STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. BUILDING _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR REHABILITATION AND HEALTHCARE CENTER	1306 SOUTH KING STREET WINDSOR, NC 27983

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E 000	Initial Comments A recertification and complaint survey was conducted onsite from 10/7/24 through 10/11/24. Additional information was obtained remotely on 10/14/24 and 10/15/24. Therefore, the exit date was 10/15/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LLR011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted onsite from 10/7/24 through 10/11/24. Additional information was obtained remotely on 10/14/24 and 10/15/24. Therefore, the exit date was 10/15/24. The following intakes were investigated NC00210578, NC00210619, NC00212467, NC00212554, NC00212600, NC00212911, NC00215307, NC00216030, NC00216114, NC00216204, NC00217544, NC00218600, NC00218716, NC00218728, NC00219029, NC00220319, NC00220750, NC00221294, NC00221320, NC00221858, NC00222021, and NC00222545. Intake NC00218600 resulted in immediate jeopardy. 14 of the 51 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/19/23 and was removed on 10/11/24. An extended survey was conducted.	F 000		

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

Electronically Signed | 11/04/2024

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

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F 000	Continued From page 1	F 000		
	The statement of deficiencies was amended on 11/5/24 at tag F657.			
F 550 SS=D	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	F 550		11/1/24

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F 550	Continued From page 2 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to treat a resident in a dignified manner when staff referred to a resident who needed assistance with eating as a "feeder" for 1 of 3 residents reviewed for dignity (Resident #64). This caused Resident #64 to "feel like an animal". Findings included: Resident #64 was admitted to the facility on 4/17/24. Resident #64's Minimum Data Set assessment dated 7/25/24 revealed she was assessed as cognitively intact. She required set up assistance with meals. Resident #64's care plan dated 10/6/24 revealed she was care planned to require assistance to total care with activities of daily living. The interventions included staff to provide assistance with meals. During a dining observation on 10/7/24 at 12:35 PM Nurse Aide #5 was observed to enter Resident #64's room and stated Resident #64	F 550	1. Resident #64 continues to remain in the facility. An education was completed on 10/7/2024 with nurse aide #5 regarding the use of the term "feeder" to ensure resident's are treated with dignity and respect. 2. All residents have the ability to be affected by the deficiency. 3. All staff will be reeducated by the DON or designee that using the term "feeder" is not acceptable. All newly hired staff will be educated on these policies and practices during orientation. 4. The Director of Nurses (DON) or designee will audit weekly for two weeks and then monthly for two months to ensure that residents receive a dignified experience not using the term "feeder." Results of these audits will be presented to the facility Quality Assurance and Peformance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. Alleged Date of Compliance: 11/1/2024	

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F 550	Continued From page 3 was a "feeder" within hearing range of Resident #64 as she provided the lunch tray to the resident. During an interview on 10/7/24 at 12:36 PM Nurse Aide #5 stated staff were not supposed to use the term "feeder" so that the residents would not feel disabled, and she should not have used it. During an interview on 10/7/24 at 12:38 PM Resident #64 stated she often heard staff refer to her as a "feeder" and it made her "feel like an animal". During an interview on 10/7/24 at 12:50 PM the Director of Nursing stated staff were not to use the term 'feeder' for the dignity of the residents.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §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.	F 561		11/6/24

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F 561	Continued From page 4 §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 observations, record review and resident and staff interviews the facility failed to ensure a sufficient number of clean mechanical lift pads were available to allow a resident to get out of bed in accordance with his preference (Resident #65) and failed to allow a resident who was assessed as a safe independent smoker to smoke in accordance with her preference (Resident #41). This was for 2 of 3 residents reviewed for self-determination. Findings included: 1. Resident #65 was admitted to the facility on 8/14/24 with a diagnosis of generalized muscle weakness. A review of Resident #65's quarterly Minimum Data Set (MDS) assessment dated 9/12/24 revealed he was cognitively intact. He was dependent for transfers. A review of Resident #65's care plan dated last revised 9/16/24 revealed a problem area of activities of daily living self-performance deficit. The goal was for Resident #65 to maintain his	F 561	1. Resident #41 and Resident #65 continue to remain in the facility. They suffered no adverse affects as a result of the deficiency. 2. All residents who require a mechanical lift have the ability to be affected by this deficiency. Resident #41 and Resident #65 both have lift pads available for use when transferring. An audit was completed on 11/1/2024 to determine that all residents that require a lift pad have them available for use at the time of transfer on October 12, 2024. All residents that are assessed as a safe smoker were reviewed for their preference to smoke on 11/1/2024. 3. All staff will be reeducated by the Director of Nurses to ensure that residents have a clean lift pad available to transfer as preferred and residents assessed as a safe smoker can smoke per their preference. Additionally, all newly hired staff will be	

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F 561	Continued From page 5 current level of function through the next review. An intervention was to praise all efforts at self-care. On 10/7/24 at 2:36 PM Resident #65 was observed in bed. An interview with Resident #65 at that time indicated he had not been able to get out of bed for the past several days because his Nurse Aide (NA) could not find a clean lift pad. He stated he asked NA #1 to assist him with getting up out of bed earlier, and she told him she could not find a clean lift pad. He reported he wanted to get out of bed every morning. Resident #65 stated not being able to get out of bed each morning was frustrating and made him feel like he was going to lose what strength and ability he had. On 10/8/24 at 2:07 PM an interview with NA #1 indicated she had been assigned to care for Resident #65 on 10/7/24 on the 7AM-3PM shift. She stated Resident #65 asked her to assist him with getting out of bed that day, but she had not been able to find a clean mechanical lift pad. NA #1 reported the clean lift pads were usually kept in the linen room, but there hadn't been any yesterday. She stated this sometimes happened at the beginning of the month, because residents needed to have their monthly weights completed, this used a lot of lift pads, and then the pads needed to be washed. She went on to say she told Resident #65 yesterday when she wasn't able to assist him with getting up out of bed that she hoped she could get him up today, but she wasn't assigned to care for Resident #65 today. She stated she had not let the nurse know she had not been able to assist Resident #65 with getting up yesterday.	F 561	educated on these policies and practices during orientation. 4. The Administrator or designee will review weekly for two weeks and then monthly for two months that residents that require a lift pad have them available for use at the time of transfer and residents that are assessed as a safe smoker were reviewed for their preference to smoke. Results of these audits will be presentd to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. Alleged Date of Compliance 11/6/2024.	

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F 561	Continued From page 6	F 561		

On 10/8/24 at 2:14 PM Resident #65 was observed in bed. An interview with Resident #65 at that time indicated he asked the NA caring for him today on and off since 10:30 AM to assist him with getting up out of bed, but she told him she couldn't find a clean lift pad, so he just quit asking.

On 10/8/24 at 2:24 PM an interview with NA #9 indicated she was assigned to care for Resident #65 that day on the 7AM-3PM shift. She stated he had asked her for assistance with getting out of bed earlier that day, but she had not been able to find a clean lift pad for him. She reported the clean lift pads were usually kept in the shower room on the 100 Hall, but the door had been locked when she went to check for one. She stated she had not asked anyone for help accessing the room, or let the nurse know she could not assist Resident #65 with getting up that day. NA #9 stated there were also sometimes clean lift pads in the clean linen room, but she had looked there earlier and there had not been any.

On 10/8/24 at 2:34 PM an observation of the laundry area was conducted with the Housekeeping Manager. One clean lift pad appropriately sized for Resident #65 was observed, however it was still damp. An interview with the Housekeeping Manager at that time indicated the lift pads could not be put into the dryer and needed to air dry. She stated yesterday NA #1 had come to her and asked for a clean lift pad for Resident #65, but there had not been any available. She reported what was happening was the pads were being left in resident's rooms and were not being returned to the laundry after use. The Housekeeping Manager stated no one had

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F 561	Continued From page 7	F 561		

asked her for a lift pad for Resident #65 today. She stated clean lift pads were usually kept in the laundry.

On 10/10/24 at 2:01 PM an interview with the Director of Nursing indicated there should be a sufficient number of clean lift pads available to use for all residents when they want to get up out of bed. She stated if the NA was not able to find a clean lift pad when a resident wanted to get out of bed, she would expect the NA to let the nurse know so the issue could be resolved.

On 10/10/24 at 3:10 PM Resident #65 was observed in bed. He stated he asked his NA for assistance with getting up earlier that day but had been told they were washing all the lift pads.

On 10/10/24 at 3:11 PM an interview with NA #10 indicated she was assigned to care for Resident #65 on the 7AM-3PM shift that day. She stated when Resident #65 asked her for assistance with getting up out of bed there had not been a clean lift pad available. She reported she had not let the nurse know she had not been able to assist Resident #65 with getting out of bed that day.

