STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345217	A. BUILDING _____ B. WING _____	C 04/24/2025

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/21/25 through 4/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #JVTP11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/21/25 through 4/24/25. Event ID# JVTP11. The following intake was investigated: NC00227825. 2 of the 2 complaint allegations did not result in 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 provision of services under the State plan for all residents regardless of payment source.	F 550		5/16/25

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

Electronically Signed | 05/12/2025

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F 550	Continued From page 1 §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 observation, record review, and staff interviews, the facility failed to treat a resident with dignity when a nurse aide did not sit while feeding a resident who needed assistance with meals for 1 of 2 dining observations (Resident #51). The reasonable person concept was applied as individuals have the expectation of being treated with dignity and would not want staff to stand over them while assisting with meals. Findings included: Resident #51 was admitted to the facility on 9/6/21. Her active diagnoses included dysphagia. Review of Resident #51's Minimum Data Set assessment dated 3/27/25 revealed she was assessed as severely cognitively impaired and totally dependent on staff for eating.	F 550	F550 Resident Rights/Exercise of Rights On 5/9/2025, Nurse Aide #4 (NA) was verbally educated by the Director of Nursing on dignity and respect with emphasis sitting at resident eye level and not standing when providing feeding assistance to a resident. On 5/7/2025, the Assistant Director of Nursing/designee initiated an audit of all residents requiring feeding assistance. This audit is to ensure all residents were treated with dignity and respect during meals with emphasis on staff sitting at resident eye level when providing feeding assistance and not standing. The Director of Nursing will address all concerns identified during the audit to include training of staff. This audit will be completed by 5/16/2025.	

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F 550	Continued From page 2 Review of Resident #51's care plan dated 4/21/25 revealed she was dependent on staff for eating. During observation on 4/23/25 at 1:06 PM Nurse Aide #4 was observed assisting Resident #51 with lunch. The nurse aide was standing next to Resident #51 who was seated in her specialized wheelchair with her bedside table in front of her with her meal tray. Nurse Aide #4 was not at eye level with the resident. A chair was available in the room and the nurse aide did not use it. During an interview on 4/23/25 at 1:12 PM Nurse Aide #4 stated they could sit or stand when providing assistance with meals. The nurse aide stated she felt like standing today but they could sit when assisting as well. During an interview on 4/23/25 at 1:19 PM the Director of Nursing stated staff were to sit when assisting residents with meals for dignity reasons. She stated some residents may not care but you never know what standing next to the resident while feeding them might imply to the resident, especially a person with dementia. Sitting puts staff at the resident's eye level and is more personable.	F 550	On 4/24/2025, the Staff Development Coordinator initiated an in-service with all nurses and nursing assistants (NA) to include NA #4 regarding Resident Rights with emphasis on treating residents with dignity and respect by sitting at resident eye level when providing feeding assistance. In-service will be completed by 5/12/2025. After 5/12/2025, any nurse or nursing assistant (NA) who has not received the in-service will complete it upon the next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Resident Rights. The Nurse Supervisor, ADON (Assistant Director of Nursing), and or Unit Managers will complete 10 resident care observations to include all mealtimes and resident # 51 x 4 weeks then monthly x 1 month utilizing the Resident Rights Audit Tool. This audit is to ensure staff treat residents with dignity and respect during mealtime by sitting at resident eye level when providing feeding assistance. The Nurse Supervisor, ADON and or Unit Managers will address all concerns identified during the audit to include retraining of staff. The Director of Nursing (DON) will review the Resident Rights Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the Resident Rights Audit Tool to the Quality Assurance Performance Improvement	

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F 550	Continued From page 3	F 550	Committee monthly x 2 months to review the Resident Rights Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring	
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 observations, record review, and resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of swallowing/nutritional status (Resident #39) and hospitalization (Resident #138). This was for 2 of 24 residents reviewed for accuracy of assessments. Findings included: 1. Resident #39 was admitted to the facility on 10/2/24. A review of an admission nursing progress note for Resident #39 dated 10/2/24 at 6:45 PM revealed in part he had a percutaneous endoscopic gastrostomy feeding tube (a PEG tube is a feeding tube placed into the stomach through the abdominal wall). A review of a physician's order for Resident #39 dated 10/2/24 revealed to flush his tube every 4 hours with 100 cubic centimeters (cc) of water (H2O).	F 641	641 Accuracy of Assessments On 5/12/2025, the Minimum Data Set (MDS) Coordinator completed a modification of the comprehensive assessment dated 3/14/25 for resident #39 to reflect accurate coding in the area of swallowing/nutritional status. On 4/23/2025, the Minimum Data Set (MDS) Coordinator completed a modification of the comprehensive assessment dated 2/10/25 for resident #138 to reflect accurate coding for discharge location. On 5/12/2025, the MDS Coordinator under the oversight of the MDS Consultant initiated an audit of all discharges from 2/1/25-5/12/2025. This audit is to ensure the resident was coded accurately for location of discharge on the MDS assessment section A. The DON will address all concerns identified during the	5/16/25

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F 641	Continued From page 4 A review of Resident #39's March 2025 Medication Administration Record (MAR) revealed documentation indicating 100 cc of H2O was administered via Resident #39's PEG tube every 4 hours at 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 6:00 PM on 3/6/25 through 3/14/25 except on 3/9/25 at 2:00 PM when it was held. A review of Resident #39's quarterly Minimum Data Set (MDS) assessment dated 3/14/25 revealed he was not coded for having a feeding tube on admission or while a resident. He was not coded for receiving fluid intake via feeding tube. On 4/23/25 at 2:01 PM an interview with the Dietary Manager (DM) indicated she would have been responsible for coding the Swallowing/Nutrition section of Resident #39's quarterly MDS assessment dated 3/14/25. She stated she was not aware that Resident #39 still had a PEG tube. On 4/23/25 at 3:39 PM an interview with the Director of Nursing (DON) indicated Resident #39's quarterly MDS assessment dated 3/14/25 should have accurately reflected the presence and use of his PEG tube. On 4/24/25 at 10:12 AM an interview with the Administrator indicated Resident #39's quarterly MDS assessment dated 3/14/25 should have been coded accurately at the time of the assessment. 2. Resident #138 was admitted to the facility on 1/21/25.	F 641	audit to include updating assessment when indicated and education of staff. The audit will be completed by 5/16/2025. On 5/9/2025, the MDS Coordinator under the oversight of the MDS Consultant initiated an audit of all residents utilizing a PEG tube most recent comprehensive, significant change assessments and/or quarterly MDS assessment section section K to ensure all MDS□s assessments completed are coded accurately for nutritional status. The DON will address all concerns identified during the audit to include updating assessment when indicated and education of staff. The audit will be completed by5/16/2025. On 5/14/2025, the MDS Consultant will complete an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinator regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis that all MDS assessments are completed accurately for swallowing/nutritional status and discharge location. All newly hired MDS Coordinators or MDS nurses will be in-service regarding MDS Assessments and Coding during orientation. 10% audit of newly completed MDS assessments utilizing the MDS Accuracy Audit Tool will be reviewed by the MDS Consultant/designee weekly x 4 weeks then monthly x 1 month to ensure accurate coding of the MDS assessment	

