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	345369	A. BUILDING _____ B. WING _____	C 05/17/2024

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/13/24 through 5/17/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # JES411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/13/24 through 5/17/24. Event ID #JES411. The following intakes were investigated: NC00208713, NC00212291 and NC00216246. Intake NC00212291 resulted in immediate jeopardy. 1 of the 9 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. An extended survey was conducted.	F 000		
F 661 SS=E	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course	F 661		5/27/24

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

Electronically Signed | 05/24/2024

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F 661	Continued From page 1 of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a recapitulation of stay for 2 of 2 residents reviewed for a planned discharge from the facility to home (Resident #79 and Resident #146). Findings included: 1. Resident #79 was admitted to the facility on 3/01/24 and discharged home on 3/07/24. The discharge Minimum Data Set dated 3/07/24 revealed Resident #79 was coded as cognitively intact.	F 661	F661 What was done for resident identified? Resident #79 and Resident #146 identified have been discharged and unable to re-create new after visit summary and recapitulation summary. The administrator placed a call to resident # 79 and resident # 146 on 5/24/24_____ to determine if either would like a copy of a recapitulation summary. Messages were left for resident #79 with no return call. Resident #146 was mailed a copy of his recapitulation summary on 5/24/2024	

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F 661	Continued From page 2 Review of Resident #79's electronic health record revealed a discharge summary completed by different disciplines dated 3/07/24. Further review of the discharge summary revealed that it did not include the required components of the recapitulation of stay and a final summary of the resident's status at discharge to include customary routine, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well-being, continence, skin conditions, dental status, physical function, and structural problems. An interview on 5/15/24 at 3:30 PM with the Social Worker (SW) revealed that she completed her section of the discharge summary and was unaware if anyone ensured all sections of the discharge summary were completed. An interview on 5/16/24 at 11:45 AM with the Administrator revealed that she was aware of the requirements for the recapitulation summary and stated that the facility utilized the electronic system form titled After Visit Summary. She stated that she did not realize that the After Visit Summary did not contain the required components. The Administrator stated that each discipline completed their discharge section and there was no one person responsible for ensuring all sections were completed. 2. Resident #146 was admitted to the facility on 10/09/23 and discharged home on 10/21/23. The discharge Minimum Data Set dated 10/21/23 revealed Resident #146 was coded as cognitively intact.	F 661	Those with potential to be affected. All residents expected to discharge from facility are at risk to be affected by the recapitulation summary. Potential discharges identified by the interdisciplinary team on _5/23/24_____ are at risk to be affected. Systemic Changes A form that encompasses the identified missing elements on the recapitulation summary to include customary routine, cognitive patterns, communication, vision, mood/behavior, psychosocial well-being, continence, dental, skin condition, and physical function and structural problems was created on 5/22/2024 and approved for use by the Administrator and Director of Nursing on 5/23/2024. The nurse who performs the discharge of a resident will complete the recapitulation form and provide a copy to the resident along with the after-visit summary and return the original to an identified box in the nursing station. The Director of Nursing or Designee will review all recapitulation summaries before providing to medical records to be scanned into the electronic medical record. Beginning 5/23/24 the Administrator or designee will complete the recapitulation of stay form and provide to the patient for discharge until training is completed with nursing staff to ensure compliance with the requirement to be completed 5/27/24. The Staff development Coordinator initiated education on 5/23/24 to nursing	

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F 661	Continued From page 3 Review of Resident #146's electronic health record revealed a discharge summary completed by different disciplines dated 10/21/23. Further review of the discharge summary revealed that it did not include the required components of the recapitulation of stay and a final summary of the resident's status at discharge to include customary routine, cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well-being, continence, skin conditions, dental status, physical function, and structural problems. An interview on 5/15/24 at 3:30 PM with the Social Worker (SW) revealed that she completed her section of the discharge summary and was unaware if anyone ensured all sections of the discharge summary were completed. An interview on 5/16/24 at 11:45 AM with the Administrator revealed that she was aware of the requirements for the recapitulation summary and stated that the facility utilized the electronic system form titled After Visit Summary. She stated that she did not realize that the After Visit Summary did not contain the required components. The Administrator stated that each discipline completed their discharge section and there was no one person responsible for ensuring all sections were completed.	F 661	staff about the recapitulation summary to be completed on or before day of discharge and a copy provided to the patient and copy placed in identified box at nursing station. The Administrator will initiate additional education to nurses on 5/27/2024 via Webex and attendance will be taken prior the start of the education. The Webex provided by the Administrator will be recorded and will be provided to all new hires by the Staff Development Coordinator. The SDC will be responsible for ensuring and tracking that all new hire nurses have received education prior to working on the units. Monitoring The Director of Nursing or Designee will audit for completed recapitulation summaries daily for 4 weeks and then weekly for one month. The results of the recapitulation summary audit will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nursing or Designee monthly. The QAPI committee will determine the frequency of audits based on results presented at the QAPI committee meeting. DATE of compliance: _5/27/2024___	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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F 689	Continued From page 4 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, facility neighbor, resident, and staff and physician interviews the facility failed to provide the necessary supervision to prevent a severely cognitively impaired resident (Resident #52) who was at high risk for falls from exiting the interior of the facility through an unlocked door leading to an enclosed exterior courtyard. On 1/14/24 an individual who resided in a nearby home heard Resident #52 yelling for help and Neighbor #1 and Neighbor #2 crossed over the fence into the facility's courtyard and found Resident #52 dressed in a night gown lying face down on the brick paved ground. Resident #175 was shivering and kept saying "I'm so cold". Her temperature was 90.9 degrees Fahrenheit (F) which was indicative of hypothermia (a condition where the body's temperature drops below 95 degrees F which can result in death). This deficient practice affected 1 of 3 residents reviewed for accidents. Findings included: Resident #52 was admitted to the facility on 8/11/21 with a diagnosis of dementia. A review of Resident #52's care plan revealed in part a problem area initiated on 8/19/21 of fall risk. The goal, with an expected end date of 2/20/24, was for Resident #52 to have no injury related to falls through the next review. Interventions included 8/24/23 draw labs for	F 689	Past noncompliance: no plan of correction required.	

