STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345505	A. BUILDING _____ B. WING _____	C 05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/29/24 through 5/03/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # EHW811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/29/24 through 5/03/24. Event ID# EHW811. The following intakes were investigated NC00199493, NC00200962, NC00207750, NC00210038, NC00212772, NC00213399, NC00215426, NC00215759, and NC00216504. 6 of the 26 complaint allegations resulted in deficiency.	F 000		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights,	F 551		5/24/24

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

Electronically Signed | 05/17/2024

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except as limited by State law.

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.
(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.
(ii) The resident's wishes and preferences must be considered in the exercise of rights by the

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F 551	Continued From page 2 representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, resident representative (RR), and nurse practitioner (NP) interviews the facility failed to allow a resident's designated representative to decide whether an application for Medicaid would be completed for the resident. This was for 1 of 5 residents (Resident #49) reviewed for personal funds. A reasonable person would feel distressed related to the potential financial consequences to their estate if an application for Medicaid was completed without their consent. Findings included: A review of Resident #49's Hospital Discharge Summary dated 12/21/23 revealed in part Resident #49 understood only basic conversations or simple direct phrases. He frequently required cues to understand. Resident #49 was admitted to the facility on 12/21/23 with a diagnosis of cerebral infarction (disrupted blood supply to the brain sometimes called a stroke). A review of Resident #49's medical record revealed his family members were his RR#1 and RR#2. A review of a Discharge Planning Psychosocial Assessment form for Resident #49 dated 12/22/23 and signed by Social Worker (SW) #2 revealed in part Resident #49's expected length	F 551	F551 1. Resident # 49 application for Medicaid was rescinded by the facility on 5/16/24. 2. All residents with cognitive impairment who need a Medicaid application have the potential to be affected by this practice. 3. All Medicaid applications within the last 30 days were reviewed by the administrator to ensure the resident responsible party has signed the appropriate paperwork in the event the resident is cognitively impaired. This was completed 5/21/2024. No further noncompliance with Medicaid applications not being signed by resident responsible party noted during audit. Business Office Manager and assistant received education on Resident Rights and obtaining permission from representative party prior to applying for Medicaid for all cognitively impaired residents by the administrator on 5/17/2024 All new Business Office Managers and assistants will receive this education upon hire by the administrator. 4. An audit will be completed on each resident applying for Medicaid to ensure the resident power of attorney has signed the appropriate paperwork in the event the resident is cognitively impaired. This audit will be completed by the Administrator/Designee prior to filing Medicaid paperwork. The results of this	

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of stay at the facility would be short term. It further revealed Resident #49 had a stroke and was unable to communicate. He depended on his RR #1 and RR #2 to make his decisions for him.

A review of Resident #49's admission Minimum Data Set (MDS) assessment dated 1/29/24 revealed in part his hearing was adequate. He had no speech. His Brief Interview of Mental Status (BIMS) score was 99 (indicating the BIMS was incomplete and the staff assessment for mental status was completed). The staff assessment indicated Resident #49 was severely cognitively impaired.

A review of a Division of Social Services (DSS) form titled "Division of Health Benefits (DHB) Appendix C Designation of Authorized Representative" for Resident #49 dated 2/7/24 revealed in part the name of the applicant was {Resident #49}. The name of the authorized representative was {the facility's Business Office Manager (BOM)}. It further revealed in part: "I understand that by signing this authorization, I am allowing the above-named individual to sign my application, complete my re-enrollment/re-determination, get official information about my case status, and act for me on all future matters with this agency". The form was signed by Resident #49 and the BOM. A further review of additional forms dated 2/7/24 including a form titled "DHB 5028 Authorization to Disclose Information, Authorization to Release Information, Consumer Consent and Authorization for Access to Financial Records," a form that listed Resident #49's income and resources including a joint checking and savings account with his family member, and a notice that advised Resident #49 his estate was subject to

audit will be forwarded to the Quality Assurance Committee for monthly review for three months and then the frequency of review will be determined by the QAPI committee.

5. Date of completion 5/24/2024

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Medicaid Recovery were signed only by the BOM.

On 5/1/24 at 2:00 PM an interview with Social Worker (SW) #1 indicated she was familiar with Resident #49. She further indicated Resident #49 was cognitively impaired. She stated although there was no Power of Attorney (POA) paperwork for the resident, his family member was his RR#1 and his surrogate decision maker as he was unable to do this for himself. She went on to say Resident #49's initial discharge planning on 12/22/23 was completed by SW #2 who no longer worked at the facility. She further indicated she would not be involved in an application for Medicaid for Resident #49, that would be the Business Office.

On 5/1/24 at 2:16 PM an interview with the Business Office Manger (BOM) indicated when Resident #49 was first admitted to the facility the plan was for him to be there short term. She stated when that plan changed, she reached out to his RR #1 and RR#2 trying to get the process started for an application for Medicaid to pay for his stay at the facility as the process took a long time. She went on to say she was not getting a response back quickly enough, so she asked the Assistant BOM to talk with Resident #49 about signing the paperwork for this himself. The BOM stated the Assistant BOM had difficulty talking with Resident #49, so she looked at Resident #49's BIMS score. She stated it was 99 and she thought the high score meant that Resident #49 could understand and sign paperwork for himself. She stated although Resident #49 had not been able to speak to her when she talked with him about this, he nodded his head when she explained it all to him and signed the form making her the designated representative to start the

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Medicaid application process. She stated she just wanted Resident #49 to get the financial assistance he was entitled to. She went on to say Resident #49 and RR#2 had a good relationship and shared a bank account. She further indicated when Resident #49's RR#2 brought in a check to pay for Resident #49's March 2024 bill, she let her know she had gotten Resident #49's signature to apply for Medicaid. She stated she had not spoken with Resident #49's RR #1 or RR#2 prior to obtaining his signature. The BOM went on to say now she understood that a BIMS score of 99 meant that Resident #49 might not be capable of understanding and signing the form giving her permission to be his designated representative in the Medicaid application process, and that she should have reached out to nursing or administration for help determining what to do. On 5/2/24 at 2:14 PM a follow up interview with the BOM indicated when she approached Resident #49 to have him sign the Medicaid application paperwork, she explained to him that whenever someone is in a Long-Term Care facility and had Medicaid, their income minus 30.00 dollars was paid to their bill in the facility. She stated she read the whole application form to him, he nodded, and signed it. She went on to say she took this as him understanding what she read to him.

On 5/1/24 at 2:23 PM an interview with the Assistant Business Office Manager (BOM) indicated she had gone to see Resident #49 about signing some paperwork for Medicaid including designating a representative and for access to his banking and other financial information documents, but Resident #49 had not been having a good day. She stated she left telephone messages for his RP and his other

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family member but hadn't heard back. She went on to say the BOM told her that Resident #49's BIMS score was 99 and so he could sign for himself. She further indicated she had not known you could do that, so the BOM went to have Resident #49 sign the forms.

On 5/2/24 at 9:13 AM Resident #49 was observed sitting in his room. During an attempt at interview with Resident #49 regarding his giving the facility permission to apply for Medicaid on his behalf he did not respond verbally but shrugged his shoulders.

On 5/1/24 at 3:52 PM a telephone interview with Resident #49's RR#2 indicated when Resident #49 was first admitted to the facility she let them know she had Power of Attorney. She stated they asked her to bring in a copy of the form, but she had not been able to locate this. She went on to say she and Resident #49's RR#1 were responsible for making both financial and health care decisions for Resident #49, as he was not capable of doing this for himself. She further indicated the facility called her when Resident #49 fell, or had other issues, but no one ever called to ask for permission to have him sign an application for Medicaid prior to or even to let her know after they completed his Medicaid application. Resident #49's RR#2 stated while Resident #49 could understand simple things, there was no way he could understand and give permission for an application to Medicaid and the complicated financial things this involved. She went on to say she had called to the facility to ask about Resident #49's bill and had been told by the Assistant BOM that the facility already had him sign an application for Medicaid. She further indicated she had been very upset by this.

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Resident #49's RR#2 stated when she found out it was the BOM who had him sign the form she spoke with her. She went on to say the BOM told her that a resident who had a BIMS score of 10 could sign things for themselves and because the resident had a score of 9 that was almost a 10 so the BOM had Resident #49 sign the form himself. On 5/2/24 at 1:20 PM a follow up telephone interview with Resident #49's RR#2 indicated she had managed Resident #49's financial affairs since prior to his admission to the facility as he had not been capable of financial management. She stated she and Resident #49 shared a bank account.

On 5/1/24 at 4:03 PM a telephone interview with Resident #49's RR#1 indicated she and RR#2 were both Resident #49's representatives. She stated together they had made all Resident #49's financial and heath care decisions since his admission to the facility because he was not able to do this for himself. She went on to say when she found out the facility had Resident #49 sign an application for Medicaid, she was so upset she immediately drove to the facility. She further indicated when she got there, the BOM told her she made a mistake having Resident #49 sign the forms because she thought his BIMS score was higher than it was. Resident #49's RR#1 stated she understood that a BIMS score was an indication of someone's ability to understand and make decisions. She went on to say she had clear conversations with the facility since Resident #49's admission that she and Resident #49's RR#2 were his decision makers. She further indicated the facility did not even call her or Resident #49's RR#2 to ask if they wanted to apply for Medicaid for Resident #49 prior to having him sign the form.

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On 5/2/24 at 9:37 AM an interview with Nurse #10 indicated she was familiar with Resident #49 and cared for him often since January 2024. She stated he had a family member (RR#1) who was Representative, and another family member (RR#2) involved in his care. She went on to say she had never had any trouble getting in touch with Resident #49's RR#1 or RR#2 to report a fall or other concerns. She further indicated she did not feel Resident #49 had the cognitive ability to make medical or financial decisions for himself. Nurse #10 stated Resident #49 had some negative and inappropriate behaviors that reflected his impaired cognition.

On 5/2/24 at 9:44 AM an interview with Nurse Aide (NA) #5 indicated she was familiar with Resident #49 and cared for him often since January 2024. She stated she did not think Resident #49 had the cognitive ability to make medical or financial decisions for himself. She went on to say he understood simple things, but she didn't feel he could understand complicated things like finances.