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F 641	Continued From page 5 A review of Resident #138's Discharge MDS assessment dated 2/10/25 revealed his discharge location to be a short term general hospital. A review of the discharge Nurse's note written by the Unit Manager dated 2/10/25 indicated Resident #138 was discharged with his belongings, medications, discharge paperwork and medication list. The Unit Manager was not available for interview. In an interview with the Director of Nursing (DON) on 4/23/25 at 8:55 AM she stated Resident #138 was discharged home on 2/10/25. MDS Nurse #1 was interviewed on 4/23/25 at 9:08 AM. MDS Nurse #1 stated she had miscoded Resident #138's Discharge MDS assessment as going to a short stay general hospital when he actually went home on 2/10/25. She stated the error was made unintentionally. An interview with the Administrator was conducted on 4/23/25 at 10:41 AM. She stated she expected Resident #138's Discharge MDS assessment to be coded that he went home from the facility on 2/10/25.	F 641	to include nutritional status and discharge locaiton. All identified areas of concern will be addressed immediately by the Director of Nursing/designee to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Audit Tool weekly x 4 weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The Quality Assurance Nurse (QA) nurse will forward the results of MDS Accuracy Audit Tool to the Quality Assurance Performance Improvement Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
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	F 656		5/16/25

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F 656	Continued From page 6	F 656		

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 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:

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F 656	Continued From page 7 Based on observation, record review, and resident, Responsible Party (RP) and staff interviews, the facility failed to implement the comprehensive care plan in the area of activities of daily living (Resident #27), and failed to develop an individualized, person-centered comprehensive care plan to include the use of a percutaneous endoscopic gastrostomy feeding tube (a PEG tube is a feeding tube placed into the stomach through the abdominal wall) (Resident #39), and the use of a noninvasive mechanical ventilator (a device to help with nighttime breathing for people with respiratory issues) (Resident #290 and Resident #71). This was for 1 of 5 residents reviewed for activities of daily living, 1 of 2 residents reviewed for tube feeding, and 2 of 4 residents reviewed for respiratory services. Findings included: 1. Resident #27 was admitted to the facility on 6/9/2014 with a diagnosis of intracerebral hemorrhage (bleeding in the brain). A review of Resident #27's annual Minimum Data Set (MDS) assessment dated 5/20/24 revealed he did not speak. Resident #27 was severely cognitively impaired. It was very important to have his family member involved in discussions about his care. His family member was the daily and activity preferences primary respondent. He had functional limitation of range of motion on both sides of his upper and lower extremities. He was dependent on staff for all transfers and mobility. His family member participated in his assessment and goal setting. A review of Resident #27's comprehensive care	F 656	F 656 Develop/Implement Comprehensive Care Plan On 4/24/2025, the resident#27 was assisted out of bed by the nursing assistant per resident preference. On 4/25/2025, the MDS Coordinator updated the care plan for resident #39 to accurately reflect the use of a percutaneous endoscopic gastrostomy feeding tube (PEG tube). On 4/23/2025, resident 290 was discharged to home from the facility. On 4/24/2025 , the resident #71 was discharged to home from the facility. On 5/7/2025, the MDS Coordinator/designee initiated an audit of all residents with PEG tubes, BiPAP, and CPAP. The care plan is person centered with measurable objectives and timeframes to meet the resident□s needs. The Director of Nursing will address all concerns identified during the audit to include updating the care plan when indicated and/or education of staff. The audit will be completed by 5/16/2022. On 5/7/2025, the Assistant Director of Nursing/Designee will complete 10 random resident audits to ensure the resident was out of bed per their preference. The Director of Nursing will address all concerns identified during the audit to include getting residents up by their care guide preference and the	

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F 656	Continued From page 8 plan dated last revised on 9/13/24 revealed a focus area for activities of daily living. The goal was for Resident #27's activities of daily living to be completed with staff support to maintain his highest level of functioning. An intervention was mobility dependent in Geri chair. The associated care guide revealed Resident #27 was to be up in his Geri chair by 10:00 AM and back to bed by 2:00 PM daily Monday through Friday. On 4/21/25 at 1:21 PM Resident #27 was observed in bed. No Geri chair was observed in his room. On 4/21/25 at 3:19 PM a telephone interview with Resident #27's RP indicated she participated in all his care plan discussions. She stated she had expressed her desire to have Resident #27 assisted up into his Geri chair daily. She went on to say she although she visited often, she had not really seen him up in his Geri chair regularly since Christmas. On 4/22/25 at 11:48 AM Resident #27 was observed in bed. No Geri chair was observed in his room. On 4/22/25 at 2:11 PM Resident #27 was observed in bed. No Geri chair was observed in his room. On 4/23/25 at 10:59 AM Resident #27 was observed in bed. No Geri chair was observed in his room. On 4/23/25 at 12:55 PM Resident #27 was observed in bed. No Geri chair was observed in	F 656	education of staff. The audit will be completed by 5/12/2025 On 5/6/2025, the Staffing Development Coordinator initiated an in-service with nurses regarding Care Plans with emphasis on the responsibility of the nurse to ensure the care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident□s medical, nursing, and mental/psychosocial needs to include use of PEG tubes, BiPAP, and CPAP. In-service will be completed by 5/12/2025. After 5/12/2025, any nurse who has not completed the in-service will be in-serviced prior to the next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Care Plans. On 4/21/2025, the Staffing Development Coordinator initiated an in-service with nurses and nursing assistant regarding Resident Preference with emphasis on following care plan for resident preferences to include but not limited to resident□s preferences for getting in and out of bed. In-service will be completed by 5/12/2025. After 5/12/2025, any nurse or nursing assistant who has not completed the in-service will be in-serviced prior to the next scheduled work shift. All newly hired nurses and nursing assistances will be in-serviced during orientation regarding Resident Preferences. The Assistant Director of Nursing will	

