STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345143	A. BUILDING ______ B. WING ______	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILER CITY CENTER	**900 W DOLPHIN STREET SILER CITY, NC 27344**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/4/24 through 11/7/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MQTZ11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 11/4/24 through 11/7/24.. Event ID# MQTZ11.The following intakes were investigated NC00211994, NC00219200, NC00214329, NC00215077 and NC00214970. Two of the eighteen complaint allegations resulted in a deficiency.	F 000		
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	F 550		12/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/25/2024

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 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident and staff interviews the facility failed to maintain the resident's dignity by not emptying urinals prior to lunch and as needed. This was evident for 1 of 4 residents (Resident #41) reviewed for dignity. Findings include: Resident #41 was admitted on 09/30/24. Review of the quarterly Minimum Data Set (MDS) dated 10/17/24 revealed Resident #41's cognition was moderately impaired. He required moderate assistance with toileting and dressing and minimal assistance with transfers. He was occasionally incontinent of bowel and bladder. Resident #41 had range of motion impairment to	F 550	Resident #41, Urinal in the resident's room was emptied and cleaned on 11/6/24. Audit was completed on 11/8/2024 by the Director of Nursing for all residents in the facility for identification of residents with urinals in use and disposal of contents prior to meals. Urinals were emptied prior to meals being served.. Education was initiated on 11/8/24 by Nurse Practice Educator for all licensed nurses and all certified nursing assistants to include (Full-time, Part-time, PRN and Agency) regarding ADL care and providing assistance with urinal and disposal of contents after use prior to meals. Any	

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F 550

Continued From page 2

both sides of his upper extremities.

An observation and interview were conducted with Resident #41 in his room on 11/04/24 at 10:39 AM. Resident #41 was observed laying on his bed watching TV. Two urinals were noted on the nightstand with urine in them. One with approximately 400 milliliters (ml) of yellow urine and one with approximately 250 ml of yellow urine. He stated the staff emptied them when they got a chance but sometimes the urinals sat there with urine in them for a while.

An observation and interview were conducted on 11/04/24 at 11:34 AM revealed the urinals with the same amount of urine were still on the nightstand. Resident #41 stated the urinals had not yet been emptied.

An observation and interview were conducted on 11/04/24 at 1:05 PM. An observation was made of Nursing Assistant #1 bringing Resident #41's lunch tray into his room and then exiting the room. She did not empty the urinals on the nightstand which still had urine in two of them. Nursing Assistant #1 indicated she did not see the urinals therefore she did not empty them.

An interview was conducted on 11/04/24 at 1:06 PM with Resident #41. He stated he would like for the urinals to be emptied more often. At least before he eats his meals because he felt it was unsanitary.

An interview was conducted with Nursing Assistant #2 on 11/04/24 at 1:15 PM. She verified she was the direct care Nursing Assistant for Resident #41. She stated she emptied Resident #41's urinals an hour ago. When Nursing

F 550

licensed nurse/certified nursing assistants including agency licensed nurses and certified nursing assistants that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses/certified nursing assistants and newly hired licensed nurses/certified nursing assistants will have this education during their orientation period by the Director of Nursing/designee

Director of Nursing, Assistant Director of Nursing, and Nurse Manager will complete an audit of 5 residents with urinals in use three times per week x 4 weeks to identify residents with urinals in use and disposal of contents prior to meals ; then 5 residents two times weekly x 4 weeks, then 5 residents weekly x 4 weeks. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance.

Date of compliance: 12/2/2024

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F 550	Continued From page 3	F 550		

Assistant #2 was asked to observe the urinals on the nightstand which were in the same place and had the same amount of urine in them as they did in the earlier observations, Nursing Assistant #2 walked away and refused to respond to the surveyor.

An observation on 11/06/24 at 10:25 AM in Resident #41's room revealed a urinal sitting on the nightstand that had approximately 300ml of yellow urine in it.

