Transportation Aide and that the Transportation Aide scheduled the appointments. UM #1 said in-house appointment referrals were entered into the electronic computer system by the provider. She said the UMs would go through orders each morning and if there was an order for an

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appointment/ referral they printed it out and would give it to the Transportation Aide to schedule. UM #1 said the appointment date/ time was not entered into the electronic computer system. UM #1 explained appointment dates/ times were in the appointment book kept at the reception desk. She said the Transportation Aide made a copy of appointments for the week and put the list out at the nurse's station for the current week. She stated the only way to know when a resident had an appointment would be for someone to look at the weekly list of appointments for the current week located at the nurse's station or to call the Transportation Aide. UM #1 explained the facility MD/ NP would not know when a resident had a specialty appointment scheduled unless it was on the current weeks appointment list at the nursing station, because it did not show up in the electronic computer system anywhere that they could see. UM #1 said the Transportation Aide was not clinical and would not know if an appointment was medically necessary versus a routine appointment. She did say the Transportation Aide asked for clinical decision-making support from nursing management when he was unsure. UM #1 stated if a residents appointment needed to be moved because another resident had an urgent appointment need, the Transportation Aide should call that day and re-schedule the appointment for as soon as possible. UM #1 said she thought a cancelled appointment would need to be re-scheduled for within a week if possible. UM #1 stated she had started working at the facility on June 10th and was unaware that Resident #49 was supposed to follow up with urology in a week after her hospital discharge on 4/26/24 and had not been seen.

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An Interview was conducted with UM # 2 on 7/10/14 at 12:38 PM. UM #2 indicated she had never been approached by the Transportation Aide about an appointment that needed to be moved or changed. UM #2 said she did not always review the providers notes after they had seen a resident because they did not put the notes into the electronic computer system right away. UM #2 did not remember why Resident #49 did not go to her urology appointment scheduled on 5/17/24. UM #2 said she did not know that Resident #49's appointment on 6/14/24 had to be moved because another resident had an urgent appointment need. UM #2 stated she remembered a patient that needed to have an urgent appointment but that she did not tell the Transportation Aide to bump or move Resident #49's urology appointment to take the other resident. UM #2 said she would tell the Transportation Aide if a resident needed to be seen urgently but that the Transportation Aide did not ask her whose appointment to move or bump to fit in the appointment. She stated if the Transportation Aide had asked her, she would have asked the MD/NP which appointment could be moved or bumped to a later date if that needed to happen. UM #2 did not remember NP #1 discussing Resident #49's urinary issues with her or that Resident #49 needed to be seen by the urologist as soon as possible. UM #2 had not been aware of the NP #1's note on 6/29/24 indicating Resident #49 needed to be seen by urology ASAP. UM #2 indicated Resident #49 needing to be seen by the urologist had been discussed during a clinical meeting but that she did not remember the date of the meeting. UM #2 had known the urology appointment for Resident #49 had been scheduled but had not known that the date had been changed, and that the

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appointment had been pushed out so far to the end of July. UM #2 had known Resident #49 had received antibiotics for treatment of UTIs but had not attributed that to be a concern. She could not say if Resident #49's UTIs could have been prevented if she had followed up with the urologist sooner.

An interview was conducted with UM #3 on 7/10/24 at 1:09 PM. UM #3 stated she had worked at the facility for 6 weeks. UM #3 did not remember NP #1 speaking to her about Resident #49's indwelling catheter, urinary issues, or that she needed to be seen by urology as soon as possible. She said orders and appointments that were needed were discussed in the morning stand up meetings but that she did not remember Resident #49 being discussed. UM #3 stated there was not a good communication flow at the facility about when appointments were scheduled.

An interview was conducted with the NP #1 on 7/10/24 at 8:18 AM. NP #1 stated she had been working at the facility for approximately 5 weeks. She said Resident #49 had her indwelling catheter placed when the urinary stent was placed during her hospitalization in April. NP #1 explained she had seen Resident #49 last week and had been trying to find an appropriate diagnosis or medical need to keep the indwelling catheter in place. NP #1 stated she had wanted to remove Resident #49's indwelling catheter due to her having another UTI but wanted to check with urology first. NP #1 explained she had entered a referral for Resident #49 to be seen by urology for follow up of the indwelling catheter and urinary stent. NP #1 stated she had not been aware that Resident #49's hospital discharge summary from 4/26/24 had included for her to follow up with

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urology in a week. NP #1 explained she knew Resident #49 needed to be seen by urology because she had a stent placed. NP #1 did not know why Resident #49 had not gone to the urologist but knew she needed to be seen. NP #1 stated she felt Resident #49's most current UA with C&S that had a colony count of 30,000-40,000 needed to be treated with antibiotics because of her history of pyelonephritis with sepsis. NP #1 said Resident #49 should have been seen by urology for follow up the week after her hospital discharge. NP #1 stated it was hard to say if her following up with urology when she was supposed to would have prevented her from developing the 2 additional UTI's. She said Resident #49's urinary catheter was an indwelling device and because it was invasive it increased the risk of bacteria growth. NP #1 stated she did not know if Resident #49 needed the surgical procedure to break up her renal stones. NP #1 stated that if Resident #49 had been seen by urology when she was supposed to be seen they could have done the surgical procedure to break up the renal stones sooner if she needed it. NP #1 said Resident #49 should be seen by urology sooner than 7/31/24. NP #1 was worried that when Resident #49's current antibiotics ended that she could potentially develop another UTI that was resistant to everything because Resident #49's most recent UTI showed the growth of two organisms which had a greater resistance to antibiotics. She said Resident #49 needed to be sooner, preferably by next week because Resident #49 would be at high risk of developing another UTI between the time, she completed her current ordered antibiotics and the appointment scheduled on 7/31/24. NP #1 said that it would put Resident #49 at high risk for sepsis or returning to the hospital if she developed another

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A telephone interview was conducted on 7/9/24 at 4:45 PM with the MD. He stated Resident #49 should have been seen the week after her hospital discharge by urology for follow up. The MD thought she was doing okay and that there was not a negative impact to Resident #49, but that she should be seen soon for follow up by the urologist. The MD said Resident #49 should be seen sooner than 7/31/24 and it would be preferable to move the appointment up.

