STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345523	A. BUILDING _____ B. WING _____	C 05/17/2024

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UNIVERSAL HEALTHCARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification and complaint investigation survey was conducted from 4/29/24 through 5/2/24, with additional information obtained on 5/3/24 and 5/6/24. A survey team returned to the facility on 5/14/24 to obtain additional information and exited on 5/17/24. Therefore, the exit date was changed to 5/17/24. Event ID# JBHD11. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# JBHD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/29/24 through 5/2/24, with additional information obtained on 5/3/24 and 5/6/24. A survey team returned to the facility on 5/14/24 to obtain additional information and exited on 5/17/24. Therefore, the exit date was changed to 5/17/24. Event ID# JBHD11. The following intakes were investigated NC00214143, NC00213611, NC00213334, NC00209350, NC00213357, NC00205381, NC00205767, NC00211362, NC00216669, NC00216881, NC00216746 and NC00216562. 5 of the 21 complaint allegations resulted in deficiencies. Intakes NC00216669, NC00216746 and NC00216562 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.12 at tag F607 at a scope and severity (K) The tags F600 and F607 constituted Substandard Quality of Care.	F 000		

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

Electronically Signed | 06/04/2024

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F 000	Continued From page 1 Immediate Jeopardy began on 5/2/24 and was removed on 5/17/24. An extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and Medical Director interviews the facility failed to protect a resident's right to be free of sexual abuse for 1 of 3 residents investigated for abuse (Resident #7). A moderately cognitively impaired male resident (Resident #39) was found beside Resident #7's bed, a severely cognitively impaired female resident, with his hand moving under the covers around her groin area when a staff member entered Resident #7's room. Resident #7's brief was open and there was stool on the outside of her brief and on her sheets, and Resident #39 had stool on his hands. Resident #39 was interviewed and stated he was "playing around" with Resident #7 "down there" and	F 600	F600 Free from Abuse and Neglect How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 5/2/2024 CNA #1 observed Resident # 4's hand under the covers of Resident #2 in her bed in resident #2's room at around 9:00am. CNA # 1 announced for Resident # 4 to abstain from touching Resident # 2. CNA #1 removed Resident # 4 from Resident # 2's room. Nurse #1 completed a skin assessment on resident #1 during 7p-7a shift on 5/2/2024 with no noted injuries. Law enforcement was notified on	6/5/24

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F 600	Continued From page 2 waved his hand in a circular motion around his groin area. Resident #39 stated he had done something stupid, and he should not have done it. Resident #7 did not have the cognition to express or understand consent for physical sexual advances, and a reasonable person would have been traumatized by unwanted physical sexual advances. Immediate Jeopardy began on 5/2/2024, when the facility failed to protect Resident #7's right to be free of sexual abuse. Immediate Jeopardy was removed on 5/17/2024 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of D (no actual harm with potential for potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems that were put into place are effective. Findings included: Resident #7 was admitted to the facility on 9/3/2022 with diagnoses of dementia and cognitive communication deficit. A quarterly Minimum Data Set assessment dated 3/6/2024 indicated Resident #7 was assessed as severely cognitively impaired; was dependent on staff for rolling from side to side in bed; was totally dependent for transferring to and from the bed to wheelchair; was always incontinent of bowel and bladder and was sometimes understood by others and sometimes understood others The Care Plan for Resident #7 which was reviewed on 3/21/2024 indicated she had difficulty	F 600	5/2/2024 around 9:30 am. Resident # 2's responsible party was notified of occurrence on 5/2/2024. Resident # 2's emergency contact was also notified of the occurrence on 5/2/2024. Resident #2 was transferred to another room on 5/2/24 for her protection. Resident #4 had no prior history of sexual aggression prior to the incident on 5/2/2024. How the facility will identify other residents potentially affected by the same deficient practice Abuse questionnaires were completed by the Business Office Manager, MDS Nurse, Admissions Director and Unit Manager on all residents with Brief Interview for Mental Status (BIMS) score of 9 and above with no adverse responses. Questionnaires were completed on 5/15/2024. The questions asked were as follows, 1. Do you feel safe? 2. Has anyone ever touched you inappropriately? 3. Are you afraid of anyone in the facility? The Unit Manager and/or Floor Nurse completed skin assessment for all residents with a BIMS score below 9 as of 5/15/2024 with no negative findings. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On 5/2/2024 at 9:40am Social Worker talked with Resident #4 about the incident that occurred and explained to resident #4 what he had done wrong. On 5/7/2024 the physician changed resident #4's medication to add Zoloft 25mg tablet daily by mouth for aggression.	