On 10/11/24 at 11:20 AM an interview with the Administrator indicated she had gone around and collected all the lift pads. She stated she determined the pads were being left in residents rooms and closets and were not being returned to the laundry promptly after use so they could be cleaned. She stated a clean lift pad should be available for a resident when they want to get up out of bed.

2. Resident #41 was admitted to the facility on 4/13/23 with a diagnosis of muscle weakness.

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F 561	Continued From page 8	F 561		

A review of Resident #41's quarterly Safe Smoking Evaluation dated 9/6/24 revealed Resident #41 was a safe smoker and no supervision was required.

A review of Resident #41's quarterly Minimum Data Set (MDS) assessment dated 9/19/24 revealed she was cognitively intact.

A review of Resident #41's care plan revealed a problem area last revised on 9/12/24 for smoking. The goal was for Resident #41 to suffer no injury from unsafe smoking practices through the next review. An intervention was Resident #41 knew the smoking times and location.

On 10/8/24 at 9:21 AM an interview with Resident #41 indicated since the new Administrator started at the facility in July 2024, she had been required to smoke only at the supervised smoking times, and this made her angry. She stated it made her feel like a child. Resident #41 stated she spoke to the Administrator about it, but was told this was just how it was going to be.

On 10/9/24 at 3:35 PM Resident #41 was observed sitting in the smoking area. No staff was present. Resident #41 was observed to have an extinguished cigarette in the ashtray in front of her. An interview with Resident #41 at that time indicated she had not been feeling well that day and had missed the assigned smoking times. She reported she had asked Nurse Aide (NA) #11 to assist her outside to smoke. Resident #41 stated she could smoke independently, but just needed help to get outside. She went on to say her cigarettes and her lighter were kept locked up and someone had to give these to her. She

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F 561	Continued From page 9	F 561		

stated NA #11 had assisted her outside, and she had been smoking her cigarette when the Director of Nursing (DON) came out, told her it was not the assigned smoking time, and asked her to put the cigarette out. Resident #41 reported she had complied with the request, but it made her angry. She stated she felt like she was in jail.

On 10/9/24 at 3:48 PM an interview with NA #11 indicated she was assigned to Resident #41 on the 3PM-11PM shift that day. She stated Resident #41 had asked her for assistance with getting outside for a cigarette and she had assisted her at about 3:30 PM. She reported while Resident #41 was outside smoking her cigarette, the DON had come outside and asked Resident #41 to put her cigarette out because it wasn't an assigned smoking time. NA #11 stated Resident #41 had not seemed angry and had done as the DON requested. NA #11 went on to say the assigned smoking times on the 3PM-11PM shift were 4PM and 7PM.

On 10/10/24 at 2:01 PM an interview with the DON indicated she recalled the incident with Resident #41 on 10/9/24. She stated she could see the smoking area from her office window. She went on to say she had seen Resident #41 smoking, it was not an assigned smoking time, and she had gone out and asked Resident #41 to put her cigarette out. She reported she asked NA #11 to return to her assigned hall because NA #11 should have been caring for her assigned residents at that time and not taking time away from this to obtain smoking materials for Resident #41. The DON reported Resident #41 could only go outside to smoke during the assigned smoking times of 9AM, 11:30AM, 1:30 PM, 4PM and 7PM,

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F 561	Continued From page 10 which were also the supervised smoking times, regardless of her independent smoking status. On 10/11/24 at 11:20 AM an interview with the Administrator indicated when she first started with the facility in July 2024, residents were smoking whenever they wanted to. She stated she had felt this was a safety concern. She reported she felt it was best to enforce the policy that there were set smoking times for everyone regardless of independent smoking status.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 582		11/1/24

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F 582	Continued From page 11 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a complete CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) by omitting the estimated cost for 1 of 3 residents reviewed for beneficiary notices (Resident #49). Findings included: Resident #49 was admitted to the facility on	F 582	1. Resident #49 no longer resides in the facility. 2. All residents that receive the skilled nursing advanced beneficiary notice have the ability to be affected by the deficient practice. 3. The social services director was reeducated by the administrator on 10/8/2024 to ensure that the estimated cost is documented on the skilled nursing advanced beneficiary	

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F 582	Continued From page 12 6/19/24 with diagnoses that included metabolic encephalopathy and dementia. Medicare part A services began the day of admission. Review of Resident # 49's record indicated the SNF ABN dated 6/22/24 had no estimated cost documented on the form. The last covered date was 6/26/24 and Resident #49 remained in the facility. The admission Minimum Data Set assessment (MDS) dated 9/26/24 revealed Resident # 49 was assessed as severely cognitively impaired. During an interview on 10/8/24 at 11:33 AM Social Worker #1 stated the estimated cost on the SNF ABN should be completed to ensure the residents or family have the cost provided to them to make an informed decision about their care. She stated she did not know why the estimate cost was not complete for Resident #49. During an interview on 10/8/24 at 11:43 AM Administrator #1 stated the SNF ABN should be completed, including the estimated cost, to allow the resident or family to make an informed decision about the care they wished to pursue.	F 582	notice. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4. The administrator or designee will review weekly for two weeks and then monthly for two months that residents who receive the advanced beneficiary notice have the estimated cost documented. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. Alleged Date of Compliance 11/1/2024.	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		11/6/24

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F 600	Continued From page 13 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident, staff and the Physician, the facility failed to protect the residents' right to be free from resident to resident abuse for 3 of 5 residents reviewed for abuse (Resident #222, Resident #61, and Resident #41). On 10/19/23 Resident #2, a male resident, entered Resident #222's room (a female resident) and punched her in her legs multiple times with a closed fist as she was sitting on her bed. On 6/22/24 Resident #2 punched Resident #61 (a female resident) in the face multiple times with a closed fist at the nurse's station due to the belief that she was cheating on him. Resident #222 and Resident #61 were vulnerable and were unable to protect themselves. The physical abuse had a high likelihood of resulting in serious physical and psychosocial harm. A reasonable person expects to be protected from physical abuse in their home and would suffer trauma such as feelings of fear, anxiety, and intimidation. Additionally, the facility failed to protect Resident #41 from verbal abuse perpetrated by Resident #6 when he verbally threatened Resident #41 stating he was going to kill her and everyone else in the facility. Immediate jeopardy began on 10/19/23 when Resident #2 punched Resident #222 multiple times in the legs with a closed fist. Immediate jeopardy was removed on 10/11/24 when the	F 600	1. Resident #2 continues to reside at the facility under psychiatric care and services. Resident #2 continues to receive medications as ordered and has not had any further altercations. He has shown a decrease in overall aggressive behaviors. Resident #222 no longer resides at the facility. Resident #61 continues to reside at the facility without further concerns. 2. All residents who reside in the facility have the ability to be affected by the deficient practice. All staff were interviewed by the Scheduler and Administrative Assistant on 10/10/2024. All residents who were able to participate were interviewed by the Social Services and Admissions Directors on 10/10/2024. The questions that they were asked were the following: Do you know about abuse? Do you know who to report abuse to? Do you feel safe in the facility? Do you have any concerns about abuse (physical, verbal, emotional, sexual, financial?) 3. All staff including nurses, certified nursing assistants,	

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facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective. Example #2 for Resident #41 was cited at scope and severity D.

Findings included:

1. Resident #2 was admitted to the facility on 4/6/23 with diagnoses that included non-traumatic intracranial hemorrhage (stroke) and hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body), schizophrenia and dementia.

Review of the care plan for Resident #2 initiated on 4/7/23, identified problems of: Behaviors including swinging at staff, yelling, history of throwing himself on the floor for attention, kicking and hitting at staff, wandering in and out of other resident's rooms, resident to resident altercation and pushing equipment forcefully. The goal was the resident would have no negative outcomes related to behaviors through the next review. Interventions included administer medications as ordered and observe for side effects and effectiveness. Anticipate and meet the resident's needs, explain all procedures to the resident before starting and allow the resident time to adjust to changes. If reasonable, discuss the behavior with the resident and explain/reinforce why the behavior is inappropriate and/or unacceptable. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner, divert attention and remove from the situation and take to an alternate location as needed. Monitor behavior episodes and attempt

agency/contract staff, all ancillary staff and all newly hired
employees will be educated on the Abuse Prevention Policy. The
policy describes the right for residents to be free from abuse and
neglect, exploitation or mistreatment. Staff will receive education
on managing residents who have aggressive behaviors. Staff will be
educated on verbal and nonverbal signs of aggression such as
increased agitation, yelling out and clenching of fists. Staff will
be educated on techniques to de-escalate residents displaying
increaed agitation such as removing the residents from the trigger
and providing a quiet place for de-escalation. Staff will be trained
to use the behavioral monitoring forms to document any aggressive
behavior, including what happened before, during, and after the
incident. All education was be completed by the Director of Nurses,
Assistant Director of Nurses or deignee by 10/10/2024. This
education included 1:1, and group training sessions. The
Administrator/designee will be the person to ensure that all licensed
nurses, certified nursing assistants, agency/contract staff, all
ancillary staff, and newly hired employees will be educated.
4. The Administrator or designee will review weekly for two weeks
and then monthly for two months any