On 5/2/24 at 12:33 PM a telephone interview with SW #2 indicated she completed Resident #49's initial discharge planning meeting on 12/22/23. She stated he was not capable of making medical or financial decisions for himself because of his cognitive status and RR#1 and RR#2 were doing that for him.

On 5/1/24 at 2:48 PM an interview with the Administrator indicated if a resident had a BIMS score of 99 that would indicate they did not have the cognitive ability to understand and consent allowing the BOM to be his designated

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F 551	Continued From page 9 representative. She stated if there were issues that required this type of signature, and the resident had no POA then the facility would need to seek guardianship. On 5/2/24 at 8:58 AM a follow-up interview with the Administrator indicated the facility did not have any signed admission paperwork for Resident #49. She stated Resident #49 was not able to sign it himself when he was admitted to the facility, and RR#2 had not been communicative. On 5/2/24 at 2:09 PM a telephone interview with Resident #49's psychiatric Nurse Practitioner indicated she was familiar with Resident #49. She stated at her assessment of him on 2/15/24 she did not feel he would be capable of making financial or medical decisions for himself. She went on to say because Resident #49 was not verbal, there really would be no way of completing the cognition assessments that would be required to decide that he was.	F 551		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.	F 567		5/24/24

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F 567	Continued From page 10 (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, responsible party (RP), nurse practitioner (NP), and Physician interviews the facility failed obtain the permission of the RP prior to opening a Resident Trust Fund account with the facility which allowed for the direct deposit of the resident's Social Security and Veterans Administration benefits and automatically transferred care cost payments to the facility. This was for 1 of 5 residents (Resident #49) reviewed for personal funds. Findings included:	F 567	F567 1. Resident number 49 trust fund account was closed on 4/26/24. 2. All residents who need a trust fund and are cognitively impaired have the potential to be affected by this practice. All residents with a trust fund account were reviewed by the administrator to ensure that Representative party permission is obtained and documented on all current resident trust fund accounts for cognitively impaired residents. This was completed on 5/21/2024. No resident trust fund	

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F 567	Continued From page 11 A review of Resident #49's Hospital Discharge Summary dated 12/21/23 revealed in part Resident #49 understood only basic conversations or simple direct phrases. He frequently required cues to understand. Resident #49 was admitted to the facility on 12/21/23 with a diagnosis of cerebral infarction (disrupted blood supply to the brain sometimes called a stroke). A review of a Discharge Planning Psychosocial Assessment form for Resident #49 dated 12/22/23 and signed by Social Worker (SW) #2 revealed in part Resident #49's expected length of stay at the facility would be short term as stated by his Responsible Party (RP). It further revealed Resident #49 had a stroke and was unable to communicate. He depended on his RP and another family member to make his decisions for him. A review of Resident #49's admission Minimum Data Set (MDS) assessment dated 1/29/24 revealed in part his hearing was adequate. He had no speech. His Brief Interview of Mental Status (BIMS) score was 99. He was severely cognitively impaired. A review of a form titled: "Resident Fund Management Service Authorization and Agreement to Handle Resident Funds" revealed in part the account type was transferring (automatic transfer of care costs due the facility with a 30.00-dollar monthly allowance). The direct deposit boxes (please enroll my indicated recurring benefit payments for direct deposit) for social security, veterans administration, railroad	F 567	accounts were identified as being opened for cognitively impaired residents without representative party permission. 3. The Business office Manager and Assistant were re-educated on resident rights and ensuring that Representative party permission is obtained and documented prior to opening a resident trust fund for cognitively impaired residents this was completed by the administrator 5/17/2024. All new Business Office Managers and assistants will receive this education upon hire by the administrator. 4. The administrator or designee will audit monthly all new trust fund accounts of cognitively impaired residents to ensure Representative party permission is documented. Results of audits will be reviewed at Quality Assurance Plan Improvement Committee meeting x2 months for analysis of patterns, trends or need for further systemic changes. 5. Date of completion 5/24/2024	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF CUMBERLAND	4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306

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retirement, supplemental security income, civil service benefits, and miners/black lung were all checked. Above the signature line of the form was a statement that read: "Resident's illegible signature or mark (X) requires two witnesses. There was an illegible signature on the resident signature line. There were no witness signatures. The form was dated 2/7/24.

A review of Resident #49's medical record on 5/1/24 revealed his family member was his Responsible Party (RP).

On 5/1/24 at 2:00 PM an interview with Social Worker (SW) #1 indicated she was familiar with Resident #49. She further indicated Resident #49 was pretty cognitively impaired. She stated although there was no Power of Attorney (POA) paperwork for the resident, his family member was his Responsible Party (RP) and his surrogate decision maker as he was unable to do this for himself. She went on to say Resident #49's initial discharge planning on 12/22/23 was completed by SW #2 who no longer worked at the facility. She further indicated she would not be involved in an application for Medicaid for Resident #49, that would be the Business Office. SW #1 stated she was currently working with Resident #49's family to have him transferred to a Veteran's Administration (VA) facility.

On 5/1/24 at 2:16 PM an interview with the Business Office Manager (BOM) indicated when Resident #49 was first admitted to the facility the plan was for him to be there short term. She stated she looked at Resident #49's BIMS score. She stated it was 99 and she thought this high score meant that Resident #49 could understand and sign things for himself. She stated although

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Resident #49 had not been able to speak to her when she talked with him about signing Medicaid application forms, he nodded his head when she explained it all to him. The BOM went on to say now she understood that a BIMS score of 99 meant that Resident #49 might not capable be of understanding and signing forms giving her permission to be his designated representative in the Medicaid application process, and that she should have reached out to nursing or administration for help determining what to do.
On 5/2/24 at 2:14 PM in a follow-up interview the BOM indicated she had Resident #49 sign the Resident Fund management Account agreement on 2/7/24 when she had him sign the Medicaid paperwork. She stated she explained to him that whenever someone is in a Long-Term Care facility and had Medicaid, their income minus 30.00 dollars was paid to their bill in the facility. She stated she read the whole form to him, he nodded, and signed it. She went on to say she took this as him understanding what she read to him. She further indicated the signature of the form was Resident #49's. The BOM stated she had not had Resident #49's RP or other family member sign the forms, because she couldn't get them to come in and do it. She further indicated she thought she let Resident #49's family member know on 4/17/24 when she came to the facility that Resident #49 had a Trust Account with the facility. She went on to say the account had been closed on 4/26/24 when Resident #49's family member came to the facility and let her know Resident #49 would be going to the Veteran's Administration (VA) facility, and she would privately pay until then. The BOM stated Resident #49 would not have had a quarterly statement yet at that time.

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A review of Resident #49's Resident Statement landscape on 5/2/24 provided by the BOM revealed in part the account was opened on 2/21/24. The account type was transferring. The current balance was zero. The account was closed on 4/26/24. On 5/1/24 a VA Treasury payment of $5232.64 was rejected. On 5/1/23 an Office of Personnel Management (OPM is a retirement benefit paid to retired federal employees) payment of $1507.58 was rejected. There were no transactions on the account.

On 5/1/24 at 2:48 PM an interview with the Administrator indicated if a resident had a BIMS score of 99 that would indicate they did not have the cognitive ability to understand and consent allowing the BOM to be his designated representative. She stated if there were issues that required this type of signature, and the resident had no POA then the facility would need to seek guardianship.

On 5/1/24 at 7:16 PM a telephone interview with Resident #49's family member indicated she and Resident #49's RP had been making both financial and medical decisions for Resident #49 since his admission to the facility as he was not able to do this for himself. She stated she was not aware Resident #49 had a Resident Trust Account with the facility, she had never given her permission for that, and no one from the facility asked her if this was okay. She went on to say a few weeks ago she got an automated text message that Resident #49's social security and veterans administration funds direct deposit destination changed. She further indicated she had asked the Business Office Manager (BOM) if she knew anything about this when she brought a check to the facility to pay for Resident #49's

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care, and the BOM told her she didn't know anything about it.

On 5/1/24 at 7:26 PM a telephone interview with Resident #49's RP indicated she did not know anything about Resident #49 having a Resident Trust account with the facility. She stated no one from the facility ever asked her about this, and she had not given her permission. She went on to say she and Resident #49's family member were responsible for making all financial and medical decisions for Resident #49, as he was unable to do this himself. She further indicated she had a clear conversation about this with the facility when Resident #49 was first admitted.

On 5/2/24 at 9:37 AM an interview with Nurse #10 indicated she was familiar with Resident #49 and cared for him often since January 2024. She stated he had a family member who was his RP, and another family member involved in his care. She went on to say she had never had any trouble getting in touch with Resident #49's family to report a fall or other concerns. She further indicated she did not feel Resident #49 had the cognitive ability to make medical or financial decisions for himself.

On 5/2/24 at 9:44 AM an interview with Nurse Aide (NA) #5 indicated she was familiar with Resident #49 and cared for him often since January 2024. She stated she did not think Resident 349 would have the cognitive ability to make medical or financial decisions for himself.