An observation and interview were conducted on 11/06/24 at 12:45 PM. Resident #41 was observed sitting in his wheelchair eating lunch in his room. There was a urinal sitting on the nightstand with approximately 300ml or yellow urine in it.

An observation and interview were conducted on 11/06/24 at 12:51 PM with Resident #41 in his room. He stated his urinal had not been emptied since that morning. He also stated "it's nasty" for the urinals to be sitting there so long and that they should at least be emptied before meals so it's not sitting there when he ate his meals. He further commented, "it won't do any good to say anything because as soon as you and I turn our backs it'll happen again".

An interview was conducted with Nursing Assistant #3 on 11/06/24 at 12:59 PM. She verified she was the direct care Nursing Assistant for Resident #41. When asked about when the last time she emptied the urinals she quickly turned away and entered Resident #41's room. She did not respond to the question. Nurse #2 was present at that time.

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F 550	Continued From page 4 An interview was conducted with Nurse #2 on 11/06/24 at 1:02 PM. He stated earlier in the shift he instructed Nursing Assistant #3 to make sure she kept Resident #41's urinals empty throughout her shift. He explained that Resident #41 requested the urinals to be emptied more often especially prior to his meals because he did not want to smell the urine while he ate. He indicated he had not looked at the urinals when he was in the room. An interview was conducted with the Director of Nursing (DON) on 11/06/24 at 1:12 PM. She stated she had reminded staff to make sure rounds were done to make sure Resident's urinals were empty. She explained she expected staff to empty urinals prior to meals being served and as needed. She indicated residents should not have to look at or smell urine in their rooms.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident and staff, the facility failed to assess and obtain a physician's order for the self-administration of medications found at bedside for 1 of 1 resident (Resident #58). The findings included: Resident #58 was admitted to the facility on 1/3/22 with diagnoses that included chronic	F 554	Medications were removed from the bedside of resident # 58 by Licensed Nurse on 11/4/2024. Resident # 58 was evaluated for self administering medication by the Director of Nursing on 11/19/2024. Resident # 58 is not clinically approved to self administer medications. Resident #58 is unable to recall medications names, dosage, and frequency. Resident #58 is unable to	12/2/24

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F 554 Continued From page 5

obstructive pulmonary disease (COPD), diabetes type 2, and hypertension.

A quarterly Minimum Data Set (MDS) assessment dated 8/16/24 indicated that Resident #58 was cognitively intact and displayed no behaviors or rejection of care.

A review of Resident #58's medical record did not reveal an order to self-administer medications.

On 11/4/24 at 10:30 AM, an observation was made of medications in a medication cup sitting on Resident #58's over the bed table. Resident #58 stated that the medication had been sitting there since his breakfast was delivered and that staff did not normally leave his medication sitting on the over the bed table. Resident #58's breakfast plate sitting on the over the bed table and Resident #58 stated he had completed his breakfast meal. He did not indicate he was going to take the medications.

An interview was conducted with Nurse #3 on 11/4/24 at 10:40 AM. She verified she was the nurse that left Resident #58's morning medication on the over the bed table for him to take. She stated, "He had them in his hand when I was in there." She returned to the room, Resident #58 stated he didn't want to take them at that time, Nurse #3 retrieved the medications and marked them as refused by Resident #58 on the Medication Administration Record (MAR). Nurse #3 further stated the medications should be secured and Resident #58 did not have an order to self-administer medications.

The medications left in the medication cup on the over the bed table included the following:

F 554

manage and secure medications.

An audit was completed on all resident rooms in the facility on 11/8/2024 by the Director of Nursing to observe for any medications at bedside. Any medications observed were removed from the resident room. After reviewing the policy for self administering medications and storing medications at bedside, no residents expressed desire to keep medications at bedside. All residents were agreeable to let the facility nurse store and administer medications as ordered.

