STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. BUILDING _____ B. WING _____	C 03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION HEALTH CENTER AT BRIGHTMORE	10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277

(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 survey was conducted on 03/11/24 through 03/26/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #37C911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 03/11/24 through 03/26/24. The following intakes were investigated NC00196669, NC00196693, NC00198943, NC00201521, NC00203669, NC00204817, NC00209001, NC00209368, NC00209389, NC00209711, NC00210049, NC00210458, NC00210543, NC00210663, NC00210927, NC00211643, NC00211762, NC00211790, NC00211819, NC00212062, NC00212443, NC00213496, NC00213571, NC00213679, NC00214526, NC00214686, NC00214687, and NC00214810. Intakes NC00209001, NC00210049, NC00214526, NC00214687, and NC00214810 resulted in immediate jeopardy. Thirty-six (36) of the 70 complaint allegations resulted in deficiencies. Past-noncompliance was identified at: CFR 483.15 at tag F602 at scope and severity D. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at scope and severity J CFR 483.45 at tag F760 at scope and severity J. Tags F600 and F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 03/09/24 and was removed on 03/19/24. An extended survey was	F 000		

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

Electronically Signed | 04/19/2024

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F 000	Continued From page 1 conducted.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be	F 550		4/16/24

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F 550	Continued From page 2 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, resident, and staff interviews, the facility failed to treat a resident (Resident #198) with dignity and respect when Nurse Aide #12 treated her roughly during personal care, causing her to cry. Resident #198 was observed to have pinkened areas at the creases of the thighs where the brief comes up between the legs. This was for 1 of 13 residents reviewed for dignity. The findings included: 1. Resident #198 was admitted to the facility on 2/27/24 with diagnoses that included a recent fracture of the left shoulder, polyneuropathy, and dementia. A review of the care plan dated 2/27/24 indicated assistance of two with activities of daily living (ADL's) and transfers, selfcare performance deficit related to impaired cognitive function/Dementia or impaired thought processes related to Dementia. A review of the Minimum Data Set dated 3/7/24 revealed Resident #198 was cognitively intact and received, substantial to maximum assistance with toileting, moderate to maximum assist with positioning and transfers, and was incontinent of bowel and bladder. An observation of the Skin assessment dated	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F550 Resident Rights/Exercise of Rights Corrective action for resident(s) affected by the alleged deficient practice: For resident #198- On 3/15/2024 24 hour/5 day were completed and submitted to State report agency. Resident assessed on 3/15/24 by Unit Manager and QA Nurse Consultant with no issues noted. MD notified of redness to inguinal areas and gave clarification order for NutraShield Barrier Cream to be applied to inguinal folds and buttocks. Psych evaluated on 3/15/24. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be	

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F 550	Continued From page 3 3/12/24 indicated there were not any skin concerns identified. An interview on 03/14/24 at 6:22 AM revealed Resident #198 in her bed crying. Resident stated she was tired of being treated rough, especially at night. She further stated Nurse Aide (NA) #7 jerked the brief off her roughly and did not clean her with a wipe but put the dry brief on. She continued to say she was hurting and burning between her legs. Resident #198 further stated that she asked for her call light. NA # 7 tossed the call light near her on the bed without attaching it to the bedding. Resident #198 further stated that when NA #7 worked with her, she was always rude and rough, and she had to wait a long time for her call light to be answered. Nurse #12 was informed 3/14/24 at 6:34 AM by this surveyor that Resident #198 complained of NA #7 being rough with her and she was burning and hurting in her thigh creases. Nurse #12 indicated Resident #198 had not been anxious or upset during the night when he was present. He further stated he was not aware of any issues during the night, until now. He further indicated he would go and apply cream for her. An interview with NA #12 on 3/14/24 at 6:48 AM revealed that Resident #198 was not assigned to her but to NA #7, but she would assist. An observation occurred of Resident #198. She had an odor of urine when the brief was unfastened, as well as pink areas in the leg creases of the thighs, on both sides where the brief had been. Resident #198 then indicated by touch the places where she was hurting and burning. NA #12 cleaned the resident and applied a dry brief after Nurse #12 put Nystatin cream to the affected	F 550	affected by the alleged deficient practice. Beginning 4/11/2024, the Director of Nurses (DON) and Assistant Director of Nursing (ADON) completed body audits of all current residents with BIMS if 12 or less to identify any signs of staff being rough during care and interviewed all current residents with BIMS of 13 or higher to identify any concerns related to staff being rough during care. The results identified no other resident affected by alleged deficient practice. This was completed by 4/12/2024 Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning 4/11/2024, the Director of Nursing began education of all full time, part time, PRN (as needed), and agency staff on facility policy related to ADL Care, Call Bells, Care Needs Requirements and Resident Rights. The Director of Nursing will ensure that any of the above identified staff (all staff including agency) who does not complete the in-service training by 4/15/2024 will not be allowed to work until the training is completed.This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or Designee will	

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F 550	Continued From page 4 areas, per standing order. Unit Manager #2 on 03/14/24 at 7:00 AM, was advised by this surveyor, that Resident #198 was crying. The Resident revealed that the aide was rough and rude with her. She further revealed that NA #7 jerked the brief off her and replaced the brief without wiping her with the wipe. She was further informed that Resident #198 stated that she was burning and hurting between her legs. She further revealed that she would inform the Director of Nursing of the complaint. An interview with NA #7 3/14/24 7:11 AM revealed she had not been rude to the resident, or rough. She stated that the resident did ask for cream and was told that Nurse #12 needed to add the cream to her skin. A review of the skin assessment dated 3/14/24 5:17 PM revealed no new skin areas. An interview with Resident #198 on 03/15/24 at 10:29 AM revealed that she did not want Aide #7 to care for her again. An interview with the Director of Nursing on 3/15/24 at 11:57 AM revealed Aide #7 had been suspended pending investigation. He further stated it was his expectations that the staff would not be rough or rude to the Residents. He further indicated that Unit Manager #2 was completing the paperwork and had called her.	F 550	monitor compliance beginning the week of 4/22/2024 utilizing the F550 Resident Rights Quality Assurance Tool weekly x 4 weeks then monthly x 2 months or until resolved to assure that residents are receiving incontinence care and that they are being treated in a dignified manner while care is being provided. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Assistant Dir of Nursing, Staff Development, MDS Coordinator, Therapy Manager, Activities Director, Social Worker, and Environmental Services Director. Date of Compliance: 4/16/2024	
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect	F 557		4/16/24

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F 557	Continued From page 5 and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to honor a resident's right to keep personal equipment in his room per his preference. This failure occurred for 1 of 2 sampled residents reviewed for personal property (Resident #36). The findings included: Resident #36 was admitted to the facility on 11/15/23. Resident #36 was his own responsible party. A quarterly Minimum Data Set (MDS) assessment dated 1/6/24 assessed Resident #36 with intact cognition, adequate hearing, adequate vision, clear speech, understood by others and able to understand others. Resident #36 was interviewed and observed on 3/11/24 at 11:48 AM. He stated that he ordered an ice cream maker online about one to two months ago and that he used it to make ice and ice cream for himself and his roommate. During the interview, an ice cream maker was observed in his room available for use. Nurse #8 documented in a progress note dated 3/11/24 that around 11:30 PM, she responded to a call for help from Resident #36 after a fall. The	F 557	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F557 Respect, Dignity/Right to have Personal Property 1. Corrective action for resident(s) affected by the alleged deficient practice: On 03/13/24, resident #36□s ice cream maker was returned to the resident 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 4/15/24, audit was completed by the maintenance director to ensure all stored items were returned to the residents timely. No issues identified from audit	

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F 557	Continued From page 6 NP was contacted, and Resident #36 was sent to the emergency room (ER) for further evaluation. Unit Manager #2 recorded a progress note dated 3/12/24 at 2:23 PM that Resident #26 returned to the facility from the ER with no new orders. During a follow up interview with Resident #36 on 3/13/24 at 1:10 PM, Resident #36 stated that he returned from the ER on 3/12/24 and when he got back to his room, his ice cream maker was gone. Resident #36 further stated "They just took it, no one told me, and I don't know why they took it" and stated that he wanted his ice cream maker back. An interview with the Maintenance Director occurred on 3/13/24 at 2:00 PM and revealed that Resident #36 had an ice cream maker in his room that he used for about 1 month. The Maintenance Director stated he checked the ice cream maker before it was used to make sure it was safe to operate in the facility. The Maintenance Director further stated that Resident #36 went to the ER and returned to the facility on 3/12/24. While Resident #36 was gone, the Maintenance Director stated that he removed the ice cream maker from his room as part of a decluttering plan the Resident agreed to and placed it in storage. The Maintenance Director stated that Resident #36 did not identify the ice cream maker as an item he wanted removed from his room as part of the declutter plan, and that he did not ask his permission before it was removed. The Maintenance Director further stated that he thought it was best to remove the ice cream maker while Resident #36 was gone. The Maintenance Director stated that he should have asked Resident #36 first before removing	F 557	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: All staff were re-educated by the Administrator by 4/15/24 on rights to personal property personal possessions, including furnishings and clothing. No employee is allowed to work until training is completed. All newly hired employees will be provided training on personal property, personal possessions, including furnishings and clothing. 100% audit of all residents in the facility was completed by the Maintenance director, Social work, Human Resources and Central supply on 4/16/24 to ensure that all residents know their right to have personal property as long as it does not infringe upon the rights or health and safety of other residents. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F557 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The tool will monitor reports of personal property being in residents possessions. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance.	

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F 557	Continued From page 7 the ice maker from his room while he was away from the facility. A phone interview with the Administrator and Regional Quality Assessment and Assurance Nurse Consultant occurred on 3/16/24 at 5:01 PM. The Administrator stated that Resident #36 had a conversation with staff about organizing his room and that she thought that while he was in the ER recently that staff should remove it to determine if the ice cream maker was a fire hazard. She stated that she was not aware that the Maintenance Director had already assessed the ice cream maker before it was used and determined that it was not a fire hazard. After further thought, the Administrator stated that she was not in support of removing the ice cream maker from Resident #36's room without his permission. The Administrator further stated that staff should have given Resident #36 a call to notify him that the ice cream maker was being removed since it was removed from his room while he was in the ER.	F 557	The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/16/2024	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		4/16/24

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F 584	Continued From page 8 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure residents wheelchairs were in good repair for 2 of 2 residents reviewed for environmental concerns (Residents #54 and #94). The findings included: A. An observation was made on 3/11/24 at 11:30 AM of Resident #54 seated in her wheelchair in	F 584	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged	

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F 584	Continued From page 9 her room. The right armrest of the wheelchair had a two inch piece of orange tape with 1 inch of yellow foam exposed. B. An observation was made on 3/11/24 at 10:15 AM of Resident #94 while she was lying in bed. Her wheelchair was observed pulled up next to her bed. The left armrest of the wheelchair had two inches of exposed yellow foam. On 3/13/24 at 8:31 AM, an interview occurred with the Maintenance Director, who stated he was responsible for the maintenance of wheelchairs. If staff found a problem, they were to fill out the maintenance work orders, and he addressed it. He observed Resident #54 and #94's wheelchair armrests with the exposed foam. The Maintenance Director stated if he had been aware of the condition of the armrests, he would have switched them out. The Administrator was interviewed on 3/14/24 at 12:31 PM and stated it was her expectation for wheelchairs to be in good repair.	F 584	deficiencies cited have been or will be corrected by the dates indicated. F584 Safe, Clean, Comfortable/Homelike Environment 1. Corrective action for resident(s) affected by the alleged deficient practice: On 03/13/24, resident #94□s and resident #54□s wheelchair armrest was replaced with new armrests. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: 100% audit of all current residents□ wheelchairs in the facility was completed by the Maintenance director, Social Workers, Human Resources and Central supply on 4/15/2024 to ensure that all wheelchairs were in good repair. Any wheelchairs that were not in good repair were reported to maintenance director and fixed per policy. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: Beginning 4/11/2024, all staff were re-educated by the Administrator and Nursing leadership on recognizing wheelchairs that need to be repaired and where and who to report it to. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has	

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F 584	Continued From page 10	F 584	been sustained. The facility specific in-service will be provided to the above identified. Any of the above identified staff who does not receive scheduled in-service training by 4/15/2024 will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F584 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The tool will monitor reports of wheelchair issues. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/16/2024	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 600		3/27/24

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PAVILION HEALTH CENTER AT BRIGHTMORE	10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277

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F 600	Continued From page 11 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, family interviews and staff interviews the facility failed to protect Resident #28 from neglect when he was not administered scheduled nebulizer treatments (medical device that delivers liquid directly into the lungs) as ordered by Hospice despite repeated requests. Resident #28 had a diagnosis of chronic obstructive pulmonary disease with oxygen use and had orders for nebulizer treatments at 9:00 am, 11:00 am, 1:00 pm and 5: 00 pm during the 7:00 am to 7:00 pm (day shift). Resident #28 reported he was only administered one nebulizer treatment during the day shift on 3/9/24 and 3/10/24 and experienced chest pain on 3/9/24. In addition, Resident #28 stated during the day shift on 3/9/24 when he requested a dietary supplement he was told there were not any. No vital signs were documented on the day shift on 3/9/24. Resident #28 reported he experienced chest pain on 3/9/24, felt belittled and that staff were retaliating against him because he had filed a complaint about care. In addition, on 3/10/24 the facility neglected to provide incontinence care and assistance with activities of daily living for Resident #17 when requested by a family member. Resident #17	F 600	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F600 Free from Abuse and Neglect Corrective action for affected residents. For Resident#17, On 3/11/2024, Resident assessed by Unit Manager. No acute distress noted. NA#14 suspended pending investigation. Initial Allegation Report submitted to state reporting agency. MD, RP, Police and Adult Protective Services were notified. For resident #28- Resident #28 has diagnoses including COPD with respiratory failure, CHF and Anxiety. Resident #28 was not administered scheduled nebulizer treatments as	

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had severe cognitive impairment and when the family member arrived had a wet brief, was wearing a t-shirt and was partially covered by a blanket. Care was not provided until later in the afternoon when a second family member arrived and requested assistance. This deficient practice occurred for 2 of 3 residents reviewed for neglect (Resident #28 and Resident #17).

Immediate jeopardy began on 3/9/24 when the facility neglected to provide necessary care and services for Resident #28. Immediate jeopardy was removed on 3/19/24 when the facility provided and implemented an acceptable credible allegation of Immediately Jeopardy removal. The facility remains out of compliance at a lower scope and severity of G (actual harm that is not Immediate Jeopardy) for example # 2 and to complete education and ensure monitoring systems put into place are effective related to neglect.

The findings included:

1. Resident #28 was admitted to the facility on 2/23/24 with diagnoses inclusive of chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (GERD), heart failure, hypertension, and anxiety.

An admission MDS assessment dated 3/1/24 indicated Resident #28 was cognitively intact, was receiving hospice care and required maximal assistance with toileting, showering, and dressing. The assessment further indicated rejection of care 1-3 times and use of oxygen.

A care plan dated 2/26/24 indicated Resident #28 was care planned for the following:

ordered by Medication Aide #1 despite repeated requests on 03/09/2024 and 03/10/2024 during the 7am to 7 pm shift.
Interview with Hospice nurse revealed Resident #28 reported to her that he experienced shortness of breath and chest pain over the weekend. On 3/11/2024, the resident was seen by Nurse Practitioner at the request of Hospice nurse for complaint of shortness of breath and chest pain to Hospice nurse. Per Nurse Practitioner, Resident #28 symptoms related to disease process and scheduled Morphine was administered with relief of symptoms. Per Nurse Practitioner, Resident #28 to continue Morphine for pain and restlessness and new order for Hydromet Syrup 5-1.5 MG/5ML (Hydrocodone-Homatropine) 5ml every 6 hrs. for cough/congestion.
Resident #28 stated he experienced chest pressure, was upset and mad and felt belittled. Resident stated he felt staff were retaliating against him because he filed a complaint and described staff as hostile towards him.
On 3/14/2024 Resident #28 was assured of facility□s zero tolerance policy related to abuse/neglect or retaliation, informed of his rights as a resident and encouraged to continue reporting any allegations of abuse/neglect to staff by Director of Nursing. Resident #28 verbalized understanding and informed the Social Worker would follow up with him weekly to address any concerns. Resident stated, that makes me feel better and thank you for handling the situation.

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F 600	Continued From page 13 -altered respiratory status/ difficulty breathing related to anxiety, COPD history of respiratory failure with intervention to provide oxygen as ordered. -continuous oxygen therapy for CHF and COPD with interventions to give medications as ordered, monitor/ document side effects and effectiveness, observe for symptoms of respiratory distress and report to physician as needed (restlessness, pulse oximetry, increased heart rate, headaches, lethargy, confusion, cough, accessory muscle usage and skin color. -altered cardiovascular status, arrythmia, CHF and hypertension with interventions to assess shortness of breath and cyanosis, diet consult as necessary, oxygen as ordered, monitor/document/report changes in lung sounds (crackles), edema, and changes in weight; vital signs as ordered/as needed and report abnormal readings to physician. -acid reflux with an intervention for medications to be given as ordered, monitor/ document side effects and effectiveness. -hospice services related to COPD, with an intervention to administer pain medications as prescribed, assess frequently and provide additional pain relief as necessary; coordinate care with hospice team; invite hospice staff to participate in resident care planning conferences; promote comfort by repositioning, adding more pillows, massage, reading, and aromatherapy. A review of the March 2024 Medication Administration Record revealed Resident #28 was to receive the following during the 7am- 7pm shift: -Omeprazole- give one tablet in evening for GERD (4pm) -Prostat- (Protein supplement) 30 milliliters one	F 600	On 3/14/2024, the Administrator notified the attending Physician, Mecklenburg Police Department and Adult Protective Services. The attending Physician gave no new orders. The responsible party/family was notified of the allegation of Abuse on 3/14/2024. An initial allegation report was completed and submitted to the Health Care Personnel Investigations on 3/14/2024. On 3/15/2024, Psych Nurse Practitioner (NP) was notified and asked to see Resident #28 on next visit to facility to follow up with resident related to his psychosocial wellbeing. Resident seen by NP on 3/15/2024 and resident calm and cooperative with no negative behaviors. On 3/15/2024, the Director of Nursing completed a follow-up assessment of Resident #28 following assessment by Nurse Practitioner for complaint of wheezing. No acute distress noted (no complaint of chest pain, no pain, no shortness of breath, no labored breathing, no anxiety). Resident #28 verbalized, he is having no acute distress and has no mental anguish and appreciates the care at the facility. Corrective action for potentially affected residents. On 3/14/2024, the Director of Nursing identified residents that were potentially impacted by this practice by completing head to toe body audits and assessed residents for any acute distress or verbal/nonverbal indicators of pain on all residents with a BIMS 12 or less on all current residents. The results included: all current residents with BIMS 12 (impaired	

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time a day for additional protein (9am)
-Budesonide inhalation suspension (nebulizer treatment)- 2 times a day for COPD (9am)
-Formoterol fumerate inhalation solution 2 times a day (every 12 hours) for COPD (1pm)
-Tamsulosin- one capsule by mouth 2 times a day (Flomax) (9am)
-Ensure (dietary supplement)- 3 times a day (10am, 2pm)
-Oxgyen 3 liters continuous nasal canular for shortness of breath- every shift O2
-Vital signs every shift
-Ipratropium-albuterol inhalation solution #60 vial-(nebulizer) inhale 4 times a day for COPD (11am, 5pm)
-Fluticasone propionate suspension- spray each nostril one time a day for allergies (9am)
-Observe or ask resident if shortness of breath (SOB) occurs when lying flat down or is resident avoiding lying flat due to SOB; every shift signs of SOB: interrupted speech pattern (only able to say a few words before taking a breath); increased respiratory rate

During an interview on 3/11/24 at 11:10 AM Resident #28 revealed he received a nebulizer treatment once on Saturday 3/9/24 and once on Sunday 3/10/24 during the 7:00 am to 7:00 pm shift (day shift), although he was supposed to receive nebulizer treatments four times during the day shift. He also stated he did not receive any of his other medications that were in pill form. Resident #28 stated he had chest difficulty on 3/9/24 and requested a "breathing" (nebulizer) treatment on several occasions but did not receive it until late afternoon. He revealed he told Nurse Aide (NA) #1 he needed a breathing treatment each time she came into his room to check on him or answer his call bell throughout

cognition) or less had no areas of concern identified related to abuse/neglect, respiratory distress or pain. On 3/14/2024, all current residents with a BIMS of 13 or above were interviewed by the Administrator and were asked if they had any concerns related to abuse/neglect or concerns with medication administration. The results included: All current resident with BIMS 13 (intact cognition) or higher denied any allegations of abuse/neglect occurred and voiced no concerns with medication administration and had no significant decline or respiratory distress.
On 3/14/2024, the Director of Nursing completed medication administration audit for 3/9/2024 to 3/10/2024 for all shifts. The results were: All scheduled medications documented as administered. Residents with a BIMS 13 or higher were interviewed and the results were all residents interviewed verbalized no issues with medication administration on 3/9/2024 and 3/10/2024.
On 3/15/2024, the Director of Nursing interviewed all full-time, part-time, and PRN direct care staff including agency (licensed nurses, certified nursing assistants, and medication aides) to determine if staff were aware of any resident verbalizing not receiving medications as ordered or allegation of abuse or neglect. The findings of the audit were: No staff were aware of any other incidents involving abuse/neglect or medication administration.
On 3/15/2024, the Administrator audited grievances for the last 30 days and Resident Council Minutes for any

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F 600	Continued From page 15 the day and NA #1 told him that she informed Nurse #10 of his requests. Resident #28 indicated on 3/9/24 he called his daughter to complain of chest pain and that he had been asking for a "breathing" treatment for 3 hours. The Resident explained NA #1 was trying to be helpful when she spoke with his daughter on the phone while she was in the room and stated she was doing all she could by reporting the Resident's need for a "breathing" treatment. The Resident stated when the Medication Aide (later identified by the Resident as Med Aide #1) finally came in to give him his breathing treatment later in the day, she stated in a hostile manner "here is your breathing treatment." The Resident stated he had not reported his concerns that occurred over the weekend to nursing management. During a follow up interview on 3/14/24 at 12:42 pm Resident #28 revealed he did not receive any medications by mouth, and he received one breathing treatment during the day shifts on 3/9/24 and 3/10/24. He stated on 3/9/24, Med Aide #1 stated in a hostile manner "you push your bell every 5 minutes", then she activated his call bell so that he could not use it and it stayed on for the remainder of the shift. The Resident further explained since Med Aide #1 pressed the call bell, there was no way for him to press it if he needed something. Resident #28 also revealed he felt belittled when he asked Med Aide #1 for his scheduled dietary supplement, and she stated in a hostile tone "there is none!" The Resident did not state if this occurred on 3/9/24 or 3/10/24. He further revealed he asked Nurse #11 on the next shift (7:00 pm- 7:00 am) for the dietary supplement and he received it. The interview further revealed Resident #28 stated he felt two staff, including Med Aide #1, were retaliating	F 600	concerns related to abuse/neglect. The results included: There were no grievances or Resident Council Minutes that included any abuse/neglect. Systemic changes On 3/14/2024 the Director of Nursing and Assistant Director of Nursing began in-service of all full-time, part-time, and PRN staff, administration, housekeeping, dietary, nursing, therapy and maintenance (including agency) on the abuse prohibition/neglect policy. This training will include all current staff including agency. This training included: Abuse/Neglect-(preventing, recognizing signs/symptoms including examples of abuse/neglect, handling catastrophic reactions in residents and zero tolerance of retaliation of residents alleging of abuse/neglect, Residents Rights, and staff burnout). The Director of Nursing will review staffing schedules daily to ensure that any of the above identified staff (all staff including agency) who does not complete the in-service training by 3/15/2024 will not be allowed to work until the training is completed. This in-service will be included into the new employee facility and agency orientation for all newly hired staff (full time, part time, and prn including agency). The Director of Nursing will ensure that any new hired staff (full-time, part-time, and as needed including agency) will receive Abuse/Neglect education during classroom orientation prior to providing direct patient care. The Interdisciplinary	