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medical evaluation, and 9/12/23 recheck the auto lock brake function on WC.

A review of Resident #52's quarterly Minimum Data Set (MDS) assessment dated 11/7/23 revealed she was severely cognitively impaired. She did not exhibit wandering behaviors. She had no functional limitation in range of motion of her upper and lower extremities. She used a wheelchair (WC) and a walker for mobility. Resident #52 required supervision for bed mobility, transfers, and walking at least 50 feet with making 2 turns. She had 2 or more falls with injury during the assessment period. Resident #52 did not use a wander/elopement alarm.

A review of the wandering risk assessment for Resident #52 dated 11/7/23 revealed she did not wander or have a history of wandering. She did not elope or have a history of elopement. She was currently cognitively impaired and had impaired decision making skills.

On 5/14/24 at 3:49 PM an interview with the MDS Coordinator indicated a wandering risk assessment was conducted for each resident every time an MDS assessment was completed and as needed. The MDS Coordinator stated the wandering risk assessments the facility used did not result in a score or draw a conclusion, but the IDT team discussed them, and decided whether or not a wander alarm was indicated for the resident. She further indicated Resident #52 had MDS assessments on 8/8/23, and again on 11/7/23 and she was discussed during the interdisciplinary team meetings (IDT) that occurred for each MDS. She reported although Resident #52 was assessed to have impaired cognition and impaired decision making skills on

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these wandering risk assessments, she had no episodes of wandering behavior, and a wander guard alarm had not been indicated for her.

A review of a fall risk assessment for Resident #52 dated 1/8/24 revealed she was at high risk for falls.

A review of a nursing progress note for Resident #52 dated 1/15/24 at 1:30 AM written by Nurse #1 revealed at 11:55 PM two men (Neighbor #1 and Neighbor #2) came to the nurse saying they heard a resident yelling for help, so they climbed through the fence and found the resident lying on the ground face downward. The nurses immediately organized a search to make sure all residents were in their bed but found that Resident #52 was not in her bed. The Neighbors had helped her to sit on a chair. On assessment, a minor scratch was noted between Resident #52's right thumb and index finger. She was shivering. An extra blanket was supplied. Her temperature was initially 90.9 degrees F (a normal body temperature is 98.6 degrees F). She was alert, verbal and in good spirits but shivering. The physician was notified and ordered first aid to right thumb area. The police and facility security were also in the building.

On 5/14/24 a review of the Weather Underground website revealed the outdoor air temperature where the facility was located on 1/14/24 at 11:51 PM was 41 degrees F.

On 5/16/24 at 12:09 PM a telephone interview was conducted with Neighbor #1 who found Resident #52 on 1/14/24. He indicated he lived in an apartment next door to the facility. He stated on 1/14/24 around 11:30 PM his wife told him she

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heard someone calling for help. He reported it was dark and cold out, and at first, he was not going to do anything. He further indicated he went outside and saw his neighbor (Neighbor #2) and asked him if he also heard someone calling for help. He stated his neighbor told him he heard it too, and they walked over and looked through the fence that bordered the facility courtyard. Neighbor #1 stated they saw a woman (Resident #52) lying face down on the brick paved walkway. He reported Neighbor #2 slipped through the fence and he himself jumped over. He stated they helped the woman up and assisted her to walk over and sit on a bench. He indicated Neighbor #2 gave the woman his coat. He stated the woman had some scrapes but no other injuries he could see, she was shivering, and she just kept saying, "I'm so cold". He indicated they left the woman on the bench, went inside through an unlocked door, told the first person they saw that a woman was outside, and asked for some blankets. He indicated this person just asked them how they got into the building. He stated another staff member came out with a WC and helped the woman into the building.