On 5/2/24 at 10:09 PM a telephone interview with Resident #49's Physician indicated in February 2024, he felt Resident #49 would have been at his baseline cognition level. He stated if he was

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F 567	Continued From page 16 making financial and health care decisions for himself prior to this, then he felt Resident #49 would have been capable of doing this in February 2024. On 5/2/24 at 12:33 PM a telephone interview with SW #2 indicated she completed Resident #49's initial discharge planning meeting on 12/22/23. She stated he was not capable of making medical or financial decisions for himself and his RP and another family member were doing that for him. On 5/2/24 at 2:09 PM a telephone interview with Resident #49's psychiatric Nurse Practitioner indicated she was familiar with Resident #49. She stated at her assessment of him on 2/15/24 she did not feel he would be capable of making financial or medical decisions for himself. She went on to say because Resident #49 was not verbal, there really would be no way of completing the cognition assessments that would be required to decide that he was.	F 567		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		5/24/24

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F 609	Continued From page 17 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, The facility failed to notify law enforcement and Adult Protective Services (APS) for an allegation of staff to resident abuse for 1 of 3 residents (Resident #316) reviewed for abuse. Findings included: A review of the initial report sent to the state regulatory agency by the Administrator revealed the facility became aware of the abuse allegation on 1/30/24 at 10:52 AM. The report further revealed that local law enforcement was not contacted regarding the allegation of staff to resident abuse and did not indicate if APS was notified. The initial report further revealed Resident #316 stated that Nurse Aide #5 was rough with his legs during care. In an interview with the Administrator on 5/1/24 The Administrator revealed she did not notify law enforcement or APS because she thought she	F 609	F609 1. Resident # 316 retracted his statement of abuse during the 5-day investigation therefore no further interventions were necessary to notify the police or adult protective services. 2. All current residents with reports of abuse/neglect/mistreatment are at risk for this deficient practice. All reportable incidents were reviewed by regional vice president of clinical services in the last two weeks to ensure that the police and adult protective services were notified. 3. Administrator and director of nursing will be educated by Regional Director of Clinical Services regarding appropriate reporting to police and adult protective services by 5/22/2024 4. All allegations of abuse will be audited by regional Director of clinical services 3x weekly x 4 weeks, then weekly x 4weeks,	

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F 609	Continued From page 18 had the five days of the investigation to notify them, and Resident #316 retracted his allegation on day 5.	F 609	then monthly x 1 Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Administrator is responsible for monitoring the audits 5. Date of completion 5/24/2024	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to ensure peri-care was postponed until the last phase of bathing for 1 of 6 residents reviewed for activities of daily living care. (Resident #49) Findings included: Resident #49 was admitted to the facility on 12/21/23. Resident #49's Minimum Data Set assessment dated 3/12/24 revealed he was assessed as severely cognitively impaired. He required maximal assistance with bathing and toileting hygiene. Resident #49's care plan dated 3/23/24 revealed he was care planned for activities of daily living care. The interventions included 1 person assist with toileting, check and change briefs frequently as needed, and provide toileting hygiene with	F 677	F 677 1. Resident #49 received a new bed bath on 5/1/2024 2. All residents have the potential to be affected by this practice. 3. The director of nursing or designee will educate all certified nursing assistants on ensuring they postpone peri care until the end of the bathing process Any certified nursing assistants who have not completed the education by 05/24/2024 will be removed from the schedule. All new hire certified nursing assistants will receive this education during the orientation process Unit Coordinator/Manager or designee will audit 5 residents for peri care during bathing daily 5 x weekly x 4 weeks, 3x weekly x 4 weeks and weekly x 4 weeks. 4. Findings from audits will be reviewed at the Quarterly Quality Assurance meeting	5/24/24

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F 677	Continued From page 19 brief changes. During observation on 5/1/24 at 2:08 PM Nurse Aide #5 was observed providing activities of daily living care for Resident #49. Resident #49 was lying on his left side and the nurse aide was cleaning the resident with a washcloth. The nurse aide was observed to wipe the crack of Resident #49's buttock and a slight smear of stool was observed on the washcloth. The nurse aide was observed to then wipe the small of Resident #49's back, both buttocks, and hamstrings with the same washcloth. There was feces visible on the washcloth. The nurse aide then dried Resident #49 and placed a new brief on Resident #49. During an interview on 5/1/24 at 2:24 PM Nurse Aide #5 stated she did not see that there was feces on the washcloth after she wiped between his buttocks. Had she noted the feces on the washcloth she would not have washed the small of his back, buttocks, and hamstrings with the same washcloth. During an interview on 5/1/24 at 2:27 PM the Director of Nursing stated the Nurse Aide should have discarded the washcloth following washing a dirty area (crack of the buttock) and not returned to the cleaner areas of Resident #49's body with the washcloth. This would have prevented the feces from then being spread during care.	F 677	x2 for any further problem resolution if needed. 5. Date of completion 5/24/2024	
F 689 SS=G	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		5/24/24

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F 689	Continued From page 20 §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 record review, staff and physician interviews, the facility failed to provide care safely to a dependent resident (Resident #216) when the resident sustained a facial fracture when her face hit the bed side rail during care for 1 of 5 residents reviewed for accidents. Findings included: Resident #216 was admitted to the facility on 2/22/22 with diagnoses which included cerebral infarct and vascular dementia. The quarterly Minimum Data Set dated 3/07/24 indicated that she had severely impaired cognition and was dependent on staff for all activities of daily living (ADL). She was coded to have no behaviors or rejection of care. Resident #216's care plan last revised 3/11/24 had a focus on risk for falls with an intervention for assistance for turning and repositioning in bed. Her care plan also had a focus on ADL care with an intervention for assistance for bathing, hygiene, and dressing. Nursing progress note by Nurse #5 dated 4/08/24 at 11:20 PM revealed Nursing Assistant (NA) #3 called for help when she noted that Resident #216 had blood under and in her mouth. Nurse #5 noted that the resident had a 0.5 centimeter (cm) laceration above her upper lip.	F 689	F 689 1. Resident #216 bed rail bars were removed from the bed on 4/9/2024. 2. Current dependent residents who have bed rails are at risk for this deficient practice. All residents were assessed by the therapy manager to ensure they can use one or both bed rails. Any resident unable to use the assist bars was removed on 4/9/2024. All bed rail tools were updated to reflect all current bed rail status this was completed 4/26/2024 by Nursing Management. 3. Current management staff were educated by administrator or designee to that dependent residents should have bed rails removed when moving rooms. This was complete 4/12/2024 All new hires for the management team will be educated on that dependent residents should have bed rails removed when moving rooms during orientation. Current licensed nursing staff were educated by the Director of Nursing to ensure that the bed rail tool is completed upon admission, quarterly and upon significant change. This was completed 5/24/2024. 4. Administrator or designee will audit all previous day room changes in morning meeting to ensure assist bars are added or removed depending on the resident□s functional level daily 5x weekly x 4 weeks,	

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F 689	Continued From page 21 Nursing progress note by Nurse #5 dated 4/09/24 at 2:12 AM indicated that Resident #216 had bruising to her chin and side of left check and nose. An interview on 5/01/24 at 6:36 AM with Nurse #5 revealed that on 4/08/24 she was assigned to the hall where Resident #216 resided. She stated that around 11:20 PM on 4/08/24, NA #3 notified her that the resident was bleeding. She assessed the resident and noted a small laceration above her upper lip. She stated that later that night she noted that Resident #216 had developed bruising on her chin and around her left eye. She stated that she notified the Physician of the resident's injury. Nurse #5 stated that Resident #216 was nonverbal and could not turn or reposition herself independently. She also stated that the resident did not have any changes in behavior during the rest of her shift. An interview on 4/30/24 at 9:34 AM with NA #3 revealed that she was assigned to provide care for Resident #216 on 4/08/24. She stated that when she went into the room to provide care, she found the resident with the left side of her face against the left bed side rail around 10:00 PM. She stated that she turned the resident onto her back, and she observed no laceration or blood on the resident's face. NA #3 stated that she started Resident #216's bed bath and when she washed her face, she observed the resident had blood coming from her mouth. She immediately notified the nurse. NA #3 stated she did not know where the blood came from or what caused the laceration. She stated the resident did not use the bed rail or turn herself in bed but sometimes when she coughed it caused her head to move.	F 689	then 3x weekly x 4 weeks, and then weekly x 4 weeks. Administrator or designer will ensure bed rail risk tool is completed at time of room change to assess for need of bed rails. Director of Nursing or designee will audit to ensure Bed rail tools are assessed on admission, quarterly and upon significant change during daily clinical meeting 5x weekly x 4 weeks, then 3x weekly x 4 weeks, and then weekly x 4 weeks. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. 5. Date of completion 5/24/2024	

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A Physician's progress note dated 4/09/24 at 9:28 AM revealed that the Physician assessed Resident #216. He noted that she appeared to be in no apparent distress. His physical exam note read in part that the resident had a contusion to the lower eye and left jaw area with no bleeding noted. His plan of care read in part that the resident possibly hit her face on the sidebar rail during treatment and that a facial x-ray would be obtained.

A mobile facial x-ray was ordered and completed on 4/09/24. The x-ray impression read there was no acute osseous (bone) or soft tissue abnormality.

A nurse's progress note dated 4/10/24 at 4:46 AM revealed that Resident #216 was showing signs of shortness of breath with wheezing and was transported to the hospital.

The hospital records for Resident #216's hospitalization were requested during the survey but were not received at the time of exit.

The medical record indicated Resident #216 did not return to the facility.

A facility investigation report completed by the Administrator on 4/17/24 indicated that on 4/9/24 Resident #216 was identified with bruising to the left side of her face after hitting her face on the side rail during care on 4/08/24. The resident was hospitalized for shortness of breath on 4/10/24 and on 4/11/24 the facility became aware of a right zygomatic arch fracture (facial bone fracture) which was consistent with her face impacting with the bed side rail. Upon initial interview with NA #3 she stated on 4/08/24

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F 689	Continued From page 23 Resident #216 coughed and hit the side rail with her face. The investigation resulted in a plan of correction initiated to ensure that bed side rails were only in use after resident assessment of functional capabilities. An interview on 4/30/24 at 3:35 PM with the Physician revealed he had been notified of Resident #216's facial injury and assessed her on 4/09/24. He stated that the resident had light facial swelling and he ordered a facial x-ray. The facial x-ray was completed on 4/09/24 and the results showed no fracture. He stated that Resident #216 was sent to the hospital on 4/10/24 for an unrelated medical condition and the hospital facial x-ray on 4/11/24 revealed a zygomatic arch fracture of unknown age. The Physician stated that he thought there was a low likelihood that the resident turned her head or hit the bed rail by herself. An interview on 5/02/24 at 11:27 AM with the Director of Nursing (DON) and Corporate Nurse Consultant revealed that when Resident #216 was moved from one room to another in the past year, her new bed had side rails. She stated that the bed rails weren't removed from the new bed and they should have been. An interview on 5/01/24 at 8:32 AM with the Administrator revealed that Resident #216 was not supposed to have bed side rails and she felt this was what caused the resident's accident. She stated that last year, the resident's room and bed had changed. She stated there was a process breakdown and the resident had not been assessed for bed rails.	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI	F 690		5/24/24