An interview with the MD on 7/10/24 at 4:30 PM revealed he did not specifically remember giving the order dated 6/4/24 for Resident #49 to follow up with urology.

An interview was conducted with the Director of Nursing (DON) on 7/10/24 at 1:55 PM. She stated that appointments were given to the Transportation Aide to schedule. She said once the Transportation Aide made an appointment, he put the appointment date/ time into the appointment book. The DON explained a weekly list of appointments was distributed to the nursing stations and administrative staff. She said if someone wanted to know when an appointment was scheduled further out than the current week, then they would have to look in the appointment book. She said the appointment book was located downstairs at the reception desk. The DON was unsure if everyone knew where the appointment book was located. The DON said she had been at the facility for 6 weeks and was not sure why Resident #49 had been hospitalized in April or why she had an indwelling catheter. The DON stated she was aware that Resident #49 had been treated for two UTIs since she returned

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from the hospital. The DON did not know that Resident #49 was supposed to have followed up with the urologist in a week when she returned from the hospital on 4/26/24. The DON only recalled one urology appointment in June that had to be rescheduled because another resident needed to go to an appointment. The DON stated no one had approached her to ask if it was medically appropriate to move Resident #49's urology appointment in June. The DON did not remember NP #1 speaking to her about Resident #49's urinary issues or telling her that she needed to be seen by urology ASAP. The DON said that they reviewed physician orders and appointments during the morning meetings and did not remember discussing Resident #49 during the morning meetings. She stated that if the urology office had an appointment that was earlier than 7/31/24 then Resident #49's appointment should have been scheduled sooner. She stated Resident #49 not following up with urology when she was supposed to, could have contributed to her infections. She said Resident #49 should have followed up with the Urologist within a week after her hospital discharge if possible. The DON was unsure where the break in the appointment process was that caused Resident #49's urology appointment to be pushed out so far to the end of July.

A follow up telephone interview was conducted with the MD on 7/10/24 at 4:30 PM. The MD was not sure if Resident #49 would have followed up with the urologist sooner if it would have prevented the other infections. He said the ureter stent could cause the urine to look infected when it was not a true infection. He explained until the stent was out, and Resident #49's ureter was given time to recover, her urine would look

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infected and have leukocytes (white blood cells) and blood in the urine. The MD said the urine would show a false positive for infection until the stent was removed. The MD stated he would not stop the antibiotics prescribed for UTI treatment, because Resident #49 was at high risk for developing sepsis. The MD explained that even though it might be a false positive UTI, it was worth treating even if it was not a true infection because of Resident #49's risk factors which included her having sepsis, pyelonephritis, ureter stent, renal stones, and an indwelling catheter.

An interview was conducted with the Administrator on 7/10/24 at 4:55 PM. The Administrator said she had heard that Resident #49 had not wanted to go to the urology appointment that had been scheduled in May. She said Resident #49's appointment in June had been moved due to another resident with an urgent appointment need. The Administrator said she could not say where the breakdown happened in scheduling an alternate transport was. She said the facility had a backup transportation service that they could use. The Administrator was not sure why the backup transportation service had not been resourced in that situation. The Administrator said they went over appointments in the morning meetings but did not remember talking specifically about Resident #49's urology appointment. She stated the Transportation Aide scheduled the facility appointments and put out a notice of appointments that were scheduled for that week. She said the Transportation Aide verbally communicated appointment changes or cancellations to the nursing staff. The Administrator said the process of communicating appointments could be looked at to see if there

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was a breakdown in how it was done.

After surveyor intervention an appointment with the Urologist was scheduled for 7/12/24. Urology provider notes dated 7/12/24 were reviewed and revealed Resident #49 was seen at the urology office on 7/12/24. The urology note stated this was a hospital follow up, new patient visit. Under assessment/ plan the note read in part:

1. Kidney stone- will get her scheduled for ureteroscopy.
The note indicated a plan for surgical procedure: cystoscopy, with ureteroscopy (putting a flexible telescope into the drainage tube of the kidney), lithotripsy (procedure that uses shock waves to break up stones), stone manipulation with holmium laser (a laser used to fragment stone), with possible stent placement.

2. Double stent present- Will have stent need evaluated during ureteroscopy

3. Indwelling catheter- managed by facility and changed per facility protocol. Will continue with catheter.

Multiple messages were left for an interview with the Urologist and/or Urology NP but they did not return the call.

The Administrator was notified of immediate jeopardy on 7/20/24 at 12:12 PM.

The facility provided the following credible allegation of immediate jeopardy removal plan.

Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome as

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a result of the noncompliance:
The facility failed to ensure that Resident #49 was seen by the Urologist the week after discharge from the hospital after having a stent placed for renal obstruction on 4-23-2024.

All residents that have urinary catheters have the potential to be affected. The Director of Nursing and Nurse Unit Manager completed an audit on 7-22-2024 of all residents with urinary catheters that required follow up medical appointments. This involved a review of resident orders received by the medical physician. Also included in this audit was a review of the physician orders and hospital discharge summaries. The Nurse Unit Manager verified that all residents did complete their follow up appointments by verbal confirmation with the physician's office and reviewing the resident's consult reports. The Director of Nursing/ Designee completed a 90-day review of urinary catheter orders for follow up appointments. There were no residents without scheduled appointments as ordered.

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

On 7-20-24 the education that was provided to the Receptionist, Transportation Aide and Nursing staff including agency nursing staff included the requirement and expectation that no appointments will be cancelled or rescheduled without notification and approval of the cancellation by the Director of Nursing. The education that was provided was provided by the Director of Nursing / Designee in person and by telephone. All licensed nursing staff including

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staff that have not been in-service by 7-25-24 will not be allowed to work until they complete this in-service. To verify the phone education provided to the nurses, Transportation Aide, and Receptionist, the Director of Nursing / Designee obtained verbal understanding from the nurse being educated. Newly hired Nurses, Receptionist, Transporters and Agency Nursing staff will receive this education during their onboarding process. This education will be provided by the Human Resource Director.