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F 600	Continued From page 16 against him by acting mean, because he filed a complaint about not receiving care a few weeks prior, when he was first admitted to the facility. The Resident stated management handled the issue and that he had not seen that staff person since then. A review of video footage from camera #14 on 3/9/24 from 7:00 am to 7:00 pm and the Medication Administration Audit (indicates the date and time medications were initialed as administered on the Medication Administration Record) report for 3/9/24 revealed following: -8:05 am- NA #1 entered Resident #28's room and exited at 8:08 am. -8:12 am to 8:13 am- two unidentified NAs deliver breakfast trays to Resident #28 and his roommate. -8:35 am- Nurse #10 (supervised Med Aide #1 on 3/9/24) arrived on 200- hall with med cart and begins med pass. -8:40 am- NA #1 approached Nurse #10 at med cart and they had a conversation then NA #1 leaves the hall. -8:44 am- 9:00 am Nurse #10 continued with med pass in other resident rooms but never entered Resident #28's during this time. -9:06 am- NA #1entered Resident #28's room, collected one breakfast tray and exited the room. -9:14 am- Nurse #10 relocated med cart to the end of 200-hall and continued med pass. -9:33 am- Nurse #10 left 200-hall without the med cart -9:44 am- Nurse #10 returned to the med cart on 200-hall. -10:00 am- NA #1 entered Resident #28's room -10:01 am- NA #1 exited Resident #28's room, spoke to Nurse #10 who was at the other end of the hall and performed a hand motion as she was	F 600	Team (Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Manager, Support nurse, Therapy, Health Information Management, Dietary Manager, Medical Director, Pharmacist), were notified of the allegation of neglect by 03/15/2024 and were involved in the removal plan. All potential new hires will be reviewed to ensure they have passed their backgrounds checks and detailed interviews in an attempt to foresee potential issues. The Administrator and Director of Nursing will communicate with all nursing staff beginning 3/18/24 via meeting, phone, and nursing huddles to reiterate that resident #28 and all other residents, are not to be neglected, retaliated against and all residents receive the ordered care and services. The Director of Nursing will ensure any staff not communicated to will not be able to work until communication is complete. All new staff will be trained during orientation by nursing leadership. Quality Assurance Beginning the week of 3/25/2024, The Administrator or designee will monitor the abuse/neglect process to ensure residents are free from neglect and any neglect identified reported and addressed according to facility policy using the QA Tool for Recognizing and Reporting Abuse/Neglect. The Administrator or designee will interview 5 staff members to monitor if staff know the procedure for reporting alleged abuse/neglect and when and who to report to and 5 residents related to abuse/neglect concerns. Also,	

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F 600	Continued From page 17 speaking. Nurse #10 then turned around and left the hall. -10:19 am- NA #1 entered Resident #28's room. NA #1 exited Resident #28's room at 10:24 am and walked across the hall to enter another resident's room. -10:22 am- Med Aide #1 entered Resident #28's room with what appeared to be a small plastic cup. It was not clear if Med Aide #1 medicated Resident #28 or his roommate. Med Aide #1 exited Resident #28's room at 10:25 am with something in her hand. -10:22 am- Per the Med Administration Audit report, Med Aide #1 signed that she administered Budesonide inhalation suspension (nebulizer) and Fluticasone propionate suspension (nasal spray) to Resident #28. -10:23 am- Per the Med Administration Audit report, Med Aide #1 signed that she administered Ensure and Tamsulosin to Resident #28. -10:24 am Per Med Administration Audit report, Med Aide #1 signed that she administered Prostat to Resident #28. -10:25 am- Per the Med Administration Audit report, Med Aide #1 signed that she conducted a pain assessment (0 of 10 scale), obtained vital signs, checked oxygen at 3 liters continuous nasal canular for shortness of breath for Resident #28. -10:25 am- Per the Medication Administration Audit report, Med Aide #1 signed that she observed or asked Resident #28 if shortness of breath (SOB) occurred when lying flat down or was resident avoiding lying flat due to SOB; monitored for signs of shortness of breath such as interrupted speech pattern (only able to say a few words before taking a breath) and increased respiratory rate. -10:31 am- NA #1 entered Resident #28's room.	F 600	the Administrator or designee will review allegation reports submitted to State Survey Agencies to ensure reports submitted per facility policy. The monitoring will be completed weekly for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Therapy Director, Health Information Manager, and the Dietary Manager. Date of compliance: 3/26/2024	

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-10:32 am- NA #1 exited Resident #28's room with water pitcher and box of gloves.
-10:33 am- NA #1 entered Resident #28's room with water pitcher the exits a few seconds later at 10:33 am.
-10:33 am- Nurse #10 moved medication cart near middle of hallway/ closer to Resident #28's room and had a conversation with NA #1.
-10:34 am- Med Aide #1 went to Nurse #10's cart while Nurse #10 was still talking to NA#1.
-10:35 am- Med Aide #1 and Nurse #10 conversing at med cart and they both leave 200-hall with the med cart.
-10:35 am- Per the Med Administration Audit report, Med Aide #1 signed that she administered Ipratropium-albuterol inhalation solution (nebulizer) to Resident #28.
-11:03 am- Med Aide #1 returns to 200-hall with med cart.
-11:15 am- NA #1 entered Resident #28's room.
-11:16 am- NA #1 exited Resident #28's room and takes linen cart from linen closet and leaves the hallway.
-11:18 am- NA #1 returned to hall and entered Resident #28's room.
-11:19 am- NA #1 exited Resident #28's room and walked past Med Aide #1 at the med cart.
-11:19 am- Med Aide #1 entered Resident #28's room with a small plastic cup in hand. It was unclear if Med Aide #1 medicated Resident #28 or his roommate.
-11:20 am- Med Aide #1 exited Resident #28's room and returned to med cart.
-11:28 am- NA #1 returned to 200-hall, removed something from the hallway floor, said something in Med Aide #1's direction and Med Aide #1 looked at NA #1 then NA #1 left the hall.
-11:55 am- Med Aide #1 left med cart, exited the hall and returned to the med cart at 11:56 am.

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-12:13 pm- Resident # 28's roommate left the room.
-12:34 pm- Per the Medication Administration Audit report, Med Aide #1 signed that she administered Formoterol fumerate inhalation solution to Resident #28.
-12:55 pm- Med Aide #1 entered Resident #28's room with a lunch tray and immediately exited with lunch tray.
-1:11 pm- Resident #28's roommate returned to their room.
-1:51 pm- Per the Medication Administration Audit report, Med Aide #1 signed that she administered Ensure Plus to Resident #28.
-1:33 pm- NA #1 entered Resident #28's room and exited at 1:36 pm then converses with another Aide in the hall.
-1:52 pm- NA #1 entered Resident #28's room and exited at 1:53 pm.
-2:00 pm- Med Aide #1 in hall talking with another NA.
-2:03 pm- Unit Manager #1 entered Resident #28's room and exited at 2:04 pm.
-2:09 pm- Unit Manager #1 re-entered Resident #28's room with a 4-ounce plastic cup in her hand and exited at 2:10 pm.

During an interview on 3/17/24 Unit Manager #1 indicated she answered Resident # 28's call bell and he requested acid reflux medication. She stated Resident #28 did not appear short of breath and he did not request a nebulizer treatment. She left the Resident's room then returned and administered the acid reflux medication, which was a standing order.

-2:21 pm NA #1 returns to 200-hall, removes her coat, places it out of camera shot and leaves hall.
-2:22 pm NA #1 entered Resident #28's room and

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exited at 2:22 pm.
-2:58 pm- Med Aide #1 returns to 200-hall with no cart and entered another resident's room.
-3:08 pm- Nurse #10 arrived on 200-hall with dirty linen bag and placed in dirty linen closet next to Resident #28's room but does not go into his room and leaves 200-hall.
-3:20 pm Nurse #10 returned to 200-hall with med cart.
-3:59 pm NA #1 entered Resident #28's room and exited at 3:59 pm with blue gloves in hand and spoke with someone out of camera footage then left 200-hall.
-4:30 pm NA #1 entered Resident #28's room and exited at 4:31 pm.
-4:34 pm Med Aide #1 arrived on 200-hall with med cart and started med pass.
-4:48 pm NA #1 returned to 200 hall and entered Resident #28's room and exited at 4:48 pm with dirty linen bag.
-4:49 pm NA #1 entered Resident #28's room.
-4:50 pm NA #1 exited Resident #28's room and spoke to Med Aide #1 at the med cart as she was pointing toward Resident #28's room, then walked to med cart and continued to speak with Med Aide #1. NA #1 walked away from Med Aide #1, put her hands up in the air and re-entered Resident #28's room.
-4:51 pm NA #1 exited Resident #28's room.
-4:51 pm Med Aide #1 left med cart with something in hand and walked past Resident #28's room as she left 200-hall.
-4:53 pm Med Aide #1 returned to 200-hall.
-4:54 pm NA #1 entered Resident #28's room with incontinence supplies and exited at 4:54 pm.
-5:00 pm- Med Aide #1 on the 200-hall with med cart.
-5:01 pm- Med Aide #1 entered Resident #28's room (something in hand) and exited at 5:03 pm.

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It was unclear if Med Aide #1 medicated Resident #28 or his roommate.
-5:03 pm- Med Aide #1 exited Resident #28's room and left 200-hall.
-5:04 pm- Per the Med Administration Audit report, Med Aide #1 signed that she administered Ipratropium-albuterol inhalation solution (nebulizer) to Resident #28.
-5:12 pm NA #1 in hall with Med Aide #1 for brief conversation.
-5:16 pm Med Aide #1 entered Resident #28's room with a small plastic cup in hand and exited at 5:16 pm. It was unclear if Med Aide #1 if she medicated Resident #28 or his roommate.
- 5:42 pm Med Aide #1 placed med cart trash bag in dirty linen closet and exited at 5:43 pm.
-5:46 pm- Med Aide #1 entered Resident #28's room after leaving dirty linen closet and exited Resident #28's room at 5:46 pm.
-5:47 pm- Med Aide #1 exited 200-hall with med cart.
-6:00 pm- Med Aide #1 returned to 200-hall without the med cart.

A review of video footage from camera #14 on 3/10/24 from 7:00 am to 7:00 pm and the Medication Administration Audit report for 3/10/24 revealed following:
-7:02 am Med Aide #1 entered Resident #28's room with the mobile vitals machine and exited at 7:04 am.
-7:55 am- NA #1 entered Resident #28's room and exited at 7:57 am.
-8:00 am- NA #1 entered Resident 28's room, exited at 8:02 and left 200-hall.
-8:18 am- NA #1 and NA #14 entered Resident #28's room with breakfast trays and exited at 8:19 am.
-8:18 am- Med Aide #1 entered Resident #28's

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room with a small plastic cup, unwrapped straw, and another item in hand and exited at 8:21 am with an unwrapped straw and a plastic bottle. It was unclear if Med Aide #1 medicated Resident #28 or his roommate.
-8:32 am- Nurse #13 (supervised Med Aide #1 on 3/10/24) arrived on the 200-hall with med cart.
-9:03 am- NA #14 re-entered Resident #28's room with a cup of coffee and exited with another breakfast tray.
-9:57 am Nurse #13 left hall with med cart laptop.
-10:01 am Nurse #13 returned to hall and resumed med pass.
-10:46 am- Med Aide #1 arrived on the hall without med cart and went to Nurse #13's med cart and exited hall at 10:52 am.
-11:27 am Per the Med Administration Audit report, Med Aide #1 signed that she administered Budesonide inhalation suspension and Fluticasone propionate suspension (nasal spray), Ipratropium-albuterol inhalation solution (nebulizer) and Prostat to Resident #28.
-11:28 am Per the Med Administration Audit report, Med Aide #1 signed that she administered Tamsulosin to Resident #28.
-11:29 am Per the Med Administration Audit report, Med Aide #1 signed that she administered Ensure Plus, conducted a pain assessment (0 of 10 scale), obtained vitals, checked oxygen, and asked/ assessed for shortness of breath of Resident #28.
-11:52 am- Med Aide #1 returned briefly to the med cart, picked up a small plastic cup, entered Resident #28's room and exited at 11:52 am. It was unclear if Med Aide #1 medicated Resident #28 or his roommate.
-12:13 pm- Resident #28's roommate (Resident #60) in bed A leaves the room via wheelchair, with a family member.

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-12:23 pm- Med Aide #1 transported/ parked the med cart to dirty linen closet outside of Resident #28's room, discarded a bag of trash in the dirty linen closet, exited the dirty linen closet, returned to med cart and picked up a small plastic cup with spoon and entered Resident #28's room with the plastic cup in hand. Med Aide #1 then exited the room with cup in hand, placed it on med cart at 12:24 pm and exited 200-hall with the med cart.
-12:29 pm- Med Aide #1 returned to 200-hall without med cart, stood outside Resident #28's room then left the hall.
-12:32 pm- NA #14 and unidentified unknown NA entered Resident #28's room with lunch trays.
-12:56 pm- Per the Med Administration Audit report, Med Aide #1 signed that she administered formoterol fumerate inhalation solution to Resident #28.
-1:02 pm- Med Aide #1 arrived on 200-hall and left the hall at 1:05 pm.
-from 2:00 pm to 4:26 pm- No staff entered Resident #28's room.
-4:24 pm- Med Aide#1 arrived on 200-hall with medication cart and began med pass.
-4:26 pm- NA #14 entered linen closet, retrieved linen, and entered Resident #28's room.
-4:27 pm- NA #14 exited Resident #28's room and into one of the rooms across the hall from Resident #28, then leaves the hall a few minutes later.
-4:53 pm- Med Aide #1 entered Resident #28's room with something in hand. It was not clear if Med Aide #1 medicated Resident #28 or his roommate.
-4:54 pm Med Aide #1 exited Resident #28's room.
-4:57 pm Med Aide #1 re-entered Resident #28's room.
-4:58 pm Med Aide #1 exited Resident #28's

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room.
-4:59 pm- Per the Med Administration Audit report, Med Aide #1 signed that she administered omeprazole and Ipratropium-albuterol inhalation solution (nebulizer) to Resident #28.
-5:00 pm- Med Aide #1 at med cart and Nurse #13 at med cart on opposite end of hall.
-5:05 pm- NA #14 and an unknown NA delivered dinner trays to Resident #28's room and exited at 5:06 pm.
-5:08 pm- Med Aide #1 entered Resident #28's room and exited a few seconds later then left the hall.
-5:09 pm- Med Aide #1 returned to 200-hall and the med cart.
-5:51 pm- Med Aide #1 left 200-hall with med cart.
-6:31 pm- NA #14 entered Resident #28's room with a bag of linens, left the room seconds later and placed bag in dirty linen closet.

Attempts to interview Nurse #13 were not successful.

Attempts to interview NA #14 were not successful.

A review of video footage from camera #7 on 3/09/24 from 7:00 am to 7:00 pm showed a hall's length view but did not show a view of the Resident #28's room. The view shows blurry parts of Med Aide #1 standing at the med cart, sometimes showing only the bottom half of her legs, leaving the med cart, returning to the med cart around similar or the same footage times that were viewed on camera #14.

During a phone interview on 3/14/24 at 11:21 am Resident #28's family member, indicated she resided out of state and received several phone

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calls from the Resident on 3/9/24. She stated she was a nurse and was working when the Resident left her a voice mail message about 1:58 pm about how he pressed his call bell, NA #1 responded, and he told her he needed a breathing treatment and he had not received it. She returned his call about 5:15 pm to see if the Resident received his treatment. Resident #28 told her that he was experiencing chest pains and had been requesting his scheduled breathing treatments for at least 3 hours. The family member further indicated at one point during the day (about 5:15 pm) when she spoke to the Resident, she also spoke with the NA #1, on the Resident's cell phone when the NA went in to check on the Resident. The family member stated NA #1 told her she had reported to Nurse #10 on several occasions the Resident needed a breathing treatment and at one point Nurse #10 stated she was on break and that the NA needed to find someone else. The family member stated she was so upset, she demanded to know what was going on and NA #1 attempted to have a nurse who was out in the hall come into the Resident's room to talk to her, but the nurse would not come to the phone. The family member further indicated every time she spoke with the Resident, he seemed out of breath as evidenced by speaking in a reserved manner to preserve his breath and she could tell he was short of breath. The family stated she was so upset she called the hospice phone number and left a voice mail message for the Hospice Administrator at 5:05 pm and left messages about the Resident's report of difficulty breathing. When the family member called the Resident about 6:00 pm, the Resident stated he had just received a nebulizer treatment from the nurse and that he was feeling better. The family member also stated the

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Resident was only confused when he needed breathing treatment, and she truly believed him when he stated he was having difficulty. The family member stated she spoke with the Resident on 3/10/24 after she came from church, and he stated he was "ok." She stated when she spoke with the Resident on Tuesday 3/12/24, he stated Sunday was a little rough, but he did not go into detail, then said it was "ok."

During an interview on 3/14/24 at 12:21 pm Med Aide #1 stated she was assigned to Resident #28 on the 7:00 am- 7:00 pm shift on 3/9/24 and 3/10/24 and was responsible for administering his medications and breathing treatments. She further stated on 3/9/24 NA #1 did not inform her that Resident #28 needed a breathing (nebulizer) treatment on 3/9/24 during the 7am- 7pm shift. Med Aide #1 indicated she administered a breathing treatment to Resident #28 three times during her shift (morning, afternoon, and before evening) on 3/9/24 and 3/10/24. Med Aide #1 denied being hostile towards Resident #28, activating his call bell so he could not use it, or telling him there was no dietary supplement to give him when he asked for one during her shift on 3/9/24.

During a phone interview on 3/14/24 at 4:36 pm NA #1 revealed she was assigned to Resident #28 on day shift on 3/9/24 and each time she answered his call bell or checked on him from the morning through the afternoon, the Resident requested a breathing treatment. She further revealed she informed Nurse #10 on at least three occasions that the Resident was requesting his breathing treatment. The third time she informed Nurse #10 of the Resident's request for his breathing treatment, Nurse #1 stated she was

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on break and that NA #1 should ask Med Aide #1. NA #1 stated she located Med Aide #1 in another resident's room watching a soccer game and informed her of the Resident's request for medication. NA #1 stated Med Aide #1 replied "ok." NA #1 further revealed when she went to check on the Resident during the afternoon, the Resident was on his cell phone with a family member and gave NA #1 the phone. NA #1 spoke with the family member on the phone and apologized that there was nothing else she could do but keep telling the nurse that the Resident was requesting a nebulizer treatment. NA #1 stated she returned to the Resident's room later in the afternoon and the Resident stated he still had not received his breathing treatment, then asked her "did you see the nurse? when is the nurse coming." The NA further stated the Resident was not gasping for air and she could not determine whether he was short of breath because he seemed frustrated and was trying to maintain his composure. NA #1 stated her assignment kept changing on 3/9/24, the communication was horrible, and the attitudes and disposition of the nurses were awful.

A follow-up call to NA #1 was placed on 3/17/24 at 4:09 pm and the voice mail box was full.

During a follow-up interview on 3/17/24 at 1:53 pm Unit Manager #1 indicated she was the Unit Manager for the entire building on Saturday 3/9/24 and Sunday 3/10/24 and that Nurse #1 oversaw the Med Aide #1. She further indicated she was not aware that the Resident did not receive nebulizer treatments and medications as ordered and scheduled.

During an interview on 3/14/24 at 12:02 pm Nurse

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#10 revealed she supervised Med Aide #1 on 3/9/24 who was assigned to Resident #28, and she was never informed the Resident reported chest pains or difficulty breathing and requested a breathing treatment. She further revealed she had no conversations with NA #1 about Resident #28 during the day shift on 3/9/24.

During an interview on 3/14/24 at 10:44 am Nurse #11 indicated he worked 7:00 pm to 7:00 am on 3/9/24 and 3/10/24 and was assigned to Resident #28. Nurse #11 stated Resident #28 did not complain about being mistreated by staff or not receiving his medication as scheduled on 3/9/24 or 3/10/24 during the 7:00 am to 7:00 pm shift. Nurse #11 further indicated he administered breathing treatments as ordered to Resident #28's, on both nights that he worked, and the off-going staff did not mention any concerns with the Resident.

A hospice nurse progress note dated 3/11/24 revealed the Resident #28 reported to the hospice social worker that he was not administered breathing treatments as ordered over the weekend and specifically complained about treatment from an evening nurse or med aide. He further reported that facility staff activated his call light so that he could not press it. The note further read that the hospice administrator was contacted by Resident #28's family member about the Resident receiving medications on 3/9/24.

During a phone interview on 3/15/24 at 8:16 pm the Hospice Nurse revealed she visits Resident #28 on Monday/Friday every week and that the Resident was very upset when he reported to her on 3/11/24 that his scheduled nebulizer

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treatments were not given on time on 3/9/24 and 3/10/24. She stated that the Resident did not give specific times he did not receive his nebulizer treatments but that he only received one treatment during 7am to 7pm shifts and should have received 4 treatments during those shifts. She stated the Resident had high anxiety and she believed what he was telling her because the hospice nurse heard similar stories from other patients related to not receiving their medications. She also stated the Resident should have received scheduled breathing treatments 4 times per day and not receiving those treatments could cause psychological stress which would affect his breathing, cardiac status, and increase his heart rate. The Hospice Nurse stated over the weekend, she received a voice mail from the Resident's family member stating the Resident was having chest pains and that the family member also contacted the hospice administrator and left a message about the Resident's unanswered requests for breathing treatments. She also stated his symptoms would have resolved faster than they did, had the Med Aide administered the medications and nebulizer treatments as ordered. The nebulizer treatments should have been spread throughout the day so he could avoid the spikes in anxiety, since he was already nervous due to the albuterol which could cause the heart rate to increase.

During an interview on 3/12/24 at 2:35 pm Unit Manager #2 agreed to follow-up with Resident #28 after the Surveyor informed Unit Manager #2 the Resident had concerns from the weekend (3/9/24 and 3/10/24) regarding the call bell incident, Med Aide #1 interactions related to not getting his medications, and dietary concerns.

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During an interview on 3/14/24 at 1:10 pm Unit Manager #2 revealed she spoke with Resident #28 on Monday or Tuesday (3/11/24 or 3/12/24), after the [State Surveyor] informed her Resident #28 had concerns about incidents that occurred over the weekend (3/9/24 and 3/10/24), related to not receiving his nebulizer treatments, call bell being activated so the Resident could not activate it and wanting to speak with the dietician about menu concerns. Unit Manager #2 further revealed the Resident did not mention he did not receive his breathing treatments but that he did not get his medications on time over the weekend and his call bell was not being answered in a timely manner. Unit Manager #2 stated she informed the Director of Nursing (DON) of the concerns after she spoke to the resident.

During an interview on 3/14/24 at 1:00 pm the DON indicated he was not made aware of Resident #28's concerns until 3/14/24 related to not receiving medications or that Med Aide #1 activated the Resident's call bell so that the Resident could not use it. The DON further indicated he expected all residents to receive their medications as prescribed and call bells to be answered in a timely manner.

During an interview on 3/14/23 at 1:10 pm, with the Corporate Nurse, Unit Manager #2 and the DON present, the Corporate Nurse spoke on behalf of Unit Manager #2 and stated Resident #28 did not report to Unit Manager #2 that he did not receive his nebulizer treatment or that the Med Aide #1 pressed his call bell so he couldn't use it". The DON indicated Unit Manager #2 made him aware of the call bell concerns on 3/14/24.

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During a phone interview on 3/14/24 at 5:00 pm the facility Nurse Practitioner (NP) indicated scheduled breathing treatments could have helped Resident #28's symptoms if he received them. She further indicated the Resident was probably upset and became more "air hungry", anxious, and bronchioles constricted despite receiving oxygen at 3 liters. The NP indicated her expectation was for Resident #28 to receive all his scheduled medications as ordered.

During a phone interview on 3/14/24 at 5:27 pm the Medical Director revealed he took over as Medical Director in January 2024 and was not yet familiar with Resident #28. He further revealed the Resident could have had a significant decline when he did not receive his breathing treatments as ordered and not receiving breathing treatments may have caused the symptoms that included: increased shortness of breath, wheezing and increased stress. The Medical Director stated the Resident's symptoms caused him to contact his family member who called hospice when he could not get assistance from the facility. The Medical Director indicated his expectation was for staff members to administer medications as ordered.

During a phone interview on 3/17/24 at 2:29 pm the Administrator indicated she didnot work on weekends but was available by phone and could come into the facility if she was needed. The Administrator stated Unit Manager #1 supervised the entire facility on the weekends and Nurse #10 supervised Med Aide #1. She further indicated she was not made aware until 3/14/24 of any issues related to neglect or that Resident #28 did not receive his scheduled medications on 3/9/24 and 3/10/24.

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The Administrator was notified of the Immediate Jeopardy on 3/16/24 at 6 pm.

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

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

Resident #28 has diagnoses including COPD with respiratory failure, CHF and Anxiety. Resident #28 was not administered scheduled nebulizer treatments as ordered by Medication Aide #1 despite repeated requests on 03/09/2024 and 03/10/2024 during the 7am to 7 pm shift. Interview with Hospice nurse revealed Resident #28 reported to her that he experienced shortness of breath and chest pain over the weekend. On 3/11/2024, the resident was seen by Nurse Practitioner at the request of Hospice nurse for complaint of shortness of breath and chest pain to Hospice nurse. Per Nurse Practitioner, Resident #28 symptoms related to disease process and scheduled Morphine was administered with relief of symptoms. Per Nurse Practitioner, Resident #28 to continue Morphine for pain and restlessness and new order for Hydromet Syrup 5-1.5 MG/5ML (Hydrocodone-Homatropine) 5ml every 6 hrs. for cough/congestion.

Resident #28 stated he experienced chest pressure, was upset and mad and felt belittled. Resident stated he felt staff were retaliating against him because he filed a complaint and described staff as hostile towards him.
On 3/14/2024 Resident #28 was assured of

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facility's zero tolerance policy related to abuse/neglect or retaliation, informed of his rights as a resident and encouraged to continue reporting any allegations of abuse/neglect to staff by Director of Nursing. Resident #28 verbalized understanding and informed the Social Worker would follow up with him weekly to address any concerns. Resident stated, "that makes me feel better and thank you for handling the situation."