Education was initiated on 11/8/24 by Nurse Practice Educator for all licensed nurses to include (Full-time, Part-time, PRN and Agency) on following the Policy and Procedure for self administering medications and medication storage at bedside. Education included that residents must have a physician order to keep medication at bedside, a self administering of medication evaluation indicating the resident is safe to administer and store medications, and a care plan must be in place indicating the resident is approved to self administer medications. Any licensed nurse (Full-time, Part-time, PRN, and Agency) that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of

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F 554	Continued From page 6 Amlodipine 10 milligrams (mg) 1 tablet, Cefdinir 300mg 1 tablet, Coreg 25mg 1 tablet, Divalproex 500mg 2 tablets, Entresto 49-51mg 1 tablet, Finasteride 5mg 1 tablet, Furosemide 20mg 1 tablet, Gabapentin 300mg 2 capsules, Levothyroxine 50 micrograms (mcg) 1 tablet, Metformin 500mg 1 tablet, Multivitamin 1 tablet, Senna Docusate 8.6-50mg 1 tablet and Sertraline 50mg 1 tablet. The Director of Nursing was interviewed on 11/4/24 at 12:37 PM and stated that medications should not be left at bedside unsecured unless the resident had an order for self-administration. She added that Resident #58 did not have an order for self-administration.	F 554	Nursing/designee Director of Nursing, Assistant Director of Nursing, and Nurse Manager will audit 5 resident rooms three times per week x 4 weeks to monitor for medications in resident rooms; then 5 resident rooms two times weekly x 4 weeks, then 5 resident rooms weekly x 4 weeks. The Director of Nursing will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance. Date of compliance: 12/2/2024	
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576		12/2/24

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F 576	Continued From page 7 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to deliver resident mail unopened for 3 of 7 residents reviewed for mail delivery (Resident #29, Resident #91, and Resident #100). The findings included: a. Resident #29 was admitted to the facility on 11/14/14. Resident #29's quarterly Minimum Data Set (MDS) assessment dated 10/10/24 revealed Resident #29 was cognitively intact. An interview on 11/05/24 at 10:24 AM with Resident #29 revealed that he had received	F 576	Resident # 29, #91, #100 were informed by the Social Service Director on 11/20/2024 that staff education was provided to all business office staff on resident□s right to include right to forms of communication with privacy. All cognitively intact residents receiving mail services shall receive unopened and untampered mail on delivery. The Social Services Director completed interviews with all cognitively intact residents on 11/20/2024 for identification of residents who have received opened mail addressed to them. Cognitively intact residents were notified that education was provided to all business office staff on	

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F 576	Continued From page 8 opened mail that was addressed to him. He stated that it had happened on more than one occasion but was unable to give specific dates. Resident #29 stated the mail that was opened was related to his financial status. b. Resident #91 was admitted to the facility on 12/07/21. Resident #91's annual MDS assessment dated 09/19/24 revealed Resident #91 was cognitively intact. An interview on 11/05/24 at 10:26 AM with Resident #91 revealed that she had received opened mail that was addressed to her. She stated that it had happened on more than one occasion but was unable to give specific dates. Resident #91 stated the mail that was opened was related to her financial status. c. Resident #100 was admitted to the facility on 08/06/24. Resident #100's quarterly MDS assessment dated 10/25/24 revealed Resident #100 was cognitively intact. An interview on 11/05/24 at 10:28 AM with Resident #100 revealed that she had received opened mail that was addressed to her. She stated that it had happened on more than one occasion but was unable to give specific dates. She also stated for staff to open her mail without her consent was against her rights. Resident #100 stated the mail that was opened was related to her financial status.	F 576	resident□s right to include right to forms of communication with privacy. All cognitively intact residents receiving mail services shall receive unopened and untampered mail on delivery. Education was provided to the business office staff on 11/8/2024 by the Administrator on resident rights including the right to forms of communication with privacy. All cognitively intact residents receiving mail services shall receive unopened and untampered mail on delivery. The Social Service Director and Social Worker audit resident□s mail distribution for Identification of residents who receive mail and ensure mail delivered unopened. 5 cognitively intact residents three times per week x 4 weeks, then two times per week x 4 weeks, then 5 residents weekly x 4 weeks. The Social Service Director will report the findings of the audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance. Date of compliance: 12/2/2024	