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F 690	Continued From page 24 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and	F 690	F690	

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F 690	Continued From page 25 resident, staff and physician interviews the facility failed to ensure the urine collection bag remained below the level of the resident's bladder by removing a urinary leg bag and applying a urinary drainage bag while the resident remained in bed (Resident #267) and failed to ensure a urinary drainage bag did not come into contact with the floor (Resident #98) for 2 of 3 residents reviewed for indwelling urinary catheters. Findings included: 1. Resident #267 was admitted to the facility on 4/22/24 with a diagnosis of overactive bladder. A review of a physician's medical note for Resident #267 dated 4/26/24 at 10:21 AM revealed in part Resident #267 was having urinary retention. An indwelling urinary catheter was present. This would have to remain in place for at least 7 to 10 days and then a voiding (urination) trial would occur. A review of Resident #267's admission Minimum Data Set (MDS) assessment dated 4/26/24 revealed in part she was cognitively intact. She had an indwelling bladder catheter. On 4/30/24 at 7:52 AM an observation of Resident #267 revealed she was lying on her back in bed with the head of her bed elevated at approximately 30 degrees. She had an indwelling urinary catheter attached to a leg bag secured to her left thigh. An interview with Resident #267 at that time indicated her indwelling urinary catheter had been attached to a leg bag for a few days including while she slept at night. She stated she had been told they were out of the hanging drainage bags. On 4/30/24 at 4:00 PM a follow-up	F 690	1. Resident 267 urinary leg bag was removed and changed to a urinary drainage bag on 4/30/2024 Resident 98 urinary drainage bag was placed in a basin to prevent the bag from touching the floor due to resident being on a lower bed on 5/02/2024 2. Current Residents with indwelling catheters are at risk. On 5/2/2024 all residents with catheters were assessed and changed to a urinary drainage bag as appropriate. On 5/2/2024 all residents with catheters were assessed to ensure the drainage bag was not touching the floor. 3. Current licensed nursing staff are educated by Staff Development Coordinator or designee on where urinary drainage bags are stored, proper positioning of urinary drainage bags when in bed and when to use a urinary leg drainage bag. Education will be completed by 5/24/2024 Education was provided to Central Supply Coordinator to ensure urinary drainage bags are available on site. This was completed 5/21/2024 by the Director of Nursing. Current licensed nursing staff and certified nursing assistant staff are educated by Staff Development Coordinator of designee on the importance of keeping urinary drainage bags from touching the floor. Education will be completed by 5/24/2024 Any nursing staff not receiving education by 5/24/2024 will be removed from the schedule. New nursing staff will receive	

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F 690	Continued From page 26 observation of Resident #267 revealed she was lying on her back in bed with the head of her bed elevated at approximately 30 degrees. Her indwelling urinary catheter remained attached to a leg bag secured to her left thigh. This leg bag was observed to be approximately half full of clear yellow urine. An interview with Resident #267 at that time indicated she slept with her indwelling urinary catheter attached to her leg bag last night. She stated she had to call for assistance in the middle of the night to have this bag emptied as it was so full she was afraid it would pop. On 4/30/24 at 8:30 PM Resident #267 was observed lying in her bed on her back with the head of her bed at approximately 30 degrees. Her indwelling urinary catheter was observed to be connected to a drainage bag with a privacy cover that was hanging from the bedframe below the level of her bladder. On 4/30/24 at 4:06 PM an interview with Nurse #4 indicated Resident #267 had her indwelling urinary catheter attached to a leg back since she saw her at 7:00 AM that morning. She stated she did not know whether Resident #267 had her urinary catheter attached to a leg bag all night, because she wasn't at the facility. On 4/30/24 at 4:16 PM an interview with the Director of Nursing (DON) indicated for residents who had indwelling urinary catheters, a leg bag was something they would wear during the day to collect their urine while they were up and about. She stated when residents were lying in bed through the night while they slept, this should be changed over to a drainage bag. She stated there were plenty of drainage bags available. On 5/3/24 at 9:17 AM a follow up interview with the DON indicated she had not become aware of the	F 690	education on where urinary drainage bags are stored, proper positioning of urinary drainage bags when in bed and when to use a urinary leg drainage bag, when to use a urinary drainage bag and the importance of keeping urinary drainage bags from touching the floor. This will be completed by Any new central supply coordinator will be educated by the Director of Nursing during the orientation process. 4. Director of Nursing or designee will audit current indwelling foley catheters to ensure bags are kept below the level of the bladder by having on appropriate leg bag or drainage bag as needed 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks. Director of Nursing or designee will audit current indwelling foley catheters to ensure urinary drainage bags are not touching the floor. Audits will be completed 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks Central supply or designee will audit urinary drainage bags to ensure they are available 3x weekly x 4 weeks, weekly x 4 and monthly x 1 Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. 5. Date of completion 5/24/2024	

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difficulty locating a drainage beg for Resident #267 until 4/30/24 at 4:16 PM. She stated she did not think Resident #267 sleeping in a leg bag would be a good thing because this could cause back flow of urine into the bladder and place Resident #267 at increased risk for a urinary tract infection.

On 5/1/24 at 2:58 PM a telephone interview with Nurse #6 indicated she cared for Resident #267 on 4/27/24 from 7PM until 7AM on 4/28/24, and on 4/28/24 from 7PM until 7AM on 4/29/24. She stated on 4/27/24 Resident #267's indwelling urinary catheter was connected to a drainage bag that was hanging below the level of her bladder on the bedframe. She went on to say at some point during the evening, the drainage bag began leaking. She further indicated she had gone to look for another drainage bag but had been unable to find one. Nurse #6 stated she let the Assistant Director of Nursing (ADON) know. She went on to say the ADON told her she also looked but had not been able to find a drainage bag either and the ADON gave her a leg bag to place on Resident #267. She further indicated Resident #267 had her indwelling urinary catheter connected to a leg bag the remainder of her shift on 4/27/24 and 4/28/24 and her entire shift on 4/28/24 through 4/29/24. Nurse #6 stated this had happened once before back in June 2024 although she couldn't recall the name of the resident. She went on to say that time they got more drainage bags in a day or so.

On 5/1/24 at 8:31 AM a telephone interview with Nurse #5 indicated she cared for Resident #267 from 4/29/24 at 11PM until 4/30/24 at 7:00 AM. She stated Resident #267 had her indwelling urinary catheter attached to a leg bag all night

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while she slept in bed. Nurse #5 went on to say she had gone to the supply room to try to find a drainage bag to change Resident #267 from her leg bag that shift but had not been able to find one. She further indicated she had not let anyone know she had been unable to find a urinary drainage bag for Resident #267.

On 5/2/24 at 8:17 AM an interview with the ADON indicated she wasn't really familiar with Resident #267. She stated usually residents who were mobile and got up during the day preferred the leg bag for their indwelling urinary catheter as it let them be up and around. She went on to say with a leg bag, when residents were lying down there wasn't much gravity and the collection bag was smaller. She further indicated it was better for residents to wear a drainage bag at night for infection control purposes to prevent the backflow of urine into the bladder. The ADON stated the backflow of urine into the bladder put residents at risk for urinary tract infection and damage to the nerves in the bladder. She went on to say she did recall last Saturday night (4/27/24) a nurse asked her to help find a drainage bag. She further indicated she checked the medication rooms and central supply as these were where the bags would normally be kept found and couldn't find one. The ADON stated she had given the nurse a leg bag instead. She went on to say on Monday (4/29/24) she attempted to determine the reason she could not locate any drainage bags. She further indicated she found out there was a resident who had been requesting their drainage bag be changed daily so more bags were being used than normal. The ADON stated the Central Supply Clerk had since contacted her supplier and an additional shipment of drainage bags was requested. She went on to say she was not aware

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of this ever happening before.

On 5/2/24 at 1:44 PM an interview with the Central Supply Clerk indicated on 4/30/24 she heard about an issue with catheter drainage bags. She stated she went looking and was able to locate one in a medication room under a cabinet. She went on to say this was the only drainage bag she was able to find in the facility. She further indicated this issue with a low supply happened because there was a resident who was requesting their drainage bag be changed daily, so more were being used than had been allotted for. The Central Supply Clerk stated her supplier had a list of all the catheters in the building and allotted the drainage bag supply based on this number, which was updated weekly. She went on to say now she had requested an extra shipment of drainage bags in addition to the usual shipment. She further indicated when a drainage bag was taken from Central Supply, it was supposed to be signed out on the inventory log by the person taking it. The Central Supply Manager stated this kept track of the inventory on hand. She went on to say she monitored this log periodically, although she could not say when she last checked it. She further indicated when she looked at the log after becoming aware of this issue only 2 had been signed out of the facility's usual allotment of 12 per month. The Central Supply Clerk stated she was not aware of this ever being an issue before.

On 5/2/24 at 10:09 AM a telephone interview with Resident #267's Physician indicated while Resident #267 wearing a leg bag from 4/27/24 until 4/30/24 including while she slept laying in bed through the night would not be an ideal situation, Resident #267 had not had any

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negative effects from this. He stated Resident #267 did not currently have a urinary tract infection.

On 5/3/24 at 11:21 AM an interview with the Administrator indicated Resident #267 had a leg bag on all throughout the day and at night while she slept, and she shouldn't have. She stated while a drainage bag had eventually been found in the facility for Resident #267, these should be readily available for residents.

Resident #98 was admitted to the facility on 12/7/23 and readmitted on 2/24/24. His diagnoses included obstructive and reflux uropathy (a condition in which the flow of urine is blocked and can cause urine to back up and injure one or both kidneys).

Review of the care plan dated 4/10/24 indicated the resident required a urinary catheter related to obstructive uropathy with a goal that Resident #98 would be free of complications related to urinary catheter use through the next review period.

Review of nurse progress notes on 4/23/24 written by Nurse #7 indicated Resident #98 continued on an antibiotic for a UTI.