The facility has re-educated the licensed nursing staff including agency on the process for following through with resident appointments, the possible complications of urinary catheters including UTIs and the seriousness of stents, resistance to antibiotics and sepsis. The education will be provided by the Director of Nursing/Designee in person and by phone and will be completed by 7-25-2024 by orders for appointments received by the Nurses, Monday through Friday and will be addressed by the Nurse communicating this to the Receptionist during the operational receptionist hours of 9:00 am and 5:00 PM. The resident's assigned Nurse will bring a copy of the order to the Receptionist. If the Receptionist is out of work between 9 AM and 5 PM on a weekday the assigned Nurse will copy the order for the appointment and place the copy in the Transportation Aide's box. The Receptionist will log the appointment with the date received, the date the physicians' office was called and date of appointment. The appointment is to be logged on to the calendar by the Receptionist for the Transportation Aide once the appointment is made. Receptionist to make appointments for residents Monday through Friday. If the appointment cannot be made as

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ordered, the Receptionist will notify the Director of Nursing. After hours and weekends the residents, assigned Nurse will copy the order for the appointment and place the copy in the Transportation Aide's mailbox. To verify the phone education provided to the nurses, the Director of Nursing and Nurse Unit Manager obtained verbal understanding from the nurse being educated.

Education will be completed by 7-22-2024 for both the Receptionist and the Transportation Aide on the process required for the scheduling of residents requiring appointments. The Receptionist is responsible for scheduling the appointments. The process is, once an order for an appointment is received by the Nurse, this Nurse will notify the Receptionist of the necessary appointment. The Receptionist will be informed of appointment orders written on the weekend or after-hours by completing a check of the Transportation Aides mailboxes located at the Nurse's and Receptionist desks every morning Monday through Friday. The Receptionist will log the appointment with the date received, the date the physicians' office was called and date of appointment. The appointment is to be logged on to the calendar by the Receptionist for the Transportation Aide once the appointment is made. Receptionist to make appointments for residents Monday through Friday. If the appointment cannot be scheduled as ordered, the Receptionist will notify the Director of Nursing. The education for this system will be provided by the Director of Nursing and Nurse Unit Manager.

If an appointment is made with the Transportation Aide by the doctor's office personnel, the Transportation Aide will notify the Receptionist so that the Receptionist can log the

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appointment and notify nursing of the appointment that is needed. If the Receptionist is absent for some reason, the Transportation Aide will serve as a backup for logging the necessary follow up appointment and will notify nursing. This in-service was provided to the Receptionist, Transportation Aide, Human Resource Director and the licensed nursing staff. The Administrator provided this education to the Receptionist and Transportation Aide on 7-20-24. The Director of Nursing / Designee provided this education to the licensed nursing staff on 7-22-24, 7-23-24 and 7-24-2024. The Human Resources Director received this education in person on 7-22-24 by the Administrator.

For all of the above-mentioned education provided to the licensed nursing staff including agency staff the Director of Nursing is tracking the staff to determine which staff members still require the education on the scheduling process for making resident appointments. Licensed nursing staff that do not receive education by the 7-25-2024 will be removed from the schedule until the education has been completed. The DON will be responsible for ensuring that no nurse including agency will be allowed to work or accept a resident assignment until they have completed this education. The Human Resources Director will be responsible for providing this education to any new hires including licensed nursing staff, Receptionist, and Transportation Aides. The Human Resources Director was notified of this responsibility on 7/22/24. New agency staff will be educated on this process by the Director of Nursing / Designee prior to the beginning of their shift.

The Director of Nursing (DON)/Unit Manager

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(UM) will check orders at standup meeting for new orders for appointments. This will be implemented 7-22-2024.

DON/UM to verify after standup meeting that the Receptionist received new order and to follow up daily till appointment date obtained.

IJ removal date 7-26-2024

On 07/30/24, the facility's credible allegation for immediate jeopardy removal with correction date of 07/26/24 was validated on-site by record review, observation, and interview with resident and staff.

A medical appointment was scheduled on 07/12/24 and Resident #49 was seen by the urologist as scheduled. The DON and Nurse Unit Manager (UM) completed an audit on 07/22/24 of all residents with urinary catheters that required follow up medical appointments by reviewing physician orders and hospital discharge summaries without any concerns noted. Interviews with the Receptionist, Transportation Aide, Human Resources Director, and licensed nursing staff including agency nursing staff revealed they had received education on the requirement and expectation that no appointments would be cancelled or rescheduled without notification and approval of the cancellation by the DON. All the staff interviewed expressed understanding and were able to describe the process in handling a medical appointment. The education included the process of following through with resident appointments, the possible complications of urinary catheters including UTIs and the seriousness of stents, resistance to antibiotics, and sepsis. It covered

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the processes required for the scheduling of residents' appointments that involved communication among residents' assigned nurse, Receptionist, and Transportation Aide; and also, appointment made with the Transportation Aide by the doctor's office personnel. All licensed nursing staff, Receptionist, and Transportation Aide including agency nursing staff and new hires that have not received the above in-service by 07/25/24 would not be allowed to work until they had completed this education.

Review of in-service sign-in sheets revealed the Administrator had provided the above education to the Receptionist and Transportation Aide on 07/20/24. The DON provided this education to the licensed nursing staff on 07/22/24 to 07/24/24. The Human Resources Director received this education in person on 07/22/24 from the Administrator. The Human Resources Director would be responsible for providing this education to any new hires including licensed nursing staff, Receptionist, and Transportation Aides. New agency staff would be educated in this process by the Director of Nursing prior to the beginning of their shift.

Interviews with alert and oriented residents who had medical appointments revealed the facility had followed through with their medical appointments without concerns.

The facility management staff started to discuss issues related to medical appointments in the daily stand-up morning meeting on 07/22/24. The DON and Nurse UM started to check new orders for medical appointments on 07/22/24 and verified with the Receptionist to ensure all new orders for medical appointments were received

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and followed up until the appointment date obtained.
Review of monitoring tools revealed the management staff started to audit all medical appointments daily per the audit tools since 07/22/24.