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F 576	Continued From page 9 During an interview on 11/05/24 at 3:02 PM with the Activity Director she revealed she delivered mail to the residents Monday through Friday. She explained that there had been times when she delivered mail that had been taped closed due to previously being opened. During an interview on 11/05/24 at 3:22 PM with the Business Office Manager (BOM), she verified that she handled mail that related to resident's financial aspects. She indicated mail that came to the business office was put in a box that was attached to her office door. She explained that she grabbed the stack of mail and opened all envelopes prior to looking at who the mail was addressed to. She stated if a resident's cognition was impaired, she opened their mail. If they were cognitively intact, she was not supposed to open their mail. When she opened mail in error, she taped it back closed, and had it delivered to the resident. She agreed she should not open any mail without verifying who it was addressed to. During an interview on 11/06/24 at 1:15 PM with the Administrator he stated he was unaware the mail addressed to cognitively intact residents had been opened prior to them receiving it and the mail should not be opened. He explained that the only time mail should be opened was if the mail was addressed to the facility or if the resident was cognitively impaired. He then indicated that employees should always follow the mail handling process.	F 576		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		12/2/24

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F 623	Continued From page 10	F 623		

Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 11 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility	F 623		

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	345143	A. BUILDING ______ B. WING ______	C 11/07/2024

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F 623	Continued From page 12 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the resident or Responsible Party (RP) written notification of the reason for a hospital transfer for 4 of 4 residents reviewed for hospitalization (Residents #22, #58, #111 and #132). The findings included: 1. Resident #22 was admitted to the facility on 1/8/24. Resident #22's medical record revealed she was transferred to the hospital on 4/15/24 and readmitted to the facility on 4/19/24 and transferred again to the hospital on 5/18/24 and readmitted to the facility on 5/25/24. There was no documentation that written notices of transfers were provided to the RP for the reasons for the transfers. A quarterly Minimum Data Set (MDS) assessment dated 10/9/24 indicated Resident	F 623	Written notice of discharge to the hospital was provided on 11/8/2024 by the Business Office Manager to the resident representative of residents #22, #58, #111, and #132. The Business Office Manager and Director of Nursing completed an audit on 11/8/2024 of all residents discharged to the hospital within the last 30 days. Written notification of the resident's discharge to the hospital including date, location, and reason was provided to the resident representative or the residents who were discharged to the hospital by the Business Office Manager on 11/8/2024. Education was provided to the Business Office Manager (BOM), Director of Nursing (DON), Assistant Director of Nursing(ADON), and Health Information Manager (HIM) by the Administrator on	

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F 623	Continued From page 13	F 623		

#22 had severely impaired cognition.

An interview occurred with Nurse #2 on 11/6/24 at 1:00 PM and explained when a resident was transferred to the hospital a copy of the face sheet, physician orders, medication list, DNR information and bed hold policy were sent with them. He was unaware of a written notice of transfer that was provided to the resident or RP.

On 11/5/24 at 3:10 PM, the Director of Nursing (DON) was interviewed and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information, physician's orders, medication list and the Bed Hold policy were sent when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and reason for the transfer. The DON stated a written notification of transfer was not sent to Resident #22's RP.

The Administrator was interviewed on 11/6/24 at 1:09 PM and stated he was unaware a written notification of transfer was not being sent to the RP and would expect the regulation to be followed.