A review of Resident #98's significant change Minimum Data Set (MDS) dated 4/10/24 revealed Resident #98 was cognitively impaired. He required substantial maximum assistance for toileting, bathing, and transfers. The resident was dependent on staff for Activities of Daily Living (ADLs). The MDS assessment indicated Resident #98 had an indwelling urinary catheter.

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Review of the facility policy entitled "Urinary/Catheter Care" item #3 under Procedure read in part that "licensed nurses would follow manufacturer's guidelines when preparing and maintaining indwelling urinary catheters".

Review of the manufacturer's guidelines directions for use for the urinary drainage bag used for Resident #98 read in part "Hang bag utilizing the hanger. Do not place on the floor."

Multiple observations were conducted of Resident #98's urinary catheter drainage bag either touching or partially lying on the floor of the resident's room. The urinary catheter bag had a built in non-removable privacy cover. These observations were as follows:

--On 4/29/24 at 10:23 AM, an observation was made of Resident #98 as he was lying in bed. The bottom of his urinary catheter drainage bag was observed to touch the floor. The urinary catheter drainage tubing was observed come out of the bottom of Resident #98's pant leg and the drainage bag hanger was not attached to anything.

--On 4/29/24 at 2:15 PM, the resident's urinary catheter drainage bag was observed to touch the floor and the bag hanger was not attached to anything.

--On 5/2/24 at 9:31 AM, the resident's urinary catheter drainage bag was observed to be partially in contact with the floor of the resident's room as he was lying in bed. Approximately four inches of the bottom of the urinary catheter drainage bag was observed to be lying on the floor.

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F 690	Continued From page 32 In an interview with the Infection Preventionist (IP) Nurse on 04/29/24 2:17 PM, she stated that orders for indwelling urinary catheters are placed on the MAR for nurses to check the catheter every shift and when they checked it they would ensure the catheter tubing was secured with a catheter anchor (to prevent movement from causing the tubing to tug on the urinary meatus (urethral opening to the outside of the body). She further indicated that the urinary collection bag should be checked to ensure it is not on the floor because this could increase the risk of a UTI. The IP nurse further indicated that nursing staff were educated to ensure a urinary catheter collection bag was not on the floor and the bag should be hung on a section of the bed frame to ensure it did not touch the floor, but that it was difficult with Resident #98 because he was in a low bed. During an observation of Resident #98's urinary catheter drainage bag on 4/29/24 at 2:24 AM an interview with the IP nurse was conducted simultaneously. At this time, the bed was noted to be in a higher position than previously observed on 4/29/24 at 2:17 PM and the urinary catheter drainage bag no longer touched the floor however, the urinary catheter drainage bag hanger was not attached to anything and dangled from Resident #98's pant leg. During the observation, the IP nurse assessed the tubing and urinary catheter drainage bag and discovered that the urinary catheter drainage tubing's anchor had come loose. She attached the urinary catheter drainage bag to the bed frame, retrieved supplies and replaced the urinary catheter anchor on Resident #98's upper thigh. The interview further revealed that Resident #98's bed was in a low position to prevent injury because he was a	F 690		

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high fall risk and he tried to get out of bed unassisted. She stated that his urinary catheter drainage bag touched the floor earlier because of the low position of the bed. She stated that to keep the bag off the floor staff would attach the bag to a mattress bracket used to prevent the mattress from sliding and that this kept the bag off the floor and kept the bag below the level of the bladder so it would drain properly. The interview further indicated that Resident #98 recently completed a course of antibiotics for a UTI.

Review of the April 2024 Medication Administration Record (MAR) revealed that Resident #98 was prescribed and received an antibiotic twice a day for 10 days from 4/20/24 through 4/29/24 for a UTI as evidenced by nurse's initials being placed in each box on the MAR for every day that the medication was administered.

During an observation of indwelling urinary catheter care for Resident #98 on 4/30/24 at 12:45 PM by Nurse #8 and Nurse #9 it was observed that incontinence care was provided prior to urinary catheter care being provided. After care was completed the urinary catheter anchor was changed and the urinary catheter drainage bag was positioned off the floor by attaching the hanger to the mattress bracket on the bed. The bed was placed in a low position.

In an interview with Nurse #8 on 04/30/24 at 2:46 PM it was revealed that the catheter urinary drainage bag should not touch the floor. She stated that Resident #98 was in a low bed, and she had not seen an issue where the bag touched the floor. She further indicated that staff

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were trained on how to perform catheter care monthly by the facility and were taught that the urinary catheter drainage bag should not touch the floor. Nurse #8 stated that if the urinary catheter drainage bag touched the floor that it put the resident at risk for a urinary tract infection.

During an interview with NA #1 on 05/01/24 at 8:52 AM it was revealed that NA's complete urinary catheter care and that included keeping the urinary catheter drainage bag off the floor. She indicated that urinary catheter care was done with ADL care each day and as needed. Care included hanging the urinary catheter drainage bag on the metal frame part of the bed so that it did not touch the floor and if it touched the floor that created a risk for infection for the resident. She further indicated she had received training for urinary catheter care and infection control.

In an interview with Nurse #7 on 05/01/24 at 3:55 PM she stated that she had never seen the urinary catheter drainage bag touch the floor and she always noted it to be attached to the WC when Resident #98 was out of bed or attached to a metal bar on the bed frame when he was in bed. She indicated that there was a concern for infection for the resident if the drainage bag touched the floor.

In an interview with the DON on 05/02/24 at 8:29 AM she stated that the urinary catheter drainage bag should not be in contact with the floor at any time. She indicated it was difficult to keep the urinary catheter drainage bag off the floor for Resident #98 because he was in a low bed. She further stated that the bag should be hung so that it did not touch the floor. She stated if the bag touched the floor the bag could become

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F 690	Continued From page 35	F 690		

contaminated and increased the risk of infection for the resident. The interview further indicated that Resident #98 would pull on his catheter and could readjust the position of the catheter himself. She further stated that the IP nurse did the training with nursing staff on infection control related to indwelling urinary catheters.

During an observation of Resident #98's urinary catheter drainage bag on 5/2/24 at 9:31 AM an interview with the IP nurse was conducted simultaneously. The urinary catheter drainage bag was noted to be attached to the bed frame and in contact with the floor. The IP nurse stated that the drainage bag should not be in contact with the floor and the drainage bag had not been attached to the correct part of the bed frame. She removed and re-attached the bag to a higher part of the bed frame but the bag remained in contact with the floor. She then raised the bed a few inches until the bag no longer rested on the floor and stated that they could not leave the bed at that height because Resident #98 was at risk for falls and required a low bed. She stated she would speak with other team members to see if they could find a solution.

In an interview with the facility Administrator on 05/2/24 at 12:37 PM she stated she was not previously aware of the urinary catheter drainage bag for Resident #98 being on floor, but she has since been made aware. She stated the urinary drainage bag should not have been on the floor. She further indicated that Resident #98's bed was maintained in a low position for his safety and that put the catheter at risk of touching the floor.

During an interview with Nurse Practitioner #1 on 05/02/24 at 12:51 PM he stated his concern with

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F 690	Continued From page 36 catheter drainage bags being in contact with the floor was the urinary catheter drainage bag could become contaminated, and infection was a concern. He further stated that it may or may not contribute to recurrent UTI's because the urinary catheter bag itself was a barrier to prevent infection from anything it comes in contact with. In an interview with NA #2 on 5/3/24 at 10:40 AM revealed that she had worked for the facility for 4 years and cared for Resident #98 on a routine basis. She further indicated she placed the catheter tubing through his pant leg to keep it in place so he could not manipulate the tubing and pull it loose. She further indicated that he would often manipulate his tubing, so she ensured that he had a urinary catheter tubing anchor in place as well. She stated that she kept the bag off the floor and hung it on the bed frame because if it touched the floor, it could become contaminated and lead to an infection for Resident #98.	F 690		
F 700 SS=G	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior	F 700		5/24/24

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F 700	Continued From page 37 to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Physician interviews, the facility failed to ensure a bedrail device assessment was completed prior to the use of bedrails for 2 of 3 residents (Resident #216 and Resident #66) and failed to ensure bedrails were maintained securely for 1 of 3 residents (Resident #66) reviewed for bedrail use. Resident #216 sustained a facial fracture when her face hit the bedrail during care. Findings included: 1a. Resident #216 was admitted to the facility on 2/22/22 with diagnoses which included cerebral infarct and vascular dementia. The discharge Minimum Data Set dated 4/10/24 indicated that she had severely impaired cognition and was dependent on staff for all activities of daily living. A facility investigation report was completed by the Administrator on 4/17/24 indicated that on 4/9/24 Resident #216 was identified with bruising to the left side of her face after hitting her face on the bedrail during care on 4/08/24. The resident was hospitalized for shortness of breath on 4/10/24 and on 4/11/24 the facility became aware of a right zygomatic arch fracture (facial bone	F 700	F 700 1.Resident #216 assist bars were removed from the bed on 4/9/2024. Resident # 66 latch as secured on 5/1/2024. 2. Current dependent residents who have assist bars are at risk for this deficient practice. All residents were assessed by the therapy manager to ensure they can use one or both assist bars. Any resident unable to use the assist bars was removed on 4/9/2024. All bed rail tools were updated to reflect all current bed rail status this was completed 4/26/2024 by Nursing Management. Maintenance Director completed an audit of all beds with rails to ensure they are properly secured. This was completed 5/3/2024. 3. Current management staff were educated by administrator or designee to that dependent residents should have assist bars removed when moving rooms. This was completed 4/12/2024. Current licensed nursing staff were educated by the Director of Nursing to ensure that the bed rail tool is completed upon admission, quarterly and upon significant change. This was completed	