On 3/14/2024, the Administrator notified the attending Physician, Mecklenburg Police Department and Adult Protective Services. The attending Physician gave no new orders. The responsible party/family was notified of the allegation of Abuse on 3/14/2024. An initial allegation report was completed and submitted to the Health Care Personnel Investigations on 3/14/2024.

On 3/14/2024, the Director of Nursing identified residents that were potentially impacted by this practice by completing head to toe body audits and assessed residents for any acute distress or verbal/nonverbal indicators of pain on all residents with a BIMS 12 or less on all current residents. The results included: all current residents with BIMS 12 (impaired cognition) or less had no areas of concern identified related to abuse/neglect, respiratory distress or pain. On 3/14/2024, all current residents with a BIMS of 13 or above were interviewed by the Administrator and were asked if they had any concerns related to abuse/neglect or concerns with medication administration. The results included: All current resident with BIMS 13 (intact cognition) or higher denied any allegations of abuse/neglect occurred and voiced no concerns with medication administration and had no significant decline or

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respiratory distress.

On 3/14/2024, the Director of Nursing completed medication administration audit for 3/9/2024 to 3/10/2024 for all shifts. The results were: All scheduled medications documented as administered. Residents with a BIMS 13 or higher were interviewed and the results were all residents interviewed verbalized no issues with medication administration on 3/9/2024 and 3/10/2024.

On 3/15/2024, Psych Nurse Practitioner was notified and asked to see Resident #28 on next visit to facility to follow up with resident related to his psychosocial wellbeing.

On 3/15/2024, the Director of Nursing interviewed all full-time, part-time, and PRN direct care staff including agency (licensed nurses, certified nursing assistants, and medication aides) to determine if staff were aware of any resident verbalizing not receiving medications as ordered or allegation of abuse or neglect. The findings of the audit were: No staff were aware of any other incidents involving abuse/neglect or medication administration.

On 3/15/2024, the Director of Nursing completed a follow-up assessment of Resident #28 following assessment by Nurse Practitioner for complaint of wheezing. No acute distress noted (no complaint of chest pain, no pain, no shortness of breath, no labored breathing, no anxiety). Resident #28 verbalized, "he is having no acute distress and has no mental anguish and appreciates the care at the facility."

On 3/15/2024, the Administrator audited

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grievances for the last 30 days and Resident Council Minutes for any concerns related to abuse/neglect. The results included: There were no grievances or Resident Council Minutes that included any abuse/neglect.

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

On 03/15/2024, the Administrator and Director of Nursing conducted a root cause analysis and determined that the root cause of the alleged error was that Medication Aide #1 failed to follow facility policy related to medication administration and 6 rights of medication administration due to disregard of resident's rights by ignoring request by Nurse Aide #1 for administration of Resident #28's nebulizer treatment. Review of video footage from 3/9/2024 and 3/10/2024 during the 7am-7pm medication pass revealed Medication Aide #1 did not administer nebulizer treatments as ordered.

On 3/14/2024 the Director of Nursing and Assistant Director of Nursing began in-service of all full-time, part-time, and PRN staff, administration, housekeeping, dietary, nursing, therapy and maintenance (including agency) on the abuse prohibition/neglect policy. This training will include all current staff including agency. This training included: Abuse/Neglect- (preventing, recognizing signs/symptoms including examples of abuse/neglect, handling catastrophic reactions in residents and zero tolerance of retaliation of residents alleging of abuse/neglect, Residents Rights, and staff burnout). The Director of Nursing will review staffing schedules daily to

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ensure that any of the above identified staff (all staff including agency) who does not complete the in-service training by 3/15/2024 will not be allowed to work until the training is completed. This in-service will be included into the new employee facility and agency orientation for all newly hired staff (full time, part time, and prn including agency). The Director of Nursing will ensure that any new hired staff (full-time, part-time, and as needed including agency) will receive Abuse/Neglect education during classroom orientation prior to providing direct patient care.

The Interdisciplinary Team (Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Manager, Support nurse, Therapy, Health Information Management, Dietary Manager, Medical Director, Pharmacist), were notified of the allegation of neglect by 03/15/2024 and were involved in the removal plan.

All potential new hires will be reviewed to ensure they have passed their backgrounds checks and detailed interviews in an attempt to foresee potential issues.

The Administrator and Director of Nursing will communicate with all nursing staff beginning 3/18/24 via meeting, phone, and nursing huddles to reiterate that resident #28 and all other residents, are not to be neglected, retaliated against and all residents receive the ordered care and services. The Director of Nursing will ensure any staff not communicated to will not be able to work until communication is complete. All new staff will be trained during orientation by nursing leadership.

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Alleged date of IJ removal 03/19/2024. Administrator will be responsible for ensuring the removal plan is implemented.

F600 - Date of immediate jeopardy removal: 03/19/2024.

On 03/26/24, the facility's immediate jeopardy removal plan effective 03/19/24 was validated by the following: facility staff interviews revealed they had received education on the 6 rights of medication administration, abuse and neglect training to include preventing, recognizing signs and symptoms, and zero-tolerance of retaliation of resident alleging abuse and neglect. Administrative staff interviews revealed they had completed audits of nurses and medication aides during medication pass and completed a root cause analysis of the medication error event. The facilities medication error rate was 0% during the medication pass facility task completed by the survey team.

The immediate jeopardy removal date of 3/19/24 was validated.

2. Resident #17 was admitted to the facility on 1/5/24 with diagnoses including dementia and anxiety.

An admission MDS assessment dated 1/12/24 indicated Resident #17 had severe cognitive impairment and required maximum assistance with toileting and showering; moderate assistance with personal hygiene and supervision with eating and oral hygiene; frequently incontinent of bowel and bladder.

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A revised care plan dated 1/17/24 indicated Resident #17 was care planned for the following: Incontinent of bladder with increased risk for skin breakdown and infections with interventions to make frequent checks throughout the shift for incontinence; provide incontinence care (wash, rinse and dry); Change clothing as needed after incontinence episodes; Provide assistance with all incontinence care; Use incontinence briefs at all times; Observe for/document and report signs and symptoms of urinary tract infection, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns; Report any open areas, rash or irritation to skin. At risk for pressure ulcers with interventions to apply moisture barrier with each brief change and as needed; Assist with position changes throughout each shift; Use pressure reducing mattress on bed.

During an interview on 3/11/24 at 12:15 pm Resident #17's Family Member #1 revealed on Sunday 3/10/24 about 12:00 pm, he arrived for a visit and found the Resident #17 lying in bed in a fetal position, with a thin blanket, legs/ feet were exposed, a wet brief, and wearing a short-sleeved t-shirt. Family Member #1 further revealed he went out of the room to the nurse's station and informed Unit Manager #1, that Resident #17 needed care (diaper changed, cleaned, dressed and out of bed). Unit Manager #1 returned to the Resident's room with Family Member #1 and turned on the call bell before she left the room. Family Member #1 stated Nurse Aide (NA) #14 answered the call bell a short time later and stated, "did you need something." Family Member

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#1 stated when he asked the Aide to get the Resident cleaned up and out of bed because out of town family members were coming to visit. Family Member #1 stated the NA replied with a bad attitude that the Resident would have to wait until after lunch, although the lunch trays had not yet arrived. Family Member #1 stated he and the Aide got into a verbal exchange and Resident #17 started to cry and ask if everything was okay and if she was doing what was asked of her. NA#14 the NA left the room without providing care. Family Member #1 explained he heard a knock at the door, and it was a law enforcement officer. The officer took a police report related to the verbal exchange and suggested the NA assignment be changed. The interview further revealed Family Member #1 decided to leave after giving his side of the story. Later in the afternoon (3/10/24), he was made aware that Family Member #2 arrived about 2 hours after he left, and Resident #17 had still not received incontinence care.

During an interview on 3/11/24 at 12:50 pm Resident #17's Family Member #2 revealed on Sunday 3/10/24 about 2:30 pm, she and her husband arrived for a visit and found Resident #17 lying in bed in a fetal position, wearing a soiled diaper (saturated with bowel movement and urine), legs exposed, and her feet were ice cold. Family Member #2 indicated the Resident kept stating "Is everything ok, I don't anyone to get upset." Family Member #2 further revealed when she pressed the call bell and no one came, she went out to find Unit Manager #1, who accompanied Family Member #2 back to the room and saw that the Resident needed care. Family Member #2 and Unit Manager #1 left the room and went to a group of Aides sitting at a

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table in the common area and confronted them. They stated to Unit Manager #1 they didn't feel comfortable going back to the Resident's room because of the incident that took place between NA #14 and Family Member #1, and no one wanted to switch assignments. Family Member #2 stated the Aides were ignoring the Unit Manager. Family Member #2 stated she became upset, started crying and practically begged the nursing staff to provide care to the Resident. Family Member #2 stated NA #14 and another Aide provided care to Resident close to 3:00 pm, while Family Member #2 observed.

During a phone interview on 3/13/24 at 11:18 am NA #14 indicated 3/10/24 (7:00 am to 7:00 pm shift) was her first day working at the facility and she was assigned to Resident #17. She explained the morning of 3/10/24, she provided incontinence care to the Resident and was told by another Aide not to get the Resident out of bed until after lunch. The NA stated the Resident was wearing an undershirt and was covered with a sheet and a blanket when she last saw her before the Family Member #1 arrived. The NA also stated she had not given the Resident a bed bath yet because the bed linens had not been delivered to the unit. NA #14 stated Unit Manager #1 informed her that Family Member #1 wanted the Resident up and out of bed, and she went to the room and told the Family Member #1 that the Resident would have to wait until after the lunch trays were passed to receive care. The NA further indicated the Family Member #1 got in her face, they exchanged words, and she left the room to call law enforcement because she didn't feel safe. The NA explained, after law enforcement left the building, Unit Manager #1 told her not to return to the Resident's room and to switch assignments

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with another NA. NA #14 stated no one would switch assignments with her and when Family Member #2 arrived, she was upset because she could not get anyone to provide care to Resident #17. NA #14 indicated she and another Aide provided care to Resident #17 after Family Member #2 arrived.

Review of camera #14 video footage on 3/10/24 (7am -7pm shift) revealed the following:
-2:29 pm- Family member #2 arrived.
-2:35 pm- Family Member #2 left Resident #17's room.
-2:38 pm- Family Member #2 and NA #14 entered Resident #17's room.
-2:38 pm- Another NA and Nurse #13 entered Resident # 17's room.
-2:40 pm- NA exited and re-entered Resident #17's room. Nurse #13 exited the room.
-2:42 pm- A nurse and Nurse #13 entered Resident #17's room.
-2:57 pm- NA #14 exited Resident #17's room.

During an interview on 3/13/24 at 5:55 pm Unit Manager #1 indicated she worked 9:00 am to 9:00 pm on 3/10/24 and supervised the entire building as Unit Manager on the weekends. She further indicated about 12:00 noon, she was approached by Resident #17's Family Member #1, who stated he would like to have the Resident up and dressed because she was going to have visitors. Unit Manager #1 stated she escorted the Family Member #1 back to the Resident's room, and pressed the call bell, for the assigned NA to respond. Unit Manager #1 stated she repositioned the Resident in bed before she left the room and that the Resident had a sheet and blanket but did not recall if the Resident was covered with the blanket. Unit Manager #1 stated

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she did not check the Resident's #17's brief or smell any odors and told the Family Member #1 that lunch trays were about to be passed out and that the Resident may not get care until after trays were passed. Unit Manager #1 stated she located NA #14 and informed her of Family Member #1's request. A few minutes later, NA #14 approached Unit Manager #1 and stated the male family member called her a curse word and got in her face. Unit Manager #1 further stated NA #14 told her to call 911. The Unit Manager stated she did not call the police because there was no physical violence and she spoke with Family Member #1 who gave his side of the story and denied calling NA #14 a curse word. The Unit Manager stated she contacted the Administrator and was told not to contact law enforcement. However, the Unit Manager stated she was not aware the NA had already contacted law enforcement. Law enforcement arrived, took a report, spoke with the Family Member #1 and staff, law enforcement left the building, and the family member decided to leave the building. UM#1 stated she spoke with the officer and told them what happened and that both the Aide and Family Member #1 were arguing/ had verbal exchange and both were responsible. The Unit Manager stated she instructed NA #14 to not return to the Resident's room and to switch assignments with another NA. Unit Manager #1 stated that she was not aware NA #14 could not find anyone to switch assignments and had she known, she would have assigned someone. The Unit Manager stated she was made aware that NA #14 could not find anyone to switch assignments when Family Member #2 arrived for a visit and came to the Unit Manager's office soon after she arrived upset and crying that she could not find anyone to provide care to Resident.

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F 600	Continued From page 43 The Unit Manager further stated she went with female family member and spoke with NA #14 to inquire about why she was not informed there was no NA assignment switch. The Unit Manager went to find an Aide to provide care and by the time she returned to the Resident's room, she observed NA #14, and another NA were providing care to the Resident. The Unit Manager spoke with Family Member #2 after care was provided and agreed to look after the Resident for the remainder of the shift. Unit Manager #1 stated there was a lot going on during her shift on 3/10/24 and she did not recognize that the Resident did not receive care as requested by family members between 12:00 pm and 2:45 pm. During an interview on 3/14/24 at 1:54 pm the Administrator indicated she was made aware of the allegation of neglect on 3/11/24 after Resident #17's family members reported it to the Regional Nurse Consultant on 3/11/24. The Administrator further indicated the investigation was on-going and a determination of neglect had not been made at the time of the interview. Her expectation was for all residents to be free from abuse and neglect.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced	F 602		

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F 602	Continued From page 44	F 602	Past noncompliance: no plan of correction required.	

by:
Based on record review, family interview, staff interviews and video observation, the facility failed to protect a resident's right to be free from misappropriation of resident property when a housekeeper staff member#1 (floor tech) used a resident's credit card and made multiple unauthorized purchases that included, the facility vending machine, grocery stores, gas stations, vape stores, shopping stores, restaurants and liquor stores. This occurred for 1 of 4 residents (Resident #98) reviewed for misappropriation of resident property.

The findings included:

Resident #98 was admitted to the facility on 12/15/2023 and discharged on 12/28/23 at 5:45am. Resident #98 passed away later the same day in the hospital.

A review of the admission Minimum Data Set (MDS) dated 12/18/2023 indicated Resident #98 was cognitively intact.

Review of the initial report to the state read in part "incident date was 12/28/23, The facility became aware of the incident on 01/02/2024 at 12:45pm when Resident #98's family member called the facility and reported Resident #98's missing credit card and driver's license."

An interview was conducted with the Administrator on 03/14/24 at 8:15am, she indicated she received a call from Resident #98's family member on 01/02/24 and the family stated Resident #98's credit card and driver's license had been stolen at the facility. The Administrator indicated that she informed the family that she

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would be following the facility's abuse protocol for the allegation of the missing items. The Administrator also indicated she called the family back on 01/03/24 and provided an update on the investigation about what was observed on the video camera of the housekeeping staff member #1 observed to enter Resident #98's room and then go to the vending machine after exiting the Resident's room. The administrator indicated she had informed the family member the police were notified of this information, and they informed her they would escalate the information to the fraud department.

On 03/14/23 at 8:30am a review of the bank credit transaction forms received from the bank was received by the facility on 01/02/24 from Resident #98's family member. The bank credit transaction forms revealed several unauthorized purchases made on 12/28/23 through 12/31/23 that included multiple charges from the facility vending machine, grocery store, gas stations, vape stores, food restaurants, shopping stores, and liquor stores.

Attempted to contact Resident #98's family was made on 03/14/24 at 8:45am and was unsuccessful.

Attempted to contact housekeeping staff member #1 on 03/14/24 at 8:55am, however voice mail indicated it was not a working number.

Attempted to contact the Police officer was made on 03/14/23 at 9:00am and again on 03/15/24 and was unsuccessful.

An interview was conducted with the Social Worker (SW) on 03/14/24 at 9:30am and she

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indicated the Housekeeping Supervisor came to her on 12/28/23, (she was unsure of the time) with Resident #98's purse. The SW indicated she directed the Housekeeping Supervisor to give the purse to the Administrator or to the Business Office. SW indicated she never touched the purse, but she knew Resident #98 had been sent out to the hospital earlier that morning.

An observation of the facility's video camera was done on 3/14/24 at 11:12am, and the video camera revealed on 12/28/23 at 12:30pm the housekeeping staff member #1 entered Resident #98 room. He left the room around 12:35pm and was observed going to the facility's vending machine near the 300 and 400 halls around 12:37pm. Housekeeping staff member #1 was observed to make two purchases from the vending machine.

An interview was conducted with Resident #98's family member on 03/15/24 at 9:00am, and he indicated they canceled the credit card, contacted the police department, and called the facility once they reviewed Resident #98's accounts. The family member indicated the police had not reached out to him since he made the report, but stated he was informed it could take 3 to 6 months or longer before the case would be closed. The family member indicated the Administrator had reached out to the family and explained the process of the investigation.

An interview was conducted with housekeeping staff member #2 on 03/15/24 at 9:30am. Housekeeping staff member #2 indicated she did not see Resident #98's purse in her room on 12/28/23. She indicated she had been informed to clean up Resident #98's room because she

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had left to go to the hospital early that morning. Housekeeping staff member #2 indicated the room was clean, and she only mopped over the floor because there were footprints on the floor. Housekeeping staff member #2 indicated she had no knowledge of any missing items at the time.

An interview with the Housekeeping Supervisor on 03/15/24 at 9:45am occurred and she indicated she retrieved Resident #98's purse from her room and was informed by the SW to take it to the Business Office. The Housekeeping Supervisor indicated that she gave the purse to the Business Office Manager on 12/28/23. She indicated she never opened the purse.

Review of statement from the Business Office Manager dated 01/08/24 read in part "To Whom It May Concern, Regarding Resident #98's personal belongings (purse). Upon Resident #98's discharge to the hospital, the Housekeeping Supervisor came to the business office and gave her Resident #98's purse. The Business Office Manager indicated she locked the purse in the closet in the business office until the family picked up the purse.

A review of the investigation report dated 01/09/24 read in part, Resident # 98 's family member reported on 01/02/24 Resident #98's credit card and driver's license were missing out of her purse. The facility contacted the police and Adult Protective Services (APS). The facility interviewed alert and oriented residents regarding misappropriation of resident property with no concerns. They audited grievances made of missing monies/items and found no issues. They collected statements from staff members who were also in the room on the day of the incident,

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and no one had observed the credit card or driver's license. The facility reviewed the cameras from 12/28/23 the day Resident #98 went to the hospital and the cameras showed the housekeeping staff member #1 entering the Resident's room, after the Resident had discharged and was showed to leave the Resident's room and go to the vending machine at 12:37pm. The family provided a charge of five dollars on 12/28/23 at 12:39pm from the facility's vending machine. The police were in contact with the family and informed them an investigation was ongoing. The video footage determined a reason to substantiate.

An interview was conducted with the Director of Nursing (DON) on 03/15/24 at 12:42pm and he revealed he had not been made aware of Resident #98's missing property until the family called the facility on 01/02/24. The DON indicated the facility had a zero tolerance of abuse, neglect, and misappropriation of resident's property.

An interview was conducted with the Administrator on 03/15/24 at 1:15pm, she indicated she followed the facility's abuse policies and procedures for the investigation for Resident #98's missing credit card and driver's license and the facility had zero tolerance of misappropriation of resident's property. She also indicated that the facility completed a full plan of correction.

The facility provided the following corrective action plan with a completion date of 01/06/24.

Corrective action for resident involved:

On 1/2/2024, Resident #98 son notified facility of charges made to resident's credit card following

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discharge from facility on 12/28/2023 to hospital. On 1/2/2024, Administrator submitted an initial allegation report for misappropriation of resident property and notified police and APS. On 1/2/2024, the Administrator suspended interviewed Housekeeper#1 pending investigation. On 1/2/2024, Administrator reviewed video footage for 12/28/2023 and noted housekeeper#1 entering and exiting resident#1 room following discharge to hospital on 12/28/2023 and using card to purchase items from vending machine in dining room between 300 and 400 halls. On 1/2/2024, Administrator provided [Mecklenburg] police department with investigation findings and completed report of incident. On 1/2/24, Resident's son notified Administrator that Citi Bank would be reimbursing resident's account for fraudulent charges. On 1/5/2024, Administrator concluded investigation and substantiated allegation related to misappropriation and based on investigation findings the root cause of incident was due to housekeeper#1 failing to follow facility policy related to abuse to include misappropriation. On 1/5/2024, a Quality Assurance and Performance Improvement meeting was held with the Interdisciplinary Team to review findings of investigation with no additional findings. On 1/9/2024, the Administrator completed an investigation report and submitted an investigation report to the Department of Health and Human Services.

Corrective action for potentially impacted residents:

Beginning 1/2/2024, the Administrator and Director of Nursing identified residents that would

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be potentially impacted by the alleged deficient practice by completing resident interviews for all current resident with BIMS of 13 or higher and asked if they had any concerns with misappropriation of property.
Grievances/concerns were reviewed for the last 30 days to identify any concerns related to misappropriation of property for residents with BIMS of 12 or less. This was completed by 1/3/2024.

Results included: No other residents identified with issues related to misappropriation of property.

On 1/5/2024, after concluding investigation, the Quality Assurance Committee convened to discuss the misappropriation of resident property and the status of the investigation.

There were no additional findings at that time.

Systemic Changes:

On 1/2/2024, the Administrator began servicing all full-time, part-time and PRN (as needed) staff (including agency) on ABUSE (Misappropriation of Resident Property) policy. This training will include all current staff including the agency. This training included: ABUSE (Misappropriation of Resident Property). On 1/3/2024, the Administrator and Director of Nursing verbally reeducated residents and family regarding policy related to Inventory List, Resident Personal Items.

As of 1/4/2024, 20 % of staff members have not attended the in-service. The Administrator will ensure that any of the above-identified staff who

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do not complete the in-service training by 1/5/2024 will not be allowed to work until the training is completed.

Quality Assurance:

Beginning the week of 1/8/2024, The Administrator or designee will monitor misappropriation of resident property using the QA Tool for Misappropriation. The Administrator will monitor Misappropriation of Residents Property using the QA Tool for Misappropriation by interviewing 4 residents weekly regarding missing money or personal items and monitor any concerns daily for 4 weeks. This will be completed weekly for 4 weeks and 8 Residents monthly for 2 months and all newly admitted Residents. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Social Worker, Therapy Manager, Health Information Manager, and the Dietary Manager.