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F 600	Continued From page 15 to determine underlying causes considering location, time of day, persons involved and situations. Document behavior and potential causes. The quarterly Minimum Data Set dated 8/25/23 revealed Resident #2 was severely cognitively impaired and required supervision or touching assistance with wheelchair mobility. He was coded as having no hallucinations or delusions and receiving antipsychotic, antianxiety and antidepressant medications. He was coded as having had other behavioral symptoms not directed toward others. The active physician's orders for Resident #2 on 10/19/23 included the following psychotropic medications: - Fluoxetine (antidepressant medication) 10 milligrams (mg) once daily - Olanzapine (antipsychotic medication) 7.5 mg once daily - Ativan (antianxiety medication) 0.5 mg twice daily - Trazodone (antidepressant used for sleep) 75 mg once daily - Depakote (mood stabilizer) 375 mg twice daily - Buspirone (antianxiety medication) 5 mg twice daily. Review of a progress note written by Nurse #2 on 10/19/23 at 2:14 AM stated Resident #2 was going in and out of other residents' rooms. He was cursing at Nurse #2 and became combative when she tried to remove him. Review of a progress note written by Nurse #2 on	F 600	residents who have an increase in aggressive behaviors. Results of these audits will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review, and if warranted, further action. 5. Alleged Date of Compliance 11/6/2024.	

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10/19/23 at 4:50 AM stated Resident #2 was in the employee break room, removing items from the refrigerator and throwing them on the floor. The note further stated Resident #2 was verbally abusive and physically combative. Nurse #2 indicated they were unable to redirect him.

a. Resident #222 was admitted to the facility on 10/2/2023 with diagnoses that included reduced mobility and moderate intellectual disabilities.

The admission MDS dated 10/9/2023 revealed Resident #222 was severely cognitively impaired with no behaviors. It further revealed she had no impairment of upper or lower extremities and needed substantial assistance with activities of daily living.

A review of Resident #222's comprehensive care plan revealed no care plan for behaviors.

A nurse's note written by Nurse #1 on 10/19/23 at 8:23 PM stated she was notified by the Physical Therapist (PT) that Resident #2 hit Resident #222 with a closed fist. The note further stated Resident #2 was fighting and kicking the PT and Nurse Aide (NA) #2 while they removed him from the room. Resident #2 was holding onto the handrails in the hall trying to get back into the room, attempted to hit NA #2 and Nurse #1 in the face with a closed fist. DON #2 attempted to calm Resident #2 but was unsuccessful. Nurse #1 notified Nurse Practitioner #1 and received a one-time order for antipsychotic medication which they gave with no effect. Emergency Medical Services (EMS) and the Sheriff were notified. They arrived at the facility and transported Resident #2 to the hospital.

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A review of Resident #2's record revealed an order dated 10/19/23 for 2.5 milliliters (ml) of Haldol (antipsychotic medication) injection solution 5 mg/1 ml to be given intramuscularly (injected into a muscle) one time only for behaviors.

An interview with the PT who witnessed the resident abuse on 10/19/23 was interviewed on 10/11/24 at 9:40 AM. He stated he heard yelling coming from the room of Resident #222 and went to investigate. When the PT entered the room, he observed Resident #222 sitting on the edge of her bed. Resident #2 had come into her room in his wheelchair and was punching her on the legs repeatedly with a closed fist. Resident #222 was not physically responding. The PT immediately removed Resident #2 from Resident #222's room. The PT further stated Resident #2 held onto furniture and the handrail outside the room when he removed him from the situation. When the PT got Resident #2 into the hall he yelled to Nurse #1 and NA #3 to help. He told them what he had witnessed and immediately went and reported the incident to the Therapy Department Manager. The PT revealed Resident #222 looked surprised but not upset or crying. The PT revealed he was familiar with Resident #2 and he was not surprised he struck another resident as he often hit staff. He further revealed that Resident #2 was unpredictable in his actions and often struck without notice.

NA #2 was not available for interview.

Nurse #1 was not available for interview.

A nurse's note written by DON #2 on 10/19/23 at 8:21 PM revealed she was called to the hallway

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outside of Resident #222's room at approximately 6:50 PM to help with Resident #2 who was striking and kicking staff and attempting to get back into the room of Resident #222. The note further revealed she brought him in his wheelchair to the nurse's station to attempt to redirect him but was unsuccessful. Resident #222 was taken to the hospital by EMS at approximately 7:10 PM due to his behaviors and being a danger to himself and others.

An interview was conducted with DON #2 on 10/9/24 at 3:24 PM. She stated she was called to the hallway outside the room of Resident #222 at approximately 6:50 PM on 10/19/23 because Nurse #1 and NA #3 needed help with Resident #2 who was fighting with staff. When she arrived, Resident #2 was holding onto the handrails in the hall while the PT, Nurse #1 and NA #3 were attempting to have him let go. Resident #2 did let go of the handrail, but then tried to punch DON #2, NA #3 and the PT. DON #2 was able to take him to the nurse's station where she attempted to calm him without success. DON #2 further stated Nurse #1 called Nurse Practitioner (NP) #1 and received a one-time order for a psychotropic medication (Haldol injection) to help calm him without effect. Nurse #1 then called EMS who sent the Sheriff and an ambulance. Resident #2 was then taken to the hospital. He returned to the facility the same evening. DON #2 revealed she assessed Resident #222 approximately 30 minutes after the incident and she was free of physical injury such as bruising or scratches. She further revealed Resident #222 did not recall the incident at that time. DON #2 indicated Resident #222 was not able to defend herself due to her cognitive status. She also indicated staff were afraid of Resident #2 as he was strong enough to

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push medication, treatment and food carts into them, sometimes backing them into a corner. He also hit, kicked and screamed at staff without warning.

NA #3 was not available for interview.

Police report dated 10/19/23 indicated that when he responded to the call Resident #2 was at the nurse's station with staff and was calm. It further indicated that Resident #2 was transported to the hospital by EMS.

An Emergency Room note dated 10/19/23 stated Resident #2 was brought to the hospital by ambulance after a combative episode at the facility. He was not combative with hospital staff. The note further stated Resident #2 was given Trazodone and Ativan to help him sleep and basic blood and urine tests were performed to rule out dehydration and infection. The tests were unremarkable. Resident #2 was transported back to the facility the same day with no new orders.

A Nurse's note written by Nurse #2 on 10/19/23 revealed Resident #2 returned to facility at 11:35 PM accompanied by two ambulance attendants. He was alert, awake and calm when returned to the facility.

Physician's orders dated 10/20/23 indicated Resident #2's olanzapine was changed from 7.5 mg once daily to 5 mg twice daily and clonazepam (antianxiety medication) 0.25 mg three times a day was initiated.

A psychiatric note completed by Nurse Practitioner (FNP) #2 on 10/30/23 revealed: Recent medication changes have had mild

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improvements in his behaviors and DON feels this is the best combination he has been on so far, but there are still concerns about how his behaviors are affecting the safety of himself, other residents and staff. He has impulsivity with rage and "loves to terrorize." He reportedly "went after a pregnant staff member." He was noted to push medication carts with his wheelchair until staff were backed into a corner or until he hit them with the cart. Staff felt he "has no problem hitting or punching people." This has created issues providing care to him as staff were scared of him when he became agitated. The facility has had to involve law enforcement due to his behaviors. He was sneaking into the staff breakroom and "will get into whatever is in there" and he has been stealing food off other residents' trays. Facility noises appeared to overstimulate him and his behaviors got notably worse at shift change around 4 pm. The note further stated Resident #2 was not a danger to himself or others at that time. Interventions included changes to his psychotropic medication regime and a referral to psychotherapy.

NP #2 was unavailable for interview.

A telephone interview with the Physician on 10/14/24 at 10:25 AM revealed he did not recall the 10/19/23 incident, and he did not see mention of it in his progress note. The Physician stated Resident #2 was capable of striking other residents in October of 2023 but did not feel he was capable recently due to a decline in function. He further stated the resident has had psychiatric services involved throughout his stay at the facility.

b. Resident #61 was admitted to the facility on

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5/14/24 with diagnoses that included encephalopathy (alteration in brain function), decreased renal function and the need for dialysis.

A review of the Admission MDS dated 5/21/24 revealed Resident #61 was severely cognitively impaired with no behaviors. She was able to walk less than 10 feet with a walker and substantial assistance.

Resident #61's comprehensive care plan revealed she was not care planned for behaviors.