The immediate jeopardy removal date of 07/26/24 was validated
2. Resident #80 was admitted to the facility on 4/09/24 with diagnoses which included urinary retention.

Resident #80's hospital discharge summary dated 4/09/24 revealed that she was admitted to the hospital for sepsis, acute kidney injury, and urinary tract infection. She was discharged to the facility on 4/09/24 with a urinary catheter.

Review of Resident #80's physician's orders revealed no order for a urinary catheter.

Resident #80's admission Minimum Data Set dated 4/09/24 revealed she was cognitively intact and was coded for an indwelling urinary catheter.

Review of Urology consult note dated 6/19/24 revealed a diagnosis of retention of urine. The plan read in part that due to mobility limitations and low blood pressures, recommend for Resident #80 to keep her urinary catheter until her bilateral lower extremity edema was addressed and she was more mobile.

An observation and interview on 7/07/24 at 11:43 AM with Resident #80 revealed that she had a urinary catheter and had no concerns about it.

Observation of Resident #80's urinary catheter

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care on 7/10/24 at 9:32 AM revealed no leg strap or urinary catheter tubing securement device. There was no tension observed on the urinary catheter tubing and the urinary bag was on the side of the bed below the resident's bladder.

An interview on 7/10/24 at 9:55 AM with Nursing Assistant #1 revealed she was aware that the resident was supposed to have a urinary securement device but had not noticed whether Resident #80 had a urinary securement device because she got nervous.

An interview on 7/08/24 at 1:33 PM with the Director of Nursing revealed that Resident #80 did not have an order for her urinary catheter or securement device for the catheter tubing and she did not know why she did not.

An additional interview on 7/10/24 at 10:45 AM with the Director of Nursing revealed that every resident with a urinary catheter should have a securement device to reduce friction and movement at the insertion sight. She stated that she did not know why NA #1 had not notified her it was missing.

An interview on 7/09/24 at 2:06 PM with the Administrator revealed that Resident #80 should have an order for her urinary catheter and a securement device for the catheter tubing and it was an oversight.

3. Resident #11 was admitted to the facility on 4/19/24 with diagnoses that included chronic subdural hemorrhage (pool of blood between the brain and its outermost covering).

The admission Minimum Data Set assessment dated 5/8/24 indicated Resident #11 was

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rarely/never understood, had no behavioral symptoms, and was frequently incontinent of urine.

Resident #11 was re-admitted to the facility on 7/5/24 after a hospital stay. There was no mention of the urinary catheter in the discharge summary.

The Nursing Admission/Readmission assessment dated 7/6/24 indicated Resident #11 had an indwelling urinary catheter but there was no diagnosis listed for the catheter. Resident #11 was a potential candidate for nursing, restorative/rehabilitation, or bladder retraining program.

Review of Resident #11's physician orders revealed no order entered for the urinary catheter.

Resident #11's care plan revised on 7/8/24 indicated Resident #11 had a urinary catheter in place during hospitalization. Interventions included to change the urinary drainage bag per physician orders.

An observation of Resident #11 on 7/7/24 at 11:28 AM revealed him lying in bed with a urinary catheter. Resident #11's urine collection bag was on top of his bed next to his left knee, and not positioned below the level of his bladder.

Another observation of Resident #11 on 7/7/24 at 1:26 PM revealed him lying in bed which was positioned low to the floor. His urine collection bag was observed to be hooked to the footboard of the bed, and it was on the same level as his bladder.

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An interview with Nurse Aide (NA) #1 on 7/7/24 at 1:32 PM revealed she had provided incontinence care to Resident #11 earlier in the morning because he had ripped off his brief. NA #1 stated that at that time, she had observed Resident #11 catheter bag to be hooked down on the footboard of the bed. NA #1 further stated that this was the first time she had provided care to Resident #11, and she did not know if staff usually placed his catheter bag on the footboard. NA #1 said she did not notice Resident #11's catheter bag being placed directly on the bed, but since it had been on the footboard, she left his catheter bag where it had been initially positioned. NA #1 stated that she knew the catheter bag had to be placed below the level of the bladder for it to drain but Resident #11's bed was too low because he was a fall risk, and there was nowhere she could hook it up on the bed without it touching the floor.

An observation and interview with Nurse #2 on 7/7/24 at 2:10 PM revealed Resident #11's catheter bag should not be positioned at the foot of the bed because it was not lower than the bladder. Nurse #2 showed where the staff should position his catheter bag which was on the side of the bed on the bed frame. Nurse #2 stated even though Resident #11's bed was too low it should be positioned below the level of his bladder for it to drain. Nurse #2 further stated that she did not notice Resident #11's catheter bag on the bed but it should not have been left on his bed. Nurse #2 shared that staff probably provided incontinence care to him and forgot to hook the urine collection bag on the side of his bed.

An interview with Unit Manager (UM) #1 on 7/8/24 at 12:37 PM revealed Resident #11 re-admitted to

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the facility from the hospital on 7/5/24, and he came back with a urinary catheter. UM #1 stated that she was going to ask Nurse Practitioner (NP) #1 if they could do a voiding trial on Resident #11 because she did not see a qualifying diagnosis for long-term use of a urinary catheter for Resident #11. UM #1 further stated that she reviewed Resident #11's hospital record and noted that the urinary catheter was placed for palliative care. UM #1 stated that Resident #11's catheter bag should be positioned below the level of his bladder for it to drain properly.

An interview with Nurse Practitioner (NP) #1 on 7/8/24 at 11:17 AM revealed when she examined Resident #11, his catheter bag had been placed to the side of his bed. The NP stated that Resident #11's catheter bag should not be placed on the footboard because it had to be lower than his bladder so it would drain and to keep urine from flowing back into the bladder which could cause an infection.

A follow-up interview with UM #1 on 7/8/24 at 1:01 PM revealed she asked NP #1 to look at Resident #11, and she ordered to discontinue Resident #11's urinary catheter.