On 5/14/24 at 4:25 PM a telephone interview with Nurse #1 indicated she was familiar with Resident #52 and assigned to her care on 1/14/24 from 11:00 PM until 7:00 AM. She stated Resident #52 was cognitively impaired and at times could walk with her walker, and other times used her WC for mobility. She went on to say it was not unusual for Resident #52 to walk out into the hall on her shift, but she would just walk Resident #52 back to her room and assist her into bed. Nurse #1 stated Resident #52 had never tried to go outside by herself that she knew of prior to the 1/14/24 incident. Nurse #1 stated that evening, she had

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gotten her report at the nurses station, her back had been to the hallway, and she had not seen Resident #52 walk by. She reported that night (1/14/24), two men (Neighbor #1 and Neighbor #2) had come into the facility and asked her to follow them because there was a resident in the courtyard. She further indicated she had been very taken aback because she had not known how they got into the facility. Nurse #1 stated she had immediately announced for everyone to check all their resident rooms, went to check all her resident rooms, and in about 2 minutes realized Resident #52 was not in her bed. She stated Resident #52 had been wearing a long sleeved cotton night gown and either gripper socks or house slippers. Nurse #1 stated it was very cold outside and Resident #52 had been shivering, but she was not wet. She stated Resident #52 was assessed and her temperature was very low. She stated she covered her with blankets, let the physician know, and monitored Resident #52 continuously, taking her temperature frequently until her temperature came back up to normal. She reported she then assisted Resident #52 back to bed.

On 5/14/24 at 8:14 PM a follow-up telephone interview with Nurse #1 stated she had not seen Resident #52 while she was in the courtyard. She indicated when she ran down to the courtyard on 1/14/24, Neighbor #1 and Neighbor #2 and an NA had already brought Resident #52 into the building in a WC. She stated Resident #52 felt cold to the touch and was shivering but she was talking. Nurse #1 stated the physician told her to warm Resident #52 up, continue taking her temperature, and if it didn't come up to send Resident #52 to the hospital. She indicated she monitored Resident #52 continuously and

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rechecked her temperature until it came up.

On 5/14/24 at 5:55 PM, in a telephone interview, NA #1 indicated on 1/14/24 she worked from 11:00 PM until 7:00 AM. She stated she was not assigned to Resident #52 on 1/14/24. She explained after reporting to work when she was coming down the hall to her assigned area, she saw Resident #52 near the nurses station. She reported she spoke with Resident #52 and helped her back to her room. She further indicated Resident #52 had not needed anything, and she helped Resident #52 get into bed, covered her up with blankets, and left her room. NA #1 stated she was familiar with Resident #52, and it was not unusual to see Resident #52 up that late walking, so she had not felt the need to report the behavior to a nurse. She went on to say she had not seen Resident #52 the rest of the night. She further indicated she had no reason to check the courtyard door to see if it was locked, because the courtyard was dark at night, and she never went out there on her shift.

On 5/15/24 at 12:11 PM a telephone interview with NA #2 indicated she worked the 11:00 PM to 7:00 AM shift on 1/14/24. She stated on 1/14/24 at about 11:30 PM two men (Neighbor #1 and Neighbor #2) came knocking on the glass Activity Room exit door which was beside the courtyard door. She further indicated Nurse #4 responded to them and reported Neighbor #1 and Neighbor #2 said there was someone lying on the patio. NA #2 stated when she got out to the courtyard, it was dark, but she could see Neighbor #1 and Neighbor #2 walking Resident #52 back towards the facility with one man on either side of Resident #52. She went on to say Resident #52 was having a hard time walking, so she ran to get

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a WC. She stated she did not ask Neighbor #1 and Neighbor #2 whether or not Resident #52 was on the ground when they found her. She reported one of the men had given Resident #52 their jacket, but Resident #52 was still shivering. She further indicated she got Resident #52 to the nurses station and took her full vital signs. NA #2 stated Resident #52's oral temperature was around 90 degrees F. She stated Nurse #1 was present and they got Resident #52 covered in blankets. She further indicated after she took Resident #52's vital signs, Nurse #1 attended to Resident #52, and she went back to her own assignment. NA #2 stated the facility's exit doors had alarms which would go off if someone tried to exit through them when they were locked, or if a resident was wearing a wander guard alarm. She went on to say there were no alarms going off that night. She further indicated she was familiar with Resident #52. NA #2 stated Resident #52 did at times walk by herself, but she would be redirected, and her needs attended to, and she would be assisted to sit back down in her WC. She indicated she had never seen Resident #52 try to exit the facility. She further indicated Resident #52 had never expressed to her a desire to leave the facility.

Documentation by NA #3 of vital signs including temperature revealed on 1/15/24 at 12:40 AM her oral temperature was 97.3 degrees F and on 1/15/24 at 1:25 AM her oral temperature was 98.7 degrees F.

A review of a physician's progress note dated 1/16/24 written by Physician #2 revealed on the evening of 1/14/24 Resident #52 wandered out of the facility into an enclosed courtyard. The resident had fallen. She was found on the ground

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face down. She was brought back to her room. There was some right hip discomfort. X-rays (radiologic imaging studies) were pending. The resident did not recall wandering.