2. Resident #58 was admitted to the facility on 1/3/22.

Resident #58's medical record revealed he was transferred to the hospital on 11/16/23 and readmitted to the facility on 11/23/23 and transferred again to the hospital on 3/24/24 and readmitted to the facility on 3/29/24. There was no documentation that written notices of transfers were provided to the resident or RP for the reasons of the transfers.

11/8/2024. Education included instructions on when a resident is discharged and admitted to the hospital a notification of transfer is either mailed to the resident representative or given to the resident if they are their own representative. The original copy is mailed to the responsible party or given to the responsible resident and a copy is maintained in the resident record.

The Business Office Manager(BOM) and Health Information Manager (HIM) will audit all hospital admissions 5 days per week for 3 months during the clinical meeting to ensure all discharge notices are provided to the resident representatives or residents. A copy will also be placed in the resident record. The BOM will report the findings of the resident representative / resident notification audits to the monthly Quality Assurance and Performance Improvement Meeting to ensure compliance x 3 months. The QAPI committee is responsible for ongoing compliance.

Date of compliance: 12/2/2024

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F 623	Continued From page 14	F 623		

A quarterly MDS assessment dated 8/16/24 indicated Resident #58 was cognitively intact.

An interview occurred with Nurse #2 on 11/6/24 at 1:00 PM and explained when a resident was transferred to the hospital a copy of the face sheet, physician orders, medication list, DNR information and bed hold policy were sent with them. He was unaware of a written notice of transfer that was provided to the resident or RP.

On 11/5/24 at 3:10 PM, the DON was interviewed and stated a copy of the face sheet, any DNR information, physician's orders, medication list and the Bed Hold policy were sent when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and reason for the transfer. The DON stated a written notification of transfer was not sent to Resident #58's RP.

The Administrator was interviewed on 11/6/24 at 1:09 PM and stated he was unaware a written notification of transfer was not being sent to the RP and would expect the regulation to be followed.

3. Resident #111 was admitted to the facility on 8/12/23.

Resident #111's medical record revealed he was transferred to the hospital on 12/5/23 and readmitted to the facility on 12/9/23, transferred to the hospital on 2/22/24 and readmitted to the facility on 3/5/24, and transferred again to the hospital on 5/7/24 and readmitted to the facility on 5/10/24. There was no documentation that written notices of transfers were provided to the resident or RP for the reasons of the transfers.

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F 623	Continued From page 15	F 623		

A quarterly MDS assessment dated 8/16/24 indicated Resident #111 had moderately impaired cognition.

An interview occurred with Nurse #2 on 11/6/24 at 1:00 PM and explained when a resident was transferred to the hospital a copy of the face sheet, physician orders, medication list, DNR information and bed hold policy were sent with them. He was unaware of a written notice of transfer that was provided to the resident or RP.

On 11/5/24 at 3:10 PM, the DON was interviewed and stated a copy of the face sheet, any DNR information, physician's orders, medication list and the Bed Hold policy were sent when a resident was transferred to the hospital. The RP would be notified by phone regarding the change and reason for the transfer. The DON stated a written notification of transfer was not sent to Resident #111's RP.

The Administrator was interviewed on 11/6/24 at 1:09 PM and stated he was unaware a written notification of transfer was not being sent to the RP and would expect the regulation to be followed.

4. Resident #132 was admitted to the facility on 09/06/24.

Resident #132's medical record revealed he was transferred to the hospital on 10/28/24. There was no documentation that written notices of transfers were provided to the RP for the reasons for the transfers.