An interview with the Director of Nursing (DON) on 7/10/24 at 1:56 PM revealed Resident #11's catheter bag should be positioned below the level of his bladder at all times to prevent urine backflow and infection. The DON stated that the nurse aides had been trained to place the urine drainage bag below the level of the bladder. The DON added that she had instructed UM #1 to do an audit of all residents with an indwelling urinary catheter because she noticed that the nurses had not been following up and making sure that there

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F 690	Continued From page 91 was an order for the urinary catheter.	F 690		
F 695 SS=D	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 by: Based on observations, record review, resident, staff, and Nurse Practitioner interviews, the facility failed to obtain a physician's order for the use of supplemental oxygen for 1 of 2 residents reviewed with oxygen (Resident #68). Findings included: Resident #68 was admitted to the facility on 9/17/23 with diagnoses which included respiratory failure. Resident #68's quarterly Minimum Data Set dated 6/25/24 revealed he had severe cognitive impairment and was coded for oxygen use. An observation and interview on 7/07/24 at 1:42 PM with Resident #68 revealed that was wearing oxygen at 2 liters per minute (lpm). The resident stated he wore oxygen due to his breathing problems and he became short of breath without it.	F 695	F695 Immediate action taken to correct this alleged deficiency included: On 7-9-2024 the oxygen order for resident # 68 was obtained by the Unit Nurse Manager. All residents on supplemental oxygen have to potential to be affected. Measures put into place to ensure that this alleged deficient practice does not recur includes : An audit was completed on 7-9-2024 to ensure that all residents with supplemental oxygen had orders. Education for all licensed nursing staff to ensure that orders are obtained for supplemental oxygen and a Skills Competency Assessment will be completed by 8-19-24. Any licensed nursing staff that have not received this education by 8-19-24 will be removed from the staffing schedule until the training is completed. This education will	8/20/24

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F 695	Continued From page 92 Review of Resident #68's physician's orders revealed no order for oxygen. Observations of Resident on 7/08/24 at 11:45 AM and 7/10/24 at 8:30 AM revealed he was wearing oxygen at 2 lpm. An interview on 7/09/24 at 8:00 AM with the Director of Nursing revealed that Resident #68 did not have an order for oxygen and should have. An interview on 7/10/24 at 10:51 AM with the Nurse Practitioner #2 revealed that she was new and unfamiliar with the resident. She stated that any resident with supplemental oxygen should have an order for oxygen. An interview on 7/09/24 at 2:06 PM with the Administrator revealed that residents should have an order for oxygen if they were using oxygen. She stated that it was an oversight that he did not have an order for oxygen.	F 695	be provided by the Director of Nursing / Designee. Monitoring will be completed as follows: The Director of Nursing/Designee will complete an audit 3 times per week x 4 weeks, then 2 times a week x 4 weeks then one time a week x 4 weeks to ensure that new admission with supplemental oxygen have orders. The results of these audits will be presented to the Quality Assurance and Process Improvement Committee monthly for 3 months. Completion date 8-20-24	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726		8/20/24

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F 726	Continued From page 93 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to ensure staff was trained on how to use a total mechanical lift for 1 of 1 resident observed for transfers (Resident #69). This was for 1 of 5 staff members (Nurse #1) reviewed for competency. The findings included: A review of the employee file for Nurse #1 indicated verification of an active license to practice in the state, and a new hire packet dated 6/7/24. The new hire staff orientation checklist did not include training on how to use a lift. Nurse #1 signed the "Nurse Supervisor" job description on 6/7/24. An observation was made on 7/7/24 at 1:50 PM of Resident #69 being transferred from bed to	F 726	F726 Competent Nursing Staff The immediate action taken to correct this alleged deficient practice includes; A Immediate education and training on how to use a total lift for transfers was provided to Nurse #1 by the Director of Nursing on 7-7-2024. The facility recognizes that all residents that are dependent on a total lift transfer has the potential to be affected by this alleged deficient practice. Measures put into place to ensure that this alleged deficient practice does not recur includes: A individual sling/lift pad was obtained for resident #69. The Director of Rehabilitation completed an inventory and audit. 7-9-2024, of the	

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F 726	Continued From page 94 wheelchair using a total mechanical lift by Nurse #1 and Nurse Aide (NA) #1. Nurse #1 brought a green sling into the room, and it was placed underneath Resident #69 while in bed. NA #1 suggested that they crisscross the sling under Resident #69's thighs before securing it to the lift. Nurse #1 positioned the total mechanical lift so that the base was underneath Resident #69's bed frame. Nurse #1 asked NA #1 how to spread the lift's legs and NA #1 instructed Nurse #1 to move the lever from left to right. Nurse #1 moved the lever from left to right and this caused the lift's legs to spread wide. Both staff members secured the sling on the bottom loop onto the total mechanical lift. Without locking the wheels on the total mechanical lift, Nurse #1 proceeded to lift Resident #69 off the bed, moved the lift to where Resident #69 was positioned over his wheelchair and started lowering Resident #69 to his wheelchair without locking the wheels on the lift. While Nurse #1 lowered Resident #69 onto his wheelchair, the lift was observed to be unstable as it kept on moving while Resident #69 was being moved. An interview with Nurse #1 on 7/7/24 at 2:02 PM revealed he was a travel nurse, and that he worked as the weekend supervisor on Fridays, Saturdays, and Sundays. Nurse #1 stated that he had never assisted before in lifting a resident with a total mechanical lift. He stated that he thought he had locked the wheels on the lift prior to moving Resident #69, but that he realized that he should have locked the wheels on the lift. Nurse #1 further stated that he did not receive training at the facility on how to use their mechanical lifts, and that he did not think that he should because he had experience at other facilities using different kinds of mechanical lifts.	F 726	available slings/lift pads for the different needs for the residents requiring lift assistance for transfers. A list was completed of all resident that require lift assistance, the type of lift, the type of lift pad/sling needed. The C N A's were taught to recognize the necessary lift pad as it pertains to the sizes assigned and as indicated on the resident's list. These size allotments are determined by weight. Each resident that requires transfers by lifts will have a personal lift pad assigned. Each resident will have a reserve lift pad to allow for proper laundering and adequate turn around time. A list of residents requiring lift transfers will be made available to all staff. These lists will be maintained in the therapy communication books that will be kept at the nurses stations. An additional list will be kept in the clean linen room. Revisions to this list will be kept current by adding any changes related to changes in conditions and identified transfer needs of the residents. Skills competency and inservice education was initiated on 7-11-24 for all direct care staff. This education was provided by the Director of Rehabiliation and the Certified Occupational Therapy Assistant. Inervices provided education on the physical mechanics of operating the different type of lifts, safety practices and the importance of locking the brakes, a review of the different type of lifts and how to know which lift pads/slings are the correct fit for the residents. Observations	