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F 656	Continued From page 9 his room. On 4/23/25 at 3:07 PM an interview with Nurse Aide (NA) #1 indicated she was assigned to care for Resident #27 on the 7:00 AM to 3:00 PM shift on 4/21/25. She reported she was familiar with Resident #27 and had cared for him previously. She stated she had not gotten Resident #27 up into a Geri chair on 4/21/24 because when she went to get him up, there had not been a Geri chair in his room. NA #1 stated that while she could have gone to the storage area to get one, she had not. On 4/23/25 at 1:05 PM an interview with NA #2 indicated he was assigned to care for Resident #27 on 4/22/25 on the 7:00 AM to 3:00 PM shift. He stated he had not gotten Resident #27 up into a Geri chair on 4/22/25. He reported he was familiar with Resident #27 and had cared for him previously. He reported that if Resident #27's family member came to visit and asked for Resident #27 to be up in a chair he would assist Resident #27. NA #2 stated while he did have access to Resident #27's care plan and care guide, he had not seen that it indicated Resident #27 should be up in his Geri chair daily. On 4/23/25 at 1:14 PM an interview with NA #3 indicated she was assigned to care for Resident #27 on the 7:00 AM to 3:00 PM shift on 4/23/25. She stated she was familiar with Resident #27 and had cared for him previously. She reported she had not gotten Resident #27 up into a Geri chair today. NA #2 indicated while she did have access to Resident #27's care plan and care guide that indicated he was to be assisted up into his Geri chair daily, she had not gotten him up yet because she had gotten busy with other things.	F 656	complete 10 Resident Care Observations tool weekly x 4 weeks, then monthly x 1, to ensure staff follow the resident□s care guide and preferences for activities of daily living, to include, but not limited to getting in and out of bed. The Director of Nursing will address all concerns identified during the audit to include re-training of staff. The Director of Nursing will review the Resident Care Observations Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The MDS Coordinator will review all newly identified residents with changes use of PEG tube, BiPAP, and CPAP x 4 weeks then monthly x 1 month using the Care Plan Audit Tool. This audit is to ensure the resident is care planned accurately for use of PEG tube, BiPAP, and CPAP, to ensure the care plan is person centered with measurable objectives and timeframes to meet the resident□s needs. The Director of nursing will address all concerns identified during the audit to include updating the care plan when indicated and/or re-training of staff. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Director of Nursing will forward the results of Resident Care Observation Tool and Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months for review and to determine trends and / or	

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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 656	Continued From page 10 On 4/23/25 at 3:39 PM an interview with the Director of Nursing (DON) indicated the NAs should be assisting Resident #27 up into a Geri chair in accordance with expressed preferences and his care plan. On 4/24/25 at 10:12 AM an interview with the Administrator indicated the NAs should be following resident's care plan and care guide when caring for resident's. 2. Resident #39 was admitted to the facility on 10/2/24 with a diagnosis of gastrostomy status. A review of an admission nursing progress note for Resident #39 dated 10/2/24 at 6:45 PM revealed in part he had a percutaneous endoscopic gastrostomy feeding tube (a PEG tube is a feeding tube placed into the stomach through the abdominal wall). A review of a physician's order for Resident #39 dated 10/2/24 revealed to flush his tube every 4 hours with 100 cubic centimeters (cc) of water (H2O). The resident had an oral diet ordered and did not receive routine nutrition via the PEG tube. A review of Resident #39's admission Minimum Data Set (MDS) assessment dated 10/8/24 revealed he had a feeding tube on admission, and while a resident. He received 501 cc per day or more of his average fluid intake per day via feeding tube. A review of the Care Area Assessment (CAA) on Resident #39's admission MDS assessment dated 10/8/24 revealed documentation indicating the CAA for feeding tube was triggered but not	F 656	issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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addressed in Resident #39's care plan.

A review of Resident #39's comprehensive care plan, dated last revised on 2/7/25, did not reveal a focus area for the use of a feeding tube nor mention of his use of a feeding tube to receive nutrition or hydration.

On 4/24/25 at 9:57 AM an observation of H2O flush via Resident #39's PEG tube by Nurse #2 was conducted.

On 4/23/25 at 2:01 PM an interview with the Dietary Manager (DM) indicated she was responsible for addressing Resident #39's use of a PEG tube on his admission MDS assessment dated 10/8/24. She reported that if the CAA for a feeding tube was triggered on the admission assessment, Resident #39's use of a feeding tube should have been reflected on his comprehensive his care plan. She stated she could not explain why it was not.

On 4/23/25 at 3:39 PM an interview with the Director of Nursing (DON) indicated Resident #39 had a PEG tube since his admission to the facility on 10/2/24. She stated if Resident #39's admission MDS assessment dated 10/8/24 reflected his use of a feeding tube and the CAA for this was triggered the DM should have included Resident #39's use of a feeding tube on his comprehensive care plan.

On 4/24/25 at 10:12 AM an interview with the Administrator indicated if Resident #39's admission MDS assessment dated 10/8/24 reflected his use of a feeding tube and the CAA for this was triggered, his use of a feeding tube should have been included on his comprehensive

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care plan.

3. Resident #290 was admitted to the facility on 4/3/25 with diagnoses that included acute and chronic respiratory failure.

The hospital discharge summary for Resident #290 dated 4/3/25 stated she needed to wear BiPAP machine (a device that delivers two levels of air pressure during inhalation and exhalation to help people with breathing difficulties) at night and with naps for obesity hypoventilation syndrome (a condition where a person breathes too shallowly, or their breathing is interrupted while sleeping due to obesity).

In an interview with Resident #290 on 4/21/25 at 2:56 PM she stated she needed the BiPAP machine at night to help her breathe while she was sleeping. Resident #290 further stated staff helped her put the mask on at night and she can remove it herself in the morning. Resident #290 indicated the BiPAP machine was delivered to her room on 4/4/25 and she had been using it nightly since then.

An interview with the Central Supply clerk was conducted on 4/23/25 at 8:38 AM. She stated Resident #290's BiPAP machine arrived on 4/4/25 and she delivered it to the resident's room herself.

A review of the delivery order for Resident #290's BiPAP was reviewed. The delivery order was dated 4/4/25.

Resident #290's Physician orders for the month of April 2025 revealed there was no order for BiPAP machine usage.

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Resident #290's comprehensive care plan dated 4/8/25 revealed no care plan that referenced BiPAP machine usage.

Resident #290's admission Minimum Data Set (MDS) dated 4/9/25 revealed she was cognitively intact and had active diagnoses of respiratory failure and pneumonia. The MDS did not code Resident #290 as using a BiPAP machine.