A nurse's note completed by Nurse #3 on 6/22/24 at 6:52 PM stated Resident #61 was punched in the face twice by Resident #2 at the nurse's station. Resident #61 was pulled to safety by staff. Resident #2 was still trying to hit the staff. NP #3 was called and ordered a one time dose of a psychotropic medication that was given with no effectiveness. EMS was called and the ambulance and Sheriff arrived. Resident #2 attempted to hit and kick the Sheriff and ambulance crew. He was taken to the hospital for evaluation.

Skin check sheet for Resident #61 dated 6/22/24 was completed by Nurse #3 and it revealed there were no injuries to Resident #61.

A review of Resident #2's record revealed an order dated 6/22/24 for 2.5 ml of Haldol injection solution 5 mg/1 ml to be given intramuscularly one time only for behaviors.

In a telephone interview with Nurse #3 on 10/9/24 at 9:07 AM she stated on 6/22/24 she witnessed Resident #2 wheel his wheelchair to the nurse's

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station where Resident #61 was sitting in her wheelchair, yelled at her that she had been cheating on him (they were not a couple) and punched her in the nose twice. Resident #2 was removed from the area by an NA and she (Nurse #3) attended to Resident #61. She stated Resident #61 was upset but not crying. Resident #61 had no physical injuries at that time. She further stated Resident #61 was not able to protect herself from an attack due to age and debility. Nurse #3 revealed Resident #2 was unpredictable and volatile at baseline. She stated he would lash out at staff, trying to punch or kick them, go into other residents' rooms, get into the staff break room and throw stuff around and push medication and food carts into staff. Nurse #3 further revealed that many staff were afraid of being, or have been, hurt by him.

A nurse's note written by DON #3 on 6/22/24 at 8:56 PM revealed he assessed Resident #61 for bruising or swelling of the nasal area and the area was clear of obvious injury.

The police report for 6/22/24 was requested and law enforcement indicated there was no police report.

The hospital emergency room visit note dated 6/22/24 revealed Resident #2 was calm and did not recall assaulting Resident #61, staff or the Sheriff. It further stated he appeared to have cognitive deficits and could not hold a full conversation but could answer yes/no questions. Basic labs were run and were reported as unremarkable. No changes or recommendations were made. Resident #2 returned to the facility on 6/23/24.

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An interview with Resident #61 was conducted on 10/7/24 at 3:00 PM. She did not recall being punched by Resident # 2 on 6/22/24.

In a telephone interview with DON #3 on 10/10/24 at 11:16 AM he stated he was not in the building at the time of the 6/22/24 incident but came in and filed a report with the State Agency, Adult Protective Services (APS) and local police. He further stated staff reported Resident #2 came up to Resident #61 at the nurse's station and punched her in the nose twice. DON #3 revealed Resident #2 was unpredictable in his actions such as screaming, kicking out or attempting to strike staff. DON #3 had not known Resident #2 to strike out at other residents, but he had only worked there for less than two weeks at the time of the incident.

Resident #2 was observed on 10/7/24 at 9:10 AM lying quietly in his bed. A second observation was conducted on 10/10/24 at 10:15 AM. Resident #2 was sitting up in his wheelchair in his room screaming. When spoken to, he stopped screaming, smiled and waved. Resident #2 continued screaming afterward.

An interview with the Physician on 10/14/24 at 10:25 AM revealed he did not recall the incident on 6/22/24 as he was out of the country at the time. The Physician stated Resident #2 was capable of striking other residents in June of 2024 but did not feel he was capable at this time due to a decline in function. He further stated the resident has had Psychiatric services involved throughout his stay at the facility.

Administrator #1 was notified of Immediate Jeopardy on 10/10/24 at 9:25 AM.

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

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

On 10/19/23 Resident #2 was in Resident #222's room when a staff member heard residents talking. The staff member went into Resident #222's room and observed Resident #222 hitting Resident #2 with a closed fist. Staff immediately removed Resident #222 from the resident's room. Residents were assessed for injuries by the staff nurse on 10/19/23. No injuries were noted. Resident #2 and Resident #222 were unable to recall the events of the incident. Resident #2's physician was notified on 10/19/23. All attempts to calm Resident #2 were unsuccessful. Resident #2 was sent to the hospital emergency department on 10/19/23 for further evaluation. On 10/20/23 Social Services offered emotional support to Resident #222 and documented no signs of distress, discomfort or pain noted. Upon Resident #2 returning to the facility resident was placed on increased supervision and assessed by psychiatric nurse practitioner on 10/30/23.

On 6/22/24 Resident #2 was observed punching Resident #61 in the nose with a closed fist twice while both were in their wheelchairs at nurses' station. Staff immediately separated the residents. Resident #2 was sent to emergency room for further evaluation. Resident #61 was assessed with no injuries noted.

Resident #2 continues to reside at the facility

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under psychiatric care and services. Resident #2 continues to receive medications as ordered and has not had any further altercations. He has shown a decrease in overall aggressive behaviors. Resident #222 no longer resides in the facility. Resident #61 continues to reside in the facility without further concerns.

All Staff were interviewed by the Scheduler and Administrative Assistant on 10/10/24. All residents that were able to participate in an interview were interviewed by the Social Services and Admissions Director on 10/10/24. The questions that they were asked were the following: Do you know about abuse? Do you know who to report abuse to? Do you feel safe in the facility? Do you have any concerns about abuse (physical, verbal, emotional, sexual, financial)? Any further allegations made will be investigated towards resolution by the Administrator and /or Director of Nurses. All residents were assessed by nurses via skin sweeps for suspicious injuries on 10/10/24. No suspicious injuries (those injuries that would be evident without a reasonable or rational explanation for the injury) were noted at those times. All residents were assessed by the Director of Nursing, Assistant Director of Nursing and Unit Manager for behaviors including verbal abuse, physical aggression to ensure appropriate care plans were in place to prevent resident to resident altercation.

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.

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Education - All staff including nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated on the Abuse Prevention Policy. The policy describes the right for residents to be free from abuse, neglect, exploitation or mistreatment. Staff will receive education on managing residents who have aggressive behaviors. Staff will be educated on verbal and nonverbal signs of aggression such as increased agitation, yelling out and clenching of fists. Staff will be educated on techniques to de-escalate residents displaying increased agitation such as removing the residents from the trigger and providing a quiet place for de-escalation. Staff will be trained to use the behavioral monitoring forms to document any aggressive behavior, including what happened before, during, and after the incident. All education will be completed by the DON/ADON designee by 10/10/2024. This education will include 1:1, and group training sessions. The Administrator/designee will be the person who will ensure all licensed nurses, certified nursing assistants, agency/contract staff, all ancillary staff, and all newly hired employees will be educated. No staff will work after 10/10/2024 until education has been received.

Alleged date of Immediate jeopardy removal: 10/11/24.

Onsite validation of the immediate jeopardy removal plan was completed on 10/11/2024. Interviews confirmed that all staff working on 10/11/24 were educated on the Abuse Prevention Policy. Staff were also educated on managing residents who have aggressive behaviors, verbal

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and nonverbal signs of aggression such as increased agitation, yelling out and clenching of fists, as well as techniques to de-escalate residents displaying increased agitation such as removing the residents from the trigger and providing a quiet place for de-escalation. Nurses were trained to use behavioral monitoring forms to document any aggressive behavior, including what happened before, during, and after the incident. Nurse aides indicated they would notify the Nurse of any aggressive behaviors, abuse, or incidents involving residents. All other staff indicated they would report to the Nurse, Director of Nursing or Administrator. Verification was completed that all staff scheduled to work 10/11/24 were reeducated prior to returning to duty. The immediate jeopardy removal date of 10/11/24 was validated.

2. Resident #41 was admitted to the facility on 4/13/23.

Review of Resident #41's Minimum Data Set assessment dated 9/29/23 revealed she was assessed as cognitively intact. She had no behaviors documented and required supervision with locomotion on and off unit.

Review of Resident #6's Minimum Data Set Assessment dated 11/28/23 revealed he was assessed as cognitively intact. He had no behaviors documented.

Resident #6's active care plan as of 11/28/23 revealed there was no care plan for behaviors.

An investigational summary completed by Previous Director of Nursing #1 dated 12/5/23 revealed on 11/29/23 Resident #41 reported that

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Resident #6 was outside in the smoking area with her. Resident #6 rolled up to Resident #41 in the wheelchair, stood up getting in her face, and stated he would kill her and other people. She stated she felt threatened and was afraid of him at that moment. She reported this to a staff member who brought her directly to the Previous Director of Nursing #1. Facility staff interviewed both residents and Resident #6 was not able to recall specific details. Resident #41 was able to recite what happened and that Resident #41 immediately removed herself from the situation and told staff about the incident.

During an interview on 10/7/24 at 1:57 PM Resident #6 stated he did not remember the incident.