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F 726	Continued From page 95 An interview with the Certified Occupational Therapist Assistant (COTA) on 7/10/24 at 8:49 AM revealed she was responsible for providing lift training to the nursing staff. The COTA stated that she had a running list of all new hires, but she did not keep up with agency staff and only provided lift training to agency staff as needed. The COTA stated she did not train Nurse #1 on how to use the mechanical lifts because she did not usually come in on the weekends, and there had been only two to three Fridays that she had worked at the facility. The COTA further stated that she used a check off list when providing training to staff, and included in the training was instruction that they had to lock the wheels on the lift prior to moving the resident. An interview with the Director of Nursing (DON) on 7/10/24 at 1:56 PM revealed staff should make sure that they were locking the wheels on the lift while using them on a resident. The DON stated that Nurse #1 told her about not locking the wheels on the total mechanical lift when he transferred Resident #69 from his bed to his wheelchair. She further stated that they needed to have a more extensive orientation list to include the use of lifts and to cover all agency staff.	F 726	were also completed of the direct staff memebers using the lifts with feedback to the staff member on proper procedures. This education will be provided to all newly hired direct care staff employees and agency/contract staff members. Any staff person that does not complete this lift and safety assessments and training before 8-19-2024 will not be allowed to work until the training is completeted. Monitoring will be accomplished by the Director of Nursing/Designee This will be proven by audits that will be conducted to observe a total lift transfer 3 times per week x 4 weeks, then 2 times a week x 4 weeks then once a week x 4 weeks to ensure that proper technique is being used during transfer with total lift. The Director of Nursing will present a report of these audits to the Quality Assurance and Process Improvement Committee monthly for 3 months. Completion date 8-20-24	
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	F 812		8/20/24

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F 812	Continued From page 96 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 ensure ready-for-use metal pans and cooking pots were clean and not stacked wet. This occurred for 1 of 2 kitchen observations. They failed to discard opened food items ready for use within 7 days of opening and failed to discard spoiled produce with white growth in 1 of 1 walk in refrigerators in the kitchen. They also failed to discard 2 loaves of bread with green growth in 1 of 1 dry storage rooms. These practices had the potential to affect food served to residents. The findings included: 1. An initial tour of the kitchen occurred on 7/7/24 at 10:30 AM with the Cook. The initial observation of the dishware storage area, cold food storage, and dry food storage revealed the following: a. Dishware that was ready for use was put away and stacked wet (wet-nested). - 4 out of 7 small square metal pans - 2 out of 5 large rectangle metal pans - 3 out of 3 deep small rectangle metal pans	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary F812 Food Procurement, Store/Prepare/Serve-Sanitary Immediate action taken to address this alleged deficient practice: On 7-9-2024 a. The Dietary Manager completed inservice and training on the proper warewashing procedures for properly managing dishware. b. Dishware that were seen stacked dirty that had been taken out of service were removed from the kitchen area and disposed of by the Dietary Manager. This occurred on 7-9-2024. c. The spoiled cucumbers were disposed of on 7-7-2024 d. The dry storage area had the loaves of bread removed and disposed of on 7-7-2024 by the Dietary Manager. e. On 7-7-2024 the dietary manager initiated daily auditing of dietary tasks, (see below), to ensure that the tasks are completed as required. This audit is	

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F 812	Continued From page 97 - 2 out of 3 deep small square metal pans b. Dishware that was ready for use was put away and/or stacked dirty. - 2 out of 3 large deep cook pots dirty - 3 out of 5 large rectangle metal pans dirty - 3 out of 3 small deep rectangle metal pans dirty c. The cold food storage had 3 out of 20 cucumbers that were spoiled. The cucumbers were soft, squishy, and had spots of white fuzzy growth. A plastic storage container, the top of the container was covered with clear plastic wrap. The top of the plastic wrap was dated 6/22. d. The dry storage area had 2 out of 6 loaves of bread with visible green and white growth visible on the bread. There was not a date on the bread. An interview was performed with the Cook on 7/7/24 at 11:10 AM. She stated that the bread came in a box from the supply company and the date was on the box. She said the bread should have been labeled with a date when it had been removed from the box. She stated the Dietary Manager checked the bread but that no one was assigned to check the bread on a routine schedule for spoilage. The Cook said the produce and food stored in the cold storage was supposed to be checked daily. She did not say if someone had checked the items in the cold storage today. She said she was not sure how the mushroom soup and spoiled produce had been missed. She said no one had been served the mushroom soup. An interview was conducted with the Dietary Manager (DM) on 7/9/24 at 3:10 PM. She said the pots and pans should have been allowed to	F 812	completed on a daily basis and documented by the Dietary Manager. The Dietary Manager and District Dietary Manager were apprised of the management responsibilities for ensuring proper food handing and proper warewashing of dishware. This was completed on 7-10-24 by the Administrator and Chief Operating Officer. The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Measures put into place to prevent this alleged deficiency from recurring include the following: Inservice training will be conducted on a weekly basis by the Dietary Manager with the dietary staff. The dietary inservices will be completed by 8-19-2024. The inservicing will focus on the proper management of food storage, the expectations of labeling and dating the facility food items to ensure food is used within the allowed time frames. Proper dishwashing and warewashing of dishware will be taught to the dietary department by the Dietary Manager on a daily basis to ensure the comprehension of the required dietary expectations. Monitoring will be completed by the dietary manager conducting daily audits and inspections of the facility's stored food to ensure all food has been properly managed. In addition the dietary staff will monitor the following, the labeling and dating of any open or left over food. Bread will be dated and monitored for signs of spoilage and will be monitored daily. The dishware will be monitored	