A review of the hip x-ray results for Resident #52 dated 1/16/24 revealed there were no new fractures or dislocations.

A review of the facility's undated timeline of the event, provided by the Administrator on 5/14/24, revealed in part the following: The courtyard door should be open from 7:00AM to 9:00 PM. On 1/14/24 at approximately 11:14 PM Resident #52 walked with her walker from her room to the courtyard exit door and exited into the courtyard. At approximately 11:46 PM two men (Neighbor #1 and Neighbor #2) entered the building through the courtyard door to inform staff that a resident had fallen in the courtyard, they heard her yelling for help, and jumped the fence. Upon assessment, Resident #52 had a small skin tear. She was wearing only her night gown and socks. Her vital signs were obtained, and her body temperature was low. She was provided extra blankets and monitored. X-rays were ordered and were negative. The physician and her family were notified. Management was notified. A wander guard band was placed on Resident #52 on 1/15/24 and verification was done to determine it locked down the courtyard door.

On 5/14/24 at 1:31 PM, in an interview, the Administrator stated there had been one incident where Resident #52 went out into the courtyard at night unsupervised and had fallen. She went onto say she had watched video surveillance footage of this. She reported the video footage showed on 1/14/24 Resident #52 was seen

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coming out of her room with her walker, walking to the end of her hall, and looking out the exit door. The Administrator stated Resident #52 was then seen walking back past the nurses station where NA #1 intercepted Resident #52 and walked with Resident #52 back to her room. She stated NA #1 was seen exiting Resident #52's room at 11:08 PM. She indicated at 11:11 PM Resident #52 was seen coming back out of her room, walked past the nurses station where the nurses were getting report, and at 11:14 PM the footage showed Resident #52 reach the courtyard door. The Administrator stated there were no cameras in the courtyard, so she was not able to see Resident #52 go through the courtyard door but at 11:46 PM two men were seen on the footage entering the building through the courtyard door.

On 5/14/24 at 4:04 PM a follow up interview with the Administrator indicated the facility's video footage currently only went back to 3/15/24, and the footage from the event on 1/14/24 could no longer be viewed.

On 5/14/24 at 1:43 PM a follow-up interview with the Administrator she indicated Resident #52 had not been assessed on her most recent wandering risk assessment prior to the event to be at risk for wandering. She stated if Resident #52 had been wearing a wander guard alarm on 1/14/24, she would not have been able to exit through the courtyard door.

On 5/14/24 at 3:30 PM a follow-up interview with the Administrator indicated the MDS Coordinator conducted a wandering risk assessment quarterly and as needed for residents. She stated normally, the courtyard door locked down automatically

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from 9:00 PM and opened up again at 7:00 AM daily. She went on to say the facility had a new wander guard system installed in October of 2023 and after the installation, the front doors, which were on the same timer, were working okay. She further indicated she had no reason to suspect the courtyard door was not functioning properly.

On 5/16/24 at 8:18 PM a follow-up interview with the Administrator indicated on 10/26/23, work was completed to install a new wander guard system. She stated she did not know whether the courtyard door had been locking as it was scheduled to after this date, because she had no reason to suspect they were not locking until the incident with Resident #52 occurred on 1/14/24. She further indicated it was determined the likely cause of the courtyard door lock failure was the wander guard system and the system which locked the door were not connected. The Administrator stated there was a wire in the wander guard system that wasn't connected properly, and she had to coordinate with the security system company and the wander guard provider to come back and connect the wires properly in order for the security system for the facility to be able to lock the doors.

On 5/14/24 at 4:05 PM an interview with the Director of Nursing (DON) indicated she watched the video footage of Resident #52's incident on 1/14/24. She stated she recalled that Resident #52 had been wearing a long sleeved cotton night gown and slippers that covered her toes. She indicated Nurse #1 had called her at the time of the incident to notify her and let her know that she had spoken with Physician #1 who told Nurse #1 to warm Resident #52 up, monitor her temperature and if it didn't start to come up to

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send her out to the hospital. The DON stated she had come in early the next morning on 1/15/24 at about 5:30 AM and a wander guard alarm was placed on Resident #52. She further indicated Resident #52's usual routine was to get up around 1:00 AM to 2:00 AM and peek out her door, but she would usually just turn around and go back to bed. She stated she was not aware of any other time Resident #52 exited unsupervised from the facility.