Compliance date: 1/06/2024

The facility's corrective action plan was validated on 03/15/24 when staff interviews revealed they received education on the Abuse policy and procedures, residents' rights to be free from physical abuse, neglect, and misappropriation of resident property . The education included documentation and reporting to management immediately when they become aware of reported, suspected abuse, misappropriation

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F 602	Continued From page 52 and/or injury. Nurse's Aides must submit the reports of misappropriation of resident property, and/or abuse issues daily to the Nurse/Unit Manager immediately. The Unit Manager will review information and submit it to the Director of Nursing and the Administrator. Facility documentation revealed staff were trained on the following topics and additional training: abuse policy and procedures, residents' rights education, misappropriation of resident property and interviewing for abuse, nurse notification and assessment, the residents. Attestations related to the abuse training were signed by trained staff for the verbal education that was provided. Staff indicated they were trained prior to working their next shifts. Newly hired staff received an in-service service prior to working and this was verified by the facility trainers and orientation form. The completion/compliance date of 01/06/24 was validated.	F 602		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 604		4/16/24

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F 604	Continued From page 53 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Nurse Practitioner, and staff interviews, the facility failed to recognize the use of an abdominal binder (a wide compression belt that encircles the abdomen) as a physical restraint for 1 of 1 resident (Resident #400) reviewed for physical restraints. The findings included: Resident #400 was admitted to the facility on 3/5/24 with diagnoses that included intracranial hemorrhage, presence of a gastrostomy tube (G-tube), and dementia. Resident #400's admission Minimum Data Set (MDS) assessment was still in progress. Review of Resident #400's baseline care plan did not include a care plan for the use of an abdominal binder as a restraint.	F 604	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F604 Right to be Free from Physical Restraints Corrective action for affected residents. For Resident#400, On 3/13/2024, Resident assessed by Unit Manager. No acute distress noted. MD notified and order given for Abdominal Binder to prevent pulling out feeding tube. Device UDA updated and consent obtained. Corrective action for potentially affected	

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F 604	Continued From page 54 A review of Resident #400's active physician orders did not include an order for the use of an abdominal binder. Review of Resident #400's medical record did not reveal documented evidence of a consent for the use of a restraint or restraint assessment. A nursing progress note dated 3/13/24 read in part: "resident pulls at G-tube, abdominal binder in place". On 3/13/24 at 1:30 PM, an interview was conducted with Nurse #1. She explained that Resident #400 had the abdominal binder present when he arrived from the hospital and it had been kept in place to prevent him from pulling out the feeding tube. She was unaware the abdominal binder could be considered a restraint. Nurse #1 further stated that the abdominal binder was unfastened when she provided tube feeding care, medications, and nutrition, otherwise it was secured in place with Velcro. She stated Resident #400 was unable to remove the abdominal binder. An interview occurred with Assistant Director of Nursing (ADON) on 3/13/24 at 1:35 PM who explained that Resident #400 was admitted to the facility with the abdominal binder in place to prevent pulling him from pulling out the feeding tube. The abdominal binder was removed during bathing, care to the feeding tube, and when medications and nutrition was provided via the feeding tube. She explained she felt the abdominal binder was used for safety and had not considered it a restraint. The Director of Nursing (DON) was interviewed	F 604	residents. Beginning 4/11/2024, the Director of Nursing (DON) audited all current residents for restraints. This was completed by assessing the resident and devices being used by the resident to identify if device restricted residents movement or access to any body part freely. Additionally, the DON audited orders and care plan task for those devices. The results of the audit identified no other resident affected by the alleged deficient practice This process was completed by 4/12/2024 Systemic changes On 4/11/2024, the Director of Nursing and Administrator began an in-service education to all full time, part time, and PRN (as needed) staff including agency. Topics included: Restraint Policy including Utilization of Bedrails, Devices and Alarms The Director of Nursing will ensure that any of the above identified staff who has not received this training by 4/15/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Restraint use. The monitoring will include reviewing a sample of 5 residents to ensure staff are following facility policy for any device that restricts	

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F 604	Continued From page 55 on 3/13/24 at 1:45 PM who confirmed there was no documentation of a restraint consent or restraint assessment in the medical record for Resident #400. The DON stated the binder was being used to prevent Resident #400 from pulling out the feeding tube and was unaware it could be considered a restraint. On 3/13/24 at 2:10 PM, an interview occurred with Nurse Practitioner #1, who stated she was aware Resident #400 was using an abdominal binder but felt it was being used as an intervention to prevent him from pulling on the feeding tube. Nurse Aide (NA) #2 was interviewed on 3/13/24 at 3:20 PM and cared for Resident #400 on the 3:00 PM to 11:00 PM shift. She explained an abdominal binder had been present since he arrived at the facility and stated, "he becomes agitated with personal care. He has very spastic movements with his hands and tries to pull out the feeding tube when the abdominal binder isn't there". She added she had not observed him trying to remove the abdominal binder. On 3/14/24 at 6:33 AM, an interview was conducted with Nurse #2 who cared for Resident #400 on the 7:00 PM to 7:00 AM shift. She explained the abdominal binder had been utilized since he was admitted to the facility and was unfastened during medication and nutrition administrations. An interview was completed with NA #3 on 3/14/24 at 6:50 AM. She was assigned to care for Resident #400 on the 11:00 PM to 7:00 AM shift and stated that Resident #400 had an abdominal binder in place since his admission to the facility.	F 604	resident movement. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by to ensure their needs are met. Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 4/16/2024	

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F 604	Continued From page 56 She explained the abdominal binder was released during personal care and that although Resident #400 becomes combative with personal care he was unable to release the abdominal binder. An observation was conducted on 3/14/24 at 8:37 AM with Nurse #1. She lifted Resident #400's shirt and a white colored abdominal binder, approximately 10-12 inches wide that extended around his abdomen and secured with Velcro was observed. Nurse #1 asked Resident #400 to attempt to remove the abdominal binder. After several prompts it was evident that Resident #400 could not follow commands and made no visible effort to touch the binder. She then proceeded to unfasten the abdominal binder and provide Resident #400 with his medications and nutrition via the feeding tube. In an interview with the Administrator on 3/14/24 at 12:31 PM, she stated Resident #400's abdominal binder was medically necessary but was unaware it could be considered a restraint.	F 604		
F 641 SS=E	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, staff interviews, and record reviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of wounds (Resident #399), hospice services (Resident #22), range of motion (Resident #11), and tube feeding (Resident #57).	F 641	F641 Accuracy of Assessments For Residents #399, #11, #22, #57 corrective action was obtained by modifying and correcting the Minimum Data Set (MDS). Resident #399 Comprehensive admission assessment	4/18/24

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F 641	Continued From page 57 This deficient practice was identified for 4 of 18 sampled residents. The findings included: 1. Resident #399 was admitted to the facility on 12/20/2023 with diagnoses that included a periprosthetic fracture of the left hip, chronic embolism (a block in the artery), and thrombosis (blood clot) of deep veins of the lower extremities, and dementia. Resident #399 was discharged from the facility on 1/2/2023. Review of the admission nursing assessment completed on 12/20/2023 by Nurse #4 revealed no alterations in skin integrity including skin conditions or wounds. Review of NP #1 visit on 12/26/2023 at 12:03 PM revealed NP #1 evaluated and noted a right heel wound with skin coming off and the right great toe with a necrotic wound with right great toe and second toe crossed. NP #1 ordered a wound physician consult for right heel and right great toe and to paint right great toe with betadine twice a day. A review of Resident #399's admission Minimum Data Set (MDS) dated 12/27/2023 revealed Resident #399 had severe cognitive impairment. The MDS revealed no presence of wounds. An interview was conducted with NP #1 on 03/14/2024 at 11:14 AM. NP #1 revealed Resident #339 presented to the facility with a wound on his right great toe. She further stated that when she evaluated Resident #399, his right great toe was necrotic, and the right great toe and the second toe were crossed. She also stated	F 641	with Assessment Reference Date (ARD) 12/27/2023 was modified for coding wounds in section MO0210 and M0300. Resident #11 Quarterly assessment with Assessment Reference Date (ARD) 3/28/2024 was modified for coding of question GG0115 to accurately reflect that resident did have limitation in bilateral lower extremities. Resident #22 Significant Change assessment with Assessment Reference Date (ARD) 12/15/2023 was modified to remove Hospice from section O0110K1B. Resident #57 Quarterly assessment with Assessment Reference Date (ARD) 10/28/2023 was modified to reflect Section GG0130A as not applicable and section K to NPO status. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. An audit of 20 current residents who have had a Minimum Data Set (MDS) assessment completed during the past three months were audited in order to identify coding errors in section MO0210, M0300, GG0115, GG0130A and O0110K1B Audit results: 2 of 20 residents coded incorrectly for section GG0115 2 of 20 residents coded incorrectly for section 00110K1B MDS was modified for 4 of 20 resident identified as coded incorrectly for sectipons GG0115 and section 00110K1B. This was completed on 4/17/2024.	

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F 641	Continued From page 58 Resident #399 also had a wound on his right heel which was opened. NP #1 also stated that wound care was ordered and a consult for the wound care doctor was made on 12/26/2023. An interview was conducted with the MDS Nurse #1 on 03/14/2024 at 12:39 PM. MDS Nurse #1 revealed he reviewed the admission nursing assessment to complete Section M (Skin Conditions) on the MDS. MDS Nurse #1 also stated that there was no nursing documentation in Resident #399 medical record related to wounds or skin conditions. An interview was conducted with the DON on 03/14/2024 at 1:20 PM. The DON stated that he expected all MDS's be completely accurately based on the resident's clinical status. An interview was conducted with the Administrator on 03/14/2023 at 2:00 PM. The administrator stated that her expectation was for the MDS to be reflective of the resident's clinical condition and completed accurately. 2. Resident #22 was originally admitted to the facility on 9/4/20 with diagnoses that included venous insufficiency and type 2 diabetes. A care plan was initiated on 3/28/23, indicating Resident #22 was to receive palliative care, no terminal diagnosis was noted. A physician's order dated 6/23/23 indicated Resident #22 received palliative care services. Review of Resident #22's medical record did not reveal hospice service documentation. A modified Significant Change in Status Minimum	F 641	Systemic Changes Education was provided and completed for training the facility Minimum Data Set (MDS) nurses that included the importance of thoroughly reviewing the medical record during the assessment process and observing each resident before coding the Minimum Data Set (MDS) assessment. Special emphasis was highlighted on: " It was detailed the importance of thorough review of the medical record including progress notes, nurse aide documentation, nursing notes and observing each resident during the seven day lookback for completion of Minimum Data Set (MDS) Assessment. This information is located in the Resident Assessment Instrument (RAI) manual in chapter 3 pages G-36 through G-39 and has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the coding of MDS items utilizing the QA Tool for Accurate Coding to ensure sections GG0115/GG0130A, M0100/M0210/M0300A and 00110K1B are coded accurately.This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee	

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F 641	Continued From page 59 Data Set (MDS) Assessment dated 12/5/23 revealed Resident #22 was coded with hospice care. During an interview with the MDS Nurse #1 on 3/14/24 at 2:23 PM, he reviewed Resident #22's MDS assessment dated 12/5/23 as well as her medical record information and stated hospice care was marked in error. The Administrator was interviewed on 3/14/24 at 12:31 PM and stated it was her expectation for the MDS assessments to be coded accurately. 3. Resident #11 was admitted to the facility on 2/13/17 and had diagnoses that included contractures to the right and left knee and dementia. A Physical Therapy (PT) discharge summary dated 1/19/24 indicated Resident #11 received therapy for limited range of motion to her bilateral knees. She was discharged to nursing to don/doff bilateral knee braces when in bed. A review of Resident #11's active care plan, last reviewed 2/21/24, included a focus area for limited physical mobility related to contractures. An annual Minimum Data Set (MDS) assessment dated 3/5/24 indicated Resident #11 had severe cognitive impairment and was not coded for any limited range of motion to the lower extremities. On 3/14/24 at 2:53 PM, an interview occurred with the Rehab Director who explained that Resident #11 had decreased range of motion to her knees and was unable to fully straighten them	F 641	by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 4/18/2024	

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F 641	Continued From page 60	F 641		

out.

An observation of Resident #11 was conducted on 3/14/24 at 3:45 PM while she was lying in bed. She was unable to fully straighten out her legs when asked to do so.

During an interview with MDS Nurse #1 on 3/15/24 at 9:22 AM, he reviewed Resident #11's MDS assessment dated 3/5/24 as well as her medical record information and stated limited range of motion should have been marked for the lower extremities.

The Administrator was interviewed on 3/14/24 at 12:31 PM and stated it was her expectation for the MDS assessments to be coded accurately.
4. Resident #57 was admitted to the facility 5/20/22.

Diagnoses included nothing by mouth and attention to percutaneous endoscopic gastrostomy (PEG) tube, among others.

A physician (MD) order dated 7/13/23, recorded NPO (nothing by mouth) diet, and NPO texture.

A quarterly Minimum Data Set (MDS) assessment dated 10/18/23 assessed Resident #57 required extensive staff assistance with eating and received 51% or more of her calories from a tube feeding.

The MDS Coordinator was interviewed on 3/18/24 at 9:21 AM and reviewed Resident #57's quarterly MDS dated 10/18/23. He stated that he did not complete this MDS, and that the MDS Coordinator who completed it no longer worked at the facility. In review of the MDS, he stated that

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F 641	Continued From page 61 Resident #57 had a NPO MD order dated 7/13/23 and that the 10/18/23 quarterly MDS should have assessed Resident #57 required total staff assistance for eating. He stated that the MDS was assessed incorrectly. The Administrator and Regional Quality Assessment & Assurance (QAA) Nurse were interviewed together via phone on 3/16/24 at 5:01 PM. During the interview, the Regional QAA Nurse stated that the quarterly MDS assessment dated 10/18/23 for Resident #57 stated that the assessment of extensive assistance with eating was inaccurate because Resident #57 was totally dependent on staff to provide all her nutrition from an enteral product via a PEG tube. The QAA Nurse stated the MDS should have been coded as requiring total staff assistance. The QAA Nurse stated that the MDS was completed by prn (as needed) MDS staff who no longer worked at the facility.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		4/16/24

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F 656	Continued From page 62 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: Based on record review, observations, and staff interviews, the facility failed to develop an individualized, person-centered comprehensive care plan in the areas of wound care (Resident #399) and splints (Resident #11). This deficient practice was for 2 of 26 residents whose comprehensive care plans were reviewed.	F 656	F656 Develop/Implement Comprehensive Care Plan Resident #399: Review of resident□s care plan did not indicate impaired skin integrity and implementation of interventions	

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F 656	Continued From page 63 The findings included: 1. Resident #399 was admitted to the facility on 12/20/2023 with diagnoses that included a periprosthetic fracture of the left hip, chronic embolism (a block in the artery), and thrombosis (blood clot) of deep veins of the lower extremities, and dementia. Resident #399 was discharged from the facility on 1/2/2023. A review of Resident #399's admission Minimum Data Set (MDS) dated 12/27/2023 revealed Resident #399 had severe cognitive impairment and required extensive 2-person assistance with activities of daily living (ADL). The MDS revealed no presence of wounds or wound care. Review of the care plan dated 12/21/2023 revealed Resident #399 was care planned for being at risk for pressure ulcer development due to decreased ability to assist with repositioning with interventions to observe skin for redness and open areas and inform nurse if any areas noted and utilize pressure reducing mattress. Resident #399's care plan did not address the presence of any actual wounds and Resident #399's care plan had not been updated or revised. Review of the admission nursing assessment completed on 12/20/2023 by Nurse #4 revealed no documented alterations in skin integrity. Review of the Nurse Practitioner (NP#1) acute visit on 12/26/2023 revealed: #1. Right great toe necrotic (dead tissue with black, dry, and leathery appearance) wound. #2. Right great toe and second toe were crossed over each other #3. Right heel wound with skin coming off	F 656	Resident #¿¿¿¿¿11: Review of resident□s care plan did not indicate use of splints daily. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents have the potential to be affected by the alleged practice. Audit: 5 Residents reviewed for timely initiation of care plans to address impaired skin integrity 5 Residents had care plans initiated 5 Residents reviewed for timely initiation of care plans to address use of splints 3 Residents had care plans initiated 2 Residents did not have care plans initiated Systemic Changes: Education was provided to the facility Minimum Data Set (MDS) Coordinator in development and revision of care plans. The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident □s current needs. A comprehensive person-centered care plan will include meeting with resident, family, power of attorney or legal representative for review at least quarterly to assess and address the current needs. Monitoring Procedure to ensure that the	

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F 656	Continued From page 64 An interview was conducted with NP #1on 03/14/2024 at 11:14 AM. NP #1 revealed Resident #399 presented to the facility with a wound on his right foot. She further stated that when she evaluated Resident #399 on 12/26/2023, his right great toe was necrotic, and the right great toe and the second toe were crossed over each other. She also stated Resident #399 also had a wound to his right heel which was opened. NP #1 further indicated that wound care was ordered and a consult for the wound care doctor was made on 12/26/2023. An interview was conducted with the MDS Nurse #1 on 03/14/2024 at 1:39 PM. MDS Nurse #1 revealed he used the admission nursing assessment to complete Resident #399's MDS (Minimum Data Set) and care plans. MDS Nurse #1 also stated that there was no documentation in Resident #399 medical record related to wounds therefore Resident #399 was only care planned for being at risk for skin breakdown. The MDS nurses also revealed that Resident #399's care plan had not been revised or updated. An interview was conducted with the Administrator on 03/14/2023 at 2:00 PM. The administrator stated she expected the care plan to be reflective of the resident's current clinical condition including skin issues and presence of wounds. 2. Resident #11 was admitted to the facility on 2/13/17 with diagnoses that included contractures to the right and left knee and dementia. A review of the annual Minimum Data Set (MDS) assessment dated 3/5/24, revealed Resident #11 had severe cognitive impairment with no	F 656	plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. To ensure compliance, The Director of Nursing and/or designee will review 5 residents care plans to ensure each focus is active. This will be done on weekly basis for 4 weeks then monthly for 2 months using the audit tool. The results of this audit will be reviewed at the weekly QA Team Meeting. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM (Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 4/16/2024	

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F 656	Continued From page 65 behaviors. Review of Resident #11's Physical Therapy Discharge Summary dated 1/19/24 indicated she was discharged from therapy with bilateral knee splints for limited range of motion to her knees. Review of a Restorative or Maintenance Form dated 1/20/24 indicated Resident #11 was to wear bilateral knee splints for five to six hours as tolerated when in bed. A review of Resident #11's active care plan, last reviewed 2/21/24, included a focus area for limited physical mobility related to contractures but did not address the use of bilateral knee splints. On 3/14/24 at 3:39 PM, an interview occurred with MDS Nurse #1 who reviewed Resident #11's active care plan and confirmed the therapy recommendation for bilateral knee splints was not present. Stated he felt it was an oversight. The Director of Nursing was interviewed on 3/14/24 at 4:58 PM and stated it was his expectation for the care plan to be comprehensive and should have included the bilateral knee splints.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		4/16/24

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F 657	Continued From page 66 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the care plan for an intravenous (IV) medication (Resident #22). This was for 1 of 26 active resident care plans reviewed. The findings included: Resident #22 was initially admitted to the facility on 9/4/20 with diagnoses that included diabetes and retention of urine. The medical record for Resident #22 was reviewed and indicated she received Vancomycin (an antibiotic) 1250 milligrams (mg) per 250 milliliters (ml). Use 1250 mg intravenously one	F 657	F657 Care Plan Timing and Revision Corrective Action for Affected Residents Corrective Action The care plan for the identified resident #22 was revised in order to accurately reflect their current needs. This was completed on 03/28/2024 Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be impacted by the alleged deficient practice. An audit was conducted on 10 current residents in house to verify timely completion and revision.	

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F 657	Continued From page 67 time a day from 2/1/24 until 2/12/24. A review of the February 2024 Medication Administration Record (MAR) revealed Resident #22 received Vancomycin via IV as ordered from 2/1/24 to 2/12/24. A practitioner progress note dated 2/14/24 indicated the midline (a type of IV catheter) was removed from Resident #22. Resident #22's active care plan, last reviewed 3/5/24, included a focus area for "I am receiving IV fluids via midline with risk for complications such as infection and infiltration". A review of the March 2024 MAR revealed Resident #22 did not receive any type of IV antibiotics or fluids. On 3/14/24 at 11:50 AM, an interview occurred with the Minimum Data Set (MDS) Nurse #1 . After reviewing Resident #22's active care plan and medical record he confirmed the IV antibiotics were discontinued on 2/12/24 and the IV catheter was discontinued on 2/14/24. He stated this care plan focus area should have been resolved when it was reviewed on 3/5/24 and felt like it was an oversight. The Administrator was interviewed on 3/14/24 at 12:31 PM and indicated it was her expectation for the care plan to be accurate representation of the resident.	F 657	Audit Findings 10 Residents randomly chosen for review 3 Residents did not reflect current status 4 Residents did not reflect timely revision Systemic Changes Education was provided to the facility Minimum Data Set (MDS)Nurses on the importance of maintaining up to date care plans that are reflective of the resident□s current status and needs. Emphasis was placed on ensuring that care plans are individualized for each resident□s specific needs, and they provide safe effective care. Care plans are to be reviewed and updated with any changes and within the 7 day look back from the Assessment Reference Date for each Omnibus Budget Reconciliation Act (OBRA) assessment. Therefore, it is critical that the care plans be reviewed quarterly, updated and revised as a resident□s condition changes. Care plan updates and revisions is an on-going process. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or designee will audit up to 5 current residents in order to validate whether or not the care plans have been revised timely with the Assessment Reference Date (ARD). This will be done on weekly basis x 4 weeks	

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F 657	Continued From page 68	F 657	then monthly x 2 months. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the Director of Nursing, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 4 /16/24	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner, and staff interviews, the facility failed to transcribe the correct medication administration route for 1 of 3 residents reviewed for gastric feeding tube (Resident #400). The findings included: Resident #400 was admitted to the facility on 3/5/24, with diagnoses that included intracranial hemorrhage and presence of a gastrostomy tube.	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	4/16/24

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	345563	A. BUILDING _____ B. WING _____	C 03/26/2024

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F 658	Continued From page 69 Review of the baseline care plan included a focus area initiated on 3/6/24 revealed Resident #400 required tube feeding for all nutrition, fluids, and medications. The active March 2024 physician orders included an order dated 3/5/24 for Labetalol 200 milligrams (mg) one table by mouth two times a day for hypertension. All other medications were written to be provided through the gastric feeding tube. The physician's orders indicated Resident #400 was to have nothing by mouth (NPO). On 3/13/24 at 11:25 AM, an interview occurred with Nurse Practitioner #1 who stated that Resident #400 was NPO and received all his medications via the feeding tube. An interview occurred with Nurse #1 on 3/13/24 at 1:30 PM who was working the medication cart for Resident #400's hall and had administered his medications earlier. The nurse confirmed Resident #400 did not receive any medications by mouth and that she had provided the morning dose of Labetalol through the feeding tube. Nurse #1 was also the nurse that entered the order for Resident #400 into the Electronic Medical Record (EMR). Nurse #1 explained she entered the medication, dose, and frequency into the EMR but failed to change the medication route to gastrostomy tube (G-tube). Stated the default route was by mouth. The Director of Nursing (DON) was interviewed on 3/14/24 at 12:41 PM. He reviewed Resident #400's physician orders and confirmed the route for the Labetalol was entered as oral instead of via G-tube. He further explained that when entering the medication into the EMR the default	F 658	F 658 Services Provided Meet Professional Standards Corrective action for resident(s) affected by the alleged deficient practice For resident #400- On 3/16/2024 the Unit Manager notified the MD and clarified resident #400 order For Labetalol to accurately state the route of medication administration and transcribed to MAR. Corrective action for residents with the potential to be affected by the deficient practice On 4/15/2024 the Director of Nursing completed a 100 % audit of all current residents who have orders for feeding tubes in order to validate that the resident order and care plan accurately reflects the route in which they should receive medications. The results of the audit were 4 of 4 resident orders and care plans were accurate. This was completed on 4/15/2024 Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning 4/11/2024, the Director of Nursing began educating all full time, part time, and PRN (as needed) licensed nurses, medication aides, nurse aides and agency staff on the following topics: Professional Standards including the importance of clear and accurate orders to assure staff are providing professional standards with patient care and ensure orders and care occur per the resident care plan. Monitoring Procedure to ensure that the plan of correction is effective and that	

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F 658	Continued From page 70 route was oral and he felt it was an oversight that the nurse failed to change the route to G-tube. The DON stated it was his expectation for all medication administration routes to be entered correctly when the order was transcribed.	F 658	specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On Beginning the week of 4/22/2024, the Director of Nursing or designee will monitor compliance utilizing the QA Tool F 658 Professional Standards monitoring QA tool. Observation will include observations of medication provided via G-tube for 3 residents weekly x 4 then monthly x 2 to ensure medications are administered via correct route. The ongoing auditing program will be reviewed at the weekly Quality Assurance Meeting until deemed as no longer necessary for compliance with dignity related to Foley bags being covered. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/16/2024	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679		4/16/24

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F 679	Continued From page 71 by: Based on record review, resident, responsible party (RP) and staff interviews, the facility failed to ensure group activities were planned for rehabilitation residents to meet the needs of the residents who expressed that it was important to them to attend group activities for 3 of 3 residents reviewed for activities (Resident #37, Resident #85 and Resident #88). The findings included: A review of the March 2024 activity calendar revealed activities for inside of the facility during the week and on the weekends. Activities were scheduled daily at 11:00 AM and 2:00 PM for the duration of the month. The calendar revealed an ice cream social dated 03/01/24 and bingo twice a week on Tuesdays and Thursdays. On 03/13/24 at 10:25 AM an interview was conducted with the Activities Assistant. During the interview she stated the activities were planned by the residents during a meeting held each month. The interview revealed most activities were held in the activity room on the long-term side of the building and events were usually held at 2:00 PM daily. She stated she would normally remind residents the day before the event and on the day of the event 30 minutes prior to start time would go to the rooms of the residents that she knew would want to participate and assist them to the activity. The interview revealed she and the Activities Director would typically split the building meaning she would ask the residents on the long-term care side of the building and the Activities Director would ask residents on the rehabilitation side of the building. She stated the Activities Director had been out of the facility	F 679	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F679 Activities Meet Interest/needs of Each Resident Corrective action for resident(s) affected by the alleged deficient practice: For resident #37, #85 and #88 □ On 3/15/2024, facility ensured calendars were in the room, offered activities until discharged and care plan reviewed Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who express desire to attend activities provided by the facility have the potential to be affected by the alleged deficient practice: Beginning 4/11/2024, the Administrator and Activities Director interviewed all current residents admitted in the last 30 days with a BIMS of 13 or higher regarding their preferences for activities. The Activities Director updated resident care plans to reflect their preference for activities. For residents with BIMS of 12	

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F 679	Continued From page 72 since the beginning of March on leave. The Activities Assistant stated she had not gone to the rehabilitation side of the facility and asked residents if they wanted to attend activities scheduled. She stated she also assisted with resident admissions into the facility as part of her job duties assigned by the Administrator. She stated she only had 30 minutes to gather residents to attend activities and did not have time to go "room to room" to ask residents if they wanted to attend. The interview revealed she assisted the residents that needed to be pushed via wheelchair to the activities and if there was a large activity the Nurse Aides (NA) on the hall would assist. She stated she would ask the NA's on the hall for assistance getting the residents to the activity room. 1. Resident #37 was admitted to the facility on 02/06/24 and most recently readmitted on 02/22/24. An Admission Minimum Data Set (MDS) dated 02/06/24 indicated Resident #37 felt that it was very important to have activities that included doing things in a group setting. The assessment further indicated Resident #37 was moderately cognitively impaired. A care plan dated 02/06/24 revealed a focus area for Resident #37's interest in group bingo events. The goal was for Resident #37 to participate in group bingo events when offered. Interventions included providing reminders and assistance to group activity of interest. On 03/11/23 at 11:39 AM an interview was conducted with Resident #37's Responsible Party	F 679	or less the Activities Director reviewed and updated resident□s activity CarePlan if needed. Facility to continue to provide activity calendars monthly to inform residents of daily activities. Staff reeducated related to offering and assisting residents to activities. This was completed by 4/14/2024. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning 4/11/2024, the Administrator began education to all full time, part time, and PRN (as needed) activity staff on the following: " Activities Program Policy to include resident□s preferences " *Offering and Assisting Resident to Daily Activities This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to the above identified staff who direct activities in the facility. Any Activity staff who does not receive scheduled in-service training by 4/16/2024 will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory	

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F 679	Continued From page 73 (RP) #1. During the interview she stated Resident #37 had been discharged to the hospital and recently readmitted back to the facility (2/22/24). She stated since he had returned, he was moved to the 400 hall on the rehabilitation side of the facility. The interview revealed no staff members had come to the room and asked Resident #37 if he wanted to attend the bingo activity that the facility had twice a week. She stated on 03/01/24 the facility had an ice cream social; the interview revealed the resident had observed a staff member walk down the hall with a bowl of ice cream and told her he would like to have some ice cream. RP #1 stated she had to push the resident in his wheelchair and go find where the facility was having the ice cream social event for him to attend. She stated activities were very important to the resident and sometimes she wasn't in the building to take him. RP #1 stated all residents should be included in the activities not just the residents on the long-term side of the building. On 03/13/24 at 10:13 AM a follow up interview was conducted with RP #1. During the interview she stated according to the March activity Calendar the facility had bingo at 2:00 PM on 03/12/24. She stated she was in the resident's room on the afternoon of 3/21/24 and no one had come to the room and asked Resident #37 if he wanted to attend the activity. On 03/13/24 at 10:50 AM an interview was conducted with Nurse Aide (NA) #2. During the interview NA #2 stated she had taken care of Resident #37 on a regular basis. NA#2 stated she had never asked Resident #37 if he wanted to attend any of the activities in the facility. NA#2 stated she thought she had seen someone from	F 679	requirements. Beginning the week of 4/22/2024, The Administrator or designee will monitor compliance utilizing the F679 Quality Assurance Tool for Activities to ensure resident preferences are being honored related participating in outside activities. This will be completed weekly x 4 weeks then monthly x 2 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 04/16/2024	

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activities ask the residents if they wanted to attend.