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F 812	Continued From page 98 air dry before they were put away. She said the pots and pans should have been checked for cleanliness and that they were dry before they had been put away for next use. She said staff needed to be re-educated. She stated that the produce should have been checked daily for spoilage and that the cold storage should have been checked daily for items that were beyond the date of use. She said once a food item had been opened, it should be dated, and should be used within three days. She said food items that were opened and not used should be discarded after three days. The DM said that there was not someone who was specifically assigned who checked the cold food storage for food items past the date of use or who checked the produce daily, but that it should be checked daily by the staff working. The DM said she checked the dry storage room for expired and spoiled food. She stated she checked the bread daily and that she had checked the bread on Friday. The DM stated that she usually dated the bread when she took it out of the delivery box. She said she had missed dating the bread when she had taken it out of the box on Friday. An interview was conducted on 7/10/24 at 4:55 PM with the Administrator. She stated that the kitchen should have checked for expired and spoiled food. She stated that the pots and pans should have been checked to ensure that they were clean and dry before they were put away.	F 812	daily to ensure that all dishes are properly sanitized for use. The dietary manager will complete weekly observations of the warewashing process to ensure that cleaning, sanitizing and storing the dishware is done properly. Any dishware that has been identified as stained will be discarded and replaced by the Dietary Manager ordering replacement items. The District Dietary Manager is expected to complete monthly reviews and a detail dietary departmental inspection to ensure that proper dietary management tasks are being completed. The dietary manager will compile a report from these audits and present the results to the monthly Quality Assurance and Process Improvement Committee for 3 months. Completion date 8-20-2024	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		8/20/24

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F 880	Continued From page 99	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 100 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff the facility failed to establish an infection control policy for or implement Enhanced Barrier Precaution (EBP) precautions when Nurse #4 was observed providing care to a resident with a feeding tube (Resident #43) and nursing assistant (NA) #1 failed to wear a gown while performing urinary catheter care and failed to change gloves or perform hand hygiene following catheter care and prior to replacing and touching clean bedding (Resident #80). The facility also failed to implement their hand hygiene policy when they did not provide hand hygiene for a resident who was dependent on staff for hand hygiene prior to eating (Resident #45). This	F 880	F880 Infection Prevention and Control Immediate action taken for this alleged deficient practice includes the following: 1.a. On 7-8-2024 the Corporate Nurse was educated by the Director of Nursing on the practice and policy expectations for enhanced barrier precautions. (EBP). b. The immediate action for Nurse#4 involved the Director of Nursing/ Nurse Unit Manager providing verbal reeducation in regard to enhanced barrier precautions. This inservice was provided on 7-9-2024. Direct care staff and licensed nursing staff received education.	

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F 880	Continued From page 101 deficient practice occurred for 3 of 3 residents reviewed for infection control. Findings included: 1. a. Review of the facility's infection control policy and procedures revealed no policy for enhanced barrier precautions (EBP). An interview on 7/08/24 at 1:45 PM with the Corporate Nurse revealed she was aware of the EBP requirement and that there was no facility EBP policy. She stated the prior DON and Infection Preventionist had not established or implemented the requirement and could not say why. b. An observation on 7/09/24 at 9:50 AM of Nurse #4 revealed she entered Resident #43's room, and donned gloves. She then opened the resident's abdominal binder at his feeding tube site. She touched the tube feeding dressing gauze. She then leaned over the resident and turned him to reposition him toward her in the bed to check the skin on his side and back for integrity under the binder. Her clothing was noted to be touching the resident's bed and linens. An interview on 7/09/24 at 10:00 AM with Nurse #4 revealed she had heard of EBP. She stated it was for residents who have catheters, wounds, feeding tubes and staff were supposed to wear a gown and gloves when providing direct care. She stated she should have worn a gown along with her gloves when opening his abdominal binder but did not explain why she had not. Nurse #4 stated that she had not seen the facility staff observing EBP before today and was not sure why not.	F 880	c. Resident #45 received nail care and hand hygiene on 7-9-2024 by the resident's assigned C N A. The inservices that were initiated on 7-9-2024 were on the Centers of Disease Control guidelines on enhanced precautions and keeping the resident's stafe. Inservices were initiated on 7-9-2024 and provided to the Certified Nursing Assistant #1 and Nurse #4. These inservices were also scheduled for all direct care staff, as well as licensed nursing staff. All residents with foley catheters, tube feed, wounds and central lines are potentially affected. Measures put into place to ensure that this alleged deficient practice does not recur includes the following: An Infection control policy was developed on 7/22/24 for Enhanced Barrier Precautions. Enhanced Barrier Precautions were put in place on 7/30/24. These precautions were initiated by the Director of Nursing. An audit was conducted 7/30/24 by the Unit Nurse Manager on all residents to determine those residents with tube feedings, catheters, open wounds and central lines. Those residents were placed on Enhanced Barrier Precautions and education was started with direct care staff on 7/9/24 by the Director of Nursing/designee. All direct care staff including agency staff are to have completed education and skills competency assessments on Donning/Doffing Personal Protective Equipment by 8-19-2024. Direct care staff	