During an interview on 10/10/24 at 11:01 AM Resident #41 stated she remembered the incident with Resident #6 a long time ago. She stated she was in the smoking area and as far as she could remember it was just herself and Resident #6 out there. She stated Resident #6 rolled up to her while she was in her wheelchair, stood up in front of her, and yelled at her, "I will kill you and everyone here!" She stated Resident #6 had never done this to her before or since. She stated at that moment, it made her afraid and she turned around, entered the dining room, and was met by the Activities Director. She told the Activities Director what Resident #6 had said to her and the Activities Director ensured her safety and removed her from the situation. She stated she did not remember much else about the incident, it did not affect her daily life at the facility, and she was not traumatized by the incident. She concluded she was being followed by psychiatric services and the facility set up a

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F 600	Continued From page 29 psychiatric evaluation following the incident as well as getting her statement. During an interview on 10/10/24 at 11:25 AM the Activities Director stated on 11/29/23 she was in the dining room preparing an activity for the residents. From the dining room she could view the smoking area through the dining room windows. Resident #6 and Resident #41 were in the smoking area at that time. She stated Resident #6 rolled over to Resident #41 and was making gestures in her face. She did not recall him standing up but he was up very "close and personal in a threatening manner." The Activities Director went to the door as Resident #41 turned to the door and motioned to the Activities Director to let her come inside. Once inside, Resident #41 told the Activities Director that Resident #6 had threatened to kill her and called her some vulgar names. The Activities Director immediately took the resident to administration at that time and let Resident #41 recount what happened as another staff member took Resident #6 to his room. During an interview on 10/10/24 at 11:41 AM Administrator #1 stated she started working at the facility on 7/29/24. She stated she was not at the facility during the time of the incident. She stated since she became the Administrator, Resident #41 had not indicated to her any concerns of being fearful of Resident #6. She concluded residents should not be verbally threatened to be killed in the facility.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		11/6/24

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F 609	Continued From page 30 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 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, staff and resident interviews the facility failed to submit a 5-day investigation report (Resident #172) and an initial 24 hour and 5-day investigation report to the State Agency and report to Adult Protective Services (APS) and local law enforcement after allegations of misappropriation of property (Resident #3). This was for 2 of 6 residents reviewed for misappropriation. Findings included:	F 609	1. Resident #172 no longer resides at the facility. Facility report for Resident #3 was submitted on 10/14/2024. 2. All residents thave the ability to be affected by the deficient practice. 3. All staff will be reeducated on the reporting of allegations timely by the Administrator. Additionally, all newly hired staff will be educated	

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F 609	Continued From page 31 1. Resident #172 was re-admitted to the facility on 10/6/23 A review of an initial 24 hour report dated as submitted to the State Agency on 12/1/23 at 3:51 PM written by the facility's previous Director of Nursing (DON) #2 indicated the facility became aware on 12/1/23 at 1:15 PM that Resident #172 reported a missing bank card and $10.00. Resident #172 had immediately called his bank to have his card cancelled, and the card had not been used. A search for the missing items was conducted, and the items had not been found. A review of the facility's investigation folder of the 12/1/23 allegation of misappropriation for Resident #172 revealed no evidence of the 5 day investigation report. An email from the State Agency on 12/13/23 to DON #2 indicated the investigation report related to the 12/1/23 initial report for Resident #172's allegation of misappropriation of property had not been received. In a telephone interview on 10/11/24 at 10:53 AM DON #2 stated she recalled the incident of Resident #172's missing property on 12/1/23. She went on to say she no longer worked at the facility. She reported she had completed and submitted the initial 24 hour allegation report to the State Agency when Resident #172 first reported the missing items. She went on to say she had done an investigation, and Resident #172's missing bank card and $10.00 had been found pretty quickly. DON #2 stated she did not recall if she had submitted the investigation report to the State Agency, but if she had, it would be in	F 609	on these policies and practice during orientation. 4. The Administrator or designee will review weekly for two weeks and then monthly for two months that residents that have an allegation have a facility report submitted timely. Results of these audits will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee for three months for review and, if warranted, further action. 5. Alleged Date of Compliance 11/6/2024.	

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the investigation folder of the incident.

On 10/11/24 at 11:12 AM an interview with the Administrator indicated while she had an investigation folder for Resident #172's allegation of missing property on 12/1/23, she did not have any documentation or confirmation that an investigation report had been submitted to the State agency for this allegation. She stated for misappropriation of property, the initial report should be submitted to the State Agency within 24 hours of the allegation and the final investigation report should be submitted to the State agency within 5 days.

2. A review of the facility abuse policy dated July 2017 stated: "All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported."

Resident #3 was admitted to the facility on 1/22/21.

A review of the quarterly Minimum Data Set (MDS) dated 8/8/24 revealed she was cognitively intact.

An interview with Resident #3 was conducted on 10/7/24 at 8:30 AM where she stated her purse had gone missing "several weeks ago" and it was never found. She further stated she did get her Social Security card and state identification replaced and that the Social Worker (SW) gave

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her a new purse to use. Resident #3 revealed there was $60 in cash in her purse as well.

In an interview with the SW on 10/8/24 at 12:22 PM she stated she was notified by Nurse Aide (NA) #4 that Resident #3 woke up the morning of 9/2/24 and her purse was missing. The SW informed Administrator #1. She further stated Resident #3 slept with her purse in her bed. The SW, NA #4 and Administrator #1 searched for the purse in the resident's room and around the facility in places such as the dining and activities rooms but it was never located. The SW revealed she brought in a purse of her own to replace it and arranged for facility transportation to take Resident #3 to the Social Security office and Department of Motor Vehicles for replacement identification. The facility was not able to replace the cash as they had no proof Resident #3 had any in her purse. The SW further revealed Resident #3 often misplaced items so she assumed that was what happened and didn't think that it could have been stolen.

In an interview with Administrator #1 on 10/8/24 at 2:47 PM she stated she was informed by the SW on 9/2/24 that Resident #3's purse was missing. She further stated she and other staff searched the building, including the trash for the purse and had assumed Resident #3 accidentally threw it away or misplaced it. Administrator #1 revealed she did not report the missing purse to the State Agency, Adult Protective Services or law enforcement because she did not think it was stolen. A facility investigation was not completed. The purse was not found. Administrator #1 further revealed she did have facility transportation take Resident #3 to have her Social Security Card and state identification replaced.

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code cognition, mood, and behavior for 1 of 24 residents reviewed for MDS accuracy (Resident #66). The findings included: Resident #66 was admitted to the facility on 7/15/24 with diagnoses that included dementia. Resident #66's most recent Minimum Data Set (MDS) assessment dated 8/21/24, a quarterly assessment revealed he was not assessed for cognition, mood and behaviors. An interview was conducted with the facility Social Worker on 10/9/24 at 10:26 AM who stated she was responsible for conducting the cognition, mood, and behavior section of the assessment. She reported that she could not recall the reason she did not assess Resident #66 for cognition, mood and behavior. The Social Worker stated it may have been an oversight. An interview was conducted with the Administrator on 10/11/24 at 10:10 AM who stated Resident #24's assessment should have been completed accurately.	F 641	1. Resident #66's MDS for mood, cognition and behavior was not completed. Resident #66's mood cognition and behavior will be completed on his future MDS assessments. 2. All residents that have impaired mood cognition and behaviors have the ability to be affected by the deficient practice. An audit was completed by the Social Service Director to ensure the accuracy of the coding of mood, cognition and behaviors on the MDS. 3. All interdisciplinary members was educated by the Administrator or designee on 11/1/2024 that assessments are accurate with coding mood cognition and behaviors. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4. The Administrator or designee will review weekly for two weeks and then monthly for two months that residents are coded accurately on the MDS for mood, cognition and behaviors. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement	11/6/24

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F 641	Continued From page 35	F 641	(QAPI) Committee monthly for three months for review, and if warranted, further action. 5. Alleged Date of Compliance 11/6/2024.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		11/6/24

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F 656	Continued From page 36 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews the facility failed to develop a comprehensive care plan that included the use of a mechanical lift device for transfers for 1 of 24 residents (Resident #65) whose comprehensive care plans were reviewed. Findings included: Resident #65 was admitted to the facility on 8/14/24 with a diagnosis of generalized muscle weakness. A review of Resident #65's quarterly Minimum Data Set (MDS) assessment dated 9/12/24 revealed he was cognitively intact. He was dependent for transfers. A review of Resident #65's comprehensive care plan dated last revised on 9/16/24 did not reveal any information regarding his use of a mechanical lift device for 2 person dependent transfers or any other transfer status.	F 656	1. Resident #65 care plan was revised on 11/1/2024 to include use of mechanical lift. 2. All residents that use a mechanical lift have the ablility to be affected by the deficient practice. An audit was completed by the MDS Coordinator or designee on 11/1/2024 to ensure that residents who use a mechanical lift are care planned. 3. All interdisciplinary team members will be reeducated by the Administrator to ensure that residents who require a mechanical lift have it on their care plan. Additionally, all newly hired staff will be educated on these policies and practices in orientation. 4. The Administrator or designee will review two residents weekly for two weeks and then four residents monthly for two months to ensure that residents who use a mechanical lift have care plans. Results of these	