In an interview with the Minimum Data Set (MDS) Coordinator and MDS Nurse #2 on 4/22/25 at 2:27 PM they stated that comprehensive care plans were made by the MDS office based on the residents' MDS information. They further stated Resident #290 was not coded as using a BiPAP machine on her 5-day MDS assessment. MDS Nurse #2 indicated that when they go to make the care plan, a respiratory care section does not automatically populate. In this case, the MDS Nurse needed to either look back at the MDS assessment or rely on memory. MDS Nurse #2 revealed she was responsible for making the comprehensive care plan for Resident #290 and must have relied on memory as she missed adding the BiPAP machine usage.

An interview was conducted with the Administrator and Director of Nursing on 4/22/25 at 2:52 PM. They stated that Resident #290 should have had a care plan for use of the BiPAP machine. They indicated Resident #290's BiPAP machine was delivered on 4/4/25 and that nursing could have added to the care plan at any time.

4. Resident #71 was admitted to the facility on 3/24/25 with diagnoses that included sleep apnea (sleep disorder characterized by repetitive pauses

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in breathing or reduced airflow during sleep).

Resident #71's Physician orders for the month of April 2025 revealed there was no order for use of the CPAP machine.

In an interview with Resident #71 on 4/22/25 at 11:38 AM she stated she wore the CPAP machine at night due to a diagnosis of sleep apnea and that she brought it from home when she was admitted.

A nursing progress note dated 3/24/25 at 12:48 AM written by Nurse #3 stated Resident #71 was wearing her CPAP machine (CPAP- a machine that used mild air pressure to keep breathing airways open while sleeping).

Nurse #3 was not able to be reached for interview.

Resident #71 was observed using the CPAP machine while asleep on 4/22/25 at 8:45 AM.

Resident #71's comprehensive care plan dated 3/24/25 revealed no reference to CPAP machine usage.

Resident #71's 5-day Minimum Data Set (MDS) dated 3/30/25 revealed she was coded as needing a noninvasive mechanical ventilator (CPAP- a machine that used mild air pressure to keep breathing airways open while sleeping).

In an interview with the Minimum Data Set (MDS) Coordinator and MDS Nurse #1 on 4/22/25 at 2:48 PM they stated that comprehensive care plans were made by the MDS office based on the residents' MDS information. They further stated

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F 656	Continued From page 15 Resident #71 was coded as using a CPAP machine on her 5-day MDS assessment. MDS Nurse #1 indicated that when they go to make the care plan, a respiratory care section does not automatically populate. In this case, the MDS Nurse needed to either look back at the MDS assessment or rely on memory. MDS Nurse #1 revealed she was responsible for making the comprehensive care plan for Resident #71 and must have relied on memory as she missed adding the CPAP machine usage. An interview was conducted with the Administrator and Director of Nursing on 4/22/25 at 2:52 PM. They stated that Resident #71 should have had a care plan for use of the CPAP machine. They indicated Resident #71 brought her CPAP from home when she was admitted to the facility and that nursing could have added to the care plan at any time.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff and Medical Director interviews the facility failed to obtain a physician's order for the use of a BiPAP machine (a device that delivers	F 695	F 695 Respiratory/ Tracheostomy Care and Suctioning On 4/22/25, the assigned nurse received	5/16/25

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F 695	Continued From page 16 two levels of air pressure during inhalation and exhalation to help people with breathing difficulties) (Resident #290) and a physician's order for use of a CPAP machine (a machine that used mild air pressure to keep breathing airways open while sleeping) (Resident #71). The facility also failed to administer oxygen by tracheostomy (a surgical opening in the neck for breathing) in accordance with the Physicians order (Resident #39). This was for 3 of 4 residents reviewed for respiratory care (Resident #290, Resident #71 and Resident #39). Findings included: 1. Resident #290 was admitted to the facility on 4/3/25 with diagnoses that included acute and chronic respiratory failure. The hospital discharge summary for Resident #290 dated 4/3/25 stated she needed to wear a BiPAP machine (a device that delivers two levels of air pressure during inhalation and exhalation to help people with breathing difficulties) at night and with naps for obesity hypoventilation syndrome (a condition where a person breathes too shallowly, or their breathing is interrupted while sleeping due to obesity). A review of Resident #290's Physician orders for the month of April 2025 revealed there was no order for BiPAP machine usage. Review of Resident #290's Admission Minimum Data Set (MDS) dated 4/9/25 revealed she was cognitively intact and had active diagnoses of respiratory failure and pneumonia. The MDS did not code Resident #290 as using a BiPAP machine.	F 695	a physician order for resident #290 to use a Bilateral Positive Airway Pressure (BiPAP) machine at night and during naps. On 4/22/25, the assigned nurse received a physician order for resident #71 to use a Continuous Positive Airway Pressure (CPAP) machine at night and during naps. On 4/25/25, the assigned nurse received an updated physician order for resident #39 to use oxygen at 4 liters/minute via nasal cannula to keep oxygen saturation rates greater than 90%. The Unit Manager validated on 5/8/2025 he was receiving oxygen per the physician order. Resident #39 was assessed by the Physician on 4/23/2025, resident #39□s oxygen saturation level was greater than 90%, with no adverse effects noted. On 5/7/2025, the Assistant Director of Nursing/Designee initiated an audit of all residents with supplemental oxygen orders, residents using a BiPAP, or residents using CPAP. This audit is to ensure all residents utilizing oxygen, BiPAP, or CPAP had a current order indicating the type of delivery system for the supplemental oxygen, the oxygen flow rate, and oxygen was administered via the route per physician order. The Director of Nursing addressed all concerns identified during the audit to include but not limited to clarification with the physician for a resident need for supplemental oxygen to include the use BiPAP, CPAP, oxygen flow rates, and to ensure oxygen was	