On 5/15/24 at 11:37 AM a telephone interview with Nurse #3 indicated she worked on 1/14/24 from 3:00 PM until 11:00 PM as an NA, and then 11:00 PM until 7:00 AM as a Nurse. She stated on the 3PM-11PM shift on 1/14/24 she saw Resident #52 self-propelling her WC in the hallway, but the NA who was assigned to Resident #52 was monitoring her. She indicated this was not unusual for Resident #52. She further indicated Resident #52 could walk with her walker, and was at high risk for falls, as she would get up without asking for assistance. Nurse #3 stated in the past, she might have just assisted Resident #52 into bed, or into her chair after seeing to her needs and Resident #52 seemed to comprehend when she told her not to get up by herself. Nurse #3 stated the minute she turned her back, Resident #52 would be up standing trying to walk by herself. She stated she had never seen Resident #52 attempt to exit the facility. She went on to say she had never heard Resident #52 say she wanted to leave the facility. Nurse #3 stated she herself had never tried the courtyard doors in the evening prior to the 1/14/24 incident to see if they were locked.

On 5/15/24 at 12:31 PM a telephone interview with Physician #1 indicated he was on call the

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night of 1/14/24 when he was notified that Resident #52 had been found outside after having fallen. He stated Resident #52 had a small cut on her hand, her temperature was around 90 degrees F, and she was shivering. He reported rather than put Resident #52 through the trauma of being sent to the hospital, they attempted to get her temperature up at the facility. He further indicated 98.6 degrees F orally was a normal body temperature. Physician #1 stated at 90 degrees F, that was a bit low and potentially early hypothermia. He went on to say Resident #52's heart rate had not been elevated, and her breathing had not been affected. He further indicated he felt she might have needed to be outside another hour or two before the potential consequences for her would have been serious. Physician #1 stated a body temperature of 90 degrees F to 95 degrees F was mild hypothermia, below 90 degrees F was moderate hypothermia, and below 82 degrees F was severe hypothermia. He indicated the nurse had been monitoring Resident #52's temperature appropriately, Resident #52's temperature had been trending in the right direction, and she had not suffered any consequences from the event.

On 5/15/24 at 12:39 PM a telephone interview with NA #6 indicated she worked on 1/14/24 from 11:00 PM until 7:00 AM. She stated she did not observe the event, and when she saw Resident #52, she was at the nurses station having her vital signs taken. She went on to say Resident #52 was shivering because she was so cold, and she had blankets on. She further indicated she was familiar with Resident #52. NA #6 stated Resident #52 was a fall risk and had interventions in place such as a low bed, and an NA sitting outside her door if she was having a restless

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night. She indicated at times the NA assigned to Resident #52 would take her to the television room, get her a snack and sit with her watching television until Resident #52 got sleepy.

On 5/15/24 at 1:10 PM a telephone interview with NA #3 indicated she was assigned to care for Resident #52 on 1/14/24 on the 11:00 PM to 7:00 AM shift and was familiar with her. She stated Resident #52 had behaviors where she would get up and walk unassisted and come out into the hall. She went on to say she would monitor Resident #52 frequently, walk with her, ask her what she needed, meet her needs, and redirect her assisting her to sit in her WC. She further indicated some nights if Resident #52 was restless, she would sit with her in the television room until Resident #52 got sleepy. NA #3 stated Resident #52 was a fall risk and she checked on her frequently throughout the night. She stated she did not observe the event that on 1/14/24. She reported when she got to work at 11:00 PM on 1/14/24 she began her rounds on her assigned residents. She indicated she had not yet gotten to Resident #52's room and was in another room assisting a resident when she was notified there was a resident outside.

On 5/15/24 at 2:37 PM an interview with the facility's Maintenance Director indicated he had been working at the facility for two years. He stated he was familiar with the event that occurred with Resident #52 on 1/14/24. He reported there had been a company at the facility within the last 6 months working on the system that alarms for residents who have a band that sets off an alarm if they attempt to go outside. He further indicated he was not aware that this company disrupted the timing of the automatic

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locking of the courtyard door, or he would have put a system in place that included a magnetic alarm that sounded when the door was open. He stated the courtyard door had been on a timer that automatically locked it down from 9:00 PM until 7:00 AM prior to the disruption. He went on to say this was supposed to happen automatically. He indicated the courtyard door had been the only door affected by the disruption to the system.

On 5/15/24 at 4:19 PM Resident #52 was observed in bed. She had a wander guard alarm in place to her right ankle. An interview with Resident #52 at that time indicated she did not recall going out by herself to the courtyard and falling.

The Administrator was notified of Immediate Jeopardy on 5/15/24 at 10:39 AM.

The Administrator provided the following corrective action plan with a compliance date of 1/16/24:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #52 was immediately brought in and assessed by Nurse #1. Resident #52's axillary temp was 90.9 Fahrenheit (F) and noted Resident #52 was shivering. Resident #52 was provided with blankets as Resident #52 stated she was cold. Nurse #1 promptly notified the Medical Director of the incident and the Resident #52's current condition. The Medical Director instructed Nurse #1 to monitor Resident #52's temperature and if it did not return to normal to send the

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Resident #52 to the Emergency Department. Resident #52 was alert and in good spirits per Nurse #1's notes. Resident #52 only displayed shivering. Resident #52's temp at 12:40AM on 1/15/2024 was 97.3F, heart rate of 72, blood pressure of 157/84, respirations at 20, and oxygen saturation of 99 percent. Resident #52 was reassessed at 1:25AM with a temperature of 98.7F, heart rate of 77, respirations at 18, and blood pressure at 152/78. At 1:30AM Nurse #1 notified Resident #52's son via phone of the incident, Resident #52's condition and the action taken to care for and monitor Resident #52. Resident #52 was monitored closely by Nurse #1 throughout the shift. Resident #52's vital signs at 8:20AM on 1/15/2024 was a temperature at 98.1F, heart rate of 70, respirations at 18 and blood pressure at 121/60. Nurse #1 maintained direct supervision of Resident #52 for the first hour and when Resident #52 returned to their room Nurse #1 implemented frequent rounding on Resident #52. All nurses increased rounding frequency on all residents in the facility.