On 03/13/24 at 10:59 AM an interview was conducted with Nurse #2. During the interview she stated she was regularly assigned to Resident #37. She indicated typically she observed someone from the Activities Department come to the hall and ask the residents if they would like to attend activities during the first week of their admission. She stated if the residents said no, then sometimes they were not asked again. She stated she had not seen anyone ask Resident #37 if he wanted to attend an activity.

On 03/13/24 at 10:35 AM an interview was conducted with the Director of Nursing (DON). During the interview he stated the Activities Director had been out of the facility on leave since the beginning of March. He stated he had not received any complaints of residents not being asked to attend activities. The interview revealed he felt the nursing staff were assisting residents to attend the activities that were scheduled.

On 03/13/24 at 11:48 AM an interview was conducted with the Administrator. During the interview she stated Resident #37's RP had never voiced any concerns to her of staff not asking if he wanted to attend activities. She stated the Activities Director had been out of the facility since the beginning of March and she was not aware of the arrangement between the Activities Director and her Assistant. The interview revealed she did not know why Resident #37 had not been asked to attend the activities in the facility.
2. Resident # 85 was admitted to the facility on 12/28/23 with diagnoses that included diabetes

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and a history of a stroke. She resided on the 300 hall, which was one of the two rehab halls.

An Activity Assessment completed by the Activity Director and dated 1/3/24 indicated the assessment was completed with Resident #85 who indicated she wanted to be invited to out of room activities.

The admission Minimum Data Set (MDS) assessment dated 1/4/24 indicated Resident #85 had severe cognitive impairment and displayed no behaviors. She was able to make herself understood and usually understood others. Preferences for Customary Routine and Activities (section F) indicated group activities were very important to her. A wheelchair was used for mobility.

On 3/13/24 at 10:25 AM, the Activities Assistant was interviewed. She explained that on a typical day when an activity is scheduled at 2:00 PM, she would remind residents the day prior and an hour before the activity by going to the rooms of the residents that she knew would participate. She added that the Activity Director normally went to the rehab side to do this task. The Activities Assistant stated that the Activity Director had been out of the facility since 3/5/24 and she had not been going to the rehab side of the building to inquire if residents wanted to go to any group activities because she didn't have enough time.

An observation and interview were conducted with Resident #85 on 3/13/24 at 1:33 PM. She was sitting in her wheelchair watching television (TV) in her room and stated she couldn't recall being asked to go to activities but, "I love being around people and it would be nice to be asked."

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A review of Resident #85's medical record from 12/28/23 to 3/14/24 didn't reveal any activity notes.

Activity logs for resident #85's participation in activities were not available for review.

On 3/14/24 at 8:32 AM, an interview occurred with Nurse Aide #13 who was assigned to care for Resident #85. She stated the activity calendars were in resident rooms and that sometimes activities will come and ask residents if they wanted to go to whatever was scheduled. She could not recall if Resident #85 was asked or assisted to attend group activities.

The Administrator was interviewed on 3/14/24 at 12:31 PM and stated she was not aware Resident #85 was not being included in group activities. The Administrator stated she didn't know the arrangement that was made by the Activity Director and Activities Assistant prior to the Activities Director leaving the facility on 3/5/24 regarding resident activity participation. She added it was her expectation that Resident #85 be invited and assisted as desired to group activities.

3. Resident #88 was admitted to the facility on 1/25/24 with recent left shoulder fracture. She resided on the 300 hall, which was one of the two rehab halls.

An Activity Assessment completed by the Activity Director and dated 2/1/24 indicated the assessment was completed with Resident #88 who indicated she wanted to be invited to out of

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room activities.

The Admission MDS assessment dated 2/1/24 indicated Resident #88 had moderately impaired cognition and displayed no behaviors. Preferences for Customary Routine and Activities (section F) indicated group activities were very important to her.

Resident #88's care plan included a focus area for an interest in group activities and a willingness to participate. One of the interventions included to provide reminders and assistance to group activities of interest before they start.

On 3/13/24 at 10:25 AM, the Activities Assistant was interviewed. She explained that on a typical day when an activity was scheduled at 2:00 PM, she would remind residents the day prior and an hour before the activity by going to the rooms of the residents that she knew would participate. She added that the Activity Director normally went to the rehab side to do this task. The Activities Assistant stated that the Activity Director had been out of the facility since 3/5/24 and she had not been going to the rehab side of the building to inquire if residents wanted to go to any group activities because she didn't have enough time.

An observation and interview were conducted with Resident #88 on 3/13/24 at 1:39 PM. She was sitting in her wheelchair watching television (TV) and stated she hadn't been asked or told anything about the activities going on for the day but would like to be given a choice of attending or not.

A review of Resident #88's medical record from 1/25/24 to 3/14/24 did not include any activity

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F 679	Continued From page 78 notes. Activity logs for resident #88's participation in activities were not available for review. On 3/14/24 at 8:32 AM, an interview occurred with Nurse Aide #13 who was assigned to care for Resident #88. She stated activity calendars were in resident rooms and that sometimes activities will come and ask residents if they wanted to go to whatever was scheduled. She could not recall if Resident #88 was asked or assisted to attend group activities. The Administrator was interviewed on 3/14/24 at 12:31 PM and stated she was not aware Resident #88 was not being included in group activities. The Administrator stated she didn't know the arrangements that were made by the Activity Director and Activities Assistant prior to her leaving the facility on 3/5/24 regarding resident activity participation. She added it was her expectation that Resident #88 was invited and assisted as desired to group activities.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		4/16/24

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F 684	Continued From page 79 Based on observations, resident, staff and Nurse Practitioner interviews, the facility failed to accurately assess and failed to obtain wound care orders for skin condition of the right great toe and the right heel (Resident #399). The facility also failed to follow a physician order to remove staples from a surgical wound (Resident #93). The deficient practice was for 2 of 4 sampled residents for wound care (Resident #93 and Resident #399). The findings included: 1. Review of Resident #399's hospital discharge summary dated 12/20/2023 revealed Resident #399 would be discharged to the facility but had no documentation regarding Resident #399 right foot wound or wound care orders. Resident #399 was admitted to the facility on 12/20/2023 with diagnoses that included a periprosthetic fracture of the left hip, chronic embolism (a block in the artery), and thrombosis (blood clot) of deep veins of the lower extremities, and dementia. Resident #399 was discharged from the facility on 1/2/2024. Review of the Nurse Practitioner's (NP #1) hospital discharge summary review of an incoming new admission note dated 12/20/2023 at 5:57 PM revealed no notation regarding Resident #399's right foot wounds or wound care orders. Review of the facility's admission skin assessment completed on 12/20/2023 at 6:48 PM by Nurse #4 revealed Resident #399 had intact skin with no skin issues identified.	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F684 Quality of Care Corrective action for resident(s) affected by the alleged deficient practice: For resident #399- No corrective action. Resident discharged from facility For resident #93- On 3/12/2024 Resident assessed by Unit Manager with no signs or symptoms or infection noted MD notified and order given to remove staples. Unit Manager removed resident #93 staples with no issues. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 4/12/2024 the Director of Nurses began auditing all current residents by completing body audits to identify any new wounds or surgical wounds that did not have treatment orders in place. The results of the audit identified no other residents affected by alleged deficient practice. This audit was completed as of 4/14/2024. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 4/11/2024, the Director of	

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F 684	Continued From page 80 Review of the facility's admission nursing assessment completed on 12/20/2023 at 6:54 PM by Nurse #4 revealed an initial skin assessment was completed with no skin abnormalities observed. An interview was completed on 03/13/2024 at 2:14 PM with Nurse #4 who admitted Resident #339 to the facility on 12/20/2023. Nurse #4 revealed that she completed the admission nursing assessment on Resident #399. She also stated that she did a head-to-toe skin assessment, and her documentation would reflect her assessment, but she did not remember much about Resident #399. Review of Resident #399's care plan dated 12/21/2023 revealed Resident #399 was care planned for being at risk for pressure ulcer development due to decreased ability to assist with repositioning with interventions to observe skin for redness and open areas and inform nurse if any areas noted and utilize pressure reducing mattress. Resident #399's care plan did not address the presence of any actual wounds. Review of a nursing note dated 12/23/2024 at 2:18 PM completed by Nurse #3 revealed the occupational therapist (OT #1) informed Nurse #3 that resident #399 was bleeding from his right heel. Nurse #3 removed Resident #399's sock and observed the right heel to have had a skin tear. The right heel wound was cleaned with normal saline (NS) and steri-strips were applied and covered with dry dressing. There were no orders written for wound care. An interview was conducted with occupational therapist (OT #1) on 03/14/2024 at 3:11 PM. OT	F 684	Nursing began in-service education to all full time, part time, and as needed and agency licensed nurses and certified nursing assistants. Topics included: " Wound Management Policy This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified nursing staff who does not receive scheduled in-service training by 4/15/2024 will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 4/22/2024, The Director of Nursing, and/or designee will utilize the QA tool for Wound Monitoring to monitor compliance with wound management protocols. The Director of Nurses, and/or designee will monitor 5 newly admitted residents to ensure treatment orders have been initiated and transcribed to MAR and completed as ordered. This will be completed weekly for 2 weeks, then monthly for 2 months This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). Identified area of	

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F 684	Continued From page 81 #1 stated that she was assisting Resident #399 on 12/23/2024 with ambulation and noticed his right sock was wet and red. She assisted Resident #399 to a sitting position and immediately went and got Resident #399's nurse (Nurse #3) to assess Resident #399's heel. Several unsuccessful attempts were made to contact and interview Nurse #3. Review of a nursing note dated 12/24/2024 at 6:37 PM by Nurse #3 revealed Resident #399 was alert with some confusion and was compliant of all medications. Resident #399 was observed with a right heel skin tear. Nurse #3 applied a dry dressing and wrapped the right heel with Kerlix. An entry was also placed in the physician's communication book for Resident #399 to be seen and evaluated by the wound physician for right heel skin tear. Review of NP #1 visit on 12/26/2023 at 12:03 PM revealed NP #1 noted a right heel wound with skin coming off and the right great toe with a necrotic wound with right the great toe and the second toe crossed. NP #1 ordered a wound physician consult for the right heel and the right great toe. NP #1 also ordered to paint Resident #399's right great toe with betadine twice a day. Review of a subsequent weekly skin assessment dated 12/27/2023 completed by Nurse #12 revealed no new skin concerns and no documentation of the right heel wound or the right great toe wound. Several unsuccessful attempts were made to contact and interview Nurse #12.	F 684	concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director. Date of Compliance: 4/16/2024	

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A review of Resident #399's admission Minimum Data Set (MDS) dated 12/27/2023 revealed Resident #399 had severe cognitive impairment and required extensive 2-person assistance with activities of daily living (ADL). The MDS revealed no presence of wounds or skin issues.

Review of the physician orders revealed on 12/28/2023 an order was placed to clean Resident #399's right heel with normal saline (NS), apply betadine, and wrap with Kling daily.

Review of Resident #399's December 2023 Treatment Administration Record revealed all treatments were completed as ordered by the physician.

Review of Resident #399 electronic medical record revealed no facility wound measurements were documented for Resident #399's right heel or right great toe.

An interview was conducted with the NP on 03/14/2024 at 11:14 AM and on 03/19/2024 at 3:30 PM. NP #1 stated Resident #339 was admitted to the facility with a necrotic right toe. NP#1 also stated from her clinical assessment and discussion with Resident #399's wife, who told the NP #1 that Resident #399 had issues with his right great toe for over 10 years. NP #1 stated the necrotic toe was not a new finding as Resident #399 had severe peripheral artery disease (PAD) and both lower legs and feet were discolored from lack of circulation to the lower extremities. She further stated that when she evaluated Resident #399 on 12/26/2023 his right great toe was black, and the right great toe and the second toe were crossed. Resident #399 also had a skin tear on his right heel which had

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started to open. NP#1 indicated she thought the right heel wound had opened because Resident #399 was walking to and from the bathroom with a walker and that caused the skin tear to open. NP #1 also stated that she ordered the right great toe painted with betadine twice a day, the right heel to be cleansed with normal saline and wrapped with gauze daily and a consult for the wound care physician to evaluate both wounds. She stated she changed the right heel wound care orders on 12/28/2024 to clean the right heel with normal saline (NS), apply betadine, and wrap with Kling daily. NP#1 also revealed it was unlikely that Resident #399's wounds on his right feet would heal due to the severity of the PAD. She further stated the wound care doctor was scheduled to see Resident #399 on 01/02/2024 but Resident #399 was transferred to the hospital before the wound care doctor saw him.

An interview was conducted with the Director of Nursing (DON) 03/14/2024 at 1:51 PM who stated he was not familiar with Resident #399, but he expected an accurate head to toe skin assessment be performed on all residents and the skin assessment should be documented completely and accurately.
2. Resident #93 was admitted to the facility on 02/21/2024 with a diagnosis of displaced intertrochanter fracture to the right femur repair.

A hospital discharge summary dated 02/21/24 revealed a physician order to remove the staples post operative day #14. The hospital discharge summary revealed Resident #93 had surgery to repair the right femur on 02/12/24.

An admission Minimum Data Set (MDS) assessment dated 02/21/24 revealed Resident

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#93 was moderately cognitively impaired. Resident #93 was coded as having a surgical wound.

The active physician's orders for February 2024 for Resident #93 included no orders to remove the resident's staples post operatively.

On 03/11/24 at 10:36 AM an interview was conducted with Resident #93's Responsible Party (RP)#1. During the interview she stated the resident had a right hip surgery repair approximately 4 weeks prior and that her surgical site was looking good with the staples still intact.

On 03/12/24 at 2:10 PM an observation was conducted with Nurse #6 of Resident #93's surgical site to the right hip. During the observation 3 incision sites were noted to the right hip with a total of 17 staples present in the surgical site. Nurse #6 stated, "the site looks great".

On 03/12/24 at 2:15 PM an interview was conducted with Nurse #6. During the interview the surveyor asked Nurse #6 to review Resident #93's hospital discharge summary orders. She stated she saw an order to remove the resident's surgical staples post operatively on day 14 which should have been 02/26/24. The interview revealed Unit Manager #1 had completed the resident's admission and should have entered the order into the system for it to show up onto the Treatment Administration Record for the nurse to remove the staples. Nurse #6 stated the order was never entered into the system. She stated she typically worked third shift and did not realize when Resident #93's surgical staples needed to

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be removed.

On 03/12/24 at 2:30 PM an interview was conducted with Unit Manager #1. During the interview she stated once a resident was admitted into the facility, she would take the hospital discharge summary and input the physician orders into the electronic system. She stated the order had been missed by her when she was completing the resident's admission. Unit Manager #1 stated the resident's staples should have been removed on 02/26/24 and she would have to notify Nurse Practitioner #1.

On 03/12/24 at 2:45 PM an interview was conducted with Nurse Practitioner #1. During the interview she stated she stated she had just given Unit Manager #1 a verbal order to remove the surgical staples immediately. She stated the staples should have been removed per the physician orders on the hospital discharge summary but since it had only been two weeks past the 14th day that it shouldn't be an issue to remove the staples. She stated she would evaluate the resident's incision site the following day.

An observation was conducted on 03/12/24 at 3:02 PM of Unit Manager #1 removing Resident #93's staples from the surgical incision located on her right hip. Unit Manager #1 removed a total of 17 staples from the surgical site without difficulty. Resident #93 fell asleep during the procedure.

On 03/12/24 at 3:50 PM an interview was conducted with the Director of Nursing (DON). During the interview he stated the nurses should follow the orders listed on the hospital discharge summary. He stated the staples should have

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F 684	Continued From page 86 been removed post operatively on day 14 and it should have been caught during the weekly skin assessments. On 03/12/24 at 4:20 PM an interview was conducted with Wound Physician #1. During the interview he stated he had not seen Resident #93 but that he often had to tell staff when he saw staples in surgical wounds, that they needed to be removed.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to apply bilateral knee splints according to therapy recommendations for 1 of 1 resident reviewed for limited range of motion (Resident #11).	F 688	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state	4/16/24

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F 688	Continued From page 87 The findings included: Resident #11 was admitted to the facility on 2/13/17 with diagnoses that included contractures to the right and left knee and dementia. A Physical Therapy (PT) initial evaluation dated 1/5/24 indicated Resident #11 would receive therapy for decreased range of motion to her bilateral knees. A PT discharge summary dated 1/19/24 indicated Resident #11 received therapy for limited range of motion to her bilateral knees. She was discharged to nursing to don/doff the braces when in bed. The Rehab Director was interviewed on 3/14/24 at 2:54 PM and explained that Resident #11 was under PT therapy caseload for decreased range of motion to her knees. When she was discharged, nursing would continue to apply the bilateral knee splints when she was in bed. The Rehab Director was interviewed again on 3/14/24 at 4:09 PM and explained that upon discharge from therapy, nursing staff were educated and trained on the application of the bilateral knee splints for Resident #11. The Rehab Director added the therapy department typically did not enter orders into the resident's chart regarding splinting devices but would have provided a referral form to nursing when the resident was discharged. Together an observation occurred of Resident #11's room and the bilateral knee splints were not present. Review of Restorative or Maintenance Record	F 688	regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F688 Increase/Prevent Decrease in ROM/Mobility Corrective action for affected residents. For Resident#11, On 3/15/2024, Resident assessed by Unit Manager. No acute distress noted. MD notified and no new orders. Order for knee splints updated on MAR and splints applied. Corrective action for potentially affected residents. Residents who utilize a splint for contractures have the potential to be affected. On 4/11/2024, the Director of Nursing audited all current residents for contractures. This was completed by assessing the resident□s extremities and placing them through ROM to determine if a contracture were present. If a new or worsening contracture was noted, a therapy referral will be initiated by the Nurse Manager. This process will be completed by 4/13/2024. Beginning 4/11/2024, the nurse managers audited all current residents to establish which residents had MD orders for devices such as a splint, brace, palm guard, or hand roll. This was accomplished by auditing orders and care plan task for those devices. Once it was determined who needed a splint, brace, palm guard, or hand roll, the nurse	

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F 688	Continued From page 88 (referral form) dated 1/20/24, indicated nursing staff was educated on the bilateral knee splints for Resident #11. The record indicated that bilateral knee extensor braces were to be worn for five to six hours as tolerated when in bed. A review of Resident #11's active care plan, last reviewed 2/21/24, included a focus area for limited physical mobility related to contractures. The interventions did not include the use of bilateral knee splints. An annual Minimum Data Set (MDS) assessment dated 3/5/24 indicated Resident #11 had severe cognitive impairment and was coded inaccurately with no limited range of motion. A review of the February 2024 and March 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not include an entry for Resident #11's bilateral knee splint application or removal. On 3/13/24 at 3:28 PM, Nurse Aide (NA) #5 was interviewed and stated she cared for Resident #11 on the 7:00 AM to 7:00 PM shift. She explained that Resident #11 used her hands to self-propel in the wheelchair. She stated she has not seen Resident #11 with bilateral knee splints on nor has she been asked to apply or remove them. NA #6 was interviewed on 3/13/24 at 5:18 PM and stated she has not seen bilateral knee splints on Resident #11 during the 7:00 AM to 7:00 PM shift. Nurse #12 was interviewed on 3/14/24 at 7:10 AM and stated he cared for Resident #11 during the	F 688	managers and MDS nurse ensured the device were in place, had an MD order, CNA task, and care plan. This process will be completed by 4/13/2024. Systemic changes Beginning 4/11/2024, the Director of Nursing began an in-service education to all full time, part time, and as needed licensed nurses and certified nursing assistants including agency. Topics included: SPLINTS ¿ The importance for applying splints, palm guards, hand rolls as ordered by the MD. ¿ Inspecting skin at least daily or more frequently as ordered for irritation, redness or skin breakdown. ¿ What to do when the device cannot be located. The Director of Nursing will ensure that any Licensed Nurse or CNA who has not received this training BY 4/15/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the Quality Assurance Tool for Splint and Brace use. The monitoring will include reviewing a sample of residents who require a splint or brace to ensure it is applied and removed per MD orders. This will be completed weekly for 4 weeks then	

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F 688	Continued From page 89 7:00 PM to 7:00 AM shift. He stated Resident #11 didn't wear bilateral knee splints and was unaware she was supposed to. An observation of Resident #11 occurred on 3/14/24 at 3:45 PM. She was lying in bed and did not have knee splints on. Nurse #5 was interviewed on 3/14/24 at 3:54 PM, who was assigned to care for Resident #11 on the 7:00 AM to 7:00 PM shift. She stated she had not applied any knee splints to her and did not see an order for this on the administration records. The Director of Nursing was interviewed on 3/14/24 at 4:58 PM and explained the order for Resident #11's bilateral knee splints did not show up on the NA flow record or nursing MAR/TAR because when the order was put in it was put in under an auxiliary tab which did not go anywhere. He further stated there was a drop down box when the order was put in and the TAR box should have been checked so the order would show up for the nursing staff to put on and remove the bilateral knee splints.	F 688	monthly times 2 months or until resolved by to ensure their needs are met. Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 4/16/2024	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters	F 692		4/16/24

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F 692	Continued From page 90 of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the Registered Dietitian (RD), the Nurse Practitioner (NP) #1 and NP #2, staff, and record review, the facility failed to follow a recommendation from the RD to reweigh Resident #36 for further evaluation after an assessment of significant weight loss. Additionally, the facility failed to implement a plan from NP #2 in response to subtherapeutic total protein lab results for Resident #11. This failure occurred for 2 of 7 sampled residents reviewed for nutritional status. The findings included: 1. Resident #36 was admitted to the facility on 11/15/23. Diagnoses included severe obesity, lymphedema, peripheral arterial disease, resistant hypertension, chronic cellulitis of right/left lower limbs, supplemental oxygen dependency, obstructive sleep apnea, hypercholesterolemia, gastro-esophageal reflux disease, and type 2 diabetes mellitus, among others. A quarterly Minimum Data Set assessment dated	F 692	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F692 Nutrition/Hydration Status Maintenance Corrective action for resident(s) affected by the alleged deficient practice: For resident #36-On 3/13/2024, Corrective action was obtained for resident by reweighing and updating the electronic medical record. Resident reweight showed weight gain of 44lbs. in 30 days. MD notified and new order given to give additional dose of Lasix 40mg daily x 3 days. Dietician and RP notified of reweight. On 4/10/2024 resident #36 has	