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F 880	Continued From page 102 An interview on 7/08/24 at 1:30 PM with the Director of Nursing (DON) and Infection Preventionist revealed they were both aware of the EBP requirements but had not yet implemented the protocols at the facility. The DON stated that she had not had time to provide staff training. c. The facility Urinary Catheter Care policy dated 2017 read in part to ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. It continued to read to put on gloves and wash the resident's peri area thoroughly, rinse and dry. Discard the soiled linen, remove gloves, wash and dry hands thoroughly. Reposition the bed covers. Resident #80 was observed on 7/10/24 at 9:32 AM as Nursing Assistant (NA) #1 provided urinary catheter care wearing a gown and gloves. Then while wearing the same gloves and without performing hand hygiene, NA#1 removed the top bed sheet and replaced it with a clean bed sheet and a clean blanket. Then she used the bed control to adjust the bed for the resident. An interview on 7/10/24 at 9:55 AM with NA #1 revealed she had worn the same gloves to perform catheter care and change the sheet and blanket. She stated that she got nervous and forgot to remove her gloves and perform hand hygiene. An interview on 7/10/24 at 10:30 AM with the Director of Nursing revealed that NA #1 should have changed her gloves and performed hand hygiene to minimize infection control risks.	F 880	that are not available on or before 8-20-2024 will not be scheduled until the education has been completed. Education on hand hygiene with skills competency assessment to be completed by 8-20-2024. Education includes assisting residents to wash their hands before meals. Direct care staff that are not available on or before 8-20-2024 will not be scheduled until the education has been completed. Monitoring will be completed by the following. Observations of catheter care will be completed by the Director of Nursing / designee weekly x 4 weeks to ensure proper technique is completed by the staff providing any care as it relates to catheters, wounds, central lines and/or tube feedings. An audit will be conducted 3 x week x 4 weeks, then 2 x week x 4 weeks then weekly x 4 weeks by the Director of Nursing/Designee to ensure enhanced barrier precautions are followed. In addition, the Director of Nursing/Designee will complete an audit will be conducted by monitoring 3 residents 3 x week x 4 weeks, then 2 x week x 4 weeks then weekly x 4 weeks to ensure residents are offered hand hygiene before meals. Completed 8-20-24	

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F 880	Continued From page 103	F 880		

An interview on 7/08/24 at 1:30 PM with the Director of Nursing (DON) and Infection Preventionist revealed they were both aware of the EBP requirements but had not yet implemented the protocols at the facility. The DON stated that she had not had time to provide staff training.
2. An observation was completed on 7/8/24 at 12:20 PM of Resident #45 eating in the dining room. Resident #45 was observed sitting at a table in the dining room eating with his hands. His fingernails were long with a dark substance visible under all his nails. He was observed to dip his fingers into his food and lick the food off of his fingers. He was further observed to scoop food up from his plate with his fingers and place it into his mouth

An interview was conducted with NA #3 on 7/8/24 at 12:59 PM. NA #3 said she wiped Resident #45's hands off after meals but that she did not typically do hand hygiene with him before meals. NA #3 said she was Resident #45's assigned NA and that she did not assist him with hand-hygiene before he came to the dining room or while he was in the dining room. NA #3 said she thought hand-hygiene before meals would be important for Resident #45 because he ate with his hands. She said she did not think to do hand-hygiene with Resident #45 because it was not something that they had done before at the facility.

An interview was conducted on 7/9/24 at 11:33 AM with Nurse #3. She said that NAs should provide residents with hand-hygiene before meals and check that their nails were clean.

An interview was conducted on 7/10/24 at 1:55

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F 880	Continued From page 104 PM with the Director of Nursing (DON). The DON said staff should have assisted Resident #45 with hand-hygiene and checked his nails for cleanliness before he ate. An interview was conducted with the Administrator on 7/10/24 at 4:55 PM. She said staff should have assisted Resident #45 with hand- hygiene before his meal and checked his nails for cleanliness.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		8/20/24

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F 883	Continued From page 105 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assess the resident for eligibility and ensure the resident was offered the pneumococcal vaccine for 1 of 5 residents reviewed for vaccines (Resident #5). Findings included: Resident #5 was admitted to the facility on 5/07/27 with diagnoses which included Diabetes	F 883	F883 Influenza and Pneumococcal Immunizations The immediate action taken to address the alleged deficient practice included the Director of Nursing/Designee offering the pneumococcal vaccine to Resident #5 on 7-14-24. On 7-16-24, and approved consent was obtained by the Responsible Party for Resident #5 to receive the pneumococcal vaccine. The	

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F 883	Continued From page 106 Mellitus and hypertension. Resident #5's admission Minimum Data Set dated 5/14/24 revealed she had severely impaired cognition. Her pneumococcal vaccination was coded as not up to date and the reason not received was coded as not offered. An interview on 7/08/24 at 1:29 PM with the Infection Preventionist and Director of Nursing (DON) revealed that they were aware that Resident #5 had not been offered or received the pneumococcal vaccine. The DON stated they had been employed at the facility a few weeks and had not had sufficient time to get a resident vaccine audit or vaccines completed. The DON stated that she did not know why the previous Infection Preventionist or DON had not offered or provided the pneumococcal vaccine to Resident #5. An interview on 7/9/24 at 2:10 PM with the Administrator revealed it was an oversight that Resident #5 had not been offered or received the pneumococcal vaccine.	F 883	pneumococcal vaccine was administered to Resident #5 by the facility' The facility recognizes that all residents have the potential to be affected by this alleged deficient practice. Measures put into place to prevent this alleged deficiency for recurring includes the following:An audit was conducted on 7-16-2024 by the nurse consultant on all residents to check vaccine status to determine residents that were eligible to receive the pneumococcal vaccine. Residents that were identified as eligible for the vaccine were offered the vaccine, consents and orders obtained. Immunizations given per order. The immunizations were completed by the Director of Nursing/Designee on 7-23-2024. Education was provided to the licensed nursing staff including agency nurses that the resident vaccine status is to be and will be completed by 8-19-24. This education was provided to the licensed nursing staff by the Director of Nursing/Designee. Licensed nursing staff that are not available on or before 8-19-2024 will not be scheduled until the education has been completed. All residents are to be checked on admission by the Unit Nurse Manager. Any residents that are determined eligible and consent to the vaccine are to be offered the vaccine within 7 days of admission. Immunizations will be tracked by the Clinical Nurse Consultant. The Director of Nursing will verify the immunization tracking to ensure that consents were obtained and the vaccinations have been administered.	

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F 883	Continued From page 107	F 883	Monitoring will be completed by the Unit Nurse Manager completing the admission/readmission checklist that directs all licensed and registered nursing staff to offer the vaccine and obtain consents if the resident is agreeable. The Director of Nursing/Designee will complete weekly checks of all admissions weekly x 12 weeks. A report will be completed of the results and presented to the Quality Assurance and Process Improvement Committee for 3 months. Completion Date: 8-20-24	