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F 695	Continued From page 17 The BiPAP machine was observed at Resident #290's bedside on 4/21/25 at 2:56 PM. In an interview with Resident #290 on 4/21/25 at 2:56 PM she stated she needed the BiPAP machine at night to help her breathe while she was sleeping. Resident #290 further stated staff helped her put the mask on at night and she can remove it herself in the morning. Resident #290 indicated the BiPAP machine was delivered to her room on 4/4/25 and she had been using it nightly since then. In an interview with the Administrator and Director of Nursing on 4/22/25 at 2:53 PM they stated they did not know why Resident #290 did not have a Physician's order for use of the BiPAP machine, but that one should have been requested from the Medical Director or Nurse Practitioner on call when she was admitted. The Medical Director was interviewed on 4/23/25 at 11:43 AM. The Medical Director indicated he often does not see new admissions for a day or two after they arrive. He further indicated any orders needed would have been requested before he saw the resident. He stated he was unaware Resident #290 was using a BiPAP machine as those orders were not requested by nursing. 2. Resident #71 was admitted to the facility on 3/24/25 with diagnoses that included sleep apnea (sleep disorder characterized by repetitive pauses in breathing or reduced airflow during sleep). Resident #71's Physician orders for the month of April 2025 revealed there was no order for use of	F 695	administered per physician order. The Staff Development Coordinator will correct and/or education of staff if concerns are identified during the audit. The audit will be completed by 5/22/25. On 5/6/2025, the Staff Development Coordinator initiated an in-service with all nurses regarding Oxygen Orders/ Respiratory Assessment with emphasis on ensuring residents utilizing supplement oxygen have an order in place for supplemental oxygen, BiPAP/ CPAP, and oxygen is administered per physician orders. The in-service will be completed by 5/12/25. After 5/12/25, any nurse who has not worked or completed the in-service will complete it at the next scheduled work shift. All newly hired nurses will be in-serviced by the Staff Development Coordinator during orientation. The Assistant Director of Nursing/Designee will review 5 residents receiving supplement oxygen, using BiPAPs, or using CPAPs weekly x 4 weeks then monthly x 1 month utilizing the Respiratory Audit Tool. This audit is to ensure all residents utilizing oxygen, BiPAP, or CPAP have an order in place and oxygen is administered per physician orders. The Director of Nursing will address all concerns identified during the audit to include clarifying orders when indicated and administering oxygen per physician orders and/or re-training of staff. The Director of Nursing (DON) will review the Respiratory Audit Tool weekly x 4	

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F 695	Continued From page 18 the CPAP machine. Review of a Nursing progress note dated 3/24/25 at 12:48 AM written by Nurse #3 stated Resident #71 was wearing her CPAP machine (CPAP- a machine that used mild air pressure to keep breathing airways open while sleeping). Nurse #3 was not able to be reached for interview. Review of Resident #71's 5-day Minimum Data Set (MDS) dated 3/30/25 revealed she was coded as using a noninvasive mechanical ventilator in the form of a CPAP machine. Resident #71 was observed using the CPAP machine while asleep on 4/22/25 at 8:45 AM. In an interview with Resident #71 on 4/22/25 at 11:38 AM she stated she wore the CPAP machine at night due to a diagnosis of sleep apnea and that she brought it from home when she was admitted. An interview was conducted with the Administrator and Director of Nursing on 4/22/25 at 2:52 PM. They stated that nursing should have requested an order for CPAP machine usage from the Medical Director or on-call Nurse Practitioner when Resident #71 was admitted. The Medical Director was interviewed on 4/23/25 at 11:43 AM. The Medical Director indicated he often does not see new admissions for a day or two after they arrive. He further indicated any orders needed would have been requested before he saw the resident. He stated he was unaware Resident #71 was using a CPAP	F 695	weeks and then monthly x 1 month to ensure all concerns are addressed. The DON will forward the Respiratory Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months for review to determine issues and trends to include continued monitoring frequency.	

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machine as those orders were not requested by nursing.

3. Resident #39 was admitted to the facility on 10/2/24 with a diagnosis of tracheostomy status.

A review of a current physician's order for Resident #39 dated as initiated on 12/12/24 revealed to administer 4 liters (L) of oxygen (O2) per minute via tracheostomy to maintain Resident #39's O2 saturations above 90 percent (%).

A review of Resident #39's quarterly Minimum Data Set (MDS) assessment dated 3/14/25 revealed he was moderately cognitively impaired. His vision was adequate. He had no functional limitation in range of motion of his upper extremities. Resident #39 had functional limitation in range of motion of his lower extremities on both sides. He received oxygen therapy and tracheostomy care.

A review of Resident #39's comprehensive care plan dated last reviewed on 4/11/25 revealed a focus area dated last revised on 10/15 24 for ineffective breathing pattern related to tracheostomy with O2 at 3L per minute via nasal cannula (NC). The goal was for Resident #39 to verbalize understanding of his disease process, treatments and the importance of compliance through the next review. An intervention was oxygen therapy at 3L via NC as ordered.

On 4/21/25 at 2:44 PM an observation of Resident #39 in his room revealed he was receiving O2 via NC at 3L per minute. He was not in any respiratory distress.

On 4/22/25 at 2:12 PM an observation of

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Resident #39 in his room revealed he was receiving O2 via NC at 3L per minute. He was not in any respiratory distress.

On 4/23/24 at 11:02 AM an observation of Resident #39 in his room revealed he was receiving O2 via NC at 3L per minute. He was not in any respiratory distress. In an interview with Resident #39 at that time he stated the correct rate for his O2 was 4L.

A review of Resident #39's Medication Administration Record (MAR) for April 2025 revealed documentation by Nurse #2 indicating Resident #39 was receiving O2 at 4L via his tracheostomy on the 7:00 AM to 3:00 PM shift on 4/21/25, 4/22/25, and 4/23/25 and his O2 saturations were 95%.

On 4/23/25 at 12:56 PM an interview with Nurse #2 revealed she was assigned to care for Resident #39 on 4/21/25, 4/22/25, and 4/23/25 on the 7:00 AM to 3:00 PM shift. She stated she was very familiar with Resident #39 and had been his regular day shift nurse since November 2024. She reported Resident #39 was receiving O2 at 3L per minute via a NC. When asked to look at the current physician's order for Resident #39, she stated the current physician's order was for O2 at 4L per minute via his tracheostomy. She reported her documentation on his MAR for 4/21/25, 4/22/25, and 4/23/25 indicated she had verified he was receiving 4L per minute via tracheostomy when she checked his O2 saturation on her shift. Nurse #2 went on to say at one time Resident #39 had been receiving O2 via his tracheostomy, but he wouldn't keep it on. She stated she should have called Resident #39's medical provider to get his O2 order changed, but

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she just hadn't thought about it. She reported Resident #39 had not experienced any respiratory distress and his O2 saturations had remained above 90 %.

On 4/23/25 at 1:20 PM an interview with the Medical Director indicated he was familiar with Resident #39 and was his facility physician. He stated Resident #39 liked to do things his way, and he didn't have any problem with that. He reported he would have gladly changed Resident #39's O2 order to 3L per minute via NC if someone had let him know this was Resident #39's preference, although he did not recall anyone asking for this. The Medical Director stated Resident #39's O2 saturation had been stable, and he did not feel Resident #39 had experienced any harm from wearing his O2 at 3L per minute via NC rather than 4L per minute via his tracheostomy.