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F 600	Continued From page 3 with making her own decisions. Resident #39 was admitted to the facility on 8/27/2021 with diagnoses of dementia and stroke. A quarterly Minimum Data Set assessment dated 3/29/2024 indicated Resident #39 was moderately cognitively impaired and had no behaviors. Resident #39's Care Plan was reviewed and on 3/29/2024 the Care Plan indicated Resident #39 had episodes of verbally aggressive behaviors and should be approached in a calm manner. A Care Plan problem added on 4/4/2024 to the Care Plan indicated Resident #39 had a history of depression, he had scheduled psychiatric visits ordered, and he had difficulty recalling recent events due to dementia. A review of a written statement made by Nurse Aide #6 on 5/2/2024 indicated she walked into Resident #7's room and Resident #39 was sitting next to her bed, and she saw something move under the covers that appeared to be Resident #39's hand. The statement further stated she asked Resident #39 what he was doing, and he said nothing. The written statement further indicated when Resident #39 left the room he had stool on his fingers and Resident #7's brief was open and there was stool on the outside of her brief and on her sheet. On 5/14/2024 at 1:11 pm Nurse Aide #6 was interviewed, and stated she cared for Resident #7 on 5/2/2024 and walked into her room between 9:00 am and 9:30 am and Resident #39 was sitting beside her bed in his wheelchair and his hand was under the covers and she saw his hand moving around her groin area. Nurse Aide #6	F 600	On 5/15/2024, around 5:30pm resident #4 was placed on 1:1. the MD reassessed. MDS Nurse updated resident #4's care plan to reflect new behavior of sexual aggression and interventions for managing behavior as of 5/16/2024. MDS Nurse updated care guide for resident #4 on 5/16/2024 and staff notified of changes through care guide on 5/16/2024. MDS Nurse will continue to update interventions as needed. As of 5/15/2024 the Staff Development Coordinator educated 100% of facility staff, including agency on the facility abuse policy to include residents right to be free from abuse to include sexual, physical, mental, verbal and misappropriation of property as well as signs of abuse and reporting of abuse or potential abuse. Staff development Coordinator will provide education for abuse training to new hires during orientation, including new agency staff. Staff will not be allowed to work until education has been received as of 5/22/24. 1:1 supervision will be documented and reported to the facility Administrator and Director of Nursing to ensure monitoring of resident. The Director of Nursing will ensure the 1:1 staff member is provided each shift with the staffing coordinator daily until 5/31/24. As of 5/15/2024 all CNA's will be educated by the Director of Nursing/Staff Development Coordinator on supervision of resident. Education will include the goal of 1:1 in	