An admission Minimum Data Set (MDS)

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F 623	Continued From page 16 assessment dated 09/13/24 indicated Resident #132's Resident #132 was cognitively intact. An interview was conducted with Nurse #6 on 11/07/24 at 4:23 PM. She indicated Resident #132 called 911 himself for transport to the hospital due to him not feeling well. He did not notify staff he was calling 911. She stated emergency medical services (EMS) arrived, took face sheet, list of medications, and DNR form and transported Resident #132 to the hospital per his request. She notified his power of attorney (POA), Hospice, and the Director of Nursing (DON) of the transfer. On 11/5/24 at 3:10 PM, the Director of Nursing (DON) was interviewed and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information, physician's orders, medication list and the Bed Hold policy were sent when a resident was transferred to the hospital. The responsible party (RP) would be notified by phone regarding the change and reason for the transfer. The DON stated a written notification of transfer was not sent to Resident #132's RP. The Administrator was interviewed on 11/6/24 at 1:09 PM and stated he was unaware a written notification of transfer was not being sent to the RP and would expect the regulation to be followed.	F 623		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 693		12/2/24

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F 693 Continued From page 17

enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations and staff interviews, the facility failed to administer water flushes via a feeding tube at the physician ordered flow rate for 1 of 2 residents reviewed with tube feedings (Resident #22).

The findings included:

Resident #22 was originally admitted to the facility on 1/8/24 with diagnoses that included dysphagia (difficulty swallowing) and presence of a feeding tube.

A quarterly Minimum Data Set (MDS) assessment dated 10/9/24 indicated Resident #22 rarely made herself understood and had severely impaired decision-making skills. She was coded as receiving 51% or more of her total calories through a tube feeding and an average

F 693

Water flush pump setting for resident # 22 was reset to the prescribed rate of 110 ml every 3 hours by the Director of Nursing on 11/5/2024.

Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an audit of all current residents receiving Enteral Nutrition to ensure feeding and water flush rates were set and running at the correct prescribed rate on 11/8/2024. Correct water flush rates were observed.

Education was initiated on 11/8/24 by Nurse Practice Educator for all licensed nurses to include (Full-time, Part-time, PRN and Agency) on ensuring residents receiving Enteral feeding with water flush are receiving correct Enteral Feeding and

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fluid intake of 501 cubic centimeters (cc) per day or more by tube feeding.

A review of Resident #22's active physician orders included an order dated 10/17/24 to flush the feeding tube with 110 milliliters (ml) of water every 3 hours during continuous feedings.

Resident #22's active care plan, last reviewed 10/25/24, revealed a focus area for an enteral feeding tube to meet nutritional needs. The interventions included to provide water as ordered.

An observation of Resident #22 on 11/5/24 at 8:35 AM, revealed her feeding tube was connected to a continuous bottle of formula with a standby bag of water. The water flush was observed to be running at 110 cc and the setting on the pump for frequency of the water flush was set at every 4 hours. Resident #22's lips were not dry or cracked in appearance.

An observation was made with Nurse #1 on 11/5/24 at 2:05 PM, of Resident #22's water flush setting on the tube feed pump. He acknowledged the settings for the water flush were set at a rate was at 110 ml and the frequency of the water flush was set at every 4 hours. After reviewing the physician orders, he verified the water flush order was for 110 ml every 3 hours. He was unable to state why the rate was different than the physician's order but would correct it on the feeding tube pump.

The Director of Nursing was interviewed on 11/5/24 at 3:10 PM and stated she expected water flushes to be at the prescribed rate.

F 693

water flush as ordered by physician. Any licensed nurse (Full-time, Part-time, PRN, and Agency) that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee

Director of Nursing, Assistant Director of Nursing, and Nurse Manager will complete an audit of all residents receiving Enteral feeding with water flush three times weekly x 4 weeks to ensure physician ordered water flush flow rates are set at the correct ordered rate, then two times weekly x 4 weeks, then weekly x 4 weeks. The Director of Nursing (DON) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance x 3 months. The QAPI committee is responsible for the ongoing compliance.