On 4/23/25 at 1:46 PM an interview with the MDS Coordinator indicated he was involved in the revision of Resident #39's care plan focus area for ineffective breathing on 10/15/24. He stated he recalled a discussion about Resident #39's preference for his O2 being 3L per minute via NC. He went on to say he had not been involved in the review of Resident #39's care plan focus area for ineffective breathing on 4/11/25.

On 4/23/25 at 1:48 PM an interview with MDS Nurse #1 indicated she had participated in the review of Resident #39's care plan focus area for ineffective breathing on 4/11/25. She stated she should have updated this area to reflect that Resident #39's preference for O2 was 3L per minute via NC as that was not actually what the physician's order was.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

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F 695	Continued From page 22 On 4/23/25 at 3:39 PM an interview with the Director of Nursing (DON) indicated Resident #39 did not like to wear his O2 via his tracheostomy collar and preferred to wear it via NC. She stated Nurse #1 should have called a medical provider and gotten Resident #39's O2 order changed. She reported his care plan focus area for ineffective breathing should have reflected wearing O2 at 3L per minute via NC was Resident #39's preference rather than as ordered. On 4/24/25 at 10:12 AM an interview with the Administrator indicated with regards to medical issues like O2 rates and routes she would have to defer to her nursing staff. She stated she did feel Nurse #1 should have called a medical provider and gotten the O2 order changed rather than just documenting on Resident #39's MAR verifying he was receiving his O2 at 4L per minute via his tracheostomy if he was not.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident	F 700		5/16/25

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F 700	Continued From page 23 representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to attempt alternatives, assess entrapment risk, review risks and benefits and obtain informed consent prior to installing and utilizing bilateral quarter length side rails for 1 of 1 resident reviewed for side rails (Resident #290). Findings included: Resident #290 was admitted to the facility on 4/3/25 with diagnoses that included acute and chronic respiratory failure. Resident #290's 5-day Minimum Data Set (MDS) assessment dated 4/9/25 revealed she was cognitively intact and had impairment to bilateral upper and lower extremities. The MDS further revealed she needed substantial to maximum assistance with bed mobility. Resident #290 was observed lying in her bed with bilateral quarter length side rails in the raised position on 4/21/25 at 11:15 AM. In an interview with Resident #290 on 4/21/25 at 11:15 AM she stated she needed the side rails for bed mobility and positioning.	F 700	F700 Bedrails On 4/23/25, the Staff Development Coordinator completed a Physical Device Use Evaluation assessment for resident #290□s bed. The assessment included the risks of use for the resident, initiating appropriate interventions, therapy referral as indicated, risks/benefits of bed rails discussed with the resident or resident representative (RR) prior to installing bedrails, and consent obtained. On 5/7/2025, the Assistant Director of Nursing/Designee initiated 100% audit of all residents utilizing bed rails to identify any resident at risk for entrapment and to ensure appropriate interventions initiated to include removal of bed rails and initiation of alternatives if indicated. The Unit Manager and assigned hall nurse will address all concerns identified during the audit to include ensuring any resident utilizing bed rails has been assessed for risk for entrapment, appropriate interventions were initiated to include removal of bed rails if indicated, risks/benefits of bed rails	

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F 700	Continued From page 24 A review of Resident #290's electronic medical record (EMR) revealed she was her own Responsible Party (RP). The EMR further revealed no evidence that the following was completed prior to the installation and usage of bilateral quarter length side rails: attempt alternatives, assess entrapment risk, review risks and benefits and obtain informed consent. An observation was conducted on 4/22/25 at 1:45 PM. Resident #290 was observed lying in her bed with bilateral quarter length side rails in the raised position. Resident #290 was observed lying in bed with bilateral quarter length side rails in the raised position on 4/23/25 at 2:50 PM. An interview with Nurse #1 on 4/23/25 at 11:28 AM she stated she was the admitting nurse for Resident #290 on 4/3/25. Nurse #1 indicated she did not do side rail assessments as they were completed by the Unit Manager. The Unit Manager could not be reached for interview. In an interview with the Director of Nursing (DON) on 4/23/25 at 12:34 PM she stated Nurse #1 should have completed the side rail assessment for Resident #290 upon admission. She further stated all Nurses were expected to complete all forms in the admissions packet when admitting a new resident to their hall. An interview was conducted with the Administrator on 4/23/25 at 2:49 PM. The Administrator stated that Resident #290 should	F 700	discussed with the resident or RR prior to installing bed rails, and RR notified, and consent obtained. Audit will be completed by 5/16/2025. On 4/23/2025 the Staff Development Coordinator initiated an in-service with all nurses regarding Bed Rails with emphasis on assessment of resident for risk of entrapment, initiating appropriate interventions, therapy referral, appropriate installation of bed rails and notification of Resident Representative (RR). In-service will be completed by 5/12/2025, After 5/12/2025, any nurse who has worked and received the in-service will complete it upon the next scheduled work shift. All newly hired nurses will be in-serviced by the Staff Facilitator during orientation regarding Bed Rails. 10% audit of residents utilizing bed rails will be completed by the Assistant Director of Nursing/Designee, utilizing the Bed Rail Audit Tool weekly x 4 weeks, then monthly x 1. This audit is to ensure any resident utilizing bed rails has been assessed for risk for entrapment, appropriate interventions were initiated to include removal of bed rails if indicated, care plan and care guide updated for use of bed rails, risks/benefits of bed rails discussed with the resident or RR prior to installing bed rails, and RR notified, and consent obtained. The Unit Manager and assigned hall nurse will address all areas of concern identified during the audit to include assessment of resident for risk of entrapment, initiating appropriate	

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F 700	Continued From page 25 have had a side rail assessment completed upon admission. She was unsure who was responsible for this task.	F 700	interventions, therapy referral as indicated, risks/benefits of bed rails discussed with the resident or RR prior to installing bed rails and notification of RR of use of bed rails and/or removal or bed rails. Director of Nursing will review the Bed Rail Audit Tool weekly x 4 weeks, then monthly x 1 to ensure all areas of concern were addressed. The DON will present the findings of the Bed Rail Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 1 months and review the Bed Rail Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		5/16/25

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F 842	Continued From page 26	F 842		

(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;