At 2:00AM Nurse #1 called the Director of Nursing to escalate the incident that occurred. The Director of Nursing returned her call at 4:30AM and Nurse #1 provided information regarding the incident, Nurse #1 stated that the Resident #52 was stable, confirmed that all residents were safe and in their rooms. Nurse #1 notified the Director of Nursing that local police and security personnel had been on site following the entrance of two unidentified males into the facility and cleared the scene after finding it safe.

On 1/15/2024, the Administrator made the executive decision to place a wander guard pendant on Resident #52, which was placed on

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Resident #52 at approximately 8:00AM. On 1/15/2024, at 9:36AM, the Minimum Data Set Coordinator updated the care plan by adding the 'Long Term Care Wander Guard' care plan for Resident #52.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

All mobile residents without a wander guard pendant had the potential to be affected. On 1/14/2024 at approximately 11:45PM, nursing staff conducted a search of the facility and determined all residents were accounted for except for Resident #52 who was not in their room. Following the search, nursing assistants and nurses increased frequency of rounding on all residents.

On the morning of 1/15/24, it was determined by the Administrator that the courtyard doors' remote locking system did not lock as intended. On 1/15/2024 at 7:40AM, the Administrator notified the Protective Services Director and the Vice President that the courtyard doors were found to not be locking properly. The Administrator also notified the wander guard company and placed a ticket for repair. The remote locking system unlocks the doors to the facility at 7AM for normal operations, because of this, no immediate action was taken to secure doors as they were unlocked for normal operations. In the afternoon of 1/15/2024 the Director of Nursing, Director of Protective Services, and the Administrator met via phone to conduct an 'Event After Action Report' to develop an action plan and monitoring processes. The 'Event After Action Report' identified the need to implement an alarm system for the courtyard

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doors to prepare for nightshift. At approximately 3PM, The Maintenance Director placed an auditory alarm on each courtyard door so that if the door opened, an alarm would sound and notify staff.

On 1/16/2024, the Director of Protective Services assessed the courtyard doors and tested the access control lock feature, which revealed it was failing. Following this assessment, the Administrator placed another ticket with the company that installed the wander guard system. On 1/17/2024, the wander guard company arrived at the facility, but was unable to correct the issue because the installation company needed to be present. On 1/19/2024, the installation company arrived and stated that both the remote locking system staff and installation company were needed to resolve the issue. The Administrator coordinated with both companies and on 1/22/2024, the installation company and remote locking system staff were able to correct the connection that prevented the courtyard doors from locking. Prior to releasing the door back to normal operations, the access control company retested the doors to confirm the issue was repaired. The courtyard doors had audible alarms in place from 1/15/2024 until 1/22/2024, while awaiting the remote locking system to be repaired.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On 1/22/2024, a new procedure was implemented by the Administrator, or designee, to coordinate with the remote locking system team to test the remote locking system after any work

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is completed on the doors that have the remote locking system in place, which includes the facility's front door, courtyard door one, and courtyard door two. Going forward, this test will be completed before the vendor leaves the premises and before releasing the door back into normal operation. On 1/22/2024, the Administrator provided education on the new procedure to the Director of Protective Services (leader for the remote locking system team), and the Director of Nursing.

The facility has a process for all staff to receive updates through a shift report with information disseminated by the Director of Nursing to the Team Leaders. The shift report is a document that includes talking points by the Team Leaders to communicate important information with staff at the beginning of their shift. On 1/15/2024 the Director of Nursing updated the shift report to include the information about the incident that occurred with the failed remote locking mechanism and that an attached manual audible alarm on the doors leading to the courtyard was being used until the remote locking mechanism could be fixed. The Director of Nursing educated the on-site Evening Team Leader about the failed remote locking mechanism and that an attached manual alarm was being used. From 3:00pm on 1/15/2024 forward no staff worked without knowing about the failed remote locking mechanism and the use of an attached manual audible alarm on the doors leading to the courtyard was being used until the remote locking mechanism could be fixed.

On 1/22/2024 the Administrator trained the Clinical Manager to perform the remote locking control audits. Later that same day, the Clinical

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Manager trained the four Nursing Assistants (NA) designated to perform the remote locking control audits. The four NAs were educated prior to performing the audits.