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F 600	Continued From page 4 stated Resident #7 was not upset but she was severely cognitively impaired. Nurse Aide #6 stated she asked Resident #39 what he was doing and when she asked him to leave the room, she noticed he had stool on his hand. She stated after Resident #39 rolled himself in his wheelchair to his room, Nurse Aide #6 stated she returned to Resident #7 to clean her up and when she pulled the sheet down her brief was open and there was stool on the outside of her brief and on her sheet. Nurse Aide #6 stated Resident #39 was sometimes confused and sometimes he was clear. Nurse Aide #6 stated Resident #38 could get up unassisted, moved himself in his wheelchair without assistance, and he wandered around the facility. Nurse Aide #6 stated Resident #38 sat in the doorway of Resident #7's room a lot but 5/2/2024 was the first time she found him in her room. A written statement dated 5/2/2024 by the Social Worker stated she interviewed Resident #39 and asked him what he was doing in Resident #7's room this morning and he stated, "I was just playing around" and when asked to elaborate on what he meant he said, " I was just playing with her down there" and he took his hand and waved it in a circular motion around his groin area and said, "down there". The Social Worker's written statement indicated Resident #39 stated, "I was doing something stupid that I should not have done". The Social Worker's written statement stated she explained to Resident #39 that Resident #7 was cognitively impaired and could not give consent to being touched sexually and he verbalized understanding that he knew what he did was inappropriate. On 5/14/2024 at 2:15 pm the Social Worker was	F 600	protecting other residents from any sexual aggression by resident #4 and ensuring resident #4 does not encounter resident #2 and documenting of any aggression during shift. How the facility will monitor its performance to ensure the deficient practice does not recur: The Social Service Director or designee will conduct random interviews of 5 alert and oriented residents weekly for 12 weeks to ensure residents feel safe in the facility. The Director of Nursing or designee will complete random skin audits of 5 cognitively impaired residents weekly for 12 weeks to ensure no signs or symptoms of abuse. The Director of Nursing or designee will review the 24-hour report 5 times a week for 12 weeks for new behaviors to ensure MD notification and appropriate interventions are in place. The Administrator or designee will be responsible for reporting results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee. Compliance Date: 6/5/24	

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interviewed and stated Resident #39 was coming down the hallway toward her office between 9:30 am and 9:45 am on 5/2/2024 and he stated, "I was playing around with Resident #7 in her room, and he did a circular hand motion towards his groin area". The Social Worker stated he said, "I did something stupid" and the Social Worker stated because he said he did something stupid he understood what he had done was wrong. The Social Worker stated he told the Police Officer that investigated the sexual abuse allegation the exact same thing about an hour after she interviewed him. The Police Officer explained to Resident #39 that Resident #7's family would have to decide to press charges and the Police Officer returned to the facility later that day and notified Resident #7 of his court appearance date and that he was charged with sexual battery.

A Police Report dated 5/2/2024 at 9:54 am indicated Resident #39 was charged with sexual battery of Resident #7. The Police Report further indicated Nurse Aide #6 entered Resident #7's room and found Resident #39 at her bedside with his hand under the blanket. Nurse Aide #6 indicated Resident #39 hand was moving under the blanket and Nurse Aide #6 confronted Resident #39 about what he was doing, and he stated, "nothing". Nurse Aide #6 reported there was stool on Resident #39's fingers and she found Resident #7's brief open and there was stool outside the brief and on the bed. The Police Report stated Resident #7 was cognitively impaired and could not recall the alleged abuse or give consent. The Police Report stated the Responsible Party was interviewed and stated Resident #7 had dementia and frequently repeats what is said to her. The Responsible Party

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indicated he wished to pursue charges for the incident on behalf of Resident #7.

An interview was conducted by phone on 5/15/2024 at 10:05 am with the Police Officer who responded to the allegation of sexual abuse on 5/2/2024. The Police Officer stated he interviewed Nurse Aide #6 and she stated she entered Resident #7's room and found Resident #39 in his wheelchair sitting beside the bed with his hand under the covers and when she approached him and asked what he was doing he said nothing, but she noticed stool on his fingers. The Police Officer stated Nursing Aide #6 stated after Resident #39 left the room she saw that Resident #7's brief was open and there was stool outside the brief and on the sheet. The Police Officer stated Resident #39 admitted to touching Resident #7 sexually and seemed to understand what he did was sexual battery. The Police Officer stated Resident #39 took advantage of a situation where no one was around, and Resident #7 confusion prevented her from stopping him.

During an interview on 5/14/2024 at 10:00 am with Resident #7's Responsible Party by phone he stated the facility notified him on 5/2/2024 at 9:30 am that Resident #7 had been sexually abused. He stated Resident #7 is severely cognitively impaired and would not have understood what happened to her. The Responsible Party stated he felt Resident #7 was sexually abused because she was unable to call for help or report what was done to her. He stated Resident #7 was a very good woman and would not have instigated a sexual encounter and would have been very upset if she understood what happened.