Date of compliance: 12/2/2024

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F 757	Continued From page 19	F 757		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and Medical Director and staff interviews, the facility failed to hold blood pressure medication as ordered by the physician for 1 of 6 residents reviewed for unnecessary medications (Resident #95). The findings included: Resident #95 was admitted to the facility on 3/5/22 with diagnoses that included low blood pressure (hypotension).	F 757	Resident #98 was discharged on 11/6/2024. Blood pressure medication was discontinued for resident #98 on 11/6/2024 by the physician. An audit was completed on 11/8/2024 by the Director of Nursing for all residents in the facility currently with a physician's order for Midodrine to ensure blood pressure parameters were ordered and followed.	12/2/24

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F 757	Continued From page 20 A review of Resident #95's active physician orders included an order dated 10/7/24 for Midodrine (a blood pressure medication) 10 milligrams (mg) one tablet by mouth three times a day for low blood pressure- take if systolic blood pressure is less than 120. A quarterly Minimum Data Set (MDS) assessment dated 10/14/24 indicated that Resident #95 was cognitively intact. The October 2024 and November 2024 Medication Administration Records (MARs) were reviewed and revealed Resident #95 had received Midodrine despite the systolic blood pressure (SBP) being greater than 120. - 10/9/24 at 1:00 PM the SBP was 122 and at 5:00 PM the SBP was 124. - 10/21/24 at 9:00 AM the SBP was 122, at 1:00 PM the SBP was 122 and at 5:00 PM the SBP was 122. - 10/24/24 at 9:00 AM the SBP was 122. - 11/1/24 at 9:00 AM the SBP was 121, at 1:00 PM the SBP was 121 and at 5:00 PM the SBP was 121. - 1/2/24 at 9:00 AM the SBP was 122 and the 5:00 PM SBP was 122. - 11/3/24 at 9:00 AM the SBP was 122, the 1:00 PM SBP was 122 and the 5:00 PM SBP was 122. - 11/5/24 at 9:00 AM the SBP was 134, the 1:00 PM SBP was 134 and the 5:00 PM SBP was 130. An interview was conducted with Nurse #5 on 11/6/24 at 12:56 PM. She was the nurse assigned to Resident #95 on 10/24/24, 11/1/24 and 11/3/24. The October 2024 and November 2024 MARs were reviewed with Nurse #5 who stated the medication should have been held per the parameter and felt it was an oversight.	F 757	Education was initiated on 11/8/24 by Nurse Practice Educator for all licensed nurses to include (Full-time, Part-time, PRN and Agency) on the medication administration procedures including the 5 rights of medication administration. Education also includes following physicians orders for medications orders written with parameters. Any licensed nurse (Full-time, Part-time, PRN, and Agency) that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee. Agency licensed nurses and newly hired licensed nurses will have this education during their orientation period by the Director of Nursing/designee Director of Nursing, Assistant Director of Nursing, and Nurse Manager will complete an audit of all residents receiving Midodrine three times weekly x 4 weeks to ensure parameters are being followed, then two times weekly x 4 weeks, then weekly x 4 weeks. The Director of Nursing (DON) will report the findings of the audits to the monthly QAPI Meeting to ensure compliance x 3 months. The QAPI committee is responsible for the ongoing compliance. Date of compliance: 12/2/2024	

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A phone interview was held with Nurse #3 on 11/6/24 at 3:30 PM, who was assigned to Resident #95 on 10/21/24. The October 2024 MAR was reviewed with Nurse #3 who stated the medication should have been held per the order and felt it was an oversight.

Attempts to contact Nurse #1 were made without success. He was assigned to Resident #95 on 11/5/24.

Attempts to contact Nurse #4 were made without success. She was assigned to Resident #95 on 10/9/24 and 11/2/24.

The Director of Nursing was interviewed on 11/7/24 at 8:52 AM who reviewed the October 2024 and November 2024 MARs. She stated she would expect the medication to be given as ordered.

A phone interview occurred with the Medical Director on 11/7/24 at 10:03 AM and stated if Resident #95 had received a few dosages of Midodrine outside the parameter it would not have caused any serious harm. The Medical Director added he would expect the nurses to follow the orders for the Midodrine as written.