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F 692	Continued From page 91 1/6/24 assessed Resident #36 with intact cognition, no behaviors, and no rejection of care. He weighed 326 pounds with no significant weight loss/gain. He received a therapeutic diet and diuretic therapy. A care plan revised on 1/9/24 revealed he had the potential for nutritional decline due to severe obesity, receipt of a therapeutic diet, diuretic therapy, and a history of weight gain. Interventions included RD evaluations and recommendations. The electronic medical record for Resident #36 recorded the following weights: - 1/2/24, 326 pounds - 2/2/24, 305 pounds (21pound loss) Review of the electronic medical record for Resident #36 revealed his last recorded weight was obtained on 2/2/24. A RD progress note dated 2/6/24, recorded a weight warning of 6.4% weight change in 30 days with a recommendation to obtain a reweight due to a large discrepancy from the previous weight. Electronic mail (email) communication dated 3/11/24 was provided to the surveyor by the RD for review. The subject was recorded as, "Weight list has been reviewed" and documented a request from the RD to the Unit Manager (UM) #2 to obtain a monthly weight for Resident #36 for March 2024. A 3/11/24 NP #1 progress note recorded Resident #36 was assessed for chronic left lower extremity edema, chronic cellulitis, and weeping. NP#1 ordered antibiotic therapy for 10 days.	F 692	new order for weekly weights x 4 weeks per MD. For resident #11- On 4/5/2024, Corrective action was obtained by collecting Complete Metabolic Panel (CMP). MD notified. Resident□s Total Protein 6.2 and within normal limits. Corrective action for residents with the potential to be affected by the alleged deficient practice. All current resident at risk for nutrition and hydration have the potential to be affected by the alleged deficient practice. Beginning 4/12/2024, the Director of Nursing completed a weight audit on all current residents for past 30 days to ensure each had accurately recorded weights and no significant weight loss. All residents have had their weights, orders and plan of care reviewed by the Director of Nursing/Unit Coordinators on 4/12/2024 to ensure proper documentation in electronic medical record. No further concerns noted. On 4/14/2024, the Director of Nursing compared most recent resident weights to assess for significant weight loss (>5% in 30 days and >10% in 180 days). On 4/14/2024, the physician, the responsible party and Registered Dietician were notified of most recent significant weight losses by Director of Nursing or Unit Coordinators. Registered Dietician and physician to review and suggest or order interventions. Additionally, the Director of Nursing reviewed all resident□s labs for CMP for the last 30 days to ensure that anyone with subtherapeutic protein levels had	

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F 692	Continued From page 92 At the request of the surveyor, staff obtained a current weight for Resident #36 on 3/13/24 of 349 pounds, a gain of 44 pounds, or 14.4%, in 30 days. A 3/13/24 nurse progress note written by Unit Manager (UM) #2 recorded the NP (NP #1) was notified of Resident #36's weight gain and a new physician (MD) order was written to give extra Lasix 40 mg once daily for three days due to significant weight gain. Review of MD orders for Resident #36 revealed the following medications were prescribed: - A MD order dated 11/15/23, Furosemide (diuretic for removing excess fluid) 20 milligrams (mg) give one tablet by mouth two times a day. - A MD order dated 3/11/24, Doxycycline Monohydrate Capsule (antibiotic) 100 mg, give 1 capsule by mouth two times a day for chronic cellulitis, for 10 days. - A MD order dated 3/13/24, Furosemide 40 mg, give one tablet by mouth in the afternoon for increased weight for 3 days. Resident #36 was interviewed and observed on 3/11/24 at 11:48 AM in his recliner in his room. His right and left lower extremities were observed swollen, red, and peeling. He stated that for the past month, he had increased pain in his left lower leg due to the swelling. He stated that he received pain medication daily for his pain, and that it usually relieved his pain, but for the past month, due to the increased swelling, the pain medication had not worked as well. He also stated that he had not reported this concern to staff.	F 692	been addressed by MD. The results identified no other resident affected by alleged deficient practice. This was completed by 4/14/2024. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: The Director of Nursing, Dietary Manager and Minimum Data Set Nurse will conduct weekly weight review to determine if new interventions are needed. On 4/11/2024, the Director of Nursing and Unit Managers were re-educated by QA Nurse Consultant on Weight Management Policy/Nutrition and Hydration, monitoring and correcting inaccuracies in weights and on the importance following up with recommendations from the dietician related to reweights no less than weekly. Beginning 4/11/2024, The Director of Nursing began educating all clinical nursing staff (RN LPN, Medication Aide or Nurse Aide) regarding the importance of notification of weight losses of 5 lbs. or more and initiation interventions to prevent further weight loss. The Director of Nursing will ensure that any licensed nurse (RN, LPN), Medication Aide or Nurse Aide who has not received this training by 4/15/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency	

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F 692	Continued From page 93 Resident #36 was interviewed and observed on 3/13/24 at 5:08 PM. During the interview, he was eating dinner. His right and left lower extremities were both observed swollen, red, and peeling. He stated that he was weighed monthly at the facility and received diuretic therapy for his legs. He stated his last weight was obtained once in February 2024 and reflected weight loss. The Unit Manager (UM) #2 was interviewed on 3/14/24 at 1:53 PM and stated that the facility received electronic mail (email) communication from the RD when she had residents, she wanted reweighed. The UM #2 stated she did recall receiving an email from the RD requesting a reweight for Resident #36 and that she was responsible for obtaining reweights for the RD. The UM #2 stated she could not recall if she obtained a reweight for Resident #36 at the request of the RD, but that she would obtain his weight. A follow up interview with the UM #2 on 3/14/24 at 2:45 PM revealed the current weight for Resident #36 was 349 pounds. The RD was interviewed on 3/14/24 at 1:01 PM. The RD stated she sent an email on 2/6/24 to the facility to request a reweight for Resident #36 because of the significant weight loss in 30 days. The RD stated she sent a second email to the facility on 3/11/24 to follow up on her request, but that she had not yet received a response. The RD provided copies of the emails for review. In a follow up interview with the RD on 3/14/24 at 3:00 PM she stated the current weight for Resident #36 was 349 pounds, which was a 14.4% gain. The RD stated that a gain of that amount, was likely fluid, and that he should be evaluated by the provider due to the significant increase for a possible decline in his cardiac status and the risk	F 692	Nurses and Nurse Aides who give residents care in the facility. QUALITY ASSURANCE- Beginning 4/22/2024, the DON and/or designee will review 5 residents to include new admissions weight weekly and CMP labs using the QA tool for monitoring Weights/Subtherapeutic Lab (protein levels) to ensure accuracy of documentation, notification, implementation and follow up of orders and interventions as appropriate. Audits will be completed weekly x 4 weeks, then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/16/2024	

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of exacerbating his diagnoses of lymphedema and chronic cellulitis.

A 3/14/24 RD progress note recorded Resident #36 was noted with a significant weight gain of 14.4% in 30 days which was discussed with the Unit Manager (UM #2) to notify the provider of the significant weight gain.

A phone interview with the NP #1 on 3/14/24 at 4:00 PM revealed she received notification on 3/14/24 of the current weight for Resident #36 and due to his significant weight gain, she ordered diuretic therapy for three days. The NP stated that Resident #36 required intermittent diuretic therapy a lot, due to diagnoses of lymphedema, severe obesity, and chronic cellulitis, but that in her current assessment, he did not present clinically with signs or symptoms of distress because of the current weight gain. NP #1 stated she saw Resident #36 asleep in his recliner during her clinical rounds on Friday, 3/8/24, but because he was asleep, she did not talk to him. She stated that his legs were swollen, but were not elevated, and that on 3/11/24 when she saw him during clinical rounds, his legs were noted with increased swelling, more swollen than they were on Friday, 3/8/24 so she ordered antibiotic therapy to address his chronic cellulitis. The NP #1 stated that she would expect the RD recommendation to obtain a reweight to be completed within a week or so for further evaluation of the clinical risks associated with significant weight changes.

A phone interview with the Administrator and Regional Quality Assessment and Assurance Nurse Consultant occurred on 3/16/24 at 5:01 PM. The Administrator stated that if the RD

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recommends a reweight, it should be obtained within one week. She further stated that if the weight results reflected a significant loss/gain, the results were discussed during clinical meetings and the provider was notified for further evaluation.

2. Resident #11 was admitted to the facility on 12/9/21. Diagnoses included protein calorie malnutrition (PCM), dementia, chronic kidney disease (CKD) stage 3, abnormality of albumin (a protein made in the liver), and adult failure to thrive, among others.

Review of the electronic medical record for Resident #11 recorded a physician order dated 12/9/21 for a pureed textured diet.

Continued review revealed lab results for Resident #11 dated 7/26/23 from a Comprehensive Metabolic Panel (CMP) (a blood test) which indicated total protein results of 5.9 grams/deciliter (g/dl). The normal range was recorded as 6.0 - 8.3 g/dl.

The nutrition care plan revised 1/9/24 identified Resident #11 was at risk for nutritional decline due to receipt of a mechanically altered diet. Interventions included obtaining and monitoring lab/diagnostic work as ordered, reporting results to the provider, and following up as indicated.

A quarterly Minimum Data Set assessment dated 1/11/24 assessed Resident #11 with severely impaired cognition, and receipt of a mechanically altered diet.

A 2/16/24 progress note written by NP #2 recorded lab results were reviewed regarding her

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diagnoses of CKD, PCM and a history of subtherapeutic total protein lab results (5.9 g/dl on 7/26/23). The NP #2 wrote a plan for PCM, to continue a (brand name) protein supplement and update labs.

Review of the medical record for Resident #11 revealed there was no active physician order for a protein supplement.

A CMP for Resident #11 dated 2/21/24 indicated total protein results were 5.8 g/dl (low).

A NP #2 progress note dated 3/6/24 recorded NP #2 assessed Resident #11 for a monthly visit and reviewed labs from February 2024 and noted her total protein results were 5.8 g/dl (low). NP #2 did not record any new orders or changes regarding the lab results.

Resident #11 was observed in her room on 3/13/24 at 5:30 PM eating her dinner meal independently. She received a pureed meal per diet order and ate 100% of her meal.

The Assistant Director of Nursing (ADON) stated in an interview on 3/14/24 at 11:44 AM that Resident #11 did not have a current order for a protein supplement. The ADON stated that it was not typical practice for nursing staff to review the NP progress notes to obtain orders, but that the NP usually wrote their own orders or gave nursing a verbal/written order to implement. The ADON stated she was not aware of a verbal/written order for a protein supplement for Resident #11.

The RD stated in an interview on 3/14/24 at 12:45 PM that she completed dietary assessments on admission, quarterly, annually and with a

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significant change, but that these assessments did not include a review of lab results. The RD stated that she would receive a request for a consultation if the provider identified a nutrition concern after admission that required RD intervention. The RD reviewed the electronic record for Resident #11 and stated that the last protein supplement order was because of low albumin lab results for Resident #11 and that the order was discontinued on 3/12/23. The RD further stated Resident #11 did not have a current order for a protein supplement.

A phone interview with NP #2 occurred on 3/14/24 at 11:24 AM. NP #2 stated that she was new to the facility, and when she completed her assessment of Resident #11 on 2/16/24 she reviewed her lab results history and noted Resident #11 had a history of total protein lab results that was slightly subtherapeutic, and that a protein supplement was effective for her in the past. NP #2 stated that since Resident #11 had been successful with receiving a protein supplement in the past, NP #2 wrote in her plan to continue the protein supplement because she thought the order for the protein supplement was still active. NP #2 stated that she thought Resident #11 was already receiving a protein supplement, so she wrote a plan to continue it. NP #2 stated it was her usual practice to write her own orders, but that in the case of Resident #11, she did not write a new order for the protein supplement because her plan was to continue a supplement that she thought Resident #11 currently received.

A phone interview with the Administrator and Regional Quality Assessment and Assurance (QAA) Nurse Consultant occurred on 3/16/24 at

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F 692	Continued From page 98 5:01 PM. The Regional QAA Nurse Consultant stated that NP #2 wrote in her progress note on 2/16/24 for Resident #11 a plan to continue the protein supplement, but the physician order should have been relayed to nursing to implement the order or NP #2 should have written and implemented the order. The Administrator stated that she expected all physician orders to be reviewed and followed.	F 692		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		4/16/24

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F 732	Continued From page 99 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post daily nurse staffing in a prominent location that was readily accessible to residents on 5 of 5 days during the survey (03/11/2024, 03/12/2024, 03/13/2024, 03/14/2024, and 03/15/2024). The findings included: An observation on 03/11/2024 at 9:45 AM revealed the daily nurse staff posting was located on the ledge of the receptionist's desk in the front lobby which was accessible to staff and visitors. The daily nurse staffing sheet was a white, 8 X 10-inch piece of paper enclosed in a hard plastic display holder. The lobby was only accessible to the residents by entering through a closed double door access which had to be manually opened. The daily nurse staff posting was not readily visible or accessible for residents to view. Additional observations on 03/12/2024 at 8:00 AM, 03/13/2024 at 7:45 AM, 03/14/2024 at 7:25 AM, and 03/15/2024 at 8:13 AM of the facility's daily nurse staff posting revealed it was located on the ledge of the receptionist's desk in the front lobby and was not readily visible or accessible for	F 732	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F732- POSTED NURSE STAFFING INFORMATIPON Corrective action for affected residents. On 3/11/2024, Facility moved daily staff posting from front entrance lobby and posted the Nurse Staffing Information at the counter in the hallway which is accessible to all residents and visitors. Corrective action for potentially affected residents. All residents who reside in the facility have the potential to be affected by the alleged deficient practice. On 3/11/24, Facility moved daily staff postings from front entrance lobby and	

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F 732	Continued From page 100 residents to view. An interview was conducted with the Director of Nursing (DON) on 03/13/2024 at 10:21 AM. The DON revealed that the residents could view the daily staff posting if they entered the lobby. He further stated the residents would have had to manually open the double doors and enter the lobby in order to view the daily staff posting. The DON also stated this is where the daily staff posting had been located for quite a long while. An interview was conducted with the Administrator on 03/14/2024 at 11:13 AM. The Administrator revealed the facility's daily staff posting should be placed in an area that was readily accessible and visible for residents to view. She also stated the staff daily staff posting had been displayed in this area since she had been with the facility.	F 732	posted the Nurse staffing information at the counter in the hallway which is accessible to all residents and visitors. Systemic changes Beginning 4/11/2024, the Administrator in-serviced the Director of Nursing, the Unit Managers, the Evening Supervisor and Scheduler on the requirements of Nursing Information Posting. The Director of Nursing will ensure that any of the above identified staff who has not received this training by 4/15/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance The Director of Nursing or the Administrator will monitor this issue using the Quality Assurance Tool for Nurse Staff Posting. The review will consist of observing staff posting sheets daily x5 x 2 weeks then weekly x 2 weeks then monthly x 2 months or until resolved. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.	

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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 732	Continued From page 101	F 732	Date of compliance: 4/16/2024	
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family member, staff interviews, Hospice Nurse, Nurse Practitioner (NP), and Medical Director interviews the facility failed to prevent a significant medication error when Resident #28 was not administered scheduled nebulizer treatments (medical device that delivers liquid directly into the lungs) as ordered by Hospice despite repeated requests. Resident #28 had a diagnosis chronic obstructive pulmonary disease with oxygen use and had orders for nebulizer treatments at 9:00 am, 11:00 am, 1:00 pm and 5: 00 pm during the 7:00 am to 7:00 pm (day shift). Resident #28 reported he was only administered one nebulizer treatment during the day shift on 3/9/24 and 3/10/24 and experienced chest pain on 3/9/24. This had the high likelihood of a serious adverse outcome including psychological stress which would affect his breathing, cardiac status, and increase his heart rate. The deficient practice occurred for 1 of 1 resident reviewed for significant medication errors. Immediate jeopardy began on 3/9/24 when Resident #28 was not administered scheduled nebulizer treatments despite repeated requests. The immediate jeopardy was removed on 3/19/24 when the facility provided and implemented an acceptable credible allegation of Immediately	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F-760 Resident are Free of Significant Med Errors Corrective action for resident(s) affected by the alleged deficient practice: The resident was interviewed by the Administrator on 3/14/24 about 3/9/24 and 3/10/24 and not receiving nebulizer treatments. The resident reported he suffered from chest pain as a result of not receiving the scheduled nebulizer medication. The resident continues to have assessments (respiratory, pain assessments) to assess for any serious adverse outcome including any significant decline or respiratory distress. Resident # 28 is receiving routine vital signs every shift including pulse ox (documented in	3/27/24

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	345563	A. BUILDING _____ B. WING _____	C 03/26/2024

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F 760	Continued From page 102 Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place are effective related to preventing a significant medication error. The findings included: Resident #28 was admitted to the facility on 2/23/24 with diagnoses inclusive of chronic obstructive pulmonary disease (COPD), heart failure, hypertension, and anxiety. An admission MDS assessment dated 3/1/24 indicated Resident #28 was cognitively intact, was receiving hospice care and required maximal assistance with toileting, showering, and dressing. The assessment further indicated rejection of care 1-3 times and use of oxygen. A care plan dated 2/26/24 indicated Resident #28 was care planned for the following: -altered respiratory status/ difficulty breathing related to anxiety, COPD history of respiratory failure with intervention to provide oxygen as ordered. -continuous oxygen therapy for CHF and COPD with interventions to give medications as ordered, monitor/ document side effects and effectiveness, observe for symptoms of respiratory distress and report to physician as needed (restlessness, pulse oximetry, increased heart rate, headaches, lethargy, confusion, cough, accessory muscle usage and skin color. -altered cardiovascular status arrythmia, CHF and hypertension with interventions to assess shortness of breath and cyanosis, diet consult as	F 760	the medical record) and daily nursing assessments of his respiratory status. On 3/14/2024, Resident #28 was assessed by Unit Manager with no acute distress noted. On 03/14/2024, the Director of Nursing notified the provider of the significant medication error when Resident #28 was not administered his scheduled nebulizer treatments as ordered by the physician which included the 9 AM (Budesonide), 11 AM (Ipratropium-Albuterol), 1 PM (Formoterol Fumarate) and 5 PM (Ipratropium-Albuterol) despite repeated requests. No new orders per MD. On 3/14/2024, Medication Aide #1 was immediately suspended pending investigation. Initial Allegation report was completed and submitted to state reporting agency. Police and Adult protective services were notified. Corrective action for residents with the potential to be affected by the deficient practice: On 3/14/2024, the Director of Nursing and Unit Managers completed medication administration audit by reviewing the electronic record for 3/9/2024 to 3/10/2024 for all shifts. The results were: All scheduled medications documented as administered. On 03/14/2024, the DON and the ADON conducted interviews that were completed on current residents with BIMs of 13 or higher indicating no cognitive impairment and they were asked if they have any concerns with medication administration and if they had received all of their	

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F 760	Continued From page 103	F 760		

necessary, oxygen as ordered, monitor/document/report changes in lung sounds (crackles), edema, and changes in weight; vital signs as ordered/as needed and report abnormal readings to physician.
-hospice services related to COPD, with an intervention to administer pain medications as prescribed, assess frequently and provide additional pain relief as necessary; coordinate care with hospice team; invite hospice staff to participate in resident care planning conferences; promote comfort by repositioning, adding more pillows, massage, reading, and aromatherapy.

A review of the March 2024 Medication Administration Record revealed Resident #28 was to receive the following during the 7am- 7pm shift:
-Budesonide inhalation suspension- 2 times a day for COPD (9am)
-Formoterol fumerate inhalation solution 2 times a day (every 12 hours) for COPD (1pm)
-Oxgyen 3 liters continuous nasal canular for shortness of breath- every shift O2
-Ipratropium-albuterol inhalation solution #60 vial-(nebulizer) inhale 4 times a day for COPD (11am, 5pm)

During an interview on 3/11/24 at 11:10 AM Resident #28 revealed he received a nebulizer treatment once on Saturday 3/9/24 and once on Sunday 3/10/24 during the 7:00 am to 7:00 pm shift (day shift), although he was supposed to receive nebulizer treatments four times during the day shift. Resident #28 stated he had chest difficulty on 3/9/24 and requested a "breathing" (nebulizer) treatment on several occasions but did not receive it until late afternoon. He revealed he told Nurse Aide (NA) #1 he needed a

scheduled medications. This included residents on the 200 halls where Resident #28 resides. The results included that there were no residents who reported any concerns with their medications being administered and they had no significant decline or respiratory distress and reported receiving their scheduled medications. All residents with a BIMs of 12 or below with cognitive impairment were assessed observing for any acute distress (shortness of breath verbal/nonverbal indicators of pain) by Unit Managers for any significant decline or respiratory distress. This included residents on the 200 halls. The results were no other residents identified with any significant decline or respiratory distress. The Director of Nursing determined on 3/15/24 that no other residents were impacted by the medication error when no other current alert residents with a Brief Interview of Mental Status (BIMs) of 13 or greater reported any concerns with having received their medications and when all other current residents with a BIMs of 12 or less indicating cognitive impairment were assessed for any change in condition including any significant decline, pain or respiratory distress with none noted and all vital signs were at baseline. On 03/15/2024 the Director of Nursing (DON) and Assistant Director of Nursing initiated random medication observations of the licensed nurses and the medication aides to ensure that all residents received their scheduled medication and that the 6 rights of medication administration were followed including documenting

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F 760	Continued From page 104 breathing treatment each time she came into his room to check on him or answer his call bell throughout the day and NA #1 told him that she informed Nurse #10 of his requests. Resident #28 indicated on 3/9/24 he called his daughter to complain of chest pain and that he had been asking for a "breathing" treatment for 3 hours. The Resident explained NA #1 was trying to be helpful when she spoke with his daughter on the phone while she was in the room and stated she was doing all she could by reporting the Resident's need for a "breathing" treatment. The Resident stated when the Medication Aide (later identified by the Resident as Med Aide #1) finally came in to give him his breathing treatment later in the day, she stated in a hostile manner "here is your breathing treatment." The Resident stated he had not reported his concerns that occurred over the weekend to nursing management. A review of video footage from camera #14 on 3/9/24 from 7:00 am to 7:00 pm and the Medication Administration Audit (indicates the date and time medications were initialed as administered on the Medication Administration Record) report for 3/9/24 revealed following: -8:05 am- NA #1 entered Resident #28's room and exited at 8:08 am. -8:35 am- Nurse #10 (supervised Med Aide #1 on 3/9/24) arrived on 200- hall with med cart and begins med pass. -8:40 am- NA #1 approached Nurse #10 at med cart and they had a conversation then NA #1 leaves the hall. -8:44 am- 9:00 am Nurse #10 continued with med pass in other resident rooms but never entered Resident #28's during this time. -9:14 am- Nurse #10 relocated med cart to the end of 200-hall and continued med pass.	F 760	administration of medications that were administered. This was completed on 03/15/2024 and there were no negative findings. Director of Nursing, and /or Assistant Director of Nursing and/or Unit Managers and /or Nurse Managers completed Medication Pass Observations using a Medication Observation Tool, on 5 licensed nurses, and 1 medication aid with no concerns identified. This was completed on 03/15/2024. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: All Full Time and Part Time and as needed (PRN) Nursing (Registered Nurses, Licensed Practical Nurses) and Medication aides will be educated on the following preventing medication errors, the 6 rights of medication administration (right medication right patient, right dose, right time, right route, and right documentation) and following medication safety practices by the Director of Nursing, Nurse Managers and Staff Development Nurse. Education began on 03/14/2024. In person training was completed and the in-service topics included preventing medication errors, the 6 rights of medication administration (right medication right patient, right dose, right time, right route, and right documentation-signing MAR after administering medication). The Director of Nursing will review staffing schedules daily to ensure that anyone that did not receive the in-service training by	

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F 760	Continued From page 105 -9:33 am- Nurse #10 left 200-hall without the med cart -9:44 am- Nurse #10 returned to the med cart on 200-hall. -10:00 am- NA #1 entered Resident #28's room -10:01 am- NA #1 exited Resident #28's room, spoke to Nurse #10 who was at the other end of the hall and performed a hand motion as she was speaking. Nurse #10 then turned around and left the hall. -10:19 am- NA #1 entered Resident #28's room. NA #1 exited Resident #28's room at 10:24 am and walked across the hall to enter another resident's room. -10:22 am- Med Aide #1 entered Resident #28's room with what appeared to be a small plastic cup. It was not clear if Med Aide #1 medicated Resident #28 or his roommate. Med Aide #1 exited Resident #28's room at 10:25 am with something in her hand. -10:22 am- Per the Med Administration Audit report, Med Aide #1 signed that she administered Budesonide inhalation suspension (nebulizer) to Resident #28. -10:23 am- Per the Med Administration Audit report, Med Aide #1 signed that she administered Ensure and Tamsulosin to Resident #28. -10:24 am Per Med Administration Audit report, Med Aide #1 signed that she administered Prostat to Resident #28. -10:31 am- NA #1 entered Resident #28's room. -10:32 am- NA #1 exited Resident #28's room with water pitcher and box of gloves. -10:33 am- Nurse #10 moved medication cart near middle of hallway/ closer to Resident #28's room and had a conversation with NA #1. -10:34 am- Med Aide #1 went to Nurse #10's cart while Nurse #10 was still talking to NA#1. -10:35 am- Med Aide #1 and Nurse #10	F 760	03/15/2024 will not be allowed to work until the training is complete. This training will be incorporated into the general orientation program and education for agency staff. The education was provided in person both days on 3/14/24 and 3/15/24 by the Assistant Director of Nursing in the facility. The Administrator and Director of Nursing will communicate with all nursing staff beginning 3/18/24 via meeting, phone, and nursing huddles to reiterate that Resident #28 and all other residents, are not to be neglected, retaliated against and all residents receive the ordered care and services. The Director of Nursing will ensure any staff not communicated with will not be able to work until communication is complete. All new staff will be trained during orientation by nursing leadership. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Director of Nursing or designee will monitor compliance utilizing the Missed Medication Quality Assurance Tool by interviewing and reviewing medication administration records of 10 residents to ensure medications administered as ordered. This is to be completed weekly x 4 weeks then monthly x 4 months. Reports will be presented to the weekly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored	