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F 700	Continued From page 38 fracture) which was consistent with her face impacting with the bedrail. Upon initial interview with NA #3 she stated on 4/08/24 Resident #216 coughed and hit the bedrail with her face. The investigation resulted in a plan of correction initiated to ensure that bed side rails were only in use after resident assessment of functional capabilities. Review of Resident #216's device assessment dated 3/01/24 revealed no bedrail device assessment was completed. An interview on 4/30/24 at 3:35 PM with the Physician revealed he had been notified of Resident #216's facial injury and assessed her on 4/09/24. He stated that the resident had light facial swelling and he ordered a facial x-ray. The mobile facial x-ray was completed on 4/09/24 and the results showed no fracture. He stated that Resident #216 was sent to the hospital on 4/10/24 for an unrelated medical condition and the hospital facial x-ray on 4/11/24 revealed a zygomatic arch fracture of unknown age. The Physician stated that he thought it a low likelihood that the resident turned her head or hit the bedrail by herself. A Physician's progress note dated 4/09/24 at 9:28 AM revealed that the Physician assessed Resident #216. He noted that she appeared to be in no apparent distress. His physical exam note read in part that the resident had a contusion to the lower eye and left jaw area with no bleeding noted. His plan of care read in part that the patient possible hit her face on the sidebar rail during treatment and that a facial xray would be obtained.	F 700	5/25/2024. Current staff were educated on ensuring bed rails are secure when in patient rooms and to notify maintenance director immediately if not secured. This was completed 5/24/2024 All new hires for the management team will be educated that dependent residents should have assist bars removed when moving rooms during orientation by the staff development coordinator. All newly hired licensed nursing staff will be educated to ensure that the bed rail tool is completed upon admission, quarterly and upon significant change during orientation by the staff development coordinator. All newly hired staff will be educated to ensure bed rails are secure when in patient rooms and to notify maintenance director immediately if not secured during orientation by the staff development coordinator. 4. Administrator or designee will audit all previous day room changes in morning meeting to ensure assist bars are added or removed depending on the resident□s functional level daily 5x weekly x 4 weeks, then 3x weekly x 4 weeks, and then weekly x 4 weeks. Administrator or designer will ensure bed rail risk tool is completed at time of room change to assess for need of bed rails. Director of Nursing or designee will audit to ensure Bed rail tools are assessed on admission, quarterly and upon significant change during daily clinical meeting 5x weekly x 4 weeks, then 3x weekly x 4 weeks, and then weekly x 4 weeks.	

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F 700	Continued From page 39 A mobile facial xray was ordered and completed on 4/09/24. The xray impression read there was no acute osseous (bone) or soft tissue abnormality. An interview on 4/30/24 at 9:34 AM with Nursing Assistant (NA) #3 revealed that she was assigned to provide care for Resident #216 on 4/08/24. She stated that when she went into the room to provide care, she found the resident with her face against the left bedrail around 10:00 PM. She stated that when she turned the resident onto her back she observed no laceration or blood on the resident's face. NA #3 stated that she started Resident #216's bed bath and when she washed her face, she observed the resident had blood coming from her mouth. She immediately notified the nurse. NA #3 stated she did not know where the blood came from or what caused the laceration. She stated the resident did not use the bed rail or turn herself in bed but sometimes when she coughed it caused her head to move. Nursing progress note by Nurse #5 dated 4/08/24 at 11:20 PM revealed Nursing Assistant (NA) #3 called for help when she noted that Resident #216 had blood under and in her mouth. Nurse #5 noted that the resident had a 0.5-centimeter (cm) laceration above her upper lip. Nursing progress note by Nurse #5 dated 4/09/24 at 2:12 AM indicated that Resident #216 had bruising to her chin and side of left check and nose. An interview on 5/01/24 at 6:36 AM with Nurse #5 revealed that on 4/08/24 she was assigned to the hall where Resident #216 resided. She stated that around 11:20 PM on 4/08/24, NA #3 notified her	F 700	The Maintenance Director or designee will audit all beds with side rails to ensure they are secure 5x weekly x4 weeks, 3x weekly x 4 weeks and weekly x 4. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. 5. Date of completion 5/24/2024	

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that the resident was bleeding. She assessed the resident and noted a small laceration above her upper lip. She stated that later that night she noted that Resident #216 had developed bruising on her chin and around her left eye. She stated that she notified the Physician of the resident's injury. Nurse #5 stated that Resident #216 was nonverbal and could not turn or reposition herself independently. She also stated that the resident did not have any changes in behavior during the rest of her shift.

A nurse's progress note dated 4/10/24 at 4:46 AM revealed that Resident #216 showed signs of shortness of breath with wheezing and was transported to the hospital.

An interview on 5/01/24 at 8:05 AM with the Maintenance Director revealed that he did not participate in the nursing bedrail assessment process. He stated that he installed or removed bedrails for resident beds based on work orders initiated by staff.

An interview on 5/02/24 at 11:27 AM with the Director of Nursing (DON) and Corporate Nurse Consultant revealed that when Resident #216 was moved from one room to another in the past year, her new bed had side rails. She stated that Resident #216 had not been assessed for the use of bedrails and there should not have been bedrails on her bed.

An interview on 5/01/24 at 8:32 AM with the Administrator revealed that Resident #216 was not assessed to have bedrails and was not supposed to have bedrails. She stated she felt this was what caused the resident's accident. She stated that last year, the resident's room and bed

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had changed. She stated there was a process breakdown and the resident had not been assessed for bedrails.

2. Resident #66 was admitted to the facility on 3/8/24 with a diagnosis of muscle weakness.

A review of Resident #66's admission Minimum Data Set (MDS) assessment dated 3/14/24 revealed in part he was cognitively intact. He was independent with rolling from left to right and from sitting on the side of the bed to lying flat in bed. He required supervision to move from lying to sitting on the side of the bed. He required partial assistance to move from sitting to standing. He was 71 inches tall and weighed 368 pounds.

A review of a Bed Side Rail Tool for Resident #66 dated 4/24/24 completed by Nurse #1 revealed in part Resident #66 needed siderails to assist with mobility and positioning. Siderails were his preference. The risk versus the benefits of siderails were discussed with Resident #66 and his consent was obtained. He used 1/8 partial siderails bilaterally. These did not restrict his movement.

A review of Resident #66's care plan revealed in part a focus area initiated on 4/29/24 for bilateral side rails. The goal was for Resident #66 to use side rails to assist with turning and repositioning in bed with no incidents through the next review. An intervention was to inform the nurse immediately of any safety concerns while using

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side rails.

On 4/29/24 at 2:49 PM an interview with Resident #66 indicated he had 1/8 siderails on both sides of his bed since his admission to the facility on 3/8/24. He stated these were already on his bed when he came. He went on to say he had problems with the left siderail from the start, as it was loose and swung outward from the bed when he tried to use it. He further indicated the siderail on the right was secure and didn't do this. Resident #66 stated he had been bracing the left siderail with his dresser, so it would be secure and not move when he used it. He went on to say this worked okay, but he knew this wasn't how it was supposed to be. He further indicated he had told an administrative nurse when she came to talk with him and had also told another staff member, but he couldn't recall their names. He stated the Maintenance Director had been in his room recently to repair his bed control, but he had not fixed the side rail. Resident #66 stated no one really came to check the side rails on a regular basis. An observation of Resident #66's 1/8 siderails at the time of the interview revealed the left side rail was attached to the bed with a post at the head of Resident #66's bed that fit onto a hole near the bedframe. The side rail swung freely outward until it was at a 90-degree angle to the bed. There was observed to be a latch pin near the foot side on the rail. One black plastic latch secured near the head of the bed at the bedframe that allowed the side rail to be locked into place with the latch pin when the rail was oriented towards the head of the bed. There was no black plastic latch secured near the foot of the bed on this siderail to allow the rail to be latched into place when oriented towards the foot of the bed. This prevented the side rail on the left from being

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latched securely in place when oriented towards the foot of the bed in the position that allowed Resident #66 to use the side rail as an assist. The right side rail was observed to be securely latched with the pin into the black plastic latch near the foot of the bed. The right side rail was also observed to have a black plastic latch secured near the head of the bed at the bedframe.

On 4/30/24 at 2:10 PM an interview with Nurse #1 indicated she had spoken with Resident #66 around 4/6/24 in his room. She stated Resident #66 had his 1/8 side rails in place at the time. She went on to say Resident #66 had not mentioned any concerns with his side rails to her then, and she herself checked them and they were secure. Nurse #1 stated she completed the Bed Rail Assessment Tool for Resident #66 on 4/24/24, because she was doing an audit to ensure all residents on her unit who had side rails had the correct assessments for them, found Resident #66 did not have one, and completed one. She went on to say normally residents would not have side rails when they were admitted, but at the first assessment meeting at 24 to 48 hours with the resident and/or family, if these were requested or indicated, an assessment would first be done and then maintenance would apply them to the bed. She further indicated Resident #66 should not have had siderails without this assessment in place first.

On 5/1/24 at 10:04 AM an interview with Resident #66 indicated he was surprised that the Maintenance Director came in last evening and fixed his left side rail, so it was secure like his right. He stated the Maintenance Director put some nuts and screws in, but it was still the same

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and not secure. An observation of Resident #66's left side rail at the time of the interview indicated the left side rail to be the same as the observation on 4/29/24, however there was a broken black plastic latch on the floor under the bed.

On 5/1/24 at 10:16 AM an observation of Resident #66's left side rail was conducted with the Maintenance Director. A broken black plastic latch was observed on Resident #66's floor under the bed on the left side. The Maintenance Director stated last evening he was passing by Resident #66's room and Resident #66 called him over to ask him to look at his side rail. He went on to say he noticed a black plastic latch was missing, and so he attached one. He further indicated this latch allowed Resident #66's side rail to be secured in a position that allowed Resident #66 to use the side rail as an assist device. He stated he asked Resident #66 if he knew where the black plastic latch had gone, but Resident #66 told him he did not. The Maintenance Director stated there had already been one black plastic latch near the head of the bed, but if the side rail latch pin was secured in this position, it would be too high for Resident #66 to use it. He went on to say the replacement latch he installed last evening had broken. He further indicated he felt Resident #66 must have put too much weight on it. The Maintenance Director stated he had never seen these break before. He went on to say the process for iinitially nstalling side rails was a Nurse would put through a work order for their installation, he would ensure the correct assessments had been done, apply the rails and then check to make sure they were safe and secure. He stated he checked all bed rails in the facility weekly to ensure they were functioning correctly. He went on to say he did not keep a log

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of the weekly checks but had last checked Resident #66's side rails last week Thursday (4/25/24) and found them to be secure. He further indicated he was not able to find the work order for the initial placement of Resident #66's side rails. The Maintenance Director stated he would not install side rails if there wasn't an assessment in place first. He went on to say he had been trained on the installation of side rails when he started at the facility in August 2023. He further indicated he had extra parts available for the rails in the Maintenance Department. He stated he would have to apply another latch to Resident #66's left side rail. On 5/3/24 at 8:32 AM a follow-up interview with the Maintenance Director indicated he recalled fixing Resident #66's bed a while back, but he did not recall exactly when. He stated Resident #66 did not say anything to him about his side rail at that time.