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F 842	Continued From page 27 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to maintain an accurate medical record with regards to documentation of actual oxygen (O2) administration rate and route. This was for 1 of 4 residents (Resident #39) reviewed for the accuracy of medical records related to respiratory care. Findings included: Resident #39 was admitted to the facility on 10/2/24 with a diagnosis of tracheostomy status. A review of a current physician's order for Resident #39 dated as initiated on 12/12/24 revealed to administer 4 liters (L) of oxygen (O2) per minute via tracheostomy to maintain Resident #39's O2 saturations above 90 percent (%). On 4/21/25 at 2:44 PM an observation of Resident #39 in his room revealed he was receiving O2 via NC at 3L per minute. He was not in any respiratory distress. On 4/22/25 at 2:12 PM an observation of Resident #39 in his room revealed he was	F 842	F842 Resident Records-Identifiable Information On 5/8/25, the assigned nurse received an updated physician order for resident #39 to use oxygen at 4 liters/minute via nasal cannula to keep oxygen saturation rates greater than 90%. The LPN Unit Manger validated he was receiving oxygen per the physician order. Resident #39 was assessed by the physician on 4/23/2025, resident #39□s oxygen saturation level was greater than 90%, with no adverse effects noted. On 5/8/2025, the Staff Development Coordinator verbally educated Nurse #2 on Documentation with emphasis it is the responsibility of the nurse to complete documentation accurately and timely this includes but is not limited to documentation of oxygen administration to include flow rate/route of administration. On 5/7/2025 the Assistant Director of Nursing/Designee initiated an audit of all	

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F 842	Continued From page 28 receiving O2 via NC at 3L per minute. He was not in any respiratory distress. On 4/23/24 at 11:02 AM an observation of Resident #39 in his room revealed he was receiving O2 via NC at 3L per minute. He was not in any respiratory distress. In an interview with Resident #39 at that time he stated the correct rate for his O2 was 4L. A review of Resident #39's Medication Administration Record (MAR) for April 2025 revealed documentation by Nurse #2 indicating Resident #39 was receiving O2 at 4L via his tracheostomy on the 7:00 AM to 3:00 PM shift on 4/21/25, 4/22/25, and 4/23/25 and his O2 saturations were 95%. On 4/23/25 at 12:56 PM an interview with Nurse #2 indicated she was assigned to care for Resident #39 on 4/21/25, 4/22/25, and 4/23/25 on the 7:00 AM to 3:00 PM shift. She stated she was very familiar with Resident #39 and had been his regular day shift nurse since November 2024. She reported Resident #39 was receiving O2 at 3L per minute via a NC. When asked to look at the current physician's order for Resident #39, Nurse #1 stated the current physician's order was for O2 at 4L per minute via his tracheostomy. She reported her documentation on his MAR for 4/21/25, 4/22/25, and 4/23/25 7:00 AM to 3:00 PM shift indicated she had verified he was receiving 4L per minute via tracheostomy when she checked his O2 saturation on her shift. Nurse #2 went on to say at one time Resident #39 had been receiving O2 via his tracheostomy, but he wouldn't keep it on. She stated she should not have documented on Resident #39's MAR verifying he was receiving his O2 at 4L per minute	F 842	residents with supplemental oxygen orders or residents utilizing supplemental oxygen. This audit is to ensure all residents utilizing oxygen had a current order indicating flow rate and oxygen was administered per physician order. The Director of Nursing addressed all concerns identified during the audit to include but not limited to clarification with the physician resident need for supplemental oxygen to include flow rate, route, and monitoring parameters, ensuring oxygen was administered per physician orders with documentation in the electronic record. The audit will be completed 5/16/25. An in-service was initiated on 5/6/2025 by the Staff Development Coordinator with all nurses regarding Documentation with emphasis was placed on it is the responsibility of the nurse to complete documentation accurately and timely this includes but is not limited to documentation of oxygen administration to include flow rate/route of administration. In-service will be completed by 5/12/2025. After 5/12/2025, any nurse who has not worked or completed the in-service will complete it at the next scheduled work shift. All newly hired nurses will be in service during orientation by the Staff Development Coordinator regarding Following Physician Orders and Documentation. 5 residents to include resident #39 physician□s orders will be compared to the MAR and an observation completed of	

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F 842	Continued From page 29 via his tracheostomy if he was not. On 4/23/25 at 3:39 PM an interview with the Director of Nursing (DON) indicated Resident #39 did not like to wear his O2 via his tracheostomy collar and preferred to wear it via NC. She stated Nurse #1 should have called a medical provider and gotten the O2 order changed and not documented on Resident #39's MAR verifying he was receiving his O2 at 4L per minute via his tracheostomy if he was not. On 4/24/25 at 10:12 AM an interview with the Administrator indicated Nurse #1 should have called a medical provider and got the order changed rather than just documenting on Resident #39's MAR verifying he was receiving his O2 at 4L per minute via his tracheostomy if he was not.	F 842	oxygen administration route and rate by the Assistant Director of Nursing/designee weekly x 4 weeks, then monthly x 1 month utilizing the Transcription/ Documentation Audit Tool. This audit is to ensure that all orders were transcribed accurately to the MAR and is being documented on the MAR after administered. The nurses will be retrained by the Staff Development Coordinator for any identified areas of concern. The Director of Nursing will review and initial the Transcription/Documentation Audit Tool weekly x 4 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed. The Director of Nursing will forward the results of the Transcription/Documentation Audit Tools to the Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/16/25

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F 880	Continued From page 30 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 31 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement their policy for enhanced barrier precautions (EPB) when Nurse #4 failed to wear a gown when providing tracheostomy (a surgical opening in the neck for breathing) care for Resident #27 and when Nurse #5 and Nurse #6 failed to wear a gown during a high contact care activity that included transfer and the provision skin care and hygiene for Resident #39 who had a tracheostomy. This was for 3 of 8 staff members observed for infection control practices. This had the potential to result in the risk of multidrug-resistant organism (MDRO) transmission. Findings included: A review of the facility's policy titled "Enhanced Barrier Precautions" dated last revised on 6/13/24	F 880	F 880 Infection Prevention & Control On 4/22/2025, the QI/Infection Control Preventionist in-serviced nurse #4 regarding Enhanced Barrier Precautions (EBP) to include the use of personal protective equipment (PPE) while providing tracheostomy care. On 4/23/2025, the QI/Infection Control Preventionist in-serviced nurse #5 and nurse #6 regarding Enhanced Barrier Precautions (EBP) to include the use of personal protective equipment (PPE) while providing care in rooms identified as requiring Enhanced Barrier Precautions. On 5/7/2025 the Assistant Director of Nursing/Designee initiated 15 random resident care observations with all staff to	