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F 760	Continued From page 106 conversing at med cart and they both leave 200-hall with the med cart. -10:35 am- Per the Med Administration Audit report, Med Aide #1 signed that she administered Ipratropium-albuterol inhalation solution (nebulizer) to Resident #28. -11:03 am- Med Aide #1 returns to 200-hall with med cart. -11:18 am- NA #1 returned to hall and entered Resident #28's room. -11:19 am- NA #1 exited Resident #28's room and walked past Med Aide #1 at the med cart. -11:19 am- Med Aide #1 entered Resident #28's room with a small plastic cup in hand. It was unclear if Med Aide #1 medicated Resident #28 or his roommate. -11:20 am- Med Aide #1 exited Resident #28's room and returned to med cart. -11:28 am- NA #1 returned to 200-hall, removed something from the hallway floor, said something in Med Aide #1's direction and Med Aide #1 looked at NA #1 then NA #1 left the hall. -11:55 am- Med Aide #1 left med cart, exited the hall and returned to the med cart at 11:56 am. -12:13 pm- Resident # 28's roommate left the room. -12:34 pm- Per the Medication Administration Audit report, Med Aide #1 signed that she administered Formoterol fumerate inhalation solution to Resident #28. -12:55 pm- Med Aide #1 entered Resident #28's room with a lunch tray and immediately exited with lunch tray. -1:52 pm- NA #1 entered Resident #28's room and exited at 1:53 pm. -2:00 pm- Med Aide #1 in hall talking with another NA. -2:22 pm NA #1 entered Resident #28's room and exited at 2:22 pm.	F 760	and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager Date of Compliance: 3/27/2024	

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-2:58 pm- Med Aide #1 returns to 200-hall with no cart and entered another resident's room.
-3:20 pm Nurse #10 returned to 200-hall with med cart.
-3:59 pm NA #1 entered Resident #28's room and exited at 3:59 pm with blue gloves in hand and spoke with someone out of camera footage then left 200-hall.
-4:30 pm NA #1 entered Resident #28's room and exited at 4:31 pm.
-4:34 pm Med Aide #1 arrived on 200-hall with med cart and started med pass.
-4:50 pm NA #1 exited Resident #28's room and spoke to Med Aide #1 at the med cart as she was pointing toward Resident #28's room, then walked to med cart and continued to speak with Med Aide #1. NA #1 walked away from Med Aide #1, put her hands up in the air and re-entered Resident #28's room.
-4:51 pm NA #1 exited Resident #28's room.
-4:51 pm Med Aide #1 left med cart with something in hand and walked past Resident #28's room as she left 200-hall.
-4:53 pm Med Aide #1 returned to 200-hall.
-5:00 pm Med Aide #1 on the 200-hall with med cart.
-5:01 pm- Med Aide #1 entered Resident #28's room (something in hand) and exited at 5:03 pm. It was unclear if Med Aide #1 medicated Resident #28 or his roommate.
-5:03 pm- Med Aide #1 exited Resident #28's room and left 200-hall.
-5:04 pm- Per the Med Administration Audit report, Med Aide #1 signed that she administered Ipratropium-albuterol inhalation solution (nebulizer) to Resident #28.
-5:12 pm NA #1 in hall with Med Aide #1 for brief conversation.
-5:16 pm Med Aide #1 entered Resident #28's

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room with a small plastic cup in hand and exited at 5:16 pm. It was unclear if Med Aide #1 if she medicated Resident #28 or his roommate.
-5:46 pm- Med Aide #1 entered Resident #28's room after leaving dirty linen closet and exited Resident #28's room at 5:46 pm.
-5:47 pm- Med Aide #1 exited 200-hall with med cart.
-6:00 pm- Med Aide #1 returned to 200-hall without the med cart.

A review of video footage from camera #14 on 3/10/24 from 7:00 am to 7:00 pm and the Medication Administration Audit report for 3/10/24 revealed following:
-8:18 am- Med Aide #1 entered Resident #28's room with a small plastic cup, unwrapped straw, and another item in hand and exited at 8:21 am- with an unwrapped straw and a plastic bottle. It was unclear if Med Aide #1 medicated Resident #28 or his roommate.
-8:32 am- Nurse #13 (supervised Med Aide #1 on 3/10/24) arrived on the 200-hall with med cart.
-9:57 am- Nurse #13 left hall with med cart laptop.
-10:01 am- Nurse #13 returned to hall and resumed med pass.
-10:46 am- Med Aide #1 arrived on the hall without med cart and went to Nurse #13's med cart and exited hall at 10:52 am.
-11:27 am- Per the Med Administration Audit report, Med Aide #1 signed that she administered Budesonide inhalation suspension and Ipratropium-albuterol inhalation solution (nebulizer) to Resident #28.
-11:52 am- Med Aide #1 returned briefly to the med cart, picked up a small plastic cup, entered Resident #28's room and exited at 11:52 am. It was unclear if Med Aide #1 medicated Resident

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#28 or his roommate.
-12:13 pm- Resident #28's roommate (Resident #60) in bed A leaves the room via wheelchair, with a family member.
-12:23 pm- Med Aide #1 transported/parked the med cart to dirty linen closet outside of Resident #28's room, discarded a bag of trash in the dirty linen closet, exited the dirty linen closet, returned to med cart and picked up a small plastic cup with spoon and entered Resident #28's room with the plastic cup in hand. Med Aide #1 then exited the room with cup in hand, placed it on med cart at 12:24 pm and exited 200-hall with the med cart.
-12:29 pm- Med Aide #1 returned to 200-hall without med cart, stood outside Resident #28's room then left the hall.
-12:56 pm- Per the Med Administration Audit report, Med Aide #1 signed that she administered formoterol fumerate inhalation solution to Resident #28.
-from 2:00 pm to 4:26 pm- No staff entered Resident #28's room.
-4:24 pm- Med Aide#1 arrived on 200-hall with medication cart and began med pass.
-4:53 pm- Med Aide #1 entered Resident #28's room with something in hand. It was not clear if Med Aide #1 medicated Resident #28 or his roommate.
-4:54 pm- Med Aide #1 exited Resident #28's room.
-4:57 pm- Med Aide #1 re-entered Resident #28's room.
-4:58 pm- Med Aide #1 exited Resident #28's room.
-4:59 pm- Per the Med Administration Audit report, Med Aide #1 signed that she administered Ipratropium-albuterol inhalation solution (nebulizer) to Resident #28.
-5:00 pm- Med Aide #1 on the 200- hall with med

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cart and Nurse #13 at med cart on opposite end of hall.
-5:08 pm- Med Aide #1 entered Resident #28's room and exited a few seconds later then left the hall.
-5:51 pm- Med Aide #1 left 200-hall with med cart and was not observed returning with the med cart before 7:00 pm.

A review of video footage from camera #7 on 3/09/24 from 7:00 am to 7:00 pm showed a hall's length view but did not show a view of the Resident #28's room. The view shows blurry parts of Med Aide #1 standing at the med cart, sometimes showing only the bottom half of her legs, leaving the med cart, returning to the med cart around similar or the same footage times that were viewed on camera #14.

During a phone interview on 3/14/24 at 4:36 pm NA #1 revealed she was assigned to Resident #28 on day shift on 3/9/24 and each time she answered his call bell or checked on him from the morning through the afternoon, the Resident requested a breathing treatment. She further revealed she informed Nurse #10 on at least three occasions that the Resident was requesting his breathing treatment. The third time she informed Nurse #10 of the Resident's request for his breathing treatment, Nurse #1 stated she was on break and that NA #1 should ask Med Aide #1. NA #1 stated she located Med Aide #1 in another resident's room watching a soccer game and informed her of the Resident's request for medication. NA #1 stated Med Aide #1 replied "ok." NA #1 further revealed when she went to check on the Resident during the afternoon, the Resident was on his cell phone with a family member and gave NA #1 the phone. NA #1 spoke

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with the family member on the phone and apologized that there was nothing else she could do but keep telling the nurse that the Resident was requesting a nebulizer treatment. NA #1 stated she returned to the Resident's room later in the afternoon and the Resident stated he still had not received his breathing treatment, then asked her "did you see the nurse? when is the nurse coming." The NA further stated the Resident was not gasping for air and she could not determine whether he was short of breath because he seemed frustrated and was trying to maintain his composure.

During an interview on 3/14/24 at 12:21 pm Med Aide #1 stated she was assigned to Resident #28 on the 7:00 am- 7:00 pm shift on 3/9/24 and 3/10/24 and was responsible for administering his medications and breathing treatments. She further stated on 3/9/24 NA #1 did not inform her that Resident #28 needed a breathing (nebulizer) treatment on 3/9/24 during the 7am- 7pm shift. Med Aide #1 indicated she administered a breathing treatment to Resident #28 three times during her shift (morning, afternoon, and before evening) on 3/9/24 and 3/10/24.

During an interview on 3/14/24 at 12:02 pm Nurse #10 revealed she supervised Med Aide #1 on 3/9/24 who was assigned to Resident #28, and she was never informed the Resident reported chest pains or difficulty breathing and requested a breathing treatment. She further revealed she had no conversations with NA #1 about Resident #28 during the day shift on 3/9/24.

During a phone interview on 3/14/24 at 11:21 am Resident #28's Family Member, indicated she resided out of state and received several phone

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calls from the Resident on 3/9/24. She stated she was a nurse and was working when the Resident left her a voice mail message about 1:58 pm about how he pressed his call bell, NA #1 responded, and he told her he needed a breathing treatment and he had not received it. She returned his call at about 5:15 pm to see if the Resident received his treatment. Resident #28 told her that he was experiencing chest pains and had been requesting his scheduled breathing treatments for at least 3 hours. The family member further indicated at one point during the day (about 5:15 pm) when she spoke to the Resident, she also spoke with the NA #1, on the Resident's cell phone when the NA went in to check on the Resident. The family member stated NA #1 told her she had reported to Nurse #10 on several occasions the Resident needed a breathing treatment and at one point Nurse #10 stated she was on break and that the NA needed to find someone else. The family member stated she was so upset, she demanded to know what was going on and NA #1 attempted to have a nurse who was out in the hall come into the Resident's room to talk to her, but the nurse would not come to the phone. The family member further indicated every time she spoke with the Resident, he seemed out of breath as evidenced by speaking in a reserved manner to preserve his breath and she could tell he was short of breath. The family stated she was so upset she called the hospice phone number and left a voice mail message for the Hospice Administrator at 5:05 pm and left messages about the Resident's report of difficulty breathing. When the family member called the Resident about 6:00 pm, the Resident stated he had just received a nebulizer treatment from the nurse and that he was feeling better. The family member also stated the

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Resident was only confused when he needed breathing treatment, and she truly believed him when he stated he was having difficulty. The family member stated she spoke with the Resident on 3/10/24 after she came from church, and he stated he was "ok." She stated when she spoke with the Resident on Tuesday 3/12/24, he stated Sunday was a little rough, but he did not go into detail, then said it was "ok."

During a phone interview on 3/15/24 at 8:16 pm the Hospice Nurse revealed she visits Resident #28 on Monday/Friday every week and that the Resident was very upset when he reported to her on 3/11/24 that his scheduled nebulizer treatments were not given on time on 3/9/24 and 3/10/24. She stated that the Resident did not give specific times he did not receive his nebulizer treatments but that he only received one treatment during 7:00 am to 7:00 pm shifts and should have received four nebulizer treatments each day during those shifts. The Hospice Nurse stated the Resident had high anxiety and she believed what he was telling her because she had heard similar stories from other residents related to not receiving their medications.

During an interview on 3/14/24 at 1:10 pm Unit Manager #2 revealed she spoke with the Resident #28 on Monday or Tuesday (3/11/24 or 3/12/24), after the State Surveyor informed her Resident #28 had concerns about incidents that occurred over the weekend (3/9/24 and 3/10/24), related to not receiving his nebulizer treatments. Unit Manager #2 further revealed the Resident did not mention he did not receive his breathing treatments but that he did not get his medications on time over the weekend. Unit Manager #2 stated she informed the Director of Nursing

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(DON) of the concerns after she spoke to the resident.

During an interview on 3/14/24 at 1:00 pm the DON indicated he was not made aware of Resident #28's concerns until 3/14/24 related to not receiving medications over the weekend (3/9/24 and 3/10/24). The DON further indicated he expected all residents to receive their medications as prescribed and call bells to be answered in a timely manner.

During a phone interview on 3/14/24 at 5:00 pm the facility Nurse Practitioner (NP) indicated scheduled breathing treatments could have helped Resident #28's symptoms if he received them. She further indicated the Resident was probably upset and became more "air hungry", anxious, and bronchioles constricted despite receiving oxygen at 3 liters. The NP indicated her expectation was for Resident #28 to receive all his scheduled medications as ordered.

During a phone interview on 3/14/24 at 5:27 pm the Medical Director revealed he took over as Medical Director in January 2024 and was not yet familiar with Resident #28. He further revealed the Resident could have had a significant decline when he did not receive his breathing treatments as ordered and not receiving breathing treatments may have caused the symptoms that included: increased shortness of breath, wheezing and increased stress. The Medical Director stated the Resident's symptoms caused him to contact his family member who called hospice when he could not get assistance from the facility. The Medical Director indicated his expectation was for staff members to administer medications as ordered.

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F 760	Continued From page 115 The Administrator was notified of immediate jeopardy on 3/16/24 at 6:00 pm. The facility provided the following credible allegation of immediate jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. On 3/9/24 and 3/10/24 the facility failed to prevent a significant medication error when Resident # 28, who has diagnoses including COPD with respiratory failure and CHF, was not administered scheduled nebulizer treatments as ordered by the physician at 9 AM (Budesonide), 11 AM (Ipratropium-Albuterol), 1 PM (Formoterol Fumarate) and 5 PM (Ipratropium-Albuterol) despite repeated requests. On 3/11/2024, Resident #28 was seen by the Nurse Practitioner at the request of Hospice nurse for shortness of breath and chest pain. He reported these symptoms to the Hospice Nurse on 3/11/24. Per Nurse Practitioner, Resident #28 to continue Morphine for pain and restlessness and new order for Hydromet Syrup 5-1.5 MG/5ML (Hydrocodone-Homatropine) 5ml every 6 hrs. for cough/congestion. Resident #28 reported to the Hospice Nurse on 3/11/24 that he only received one nebulizer treatment for the 7am to 7pm shifts on 3/9/24 and 3/10/24 was having shortness of breath and chest pain. Hospice nurse reports resident does have anxiety regarding not receiving medications and a combination of the anxiety and trouble breathing is triggering his PTSD per the hospice progress note.	F 760		

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The resident was interviewed by the Administrator on 3/14/24 about 3/9/24 and 3/10/24 and not receiving nebulizer treatments. The resident reported he suffered from chest pain as a result of not receiving the scheduled nebulizer medication. The resident continues to have assessments (respiratory, pain assessments) to assess for any serious adverse outcome including any significant decline or respiratory distress. Resident # 28 is receiving routine vital signs every shift including pulse ox (documented in the medical record) and daily nursing assessments of his respiratory status.

On 3/14/2024, Medication Aide #1 was immediately suspended pending investigation.

On 03/14/2024, the Director of Nursing notified the provider of the significant medication error when Resident #28 was not administered his scheduled nebulizer treatments as ordered by the physician which included the 9 AM (Budesonide), 11 AM (Ipratropium-Albuterol), 1 PM (Formoterol Fumarate) and 5 PM (Ipratropium-Albuterol) despite repeated requests.

On 3/14/2024, the Director of Nursing and Unit Managers completed medication administration audit by reviewing the electronic record for 3/9/2024 to 3/10/2024 for all shifts. The results were: All scheduled medications documented as administered.

On 03/14/2024, the DON and the ADON conducted interviews that were completed on current residents with BIMs of 13 or higher indicating no cognitive impairment and they were asked if they have any concerns with medication administration and if they had received all of their

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scheduled medications. This included residents on the 200 halls where Resident #28 resides. The results included that there were no residents who reported any concerns with their medications being administered and they had no significant decline or respiratory distress and reported receiving their scheduled medications. All residents with a BIMs of 12 or below with cognitive impairment were assessed observing for any acute distress (shortness of breath verbal/nonverbal indicators of pain) by Unit Managers for any significant decline or respiratory distress. This included residents on the 200 halls. The results were no other residents identified with any significant decline or respiratory distress.

The Director of Nursing determined on 3/15/24 that no other residents were impacted by the medication error when no other current alert residents with a Brief Interview of Mental Status (BIMs) of 13 or greater reported any concerns with having received their medications and when all other current residents with a BIMs of 12 or less indicating cognitive impairment were assessed for any change in condition including any significant decline, pain or respiratory distress with none noted and all vital signs were at baseline.

On 03/15/2024 the Director of Nursing (DON) and Assistant Director of Nursing initiated random medication observations of the licensed nurses and the medication aides to ensure that all residents received their scheduled medication and that the 6 rights of medication administration were followed including documenting administration of medications that were administered. This was completed on 03/15/2024

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and there were no negative findings.
Director of Nursing, and /or Assistant Director of Nursing and/or Unit Managers and /or Nurse Managers completed Medication Pass Observations using a Medication Observation Tool, on 5 licensed nurses, and 1 medication aid with no concerns identified. This was completed on 03/15/2024.

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

On 03/15/2024, the Administrator and Director of Nursing conducted a root cause analysis and determined that the root cause of the alleged error was that Medication Aide #1 failed to follow facility policy related to medication administration and 6 rights of medication administration and disregard of resident's rights by ignoring request by Nurse Aide #1 for administration of Resident #28's nebulizer treatment. Video footage revealed Medication Aide #1 did not administer nebulizer treatments as ordered. The video was reviewed for the 7a-7p shifts on 3/9/24 and 3/10/24.

All Full Time and Part Time and as needed (PRN) Nursing (Registered Nurses, Licensed Practical Nurses) and Medication aides will be educated on the following preventing medication errors, the 6 rights of medication administration (right medication right patient, right dose, right time, right route, and right documentation) and following medication safety practices by the Director of Nursing, Nurse Managers and Staff Development Nurse. Education began on 03/14/2024. In person training was completed and the in-service topics included preventing

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medication errors, the 6 rights of medication administration (right medication right patient, right dose, right time, right route, and right documentation-signing MAR after administering medication). The Director of Nursing will review staffing schedules daily to ensure that anyone that did not receive the in-service training by 03/15/2024 will not be allowed to work until the training is complete. This training will be incorporated into the general orientation program and education for agency staff. The education was provided in person both days on 3/14/24 and 3/15/24 by the Assistant Director of Nursing in the facility.

The Administrator and Director of Nursing will communicate with all nursing staff beginning 3/18/24 via meeting, phone, and nursing huddles to reiterate that Resident #28 and all other residents, are not to be neglected, retaliated against and all residents receive the ordered care and services. The Director of Nursing will ensure any staff not communicated with will not be able to work until communication is complete. All new staff will be trained during orientation by nursing leadership.

The Interdisciplinary Team (Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Manager, Support nurse, Therapy, Health Information Management, Dietary Manager, Medical Director, Pharmacist), were notified of the significant medication error by 03/15/2024 and were involved in the removal plan. DON will be responsible for ensuring the removal plan is implemented. Immediate Jeopardy Removal Date: 03/19/2024

F760 - Date of immediate jeopardy removal:

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F 760	Continued From page 120 03/19/2024. On 03/26/24, the facility's immediate jeopardy removal plan effective 03/19/24 was validated by the following: Nursing staff interviews revealed they had received education on the 6 rights of medication administration. Administrative staff interviews revealed they had completed audits of nurses and medication aides during medication pass. The facilities medication error rate was 0% during the medication pass facility task completed by the survey team. The immediate jeopardy removal date of 3/19/24 was validated.	F 760		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to provide a diet regular soft & bite sized, for 1 of 1 resident during dining observation (Resident #298). The findings included: Resident #298 was admitted to the facility on 3/6/24 with the diagnosis of dysphagia following cerebral infarct (stroke), severe protein calorie malnutrition, and dementia. A review of the care plan dated 2/05/24 revealed	F 805	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F805	4/16/24

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F 805	Continued From page 121 resident #298 was at risk for choking and aspiration due to difficulty chewing, difficulty swallowing, and altered mental status. A review of the Minimum Data Set (MDS) assessment dated 3/6/24 revealed Resident #298 had moderately impaired cognition and received a soft, bite sized diet. An observation of Resident #298 was conducted on 3/11/24 at 12:31 PM. Resident #298 was not able to cut her meat and could not chew the cauliflower. The family attempted to cut the pork chop and cauliflower and indicated both were very difficult to cut. A review of the provider order dated 3/7/24 indicated Resident #298's diet was regular, soft bite sized, thin consistency. An observation of the lunch tray revealed Regular, soft bite sized on 3/11/2024 at 12:31PM. A review of Resident #298's diet order, dated 03/11/24 at 1:02 PM, revealed an order for regular, soft, bite sized foods. An interview was conducted with the Dietary Manager (DM) on 3/12/24 time at 12:41 PM. The DM indicated soft bite size diet meant soft vegetables and cut up meat. She further indicated that soft vegetables had to be soft when picked up with the tongs. The DM further indicated the porkchop should have been cut into small pieces. An interview with NA #8 on 03/13/24 1:09 PM, removing her tray, revealed she did not know the resident's diets, she had to look on the ticket. NA# 8 indicated she had not looked at the ticket	F 805	1. Corrective action Interview 3/12/2024 with Dietary Manger indicated Soft and Bite Sized diet received cut up meats and soft vegetables. On 3/13/2024, dietitian visited resident #298 to review diet and update food preferences. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 4/15/24, Corporate Dietary Consultant CDM CFPP with Dietary Manager completed audit diets in PCC and matched to tray card system. In addition, on 4/14/24, reviewed all residents with textured diets with SLP. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff by the Dietary Services Director and Registered Dietician on 3/13/24. Topics included: ¿ Tray Accuracy Education ¿ Diet Consistency Policies Any of the above identified staff who has not received education by 4/15/2024 will not be allowed to work until education is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring	

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F 805	Continued From page 122 before she delivered the tray. A review of the Nurse Practitioner notes dated 3/13/2024 at 12:54 PM indicated a new order for chopped meats for Resident #298. A review of the Registered Dietitian note dated 3/13/2024 3:42 PM revealed the Registered Dietitian visited Resident #298 to discuss meal preferences. The family discussed needed texture change for meats and vegetables, the diet was currently soft and bite sized foods. An observation of the lunch meal tray 3/14/24 at 12:30 pm revealed mashed potatoes, diced cooked carrots, and chopped meat with extra portions.	F 805	procedure. The Dietary Services Director will monitor test tray of selected mechanically altered diets served to residents per Dietary QA Audit Tool weekly x4 and then monthly x3. Reports will be presented to the weekly Quality Assurance committee by the Dietary Service Director and/or Dietitian. Compliance will be monitored by the Ambassador Program daily and reviewed at the weekly Quality Assurance Meeting. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Services Director. Date of Compliance: 4/16/2024	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(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(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		4/16/24

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F 842	Continued From page 123 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(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(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(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(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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F 842	Continued From page 124 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 record review and staff interviews the facility failed to maintain accurate electronic records for Resident #28 (1 of 6 sampled for administration of medications), Resident #71 (1 of 4 sampled for nutrition), and Resident #198 (1 of 1 resident sampled for the application of a medicated cream) who were reviewed for accuracy of resident records. 1. During an interview on 3/17/24 Unit Manager #1 indicated she answered Resident # 28's call bell and he requested acid reflux medication. Unit Manager #1 further indicated she left the Resident's room, retrieved an acid reflux medication, then returned and administered the acid reflux medication, which was a standing order. She stated since the Resident was not due for his scheduled omeprazole medication, she administered an acid reflux medication from the standing orders. Unit Manager #1 stated she was assisting Medication Aide #1 by administering the acid reflux medication to Resident #28 and expected Medication Aide #1 to sign off that the medication was given. Unit Manager #1 further indicated 3/9/24 was a very busy day and there was a lot going on. Unit Manager #1 stated she should have checked the Resident's Medication Administration Record (MAR) and entered that she had administered the medication.	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F842 Resident Records- Identifiable Information Corrective action for resident(s) affected by the alleged deficient practice: For resident #28- On 3/15/2024, the Director of Nursing (DON) notified Medical Director. No new orders. DON verbally reeducated Unit Manager #1 related Medication Administration Record Documentation. For resident #71- On 3/13/2024, nurse #10 updated resident□s electronic medical record with weights for 3/1/2024 and 3/9/2024. The Director of Nursing verbally trained nurse #10 related resident records and documenting weights as ordered in medical record when obtained.	