On 5/3/24 at 8:39 AM a review of the work order log provided by the Administrator for Resident #66's room revealed in part on 3/11/24 and on 3/28/24 his electric bed was serviced by the Maintenance Director. There was no record on this log of the initial placement of Resident #66's side rails, or any subsequent service to them. An interview with the Administrator indicated this was a complete listing of all the work orders for Resident #66 since his admission to the facility.

A review of the Manufacturer's User Service Manual for Resident #66's bed provided by the Administrator revealed in part the weight capacity for Resident #66's bed was 500 pounds. The Manufacturer's User Service Manual Operation Instructions for Resident #66's side rails revealed in part they were compatible with his bed. The instructions further revealed there was no weight

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capacity provided in the manual for the side rails. This side rail instruction manual indicated 2 black plastic latches, one near the head of the bed and one near the foot, were to be used to allow the latch pin to lock the side rail, which could rotate 90 degrees either towards the head or the foot of the bed, into place. It further instructed to verify that the side rail was locked prior to leaving any resident unattended.

On 5/3/24 at 8:50 AM an interview with Nurse Aide (NA) #6 indicated she regularly cared for Resident #66 since his admission to the facility. She stated he usually had his dresser placed up against the left side rail. She went on to say he never mentioned to her there was any concern about the left side rail not being secure and she had never noticed any concerns.

On 5/3/24 at 10:11 AM a telephone interview with Housekeeper #1 indicated she was the regular Housekeeper for Resident #66's unit. She stated more than 2 weeks ago Resident #66 mentioned to her that his side rail was loose, and she noticed there was no black piece holding it in place. She went on to say she asked her supervisor and was told maintenance handled this. She further indicated she let Resident #66's aide that day know about his side rail. Housekeeper #1stated she did not recall which aide, and she did not follow-up to see if Resident #66's side rail got fixed.

On 5/3/24 at 9:21 AM an interview with the Administrator indicated Resident #66's side rails were compatible for his bed. She stated there was nothing in the manufacturer's instructions that indicated the side rails had a weight limit, and his bed weight limit was 500 pounds. She went on

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F 700	Continued From page 47 to say she didn't think Resident #66's side rail should have to be repaired twice in one week, and she would have to contact the manufacturer to get more information about why it failed.	F 700		
F 760 SS=E	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 staff and physician interviews and record review the facility failed to administer prednisone per the resident's hospital discharge summary for 23 days for 1 of 1 resident reviewed for medication reconciliation. (Resident #166) Findings included: Review of Resident #166's discharge medication list from the hospital dated 6/9/23 revealed he was ordered to continue taking prednisone 5 milligrams by mouth once daily. Resident #166 was admitted to the facility on 6/9/23. His active diagnoses included encounter for orthopedic aftercare following surgical amputation, peripheral vascular disease or peripheral arterial disease, asthma (COPD) or chronic lung disease, pulmonary fibrosis, and interstitial pulmonary disease. Review of Resident #166's minimum data set assessment dated 6/15/23 revealed he was assessed as cognitively intact. Review of Resident #166's medication orders	F 760	F760 1. Resident 166 failed to receive ordered medication on DC summary. Medication was initiated 23 days after admission. 2. All new admissions are at risk 3. Current licensed nurses received education provided by Staff Development Coordinator or designee on transcription of orders from discharge summary on admission. Education completed by 5/24/2024. Any licensed nursing staff not receiving education by 5/24/2024 will be removed from the schedule. New licensed nurses will receive education during the orientation process. 4. Director of Nursing or designee will audit admission orders within 24 hours of admission 5x weekly x 4 weeks, then 3x weekly x 4 weeks, and then weekly x 1 Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. 5. Date of completion 5/24/2024	5/24/24

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F 760	Continued From page 48	F 760		

during his stay in the facility revealed he was not ordered prednisone 5 milligrams daily until 7/2/23.

Review of a nursing note dated 7/3/23 revealed on 7/2/23 Resident #166's family member called and asked if Resident #166 had been taking prednisone and asked to restart this medication. The resident was made aware, and the physician was notified and gave an order to start Resident #166 on prednisone 5 milligrams daily. The family member was called back and notified of the changes.

Review of a nursing note dated 7/4/23 revealed the pulmonary physician for Resident #166 updated the order for prednisone to be 10 mg give 3 tablets by mouth one time a day for 28 days then give 2 tablets by mouth one time a day for 14 days then give 1.5 tablets by mouth one time a day.

During an interview on 4/30/24 at 3:47 PM the Physician stated Resident #166 was diagnosed with cryptogenic pneumonia, and he was on steroids in the hospital to treat this. The Physician further stated Resident #166 should have been on prednisone since his admission on 6/9/23 as it was on the discharge summary from the hospital as well as the after-visit sheet provided to the facility from the hospital upon admission. He did not know why the admitting nurse missed this. He stated at some point during the resident's stay the family questioned if prednisone was being given to the resident and at that point, the nurse called him, and he restarted the medication. The Physician stated, in his opinion, the missed prednisone doses did not cause any harm or deterioration to Resident #166.

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F 760	Continued From page 49 During an interview on 4/30/24 at 4:22 PM with the Director of Nursing she did not recall being made aware of Resident #166 not having his prednisone 5 milligrams per day carried over from his hospital medication list. She stated did not know what medication list was provided from the hospital and was used for medication reconciliation upon admission. She stated the admitting nurse reconciled the medication orders upon admission from the hospital. She concluded prednisone 5 milligrams once a day was documented by the hospital to be continued in the facility on his discharge summary and should have been continued at the facility, but it was missed until the family brought it to their attention in July 2023. Nurse #11 who admitted Resident #166 was unavailable for interview.	F 760		
F 867 SS=G	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	F 867		5/24/24

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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, 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

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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 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.

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F 867	Continued From page 52 §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 observations, record review, and interviews with the physician and staff, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place in order to sustain compliance. This included a recited deficiency in the area of Supervision to Prevent Accidents (F689) as evidenced by repeat citations resulting in harm or immediate jeopardy for a high likelihood of harm to residents. During the 6/11/21 recertification and complaint investigation survey, deficient practice at F689 was identified as immediate jeopardy for a high likelihood of harm when a resident was found smoking in their room with oxygen in use on three occasions. During the 11/10/21 complaint investigation survey, deficient practice at F689 was cited for failing to prevent a resident from rolling off the bed during care resulting in right frontal hematoma (a pool of mostly clotted blood that	F 867	F867 1. The facility failed to maintain implemented procedures and monitor previous interventions set in place by the Committee after each of the surveys. 2. Current residents are at risk. 3. The current Quality Assessment and Assurance Committee will be trained on the importance of the development of systemic programs with sustained results to prevent further repeat deficient practices. As a team, the committee will work on developing Performance improvement plans and Ad Hoc teams' meetings. The team is also learning how to monitor current Performance improvement plans for efficacy and the importance of modifications if or when systemic changes are no longer effective. Education will be completed by the Administrator and/ or designee by	

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F 867	Continued From page 53 forms in an organ, tissue, or body space), laceration, and right periorbital (around the eyes) swelling. During the 3/25/24 complaint investigation survey, deficient practice at F689 was cited for failing to provide a safe transfer resulting in a leg fracture. On the current recertification and complaint investigation survey of 5/3/24, deficient practice at F689 resulted in the resident sustaining a facial fracture. In addition to the repeat deficiency at F689, the facility had 2 other repeat deficiencies in the areas of Activities of Daily Living Care Provided for Dependent Residents (F677) and Posted Nurse Staffing Information (F732) that were originally cited on the 6/11/21 recertification and complaint investigation survey. The continued failure of the facility during 4 federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F677: Based on observations, staff interviews, and record review the facility failed to ensure peri-care was postponed until the last phase of bathing for 1 of 6 residents reviewed for activities of daily living care. (Resident #49) During the recertification and complaint investigation survey on 6/11/21 the facility failed to shave 2 of 2 dependent male residents. F689: Based on record review, staff and physician interviews, the facility failed to provide care safely to a dependent resident (Resident #216) when the resident sustained a facial fracture when her face hit the bed side rail during	F 867	04/2/24. Any newly hired department heads or members of the QAA/QAPI team will be educated by the Administrator or Director of Nursing or designee during orientation week to ensure compliance in our facility. 4. Regional Director of Clinical Services to audit all Performance improvement plans related to the repeat tags weekly x 12 weeks then 3 times weekly. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed 5. Date of completion 5/24/2024	

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care for 1 of 5 residents reviewed for accidents.

During the recertification and complaint investigation survey on 6/11/21 the facility was cited for failing to supervise and monitor a resident who was not compliant with the smoking policy and was found smoking in room with oxygen via nasal cannula on three occasions. There was also no system or interventions in place to prevent recurrent noncompliance with the smoking policy by residents.

During the complaint investigation survey on 11/10/21 the facility was cited for failing to prevent a resident from rolling off the bed during care which resulted in a right frontal hematoma and laceration, and right periorbital swelling from a fall and hospitalization.

During the complaint investigation survey on 3/25/24 facility was citing for failing to ensure transfer a resident safely when the resident sustained a fractured leg when two nursing staff members used a sliding board to transfer for the resident after therapy had determined she did not have the functional ability to use the sliding board safely.