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F 656	Continued From page 37 On 10/7/24 at 2:36 PM an interview with Resident #65 indicated he used a mechanical lift with 2 person assistance for his transfers. A review of Resident #65's Kardex (an informational sheet) dated 10/8/24 did not reveal any information regarding his use of a mechanical lift for 2 person dependent transfers. On 10/8/24 at 2:07 PM an interview with Nurse Aide (NA) #1 indicated she was caring for Resident #65 on the 7AM-3PM shift that day. She stated she was familiar with Resident #65 and had cared for him before. She reported she did have access to Resident #65's care plan but she had not looked at it recently. NA # stated Resident #65 had required the assistance of 2 people for a mechanical lift transfer since his admission to the facility. On 10/8/24 at 2:18 PM an interview with Nurse #4 indicated she was caring for Resident #65 on the 7AM-7PM shift that day and was familiar with him. She stated Resident #65 was dependent for the use of a mechanical lift with the assistance of 2 people to transfer. She stated this should be on his care plan, but she had not looked at this recently. On 10/9/24 at 8:27 AM a telephone interview with MDS Nurse #1 indicated she worked part-time in the facility 3 days per week filling in until the facility hired someone permanently. She stated while she would have participated in Resident #65's initial and quarterly care plan reviews, she would not have been responsible for including his transfer status in his care plan. She reported she would not have known that Resident #65 required a mechanical lift to transfer. MDS Nurse #1	F 656	audits will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee for three months for review and, if warranted, further action. 5. Alleged Date of Compliance 11/6/2024.	

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F 656	Continued From page 38 stated nursing would have been responsible for including this in his care plan. On 10/11/24 at 11:20 AM an interview with the Administrator indicated Resident #65's use of a mechanical lift for transfers was something that should have been included on his care plan. On 10/11/24 at 2:01 PM an interview with the Director of Nursing (DON) indicated the MDS Nurse should have ensured that Resident #65's use of a mechanical lift device with 2 person assistance was included on Resident #65's care plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		11/6/24

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F 657	Continued From page 39 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, Physician, staff and resident interviews, the facility failed to update care plan interventions (Resident # 2) and invite residents to care plan meetings (Resident # 43 and Resident #11) for 3 of 5 residents reviewed for care planning. Findings included: a. Resident #2 was admitted to the facility on 4/6/23 with diagnoses that included dementia and schizophrenia. The quarterly Minimum Data Set dated 8/22/24 revealed Resident #2 was severely cognitively impaired and other behavioral symptoms not directed at others. Review of the Care Plan for Resident #2 initiated on 4/7/23, identified problems of: Behaviors including swinging at staff, yelling, history of throwing himself on the floor for attention, kicking and hitting at staff, wandering in and out of other resident's rooms, resident to resident altercation and pushing equipment forcefully. The goal was that the resident would have no negative outcomes related to behaviors through the next review. Current interventions included one on one, meaning he was to always have a staff member with him.	F 657	1. Resident #2's care plan was updated on 11/1/2024. Resident # 43 was invited to participate in their care plan meeting on 10/23/24. Resident #11 was invited to participate in their care plan on 10/31/2024. 2. All residents that reside at the facility have the ability to be a affected by the deficient practice. An audit was completed by the MDS Coordinator or designee on 10/30/2024 t ensure that care plans have been updated and revised. An audit was completed by the Social Services Director on 10/31/2024 to ensure all current residents have been given the opportunity to participate with their care plan meeting. 3. All interdisciplinary team members will be reeducated by the Administrator or designee to ensure that residents' care plans are updated timely and residents are invited to participate with their care plan meeting. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4. The Administraor or designee will	

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F 657	Continued From page 40 Resident #2's Physician orders revealed no order for one on one supervision. In an interview with Nurse Aide (NA) #12 on 10/09/24 at 8:34 AM she stated Resident #2 did not have one on one supervision. In an interview with Nurse #3 on 10/9/24 at 9:07 AM she stated Resident #2 wandered the facility freely. She did not recall the resident ever having one on one supervision and did not know why that was noted on his current care plan. In an interview with Nurse #7 on 10/09/24 at 8:40 AM she stated she was not aware of a time Resident #2 had one on one supervision and did not know why it was in his current care plan. An interview with the Director Of Nursing (DON) #1 was conducted on 10/9/24 at 8:43 AM and she stated Resident #2 did not have one on one supervision. She further stated he had not had it in the 3 months she had been employed at the facility. DON #1 revealed care plans were reviewed every 3 months or when there is a change, and she did not know why one on one supervision was on his current care plan. An interview on 10/8/24 at 12:09 PM with the Social Worker (SW #1) revealed that she had only worked there for the last four months and did not recall a time Resident #2 had one on one supervision. She stated care plans were reviewed every 3 months and does not know why one on one supervision was on his current care plan. An interview on 10/8/24 at 2:38 PM with the Administrator revealed she did not recall a time Resident #2 had been on one on one supervision	F 657	review two residents weekly for two weeks and then four residents monthly for two months to ensure that care plans have been revised timely and residents are invited to participate in their care plan meeting. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. Alleged Date of Compliance 11/6/2024.	

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since she started working at the facility in June. She was unaware one on one supervision was included in his current care plan.

In an interview with the Physician on 10/14/24 at 10:25 AM he stated he did not recall a time Resident #2 had one on one supervision and did not know why that was included in his current care plan.

b. Resident #43 was admitted to the facility on 7/10/23 with diagnoses which included acute on chronic respiratory failure.

The quarterly Minimum Data Set dated 9/13/24 indicated that Resident #43 was cognitively intact.

An interview on 10/8/24 at 8:55 AM with Resident #43 revealed they had not been invited to a care plan meeting at any time since admission.

An interview on 10/8/24 at 12:09 PM with the Social Worker (SW #1) revealed that based on Resident #43's record, it appeared he had not had a care plan meeting since admission. She further revealed she had been employed there since July 2024. SW #1 stated Resident #43 had a meeting scheduled in two weeks and his letter would be hand delivered to him since he was his own responsible party. The SW indicated she was aware of the requirement to hold care plan meetings quarterly.

Attempts to reach SW #2, who handled care plan meetings before July 2024, were unsuccessful.

An interview on 10/8/24 at 2:38 PM with the Administrator revealed she was unaware that Resident #43 had not had a care plan meeting

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F 657	Continued From page 42	F 657		

quarterly. She had only been employed at the facility for 4 months.

c. Resident #11 was admitted to the facility on 9/11/23 with a diagnosis of muscle weakness.

A review of Resident #11's annual Minimum Data Set (MDS) assessment dated 8/11/24 revealed she was cognitively intact.

A review of Resident #11's care plan revealed it was dated last revised on 8/26/24.

On 10/7/24 at 2:03 PM an interview with Resident #11 indicated she did not recall being invited to attend a care plan meeting in some time. She stated had attended one a while ago and would go if she were invited because she felt attending these meetings was important.

On 10/8/24 at 4:12 PM an interview with Social Worker (SW) #1 indicated she would have been responsible for inviting Resident #11 to her care plan meeting. She stated the MDS Nurse provided her with a copy of the schedule according to each resident's MDS assessment, and she sent out the invitations to the meetings. She reported she could not find any documentation that a care plan meeting was conducted for Resident #11after her most recent MDS assessment in August 2024. SW #1 stated there should have been documentation this meeting occurred in Resident #11's record, and a meeting attendance signature sheet, but there was not. She went on to say she was not sure why the meeting had not occurred.