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F 880	Continued From page 32 revealed in part the following: "Enhanced Barrier Precautions are used in conjunction with standard precautions to reduce the risk of MDRO transmission during high-contact resident care activities. It includes the use of both gown and gloves. Enhanced Barrier Precautions apply to residents with any of the following: Presence of an indwelling medical device with or without the presence of an MDRO infection or colonization. Examples of indwelling medical devices: Tracheostomies. Resident care activities that are considered high contact include but are not limited to: Transferring. EBP should be utilized for transfers under the following circumstances: Providing hygiene." 1. On 4/22/25 at 4:05 PM a continuous observation of tracheostomy care was conducted for Resident #27 with Nurse #4. Personal Protective Equipment (PPE) supplies including gowns were observed outside Resident #27's room. An EBP sign was observed over the head of Resident #27's bed. Nurse #4 was observed to perform hand hygiene and don (apply) clean gloves prior to the start of the procedure. She was not wearing a gown. At 4:17 PM Nurse #4 was observed to remove Resident #27's tracheostomy collar, and as she attempted to remove Resident #27's tracheostomy inner cannula she was stopped and asked to step outside Resident #27's room. Nurse #4 replaced Resident #27's tracheostomy collar at 4:17 PM, remove her soiled gloves and performed hand hygiene at which time the continuous observation ended. On 4/22/25 at 4:18 PM an interview with Nurse #4 was conducted in the hall outside Resident #27's room. Nurse #4 indicated she had not been	F 880	include all shifts. This audit is to ensure staff were utilizing appropriate use of PPE when in rooms designated as requiring isolation precautions to include but not limited to EBP. The nurse supervisors and/or the DON will address all concerns identified during the audit to include education of staff. The observations will be completed by 5/16/25. On 4/22/2025 the Staff Development Coordinator initiated an in-service with all nurses, medication aides, and nursing assistants regarding Enhanced Barrier Precautions with emphasis on donning/doffing PPE while providing direct patient care to include tracheostomy care and high contact activities, to any resident identified as requiring EBP. In-service will be completed by 5/12/25. After 5/12/25, any staff who have not worked or received the in-service will complete it prior to the next scheduled work shift. All newly hired nurses, medication aides, and nursing assistants will be in-service by the Staff Development Coordinator regarding Enhanced Barrier Precautions with emphasis on donning/doffing PPE while providing high contact direct patient care. The Infection Preventionist/QA Nurse and/or Staff Facilitator will complete 10 Resident Care Audits weekly x 4 weeks then monthly x 1 month. This audit is to ensure staff utilize appropriate PPE when providing tracheostomy care and when in rooms designated as requiring isolation precautions to include but not limited to EBP. The Infection Preventionist will	

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	345217	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER NURSING AND REHABILITATION CENTER	225 WHITE STREET JACKSONVILLE, NC 28546

(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 880	Continued From page 33 wearing a gown when she was performing tracheostomy care for Resident #27. She stated she had received education on the use of EBP for residents who had tracheostomies, and there were PPE supplies including gowns outside Resident #27's room. She reported EBP precautions were designed to prevent the spread of germs to Resident #27 during his tracheostomy care. Nurse #4 stated she did usually wear a gown during this care but had been nervous and had forgotten. On 4/23/25 at 3:39 PM an interview with the Director of Nursing (DON) indicated she had been made aware of the concern that Nurse #4 had not adhered to EBP precautions when providing tracheostomy care to Resident #27 on 4/22/25. She stated while Nurse #4 had previously received education on the use of EPB precautions, she had been reeducated immediately after the incident. The DON stated Nurse #4 should have been wearing a gown during Resident #27's tracheostomy care to prevent the spread of microorganisms to Resident #27. On 4/24/25 at 10:12 AM an interview with the Administrator indicated Nurse #4 should have followed EPB which included wearing a gown while performing tracheostomy care to Resident #27 to prevent the potential spread of microorganisms. 2. On 4/23/25 at 11:02 AM a continuous observation of skin care for a rash and abrasion was conducted for Resident #39 with Nurse #5 and Nurse #6. An EBP sign was observed at the entry of Resident #39's room. PPE including gowns were	F 880	address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the Resident Care Audits weekly x 4 weeks and then monthly for 1 month to ensure all identified areas of concern have been addressed. The Director of Nursing will forward the results of the Resident Care Audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 880	Continued From page 34	F 880		

observed on the treatment cart. Nurse #5 and Nurse #6 were observed to perform hand hygiene and apply clean gloves prior to entering Resident #39's room. Resident #39 was observed to have a tracheostomy. Nurse #5 was observed to assist Resident #39 to transfer to a standing position and use a washcloth with soap and water to wash Resident #39's inner thighs and buttocks, rinse and dry the area. Nurse #6 was then observed to apply a barrier cream to the same area. While applying the cream to Resident #39's inner thigh and buttocks area, the right arm sleeve of Nurse #6's shirt was observed to contact the skin of Resident #39's back. Neither Nurse #5 nor Nurse #6 were observed to be wearing a gown during the activity. At 11:10 AM Nurse #5 and Nurse #6 were observed to remove their soiled gloves, perform hand hygiene, and exit Resident #39's room at which time the continuous observation ended.

At 11:10 AM, in the hall outside of Resident #39's room, an interview was conducted with Nurse #5 and Nurse #6. Nurse #5 stated she had previously received education of the importance of EBP for residents who had an indwelling device such as a tracheostomy like Resident #39 did to prevent the potential spread of microorganisms, and she usually did wear a gown, but she had just not been thinking about it this time. She stated there were gowns available in the treatment cart outside Resident #39's room. Nurse #6 stated she did not usually wear a gown when providing skin treatments to Resident #39, because sometimes it made him nervous.

On 4/23/25 at 3:39 PM an interview with the Director of Nursing (DON) indicated she was not aware of any issues with Resident #39 being

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F 880	Continued From page 35	F 880		

nervous about staff wearing gowns when performing activities that required the use of EBP, and this was not currently reflected on his care plan. The DON stated if that were the case, she would expect the nurse to provide education to Resident #39 regarding the reason and importance of EBP, and if he was still resistant, the nurse should report this to her so she could speak with Resident #39. The DON indicated all nursing staff had been educated on the facility's EBP policy and should be adhering to this when providing care to residents such as Resident #39 who had a tracheostomy.

On 4/24/25 at 10:12 AM an interview with the Administrator indicated nurses should be adhering to the facility's EBP policy when providing care to residents.