F732: Based on staff interviews and record review the facility failed to post accurate Registered Nurse (RN) staffing each shift for 2 of 30 days of posting reviewed.

During the recertification and complaint investigation survey on 6/11/21 the facility failed to post the resident census on the daily nursing staffing sheets for 1 of 4 days of the recertification survey.

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F 867	Continued From page 55 An interview with the Administrator on 5/02/24 at 11:01 AM revealed the facility met monthly and made a good faith attempt to identify areas of concern. She stated the committee members included herself, the Director of Nursing, the Medical Director, the Infection Preventionist as well as other staff members. She also revealed the facility had contacted an independent company to help the facility determine the root causes of their repeat accidents. She stated they had determined the cause to be the lack of Nursing Assistant competency due to the lack of hands-on training during the Covid pandemic. She stated they had increased their training and monitoring program for new hires.	F 867		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		5/24/24

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F 883	Continued From page 56 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and Physician, resident, and staff interviews the facility failed to document the Pneumococcal and Influenza vaccines were offered and declined, and the reason. The facility further failed to document that the resident or the	F 883	F883 1. The facility has taken immediate action to offer and administer missing influenza and pneumococcal vaccinations to the identified residents unless medically	

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F 883	Continued From page 57 resident's representative was provided education regarding the benefits and potential side effects of the vaccine for resident for 5 of 5 residents reviewed (Resident #14, Resident #55, Resident #59, Resident #92, and Resident #96). Findings included: a. Resident #14 was admitted to the facility on 9/15/23. She was 79 years old. Her active diagnoses included hypertension (high blood pressure) and Parkinson's Disease. Resident #14's quarterly minimum data set assessment (MDS) dated 3/25/24 revealed she was assessed as not cognitively intact. The immunization record of Resident #14 revealed that the 2023 influenza vaccine was refused, and the pneumococcal 23 vaccine was marked as refused but there was no documented proof of the refusals, reasons refused, or that education was provided regarding the benefits or potential side effects of the vaccines. Review of vaccine consent forms for Resident #14 revealed that she had no pneumococcal or influenza vaccine consent forms on file. Resident #14 was not interviewable and her responsible representative was unable to be reached by phone. b. Resident #55 was admitted to the facility on 1/24/24. He was 59 years old. His active diagnoses included Diabetes Mellitus, pressure ulcers, and heart failure. Resident #55's admission minimum data set	F 883	contraindicated or refused by the resident or their representative. The facility has documented the administration of the vaccines or the reason for not administering (medical contraindication or refusal) in the residents' medical records this was completed 5/24/2024. 2. Current residents in the facility have the potential to be affected. An Audit of current residents to educate, offer and administer missing influenza and pneumococcal vaccinations to the identified residents unless medically contraindicated or refused by the resident or their representative will be complete by 5/24/2024. The facility will document the education, the administration of the vaccines or the reason for not administering (medical contraindication or refusal) in the resident's medical record by 5/24/2024. 3. Staff Development Coordinator or designee will educate licensed nurses on the process for Flu (influenza) and pneumonia vaccinations, education, and accuracy of documentation for education and administration, offered and administered or declines with education provided and documented in the resident medical record by 5/24/2024. Licensed nursing not receiving education by 5/24/2024 will be removed from the schedule. New licensed nurses will receive education during the orientation process 4. The infection preventionist or	

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F 883	Continued From page 58 assessment (MDS) dated 01/30/24 revealed he was assessed as cognitively intact. The immunization record of Resident #55 revealed that he refused the 2023 influenza and the pneumococcal Prevnar 13 vaccine. The vaccines were marked as refused but there was no documented proof of the refusals, reasons refused, or that education was provided regarding the benefits or potential side effects of the vaccines. Review of vaccine consent forms for Resident #55 revealed that he had no influenza or pneumococcal vaccine consent forms on file. Interview with Resident #55 on 5/5/24 at 9:33 am revealed that he was never offered a pneumonia or influenza vaccine and he recalled that he received the influenza vaccine at a local pharmacy before he was admitted to the facility, he was unsure of the date but recalled it was recent. He further stated that he received the pneumococcal vaccine last year and it was good for 5 years. He stated that he takes all recommended vaccines, and he would have remembered if they had offered it to him. c. Resident #59 was admitted to the facility on 8/25/22. She was 82 years old. Her active diagnoses included cancer of the thorax (the portion of the body between the neck and abdomen) and hypertension (high blood pressure). Resident #59's quarterly minimum data set assessment (MDS) dated 2/28/24 revealed she was assessed as not cognitively intact.	F 883	designee will audit 10 residents weekly x 4 then monthly x 2 to verify vaccination offered and if declined, education provided with accurate documentation. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. 5. Date of completion 5/24/2024	

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The immunization record of Resident #59 revealed that the pneumovax vaccine was refused but there was no documented proof of the refusal or reason refused and no documented proof that education was provided regarding the benefits or potential side effects of the vaccine.

Review of the vaccine consent forms for Resident #59 revealed that she had no pneumococcal vaccine consent form on file.

Resident #59 was not interviewable and her responsible representative was unable to be reached by phone.

d. Resident #92 was admitted to the facility on 10/17/23. She was 83 years old. Her active diagnoses included Chronic Kidney Disease, Hypertension (high blood pressure), and Diabetes Mellitus.

Resident #92's quarterly minimum data set assessment (MDS) dated 1/29/24 revealed she was assessed as cognitively intact.

The immunization record of Resident #92 revealed that she had not received a pneumococcal vaccine and there was no documented proof of a refusal or reason refused and no documented proof that education was provided regarding the benefits or potential side effects of the vaccine.

Review of vaccine consent forms for Resident #92 revealed that she had no pneumococcal vaccine consent form on file.

Interview with Resident #92 on 5/3/24 at 10:52 am revealed that she always took vaccines that

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	345505	A. BUILDING _____ B. WING _____	C 05/03/2024

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were offered to her since she had COVID and pneumonia at the same time in the past. She further indicated that she was not offered a pneumonia vaccine and she had not declined to take one while at the facility. She stated that she would not have declined to take a vaccine if it was offered to her.

e. Resident #96 was admitted to the facility on 1/3/24. He was 64 years old. His active diagnoses included Atherosclerosis (the buildup of plaque in the artery walls), Hypertension (high blood pressure), and Cardiomyopathy (a disorder that affects the heart muscle).

Resident #96's quarterly minimum data set assessment (MDS) dated 4/15/24 revealed he was assessed as cognitively intact.

The immunization record of Resident #96 revealed that the 2023 influenza vaccine was refused but there was no documented proof of the refusal or reason refused and no documented proof that education was provided regarding the benefits or potential side effects of the vaccine.

Review of vaccine consent forms for Resident #96 revealed that he had no pneumococcal vaccine consent form on file.

Interview with Resident #96 on 5/3/24 at 9:48 am revealed that he was not offered an influenza vaccine by the facility and he would have taken it if he was offered.

In an interview with the Infection Preventionist on 5/1/24 at 2:18 PM she stated she could not determine whether Resident #14, Resident #55, Resident #59, Resident #92, and Resident #96

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had consented or refused the influenza and/or pneumococcal vaccines because there was no documented record of a consent or refusal, reason for refusal, or proof that a Vaccine Information Sheet (VIS) was provided to each resident and/or RP regarding the vaccines. She stated she had been in the IP position since 2/19/24 and her process was she offered vaccine to residents and if they declined she got them to sign the VIS to indicate that education was provided on the risks and benefits of the vaccines and she kept the signed VIS consent/declination in a book, but that she did not have a signed VIS consent/declination for Resident #14, Resident #55, Resident #59, Resident #92, or Resident #96.

In an interview with the facility Nurse Consultant on 05/01/24 02:27 PM she stated a written refusal should have been signed and kept on file or that an immunization refusal should have been documented in the electronic medical record under the immunization assessment tab. She further indicated that a recent change in the immunization process was they had the resident or RP initial or sign the VIS and the signed VIS was uploaded to the electronic medical record to prove they received education on the risks and benefits of the vaccines. She stated that this had not been done for Resident #14, Resident #55, Resident #59, Resident #92, or Resident #96.

During an interview with the Director of Nursing (DON) on 5/2/24 at 8:37 AM it was revealed she was unaware there was no documentation that Resident #14, Resident #55, Resident #59, Resident #92, or Resident #96 were offered and declined vaccination, no documentation of reason for refusal, and no proof education was provided

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on the risks and benefits of the vaccines. She stated the facility had a new IP and the prior IP no longer was employed by the facility. She stated the current process for immunizations was the IP reviewed newly admitted residents to determine vaccine status, offered vaccines, and educated the resident using the VIS. The resident signed a copy of the VIS to indicate they consented or declined a vaccine and received the education. She further indicated they would write the word declined or refused on the VIS if the resident declined a vaccine and the resident or RP signed the VIS as proof they declined. The interview further revealed the process prior to the employment of the current IP was that the refusal or consent was entered under the immunizations tab in the electronic medical record and there was a notes box where they entered the refusal and reason refused. The DON stated Resident #14, Resident #55, Resident #59, Resident #92, or Resident #96 should have received a VIS and there should have been proof if they declined a vaccine and the reason why.

In an interview with the facility Administrator on 5/2/24 at 10:40 AM she stated newly admitted residents were screened for vaccine status through the North Carolina Immunization Registry and the facility provided the VIS to the resident or RP and reviewed it with them. She stated the resident or RP could decline a vaccine but the facility was not required to get a signed declination or consent because it was not required in the regulations. She further indicated it should be documented that a resident consented to or refused a vaccination in the electronic medical record or somewhere and that would be the proof a resident consented or refused.

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F 883	Continued From page 63 In an interview with Nurse Practitioner on 5/2/24 at 12:53 PM he stated that he recommended residents become vaccinated if it was not contraindicated. He stated he encouraged vaccinations for all residents because most had preexisting conditions that put them at risk of contracting an infection. He stated residents should be offered vaccinations and staff should educate residents or resident representatives on the risks and benefits of the vaccine and if a resident declined that should documented in the medical record they declined and why.	F 883		