On 2/13/2024 the decision was made by the Administrator to change the responsible staff to night shift nurse team leaders to begin performing the weekly audits based on staffing availability. On 2/13/2024 the Administrator educated all evening and night shift nurse team leaders on how to perform the remote locking control audits prior to them performing the weekly audits.

During orientation all staff receive education regarding the chain of command used to escalate safety concerns, including concerns with security of the facility. Staff are educated to escalate to the Team Leader, Director of Nursing and/or the Administrator. The Staff Department Coordinator is responsible for providing this education to staff prior to the staff working in the facility.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

The monitoring plan, determined by the 'Event After Action Report', started with daily audits beginning when the door locks were repaired, and the auditory alarms removed. After three weeks of audits showing no failures, the audits became weekly. Specific dates are as follows: On 1/15/2024, the courtyard doors had an alarm in place that would alert staff if the door was opened. On 1/22/2024, once the doors were fixed, the temporary alarms were removed, and nightly audits were completed by a lead nursing

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assistant until 2/10/2024. The week of 2/11/2024 the nightshift nurse team leader began weekly audits to ensure that the doors remain locked at night.

The audits collected, in addition to the new procedure, are reported out to the Quality Assurance and Performance Improvement (QAPI) committee monthly by the Administrator. The QAPI committee determines the frequency of monitoring required based on audit results.

All action items were discussed at the February 29, 2024, QAPI meeting. Members of the QAPI committee include: Administrator, Medical Directors, Director of Nursing, Pharmacist Consultant, Business Office Manager, Rehabilitation Director, Rehabilitation Team Lead, Staff Development Infection Control Nurse, Activities Coordinators, Dietary Manager, Wound Nurse, Admissions Director, Dietician, MDS coordinators, Health Information Management HIM Specialist, Administrative Assistant, Business Office Assistant.

Include dates when corrective action will be completed:

Alleged immediate jeopardy removal date and compliance date: 1/16/2024.

Validation of the corrective action plan was completed on 5/17/24. This included interviews with the Director of Protective Services, the DON, the Evening Team Leader, two NAs who worked after 1/15/24, the Clinical Manager, one NA who was designated to perform the courtyard door locking control audits, and a Night Shift Team Leader. These interviews verified that the remote

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F 689	Continued From page 24 locking function of the courtyard door was being monitored and was locking at 9:00 PM and unlocking at 7:00 AM. The Shift Report Document for 1/15/24 was reviewed. The Event After Action Report was reviewed. The facility's audits, orientation education, and QAPI minutes were reviewed. The facility's alleged immediate jeopardy removal date and compliance date of 1/16/24 was verified.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Nurse Practitioner interviews, the facility failed to obtain orders for the use of supplemental oxygen for 1 of 1 resident reviewed with oxygen (Resident #133). Findings included: Resident #133 was admitted to the facility on 5/07/24 with diagnoses which included shortness of breath and acute kidney failure. Resident #133's admission Minimum Data Set was in progress.	F 695	F695 What was done for resident identified? Order was obtained for adult oxygen therapy by Staff Development Coordinator on 5/15/2024 for resident #133. Education was provided to nurse #5 and Nurse practitioner #1 on 5/15/2024 on the requirements for an order to be in place to administer oxygen. How does this affect the potential for others? Clinical manager completed an audit of all in house residents on 5/15/2024 to determine if oxygen was in use without an	5/24/24

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F 695	Continued From page 25 Review of Resident #133's care plan last updated 5/14/24 revealed a problem for impaired gas exchange. The goal was that the resident maintained adequate gas exchange as evidenced by oxygen saturation within normal limits and absence of hypoxia through the next review. The interventions included monitoring for signs and symptoms of hypoxia and administer oxygen as ordered. Review of the physician orders revealed no order for supplemental oxygen use. An observation made on 5/13/24 at 2:25 PM revealed that Resident #133 wore oxygen via nasal cannula at 2 liters per minute. An observation made on 5/14/24 at 8:50 AM revealed that Resident #133 wore oxygen via nasal cannula at 2 liters per minute. An observation made on 5/15/24 at 11:29 AM revealed that Resident #133 wore oxygen via nasal cannula at 2 liters per minute. An interview on 5/15/24 at 11:19 AM with Nurse #5 revealed that Resident #133 wore supplemental oxygen for comfort. She confirmed that there was no physician's order for oxygen for Resident #133. She stated that there should be an order and she did not know why there was no order. An interview on 5/15/24 at 2:42 PM with Nurse Practitioner #1 revealed that Resident #133 should have an order for supplemental oxygen and she did not know why there was no order.	F 695	order, no other residents were identified. Systemic changes On 5/16/24 Staff Development Coordinator initiated education to all nurses and providers regarding the use of oxygen and ensuring active order in place for adult oxygen therapy. The SDC will be responsible for ensuring and tracking that all new hire nurses and medical providers have received education prior to working on the units. Daily audits of adult oxygen therapy use are and will continue to be conducted by the Administrator or Designee for two weeks, then weekly for 4 weeks which began on 5-16-2024. Monitoring Audit results of adult oxygen therapy use will be presented to the Quality Assurance Performance Improvement Committee by the Administrator or Designee at the monthly QAPI meeting. The QAPI committee will determine the frequency of ongoing audits based on results provided at the meeting. DATE of compliance: _5/24/2024_____	