On 10/9/24 at 8:40 AM a telephone interview with MDS Nurse #1 indicated Resident #11 would

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F 657	Continued From page 43 have been due for a care plan meeting after her MDS assessment on 8/11/24. She stated she created the monthly care plan meeting schedule in conjunction with resident's MDS assessment dates and provided this to the SW. She went on to say she did not attend care plan meetings or follow-up to make sure they occurred. She reported there should be documentation in a resident's record, and a signature sheet indicating the occurrence of each care plan meeting, and who attended. On 10/10/24 at 2:01 PM an interview with the Director of Nursing indicated residents should be having a care plan meeting at least every 3 months and the resident and/or their representative should be offered the opportunity to participate in the meeting. She stated there should be documentation of these meetings in resident's records. On 10/10/23 at 11:20 AM interview with the Administrator indicated residents should be having a care plan meeting at least every 3 months and the resident and/or their representative should be offered the opportunity to participate in the meeting. She stated there should be documentation of these meetings in resident's records.	F 657		
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 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		11/6/24

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F 689	Continued From page 44 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to prevent a cognitively impaired resident from exiting the facility without staff knowledge for 1 of 8 residents reviewed for accidents (Resident #2). Resident #2 exited the building through a back door and was found by a staff member sitting outside in his wheelchair facing the door. Findings included: Resident #2 was admitted to the facility on 4/6/23 with diagnoses that included dementia. The quarterly Minimum Data Set dated 8/25/23 revealed Resident #2 was severely cognitively impaired and required supervision or touching assistance with wheelchair mobility. Resident #2 was not coded with wandering behaviors. The care plan for Resident #2, initiated on 4/7/23 and updated on 9/29/23, identified a problem of exit seeking and wandering. The goal was the resident would have no negative outcomes related to exit seeking or wandering through the next review. On 9/29/23 an intervention was added for a Wanderguard alarm system (a sensor worn by the resident that would remotely lock a door if the resident moved too close to the door). Weekly testing of the Wanderguard was added as well. An elopement risk assessment was completed for Resident #2 on 9/26/23 that identified him as at risk of elopement. A Wanderguard bracelet	F 689	1. Resident #2 continues to reside in the facility. 2. Resident #2 suffered no adverse effects as a result of the deficient practice. All residents at risk for elopement have the ability to be affected by the deficient practice. An audit was completed by the Director of Nurses (DON) or designee on 11/1/2024 to ensure that all elopement risk assessments have been completed and interventions are in place to pre- vent elopement. 3. The DON reeducated all staff to ensure that residents are assessed for elopement risk and have interventions in place when at risk for elope- ment. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4. The DON or designee will review two residents weekly for two weeks and then four residents monthly for two months to ensure that residents are assessed for the risk of elopement and interventions are in place to prevent elopement. Results of these audits will be presented to the Quality Assurance and Performance Improvement (QAPI)Committee for three months for review and, if warranted, further action. 5. Alleged Date of Compliance 11/6/2024.	

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was applied on 9/29/23.

A Nurse's progress note written on 10/29/23 by Nurse #2 stated the Administrative Assistant reported to Nurse #2 that she noticed Resident #2 outside when she went down the back hallway to clock out. The Administrative Assistant called staff for help, and they were able to safely return Resident #2 inside the facility. The Director of Nursing (DON) #2 was notified immediately, 30-minute safety checks were initiated immediately, and Resident #2 had no visible injuries.

An interview with the Administrative Assistant was conducted on 10/9/24 at 1:30 PM. She stated she was walking down the back hall on 10/29/23 at about 8:15 PM to clock out when she noticed Resident #2 sitting outside the back door. The door was at the end of the hall and next to the break room. The door had a key code lock system, but no Wanderguard system. She stated the door sometimes didn't close the whole way and it didn't alarm if it was left open for any length of time. The door was locked when she opened it to check on Resident #2. The Administrative Assistant further stated Resident #2 was in his wheelchair, a couple of feet from the door, facing the building, waiting to get back inside. He was facing away from the sidewalk that led to the parking lot. He was wearing a short-sleeved shirt, long pants, one sock and no shoes. It was not cold out. The Administrative Assistant revealed Resident #2 stated to her that he was outside looking for food, he was calm and stated he was fine. Resident #2 had a feeding tube and only allowed pureed foods and nectar thick liquids by mouth. She stated he was often looking for food as he did not like his ordered dietary restrictions.

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After the Administrative Assistant checked on Resident #2, she got Nurse Aide (NA) #7 to help her move him into the building. She stated she wasn't sure she was allowed to bring him in herself, so she went to get a member of nursing staff. The Administrative Assistant further stated there was no traffic in the parking lot as it was between shifts.

A review of the website Weather Underground revealed that on 10/29/23 at 8:15 PM the temperature was 63 degrees Fahrenheit with no precipitation or wind.

A witness statement by NA #7 dated 10/30/23 stated she last saw Resident #2 at about 8:30 PM at the nurses station in his wheelchair. NA #7 indicated she had gone into another resident's room and when she came out Resident #2 was no longer at the nurses station. She then heard the Administrative Assistant call for help at about 9:00 PM. NA #7 went to get Resident #2 from outside. She stated he came into the building with the resident without issue.

NA #7 was unavailable for interview.

A witness statement by Nurse #2 dated 11/1/23 stated she last saw Resident #2 at 8:00-8:15 PM at the Nurses station. She indicated it was about 8:30 PM when the Administrative Assistant came to tell her Resident #2 had been outside the back door. Nurse #2 revealed NA #7 brought him inside.

Nurse #2 was not available for interview.

In an interview with the Maintenance Director on 10/9/24 at 2:57 PM he stated on 10/29/23, the

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F 689	Continued From page 47	F 689		

double doors leading to the back door did not have a keypad lock system on them and that was how Resident #2 was able to access that area. He further stated he put a keypad lock on the double doors himself sometime at the end of 2023, but he was unable to produce the exact date. He did remember it was after Resident #2 had eloped on 10/29/23. The Maintenance Director revealed only the front door of the building had was connected to the a Wanderguard system.

An observation of the route from the Nurses station (there was only one route) to the back door was completed on 10/9/24 at 2:35 PM. Resident #2 passed four resident rooms, turned right and traveled approximately 50 feet to a set of double doors that lead to the staff break room, the laundry room and the back door. The double doors had a keypad lock. The back door was observed to be closed, locked and to require keypad entry on the inside and the outside of the building. The back door closed and locked on its own after opening. An observation of the building outside the back door revealed a sidewalk about 20 feet long leading to the parking lot at the side of the building.

A psychiatric note written on 10/30/23 by Nurse Practitioner (NP) #2 mentioned Resident #2 eloped from the building.

NP #2 was not available for interview.

In an interview with Administrator #1 on 10/10/24 at 10:19 AM, she stated she was not employed at the facility at the time of the elopement on 10/29/23.

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	345339	A. BUILDING _____ B. WING _____	C 10/15/2024

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F 689	Continued From page 48 Administrator #2, who was employed at the facility on 10/29/23, was not available for interview.	F 689		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Registered Nurse (RN) for 8 consecutive hours per day, 7 days per week for 9 of 163 days reviewed. Findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 3, 2024 (April 1-June 30, 2024) revealed the facility had no Registered Nurse (RN) coverage on 5/15/24, 5/25/24, 5/26/24, 6/1/24, 6/2/24, 6/8/24, 6/9/24, 6/22/24, and 6/23/24. There were no daily assignment schedules or daily nursing positing available for review for the	F 727	1. No RN on duty at least 8hrs. a day on 5/14/2024, 5/15/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/22/2024 and 6/23/2024. 2. There were no residents affected by the deficient practice. Audit was completed by the Administrator on 10/31/2024 to ensure 8hrs. of consecutive RN coverage each day. 3. Administrator educated staffing coordinator on 10/31/2024 to ensure 8hrs. of consecutive RN coverage each day. Additionally, all newly hired staff will be educated on these policies and practices during	11/1/24

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F 727	Continued From page 49 period that included May 2024 and June 2024. Review of payroll punches revealed no RN's worked any shift on 5/15/24, 5/25/24, 5/26/24, 6/1/24, 6/2/24, 6/8/24, 6/9/24, 6/22/24, and 6/23/24. a. The time sheets for 5/14/24 were reviewed and no RN had worked any shift on 5/14/24. b. The time sheets for 5/25/24 were reviewed and no RN had worked any shift on 5/25/24. c. The time sheets for 5/26/24 were reviewed and no RN had worked any shift on 5/26/24. d. The time sheets for 6/1/24 were reviewed and no RN had worked any shift on 6/1/24. e. The time sheets for 6/2/24 were reviewed and no RN had worked any shift on 6/2/24. f. The time sheets for 6/8/24 were reviewed and no RN had worked any shift on 6/8/24. g. The time sheets for 6/9/24 were reviewed and no RN had worked any shift on 6/9/24. h. The time sheets for 6/22/24 were reviewed and no RN had worked any shift on 6/22/24. i. The time sheets for 6/23/24 were reviewed and no RN had worked any shift on 6/23/24. In an interview with the facility Staffing Coordinator on 10/10/24 at 4:15 pm she stated she was hired 7/25/24 and started doing the schedule 8/1/24. She stated she had RN coverage 8 hours a day 7 days a week since she started doing the scheduling. She stated if she had a problem that the Assistant Director of Nursing (ADON) would cover the 8-hour shift. She further indicated that she was not here in May or June of 2024, and she could not locate the staffing assignment records or the daily staffing posting records for those months. In a interview on 10/10/24 at 4:30 pm with the	F 727	orientation. 4. The Administrator or designee will review two daily staffing sheets weekly for two weeks and then four daily staffing sheets monthly for two months to ensure RN coverage at least 8 consecutive hours per day. Results of these audits will be presented to the facility Quality Assurance and Performance Imporvement (QAPI) Committee for three months for review and, if warranted, further action. 5. Alleged Date of Compliance 11/1/2024.	