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F 842	Continued From page 125 A review of the MAR and Medication Administration Review audit report (indicates the date and time medications were initialed as administered on the Medication Administration Record) did not indicate the acid reflux medication was given on 3/9/24. An interview with the Director of Nursing on 3/15/24 at 4:00 PM indicated his expectations would be for the staff to always document any medication administered on the MAR. Medication Aide #1 was not available for an interview. 2. A physician's order dated 3/1/24 revealed weekly weights times 4 weeks, then monthly and as needed on day shift every 7 days were ordered for Resident #71. Further review of the medical record revealed the most recent documented weight of 146 pounds on 2/23/24. There were no weights documented as ordered weekly from 3/1/24 through 3/13/24. During an interview on 3/13/24 at 2:35 pm Nurse #10 revealed she kept a report sheet where she recorded Resident #71's weight from 3/1/24 as 145.5 pounds. Nurse #10 further revealed she weighed Resident #71 via geriatric wheelchair on 3/9/24 and could not locate the report sheet showing a weight for that day but could recall the Resident weighed 145 pounds. Nurse #10 stated she had not entered the Resident's weights for 3/1/24 and 3/9/24 into the electronic medical record.	F 842	For resident #198- On 4/15/2024, Resident assessed by the Director of Nursing. MD was notified and order clarification given for Remedy NutraShield Cream to inguinal folds/buttocks every shift and as needed. The Director of Nursing verbally reeducated nurse #12 related to documenting treatments and site of treatment in the medication administration record (MAR). Corrective action for residents with the potential to be affected by the deficient practice: All current residents have the potential to be affected by the alleged deficient practice. On 4/11/2024 the Director of Nursing reviewed 100 % of current resident with orders for weekly weight for the past 30 days to ensure weights were documented in MAR as ordered. The results identified no other residents affected by alleged deficient practice. Also, the Director of Nursing reviewed 100% of current resident MAR and new orders for the past two weeks for accurate medication administration records. The results identified no other residents affected by alleged deficient practice. This was completed by 4/12/2024 Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning 4/11/2024, the Director of Nursing began educating all full time, part time, and PRN (as needed) nurses, medication aides, nurse aides and agency staff on the following topics: *Accuracy of Resident Records and Documentation. The Director of Nursing will ensure that	

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F 842	Continued From page 126 3. Resident #198 was admitted to the facility on 2/27/24. A physician order dated 2/27/24 specified Remedy nutrashield cream to buttock every shift and as needed for wound healing/prevention. Resident #198's physician orders did not indicate a cream ordered as needed to other areas of the skin. A review of the Minimum Data Set assessment dated 3/7/24 revealed Resident #198 was moderately cognitively impaired. An interview on 03/14/24 at 6:22 AM revealed Resident #198 was hurting and burning between her legs. Nurse #12 was informed 3/14/24 at 6:34 AM by this surveyor that Resident #198 was burning and hurting between her legs. Nurse #12 indicated he would go get cream for her. An observation with Nurse #12 of Resident #198 on 3/14/24 at 6:48 AM revealed Nurse #12 applied cream from a small tube to Resident #198's affected area. A review of the standing orders 3/15/24 revealed orders for pressure ulcers and skin tears, but not for skin irritation. A review of the nurse's progress notes dated 3/14/24 and 3/15/24 did not indicate any documentation regarding the skin assessment or the application of cream to the pink areas at the inguinal creases by Nurse #12.	F 842	any Licensed Nurse or Certified Nursing Assistant, or Medication Aide including agency who has not received this training by 4/15/2024 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided all agency Nurses, Medication Aides and CNA□s who give residents care in the facility. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. On Beginning the week of 4/22/2024, The Director of Nurses or designee will monitor Compliance utilizing the QA Tool F 842 to ensure accuracy of resident records. The monitoring will include reviewing a sample of residents with orders for weekly weights and treatments to ensure accuracy of resident record. This will be completed weekly for 4 weeks then monthly x 2 months or until resolved to ensure medications are administered without delay. Reports will be given to the Monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager,	

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F 842	Continued From page 127 Nurse #12 could not be reached for interview. An interview with the Director of Nursing on 3/15/24 at 4:00 PM indicated his expectations would be for the staff to always document any treatment in the MAR and to document in the notes what treatment was for.	F 842	Health Information Manager, Dietary Manager and Social Worker, and Maintenance Director. Date of Compliance: 4/16/2024	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such	F 867		4/16/24

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development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity

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of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including

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F 867	Continued From page 130 data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 9/29/22. This failure occurred for four repeat deficiencies cited for resident's rights, accuracy of assessments, maintenance of nutrition and hydration status, and infection prevention and control that was subsequently recited on the current recertification and complaint investigation survey of 3/26/24. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA Program. The findings included: This tag is cross referenced to: F550 (Resident's Rights): Based on record review, observations, resident, and staff interviews, the facility failed to treat a resident (Resident #198) with dignity and respect when Nurse Aide #12 treated her roughly during personal care, causing her to cry. Resident #198 was observed to have pinkened areas at the creases of the thighs where the brief comes up between the legs. The facility also failed to provide care for 1 of 1 resident (Resident #17) in a dignified manner by leaving her uncovered in bed, in a soiled brief after being made aware of	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilitys allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 QAPI/QAA Improvement Activities Corrective action for resident(s) affected by the alleged deficient practice: Based on observations, record reviews, resident, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 9/29/22. This failure was for occurred for four repeated deficiencies cited in the areas of Residents Rights(F550), Accuracy of Assessments (F641), Maintenance of Nutrition and Hydration Status (F692), and Infection Prevention (F880) that were subsequently recited on the current recertification and complaint investigation survey of 03/26/24. The continued failure of the facility during two federal surveys of	

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F 867	Continued From page 131 care needs. This was for 2 of 13 residents reviewed for dignity. During the recertification and complaint survey of 9/29/22, the facility failed to provide incontinence care when requested to 1 of 6 sampled residents reviewed for dignity. This failure caused the resident to cry, expressing she felt worthless, horrible, bad and did not deserve this treatment. F641 (Accuracy of Assessments): Based on observations, staff interviews, and record reviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of wounds (Resident #399), hospice services (Resident #22), range of motion (Resident #11), and tube feeding (Resident #57). This deficient practice was identified for 4 of 18 sampled residents. During the recertification and complaint survey of 9/29/22, the facility failed to code range of motion status accurately on the MDS for 1 of 19 residents reviewed for accuracy of assessments. F692 (Maintenance of Nutrition and Hydration Status): Based on observations, interviews with the Registered Dietitian (RD), the Nurse Practitioner (NP) #1 and NP #2, staff, and record review, the facility failed to follow a recommendation from the RD to reweigh Resident #36 for further evaluation after an assessment of significant weight loss. Additionally, the facility failed to implement a plan from NP #2 in response to subtherapeutic total protein lab results for Resident #11. This failure occurred for 2 of 7 sampled residents reviewed for nutritional status.	F 867	record shows a pattern of the facility's inability to sustain an effective QA program Corrective action for residents with the potential to be affected by the alleged deficient practice: "Corrective action has been taken for the identified concerns in the areas of: Residents Rights (F550) "Corrective action has been taken for the identified concerns in the areas of: Accuracy of Assessments (F641) "Corrective action has been taken for the identified concerns in the areas of: Maintenance of Nutrition and Hydration Status (F692) "Corrective action has been taken for the identified concerns in the areas of: Infection Prevention and Control (F880) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 4/10/2024/ to review the deficiencies from the 3/11/2024-3/26/2024 recertification and complaint investigation survey and reviewed the citations. On 4/10/2024, the Regional Clinical Nurse Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: Beginning 4/11/ 2024 the Regional Clinical	

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F 867	Continued From page 132 During the recertification and complaint survey of 9/29/22, the facility failed to follow the recommendation of the Registered Dietitian to reweigh a resident with significant weight loss to determine the accuracy of the weight status. This failure occurred for 1 of 6 sampled residents reviewed for maintenance of nutrition status. F880 (Infection Prevention and Control): Based on observations, staff interviews and record reviews the facility failed to implement their infection control policy when Nurse Aide (NA #4) did not perform hand hygiene between residents during meal delivery and meal assistance and Nurse Aide (NA #12) failed to doff soiled gloves and perform hand hygiene before exiting Resident #57's room to obtain incontinence care supplies. This deficient practice was observed for 2 of 2 nursing assistants observed for hand hygiene and had the potential to result in the cross contamination of microorganisms between residents and environmental surfaces. During the recertification and complaint survey of 9/29/22, the facility failed to follow manufacturer guidelines for cleaning and disinfection of a glucose meter, stored in the medication cart that was used for a resident but was not designated for individual resident use. The Administrator and the Regional QAA Nurse Consultant were interviewed by phone on 3/16/24 at 5:01 PM. During the interview, the Administrator stated that repeat deficiencies were reviewed during quarterly QA meetings which included a review of the QA plan to ensure that monitoring of the deficiency continued to prevent a reoccurrence of the same deficient practice. The Administrator also stated that during	F 867	Nurse Consultant completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Unit Managers, Health Information Manager, Maintenance Director, Environmental Services Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above identified staff who does not receive scheduled in-service training by 4/15/2024 will not be allowed to work until training has been completed. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 4/22/2024, The Director of Nursing or Administrator will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the Regional Director of Operations or	

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F 867	Continued From page 133 monitoring, if QAA committee identified that the deficiency was ongoing, staff received re-education and the concern was discussed during QAA meetings to identify any trends for continued monitoring. The Administrator stated that she was aware of the deficiencies from the 9/29/22 survey. The Regional QAA Nurse Consultant stated that the repeat deficiencies were related to staff taking shortcuts, the use of agency staff, MDS staffing changes and staff oversight despite continued efforts to re-educate staff.	F 867	Regional Nurse Consultant weekly by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/16/2024	
F 880 SS=E	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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		4/16/24

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F 880	Continued From page 134 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 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.	F 880		

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F 880	Continued From page 135 §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, staff interviews and record reviews the facility failed to implement their infection control policy when Nurse Aide (NA #4)) did not perform hand hygiene between residents during meal delivery and meal assistance and Nurse Aide (NA #12) failed to doff soiled gloves and perform hand hygiene before exiting Resident #57's room. This deficient practice was observed for 2 of 2 nursing assistants observed for hand hygiene and had the potential to result in the cross contamination of microorganisms between residents and environmental surfaces. The findings included: 1. Review of the facility's policy titled "Hand Hygiene" dated July 2002 and last revised on July 2023, stated in part, "It is the policy of this facility that hand hygiene be regarded as the single most important means of preventing the spread of infections". 1. "Specific Indications for hand hygiene included before resident contact, and after direct contact with the resident's skin and touching equipment or furniture near a resident." On 03/11/2024 from 1:08 PM to 1:14 PM a continuous observation of the lunch tray meal delivery service was conducted in the facility on the 300 hall. Hand sanitizing dispensers were observed in place at intervals on the wall of the 300 hall. During this continuous observation, NA #4 removed a meal tray from the meal cart,	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880 INFECTION CONTROL Corrective action for affected residents. For residents #57, 88, 404, and 405- On 3/11/2024, Assistant Director of Nursing verbally reeducated Nurse Aide #4 related hand hygiene during meal tray pass. No sign or symptoms of infection for residents noteded. For resident #57- On 3/11/2024, Assistant Director of Nursing verbally reeducated Nurse Aide #12 related hand hygiene and donning/doffing PPE. No sign or symptoms of infection for resident noted. Corrective Action for Potentially Affected Residents. All current residents and staff have potential to be affected by deficient infection control practices. Beginning 4/10/2024, the Infection Control licensed nurse completed Infection Control Rounds Audit on 100 hall, 200 hall, 300 hall, and	

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F 880	Continued From page 136 entered Resident #88's room, placed the meal tray on Resident #88's overbed table and repositioned the resident's overbed table in front of the resident. NA #4 was then observed to exit the room and returned to the meal cart without performing hand hygiene. NA #4 pushed the meal cart further down the 300 hall and removed Resident #404's meal tray from the cart. NA #4 served the lunch tray to Resident #404 and assisted the Resident #404 with tray set up. NA #4 exited Resident #404's room and returned to the meal cart without performing hand hygiene. NA #4 removed Resident #405's meal tray from the cart. NA #4 served the lunch tray to Resident #405. NA#4 exited Resident #405's room without performing hand hygiene. An interview was conducted with the Assistant Director of Nursing (ADON) on 03/11/2024 at 1:15 PM who was also serving lunch trays on the 300 Hall. The ADON stopped NA #4 and asked NA #4 to perform hand hygiene after NA #4 served Resident 405's meal tray. The ADON also provided hand hygiene education to NA #4 specific to meal delivery and entering and exiting resident rooms. The ADON further stated that all staff should clean their hands between each resident. She also revealed that NA #4 had been educated in proper hand hygiene. An interview was conducted with NA #4 on 03/13/2024 at 10:45 AM. NA#4 stated that he thought he performed hand hygiene after serving meal trays and exiting resident's rooms. He also stated that he had received hand hygiene education specific to meal delivery and when entering and exiting resident rooms. An interview was conducted with the ADON on	F 880	400 hall to determine if deficient practices noted related to hand hygiene, glove use, and donning/doffing PPE prior to entering or exiting rooms. The results of the audit identified no deficient practices related to infection control. This was completed on 4/12/2024. Systemic Changes Beginning 4/11/2024, the Director of Nursing/Infection Control Nurse began education with all staff on hand hygiene, glove use, and donning/doffing PPE prior to entering or exiting rooms. Education for all facility Registered nurses, Licensed practical nurse, medication aides, nursing aides, nonclinical staff, department heads, therapy department, environmental services, maintenance and dietary staff will be completed by 4/15/2024. Any of the above identified staff who does not complete the training by 4/15/2024 will not be allowed to work until the training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance Beginning the week of 4/22/2024, the Administrator, Director of Nursing or designee will observe and monitor hand hygiene during meal tray pass and glove use during incontinent care, and donning/doffing PPE prior to exiting rooms using the QA Tool for Infection Control to ensure that proper hand hygiene, glove	

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F 880	Continued From page 137 03/13/2024 at 11:23 AM. The ADON stated that she was the facility's Infection Preventionist and was responsible for the Infection Prevention Program for the facility. She further stated that all staff had received hand hygiene education on hire and yearly thereafter. She also stated that throughout the year there are several Infection Control educational sessions for employees including hand hygiene. She also stated that NA #4 had received hand hygiene education and was aware of the indications for hand hygiene during meal delivery. On 03/13/2024 at 9:15 AM an interview was conducted with the Director of Nursing (DON). The DON revealed that staff were expected to perform hand hygiene after caring for each resident including during meal delivery. On 03/13/2024 at 2:25 PM an interview was conducted with the Administrator. The Administrator indicated NA #4 should have performed hand hygiene in accordance with the facility's policy. She also revealed that all staff had received hand hygiene education. 2. Review of the facility policy, Hand Hygiene, revised October 2022, recorded in part, Specific Indications for Hand Hygiene, after contact with bodily fluids, excretions, urine, or feces. Review of the facility policy, Perineal Care, revised October 2011, recorded in part, if gloves become soiled anytime during the care, change gloves and perform hand hygiene. Resident #57 was observed on 3/14/24 at 6:50 AM in bed alert, awake, nonverbal and lying on her back. Nurse Aide (NA) #12 donned gloves pulled the covers back and rolled Resident #57	F 880	use and donning/doffing PPE appropriately is occurring. This will be completed weekly x 4 weeks then monthly x 2 months. QA Reports will be presented in the weekly Quality of Life/Quality Assurance meeting by the Administrator or Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Minimum Data Set Registered Nurse, Environmental Services Director, Social Services Director, Dietary Manager, Health Information Manager, and Activities Director, Maintenance Director and Rehab Director. Date of Compliance: 4/16/2024	

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F 880	Continued From page 138	F 880		

onto her right side to observe Resident #57 for signs of incontinence. Resident #57 was observed wearing a night gown and a disposable brief. NA #12 was asked by the surveyor if she saw any signs of incontinence, NA #12 stated, "No, but I don't usually check like that." NA #12 then rolled Resident #57 onto her back, unfastened the disposable brief, placed both gloved hands inside the opened brief and reached toward the Resident's buttocks until both gloved hands were observed to contact bowel movement. NA #12 then asked Resident #57 if she could change her brief and Resident #57 smiled. NA #12 said to the resident, "Ok, I am going to go get some wipes and change your brief." NA #12 exited the Resident's room but did not remove the gloves that had contacted bowel movement in the Resident's disposable brief. NA #12 then walked to the clean linen closet that was to the right of the Resident's room, opened the closet door, removed a package of disposable wipes, and opened the lid of the disposable wipes while wearing the same soiled glove. NA #12 was interviewed prior to going back into the Resident's room and asked if she realized that she still had on the same gloves she used to check Resident #57 for incontinence? NA #12 sighed and stated that she did have on the same gloves she used to check Resident #57 for incontinence, and that she received infection control and hand hygiene in-services often. NA #12 stated that according to the training she received, she should have removed the soiled gloves and washed her hands before exiting the Resident's room. She further stated, "I know that."

Unit Manager (UM) #2 was interviewed on 3/14/24 at 11:44 AM. UM #2 stated NA #12 did not follow infection control practices and would

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F 880	Continued From page 139 need re-education on incontinence care and hand hygiene. UM #2 further stated that NA #12 should have removed the soiled gloves, and performed hand hygiene before she left the Residents' room. The Assistant Director of Nursing (ADON)/Infection Preventionist (IP), was interviewed on 3/14/24 at 11:20 AM and stated once the gloves become soiled, staff should remove the soiled gloves in the room, and perform hand hygiene before exiting the room. The ADON/IP also stated staff should not exit a resident's room with soiled gloves and then use the same soiled gloves to contact other items or surfaces. The ADON/IP stated NA #12 and other nursing staff would need re-education regarding the proper way to provide incontinence care and when to perform hand hygiene. A phone interview with the Administrator and Regional Quality Assessment and Assurance Nurse Consultant occurred on 3/16/24 at 5:01 PM. The Administrator stated that when NA #12 assessed Resident #57 to see if she needed incontinence care, NA #12 should have removed the soiled gloves, performed hand hygiene, obtained the needed supplies, and then put on new gloves.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F 919		4/16/24

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F 919	Continued From page 140 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to provide Resident #11 with a functional call light to request staff assistance for 3 of 3 days. This failure occurred for 1 of 2 sampled residents reviewed for a decline in activities of daily living. The findings included: Resident #11 was admitted to the facility on 12/9/21. Diagnoses included moderate dementia with agitation. The care plan revised 2/21/24 identified Resident #11 was at risk for decline in activities of daily living due to diagnoses of dementia, incontinence, and receipt of palliative services. Interventions included assisting with incontinence care, encouraging Resident to call for staff assistance prior to transfers, and keeping the call light within the Resident's reach. An annual Minimum Data Set assessment dated 3/5/24 assessed Resident #11 with severely impaired cognition, adequate hearing, adequate vision with corrective lenses, clear speech, understood, understands, no impairment in range of motion, required extensive staff assistance with toileting and frequently incontinent of bowel/bladder. Resident #11 was observed in her room and interviewed on 3/11/24 at 12:19 PM. Resident #11 was dressed in clothing, seated in her wheelchair, wearing gloves on both hands with a box of facial	F 919	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F919 Resident Call System The facility failed to ensure call light system was functioning properly for 1 of 2 sampled residents Corrective action for affected residents. For resident #11, the malfunctioning call light was replaced on 3/13/24 by the Maintenance Director. Corrective Action for Potentially Affected Residents. All current residents residing in the facility have the potential to be affected the alleged deficient practice. On 4/11/2024, the Maintenance Director, Central Supply Clerk, Social Workers and Human Resource Manager completed A 100% audit of all call lights was completed to ensure all call lights were functioning properly. The results of the audit revealed: No call lights were identified to be broken and or not functioning properly. This was completed on 4/11/2024. Systemic Changes	

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F 919	Continued From page 141 tissue next to her on the bed. Her call light was in reach. Her pants and brief were both pulled down to her knees and her right hand was inside the front section of her brief. Resident #11 stated that there was no toilet tissue in her bathroom, so she had to use "this tissue" (facial tissue) and that she needed toilet tissue. Resident #11 stated "I need some tissue to wipe myself and there is none in here." Resident #11 was asked by the surveyor if she used her call light in her room to ask for staff assistance and she replied, "I am not dumb you know, I know how to use my call bell, I pressed it, but no one came, so I am doing it myself." The surveyor observed that neither the wall panel light nor the light outside the room door were on when the Resident's call light in her room was engaged. Resident #11 stated she last used her call light "yesterday", to request staff assistance and staff responded. Nurse #6 was notified by the surveyor on 3/11/24 at 12:25 PM that Resident #11 needed staff assistance. Nurse #6 entered the Resident's room on 3/11/24 at 12:26 PM, observed Resident #11 and stated that she was wearing gloves with her brief and pants pulled down to her knees. Nurse #6 asked Resident #11 what she was doing, and the Resident stated that she needed toilet tissue to wipe herself. Nurse #6 reminded Resident #11 to use her call light when she needed staff assistance. The Resident replied, "I did, but you didn't come, so I had to wipe myself." Nurse #6 stated to the Resident that her call light in her room was not on. Nurse #6 pressed the Resident's call light in her room, looked at the wall panel and the light outside the room door and said she would notify the Maintenance Director that her call light in her room did not work. Resident #11 received assistance from staff with	F 919	Beginning 4/11/2024, the Administrator and Director of Nursing began in servicing all full-time, part-time, PRN (as needed) and agency staff on the Call Light Policy to include correct process for reporting when call lights are not functioning properly and follow up to ensure repaired or replaced. Additionally, the Administrator reeducated the Maintenance Director related to prompt response to completing repair to resident call light when not functioning properly. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all full-time, part-time, and PRN staff. Any staff who does not receive scheduled in-service training 4/15/2024 will not be allowed to work until training has been completed. Quality Assurance Beginning the week of 4/22/2024, The Administrator or Maintenance Director will monitor call light function utilizing the QA Tool for Call Lights to ensure call lights are functioning properly. This will be completed weekly x 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored	

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F 919	Continued From page 142 incontinence care. An observation occurred on 3/13/24 at 10:42 AM of the call light engaged for Resident #11 but the light on the wall panel in her room and the light outside the room door did not turn on. Nurse #6 was interviewed on 3/13/24 at 10:45 AM and she stated that she reported to the Maintenance Director on Monday, 3/11/24 that the call light in the room for Resident #11 was not working. She did not recall what time she reported the call light to the Maintenance Director, but said she reported it as soon as she left the Resident's room on Monday, 3/11/24. Nurse Aide (NA) #5 was interviewed on 3/13/24 at 3:28 PM. NA #5 stated she was assigned to care for Resident #11 at times on the 7 AM to 7 PM shift for the past five to six months. NA #5 described Resident #11 as alert, oriented with confusion, used her call light in her room frequently throughout the shift, but would also propel herself in her wheelchair into the hallway with her brief below her knees to wait for staff to come answer her call light. NA #5 stated Resident #11 required more assistance now with her care. An interview with NA #6 occurred on 3/13/24 at 5:18 PM. NA #6 stated she was the assigned NA for Resident #11 routinely on the 7 AM to 7 PM shift. NA #6 stated Resident #11 required limited to extensive staff assistance with her nursing care due to dementia. NA #6 stated Resident #11 would use her call light in her room to ask for staff assistance and sometimes she would transfer herself to the toilet without requesting assistance. NA #6 stated that for the last couple of days Resident #11 did not use her call light as much.	F 919	and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting indefinitely or until no longer deemed necessary for compliance with the housekeeping and personal laundry issues. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Rehab Manager, Health Information Manager, Environmental Services Manager, and the Dietary Manager Date of Compliance: 4/16/2024	

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F 919	Continued From page 143	F 919		

Nurse #12 stated in an interview on 3/14/24 at 7:15 AM that he was the assigned Nurse routinely for Resident #11 on the 7 PM to 7 AM shift. He stated Resident #11 used her call light in her room "all the time." He described that when she turned on her call light in her room, she then came into the hallway to see if staff were coming to see what she wanted.

An interview with the Maintenance Director occurred on 3/13/24 at 11:34 AM. He stated that Nurse #6 told him "Yesterday", Tuesday, 3/12/24 that the call light in room 105 - B was not working. He stated, "I repaired it today, I know that since it is a call light, it should be repaired immediately." He stated that when he went to room 105 - B, he identified that the call light cord in the room was burned out, so he replaced it. He further stated that the call light cord can burn out without notice and would not be identified until the call light was pressed, and staff noticed that the wall light in the room and the hall light outside the room door did not light up. The Maintenance Director further stated that he conducted room rounds daily and call light audits weekly checking randomly to identify any call lights that needed repair. He stated that he checked all call lights in the facility monthly and that his last monthly check was conducted on 2/29/24. He provided documentation of his last monthly call light audit dated 2/29/24 for review.

A phone interview with the Administrator and Regional Quality Assessment and Assurance Nurse Consultant occurred on 3/16/24 at 5:01 PM. The Administrator stated that maintenance staff should ensure all call lights were functional for residents who used them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345563	A. BUILDING _____ B. WING _____	C 03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION HEALTH CENTER AT BRIGHTMORE	**10011 PROVIDENCE ROAD WEST CHARLOTTE, NC 28277**

(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