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A Physician's Progress Note stated 5/6/2024 by the Medical Director indicated he saw Resident #7 and evaluated her mental status and ability to give/withhold informed consent. The Progress Note further stated Resident #7 was a poor historian due to her cognition and information was obtained through chart review and discussion with medical staff; and she was not able to give informed consent.

A Physician's Progress Note dated 5/6/2024 indicated the Medical Director evaluated Resident #39 for the ability to give/withhold informed consent. The Progress Report stated Resident #39 had a history of dementia; had no recent cognitive decline noted; and Resident had cognitive impairment with poor ability to give or withhold consent and was unlikely to understand the nature of his actions.

On 5/14/2024 at 5:32 pm the Medical Director was interviewed by phone and stated he did not believe Resident #39 understood what he was doing when he evaluated him on 5/6/2024 after the incident that occurred on 5/2/2024. The Medical Director stated Resident #39 responded, "it was bad" when he asked if he understood what he did was bad; and he responded, "it was bad" when he asked Resident #39 if he understood why what he did was bad.

Resident #39 was interviewed on 5/14/2024 at 11:20 am and he stated he has lived at the facility for 2 years. When asked if he had any altercations with another resident he stated, "I got in trouble for touching another resident". Resident #39 stated he did not know the name of the resident and stated he did not remember how long ago the incident happened.

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The Director of Nursing was interviewed on 5/14/2024 at 5:37 pm and stated Unit Manager #2 reported to her on 5/2/2024 around 9:30 am to 9:40 am that Resident #39 was found in Resident #7's room by Nurse Aide #6 sitting beside her bed in his wheelchair with his hand under the covers. She stated Nurse Aide #6 reported Resident #7's brief was open, and stool was on the outside of her brief and on her sheet, and Resident #39 had stool on his hand. The Director of Nursing stated they began an investigation and had substantiated the sexual abuse.

On 5/15/2024 at 8:42 am the previous Administrator was interviewed by phone and stated the facility had initiated an investigation when Nurse Aide #6 reported Resident #39 was found in his wheelchair beside Resident #7's bed with his hand under the covers. The Administrator stated the Medical Director spoke with Resident #39 and the Medical Director felt Resident #39 did not understand what he had done wrong. The previous Administrator stated the Medical Director prescribed Zoloft (an antidepressant) to treat Resident #39's libido and aggression after the incident. The previous Administrator indicated Resident #39 was put on every 15-minute observations by nursing after the incident was reported and the Medical Director felt that every 15-minute observations by nursing was sufficient to protect Resident #7 and other resident's safety. He stated Resident #39 did wander in the facility between the every 15-minute observations.

An interview was conducted with the Administrator on 5/17/2024 at 3:32 pm and he stated the facility had provided education to all

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staff regarding their Abuse Prevention, Intervention, Reporting, and Investigation Policy. He stated the facility was responsible for protecting the residents from all forms of abuse.

The Administrator was notified of immediate jeopardy on 5/15/2024 at 4:24 pm.

The facility provided the following Credible Allegation of Immediate Jeopardy Removal:

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

On 5/2/2024 NA #6 observed Resident # 39's hand under the covers of Resident #7 in her bed in resident #7's room at around 9:00am. NA # 6 announced for Resident #39 to abstain from touching Resident # 7. NA #6 removed Resident #39 from Resident # 7's room. Nurse #6 completed a skin assessment on Resident #7 during 7p-7a shift on 5/2/2024 with no noted injuries.

Law enforcement was notified on 5/2/2024 around 9:30 am.

Resident # 7's responsible party was notified of occurrence on 5/2/2024. Resident # 7's emergency contact was also notified of the occurrence on 5/2/2024. Resident #7 was transferred to another room on 5/2/24 for her protection.

Resident #39 had no prior history of sexual aggression prior to the incident on 5/2/2024.

Abuse questionnaires were completed by the

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Business Office Manager, MDS Nurse, Admissions Director and Unit Manager on all residents with Brief Interview for Mental Status (BIMS) score of 9 and above with no adverse responses. Questionnaires were completed on 5/15/2024. The questions asked were as follows, 1. Do you feel safe? 2. Has anyone ever touched you inappropriately? 3. Are you afraid of anyone in the facility? The Unit Manager and/or Floor Nurse completed skin assessment for all residents with a BIMS score below 9 as of 5/15/2024 with no negative findings.