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F 727	Continued From page 50 Payroll and Human Resources Coordinator she verified by payroll punches that there was no RN coverage on the 9 dates reviewed. In an interview with the Administrator on 10/11/24 at 11:41 am she stated she was not employed by the facility in May or June of 2024 and she attempted but could not locate daily staffing schedules or daily nursing posting for that period. She further indicated that the facility should have had RN coverage for 8 consecutive hours 7days a week but could not account for a period that she was not here. She stated she had not had a problem with RN coverage since she was hired on 7/29/24. She stated if they had an RN callout, they used the ADON for coverage.	F 727		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to ensure a Resident #322 was driven to her physician's office in time to attend an 11:00 AM medical appointment. Resident #322 arrived one- and one-half hours late and the physician was unable to see her. The appointment had to be rescheduled for the following week. This deficient practice affected 1 of 1 sampled resident reviewed for medically related social services (Resident # 322). The findings included:	F 745	1. Resident #322 no longer resides at the facility. 2. All residents that have appointments have the ability to be affected by the deficient practice. An audit was completed by the administrator that all residents have been transported to their appointments on 11/1//2024. 3. All disciplinary team members will be reeducated by the Administrator to ensure residents are transported to their scheduled	11/1/24

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F 745	Continued From page 51 Resident #322 was admitted on 3/27/24 with diagnoses that included an acquired absence of her right leg. Resident #322's admission Minimum Data Set (MDS) assessment dated 4/3/24 revealed she was cognitively intact with no moods or behaviors. An interview was conducted with Resident #322 on 10/9/24 at 9:45 AM who stated she had an appointment on 4/16/24 at 11:00 AM to have the staples removed from her right leg. She stated she arrived at her appointment two hours late and the doctor could not see her. Her appointment was rescheduled for 4/22/24. She stated she was upset that she had to have staples in her leg for an additional week. An interview with the scheduler on 10/9/24 at 10:29 AM who stated she had been employed as the scheduler since 7/26/24. She reported she looked through the previous scheduler's paperwork and discovered Resident #322 missed an appointment on 4/15/24. The appointment was rescheduled on 4/22/24. An interview was conducted with an employee with the transportation company on 10/9/24 at 11:58 PM. The transporter arrived at the facility at 11:30 AM on 4/16/24. The transportation company employee stated the physician's office was contacted by the transportation company and they agreed to see Resident #322 late. The transportation company employee stated that when the transporter arrived at 12:36 PM on 4/16/24, the physician's office could not see Resident #322.	F 745	appointments. Additionally all newly hired staff will be educated on these policies and practices during orientation. 4. The Administrator or designee will review weekly for two weeks and then motnhly for two months that residents have been transported to their appointments. Results of these audits will be presented to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action. 5. Alleged Date of Compliance 11/1/2024.	

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F 745	Continued From page 52 An interview was conducted with the Administrator of the facility on 10/9/24 at 1:26 PM who stated the staff at the transportation company should have arrived to transport Resident #322 to her appointment at 10:00 AM on 4/16/24 in order for her to be seen for her scheduled appointment.	F 745		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interviews, the	F 761	1. The undated vial was discarded on	11/6/24

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F 761	Continued From page 53 facility failed to label and date an opened vial of influenza vaccine stored in the medication room refrigerator for 1 of 1 medication storage rooms reviewed. Finding included: An observation of the medication storage room was made on 10/9/24 at 8:40 am in the presence of the Assistant Director of Nursing (ADON). An opened 5 milliliter multidose vial of Flucelvax 2024-2025 influenza vaccine was in the refrigerator. The protective plastic cap/tab had been removed and the rubber stopper was noted to have needle entry marks. There was no open date or discard date marked on the vaccine vial. During an interview with the ADON on 10/09/24 at 8:50 am she stated the opened influenza vial should have been labeled with the nurse's initial, date opened, and a discard date that should have been 28 days after it was opened. She stated she did not know when the vial was opened but thought it was 2 weeks ago. The ADON discarded the opened, unlabeled vial. In an interview with the Administrator on 10/11/24 at 11:44 am she stated she expected all medications to be dated when opened with the date opened and a discard date. She stated she thought it was an oversight. In an interview with Director of Nursing on 10/11/24 at 12:05 pm she stated the opened influenza vial should have been labeled with an open date and expiration date at the time the seal was broken, and the vial was opened. She stated she was not sure why it had not been labeled and	F 761	10/9/2024. 2. No residents were affected by the deficient practice. All residents had the potential to be affected by the deficiency. The Director of Nurses (DON) completed an audit on 10/10/2024 to ensure that medications are stored properly. 3. The DON or designee will reeducate the licensed staff by 11/4/2024 that medications are to be stored appropriately. Additionally, all newly hired staff, will be educated on these policies and practices in orientation. 4. The DON or designee will reveiw weekly for two weeks and then monthly for two months that medicaitons are stored appropriately. Results of these audits will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee for three months for review and, if warranted, further action. 5. Alleged Date of Completion 11/6/2024.	

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F 761	Continued From page 54 dated when opened.	F 761		
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 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	F 883		11/6/24

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F 883	Continued From page 55 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, staff, and physician interviews the facility failed to provide a pneumococcal vaccine to a resident with a signed consent form to receive the vaccine. This was for 1 of 5 residents reviewed for immunizations (Resident #61). Findings included: Resident #61 was admitted to the facility on 5/14/24. A review of Resident #61's quarterly Minimum Data Set (MDS) assessment dated 8/20/24 revealed she was severely cognitively impaired. Her pneumococcal vaccine was not up to date because it had not been offered. A review Resident #61's Pneumococcal	F 883	1. Resident #61 received their pneumococcal vaccine on 10/1/2024. 2. The Director of Nurses or designee (DON) completed an audit on 11/1/2024 to ensure all residents have been offered the pneumococcal vaccine. 3. The DON or designee will reeducate the licensed staff by 11/4/2024 that residents are offered their pneumococcal vaccine. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4. The DON or designee willl review two residents weekly for two weeks and then four residents monthly for two months to ensure that residents have been offerd the pneumococcal vaccine. Results of these audits will be	

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F 883	Continued From page 56 Immunization Consent Form dated 9/10/24 revealed in part the date of Resident #61's last pneumococcal vaccination was unknown. It further revealed Resident #61's Responsible Party (RP) accepted pneumococcal vaccine immunization for Resident #61. A review of Resident #61's medical record did not reveal any evidence a pneumococcal vaccine had been administered to her since her admission to the facility. On 10/11/24 at 10:12 AM an interview with the Assistant Director of Nursing (ADON) indicated she assumed responsibility for the immunization of residents in August 2024. She stated when she took over this responsibility, she did an audit of all resident's pneumococcal immunization status, she found some residents had not received their pneumococcal vaccine and planned to get these up to date. She reported Resident #61 had not received her pneumococcal vaccine yet because when Resident #61's RP consented to the vaccine on 9/10/24 she did not have any pneumococcal vaccine in the building. The ADON stated it was her understanding that if she had ordered a pneumococcal vaccine for Resident #61 from the pharmacy, it would only have taken a day or 2 to get it delivered. She reported she had not ordered any of the pneumococcal vaccines. She went on to say she had been working on getting influenza vaccines offered to residents first before she moved on to the pneumococcal vaccine because influenza season was coming. She stated it was her understanding Resident #61's Physician wanted at least 2 weeks between the influenza and pneumococcal vaccines.	F 883	presented to the Quality Assurance and Performance Improvement (QAPI) committee for three months for review and, if warranted, furhter action. 5. Alleged Date of Compliance 11/6/2024.	

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F 883	Continued From page 57	F 883		

On 10/11/24 at 10:17 AM an interview with the Director of Nursing indicated she was involved in the plan to ensure all residents immunization status was brought up to date. She reported this plan involved obtaining consents for residents whose pneumococcal immunizations were not up to date including Resident #61. She went on to say although Resident #61's RP consented to have Resident #61 receive a pneumococcal vaccine on 9/10/24, the plan was to first obtain consents and administer the influenza vaccine on 10/1/24 because influenza season was coming, and then wait 2 weeks to administer the pneumococcal vaccine to residents who needed these. She stated it was her understanding Resident #61's Physician wanted at least 2 weeks between the influenza and pneumococcal vaccines.

On 10/11/24 at 11:20 AM an interview with the Administrator indicated Resident #61 should have been offered a pneumococcal vaccine upon her admission to the facility. She went on to say Resident #61 should have received a pneumococcal vaccine when the consent for this vaccine was obtained.

On 10/11/24 at 11:29 AM a telephone interview with Resident #61's Physician indicated it was good that the facility had completed an audit and implemented a plan to get resident's pneumococcal vaccines up to date. He reported while he liked to have a few days between administration of the influenza vaccine and the pneumococcal vaccine there was no reason why Resident #61 should not have already received a pneumococcal vaccine when her RP consented to one on 9/10/24. He stated it should not have taken a month.

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