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F 695	Continued From page 26 An interview on 5/16/24 at 11:45 AM with the Administrator revealed that Resident #133 should have an order for supplemental oxygen. She stated that she thought the Nurse Practitioner had just forgotten to enter the order.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure resident medications stored in an unattended and unlocked medication	F 761	F 761 What was done for resident identified? NO resident was identified. Nurse #2 was	5/23/24

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F 761	Continued From page 27 cart (Wing D) for 1 of 5 medication carts. The findings included: A continuous observation was conducted of the Wing D medication cart on 5/16/24 at 9:50 AM through 9:56 AM. The cart was parked midway down the hall with the drawers of the cart facing out. The medication cart was observed with the lock not engaged as evidenced by the red dot on the lock being visible. There was no staff member with the medication cart. Four staff members, one resident, and 2 visitors were observed walking past the unlocked medication cart. Nurse #2 came out of a resident room and returned to the medication cart at 9:56 AM. Nurse #2 was asked to open the top drawer and realized she had left the medication cart unlocked. Nurse #2 stated she usually locked her cart and revealed it should be locked any time she was not using it. An interview with the Director of Nursing (DON) on 05/16/24 09:59 AM was completed. The DON stated the medication cart should have been secured and locked unless the nurse was present at the cart. The DON further stated that the nurse assigned to the medication cart was responsible for it and ensuring that it was secured. An interview with the Administrator on 05/16/24 10:02 AM revealed medication carts should not be unlocked unless the Nurse was standing in front of it. The Administrator stated the nurse assigned to that medication cart was responsible for it for their entire shift.	F 761	educated on 5-16-24 by the Director of Nursing on medication storage requirements and that the medication cart must be locked when not in line of sight. How does this affect the potential for others? The Director of Nursing audited all residents to determine those who were mobile who would have been at risk on 5-16-2024. No residents were affected by the unlocked medication cart. Systemic Changes The Staff Development Coordinator and the Director of Nursing initiated education to all nurses on medication storage requirements and that medication carts are required to be locked when out of line of sight. The SDC will be responsible for ensuring and tracking that all new hire nurses have received education prior to working on the units. The Administrator and Director of Nursing initiated audits on 5-16-2024 for medication cart lock compliance. Daily audits to be at random times will be conducted for two weeks, then weekly for four weeks by the Administrator or Director of Nursing and / or Designee. Monitoring The results of the medication cart lock compliance will be presented to the Quality Assurance Performance Improvement Committee by the Administrator or Designee monthly. The QAPI committee will determine the frequency of audits based on results presented at the QAPI committee	

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F 761	Continued From page 28	F 761	meeting. DATE of compliance: __5/23/2024__	
F 867 SS=D	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 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,	F 867		5/30/24

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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 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

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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 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 observation and staff interview, the

F 867

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F 867	Continued From page 31 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 3/23/23 recertification and complaint survey in the area of Medication Storage (F761). This deficiency weas cited again on the current recertification and complaint survey of 5/17/24. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. The findings included: This tag is cross referenced to: 1. 761: Based on observations and staff interviews the facility failed to secure resident medications stored in an unattended and unlocked medication cart (Wing D) for 1 of 5 medication carts. During the recertification and complaint investigation survey of 3/23/23 the facility was cited for failing to keep medications secure. An interview was conducted with the Administrator on 5/17/24 at 12:14 PM. The Administrator stated constant rounds were still being conducted throughout the day in response to the survey of 2023. She reported medication storage rooms and medication carts continued to be monitored daily to ensure they were secure and nurses were being reminded of this. She indicated it was unfortunate that a medication cart had still been found unlocked.	F 867	Resident affected: No residents were identified. Those with potential to be affected. All residents residing within the facility have the potential to be affected by the Quality Assurance Performance Improvement processes and analysis and medication storage requrements Systemic Changes The compliance officer educated the Administrator on 5/21/24 regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include medication cart locking compliance and medication storage compliance. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. The Administrator educated the Quality Assurance Performance Improvement Committee on 5/21/24 regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include medication cart locking compliance and medication storage compliance. In-service also	

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F 867	Continued From page 32	F 867	included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. Monitoring The compliance officer will provide oversight and feedback of monthly Quality Assurance Performance Improvement meetings to ensure compliance with medication cart locking and medication storage requirements. The Compliance officer will provide feedback to the QAPI committee on data reported out to the QAPI committee to ensure ongoing compliance and identify any new opportunities for improvement. The compliance officer will attend the monthly QAPI meeting for six months. The compliance officer will determine if oversight remains once the facility has maintained substantial compliance for six months. Next QPAI meeting 5/30/2024 DATE of compliance: __5/30/2024__	