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

On 5/2/2024 at 9:40am Social Worker talked with Resident #39 about the incident that occurred and explained to resident #39 what he had done wrong. On 5/7/2024 the physician changed resident #39's medication to add Zoloft 25mg tablet daily by mouth for aggression. As of 5/15/2024, around 5:30pm resident #39 has been placed on 1 on 1 observation. MDS Nurse updated resident #39's care plan to reflect new behavior of sexual aggression and interventions for managing behavior as of 5/16/2024. MDS Nurse updated care guide for resident #39 on 5/16/2024 and staff notified of changes through care guide on 5/16/2024. MDS Nurse will continue to update interventions as needed.

As of 5/15/2024 the Staff Development Coordinator educated 100% of facility staff on the facility abuse policy to include residents right to be free from abuse to include sexual, physical, mental, verbal and misappropriation of property

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as well as signs of abuse and reporting of abuse or potential abuse. Staff development Coordinator will provide education for abuse training to new hires during orientation. 1:1 supervision will be documented and reported to the facility Administrator and Director of Nursing to ensure monitoring of resident. The Director of Nursing will ensure the 1:1 staff member is provided each shift with the staffing coordinator daily. As of 5/15/2024 all CNA's will be educated by the Director of Nursing/Staff Development Coordinator on supervision of resident during 1:1 duty. Education will include a goal of 1:1 in protecting other residents from any sexual aggression by resident #39 and ensuring resident #39 does not encounter resident #7 and documenting of any aggression during shift.

On 5/15/2024 the facility completed Ad Hoc QAPI to review investigation and current action plan to ensure all components were done and followed. The facility administrator and Director of Nursing are responsible for continued compliance.

Alleged date of IJ removal: 5/17/2024

Credible Allegation of IJ Removal:
The Credible Allegation of IJ Removal was validated on 5/17/2024. The facility provided documentation of the in-service education that was provided to all facility staff which included review of the facility's Abuse Policy to include residents right to be free from abuse to include sexual, physical, mental, verbal and misappropriation of property; signs of abuse; and reporting of abuse or potential abuse. The Staff Development Coordinator provided the education to the staff which will also be covered in the facility's orientation of new employees. The Staff

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F 600	Continued From page 12 Development Coordinator was interviewed and stated they have ensured staff are educated on the abuse policy before they are allowed to care for residents. During interviews with staff from all departments, they were able to verbalize the types of abuse, resident's right to be free from abuse, signs of abuse, reporting of abuse and potential abuse and protection of residents from abuse. Observations were made of Resident #39 during the validation of the Credible Allegation, and he remained on 1 to 1 observation during the validation. The facility provided skin assessments that were completed on residents with a Brief Interview for Mental Status (BIMS) score of less than 9 and interviews forms that were completed on all residents with a BIMs score of 9 or above. The facility provided the minutes for their Quality Assurance Performance Improvement (QAPI) meeting which was completed on 5/15/2024. The alleged date of IJ removal of 5/17/24 was validated.	F 600		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to protect the residents right to be free from misappropriation of a narcotic medication (Oxycodone) prescribed to	F 602	Past noncompliance: no plan of correction required.	

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treat pain for Resident #16, Resident #75, and Resident #239. This was for 3 of 3 residents reviewed for misappropriation.

The findings included:

1) Resident #16 was admitted to the facility on 1/10/23.

A review of Resident #16's quarterly Minimum Data Set assessment, dated 2/29/24, indicated her cognition was intact and she received opioid medication.

Resident #16 had an order dated 2/13/24 for Oxycodone 10 milligrams (mg) every 6 hours as needed for 5 days and to record the resident's pain level.

A review of Resident #16's February Medication Administration Record (MAR) revealed the resident received Oxycodone 10 mg administered by Nurse #2, #7, and #12 for pain on 2/14/24.

The second Oxycodone order, dated 2/18/24, was for 10 mg every 6 hours as needed for pain.

The Narcotic Count Sheet documented for Resident #16's Oxycodone 10 mg every 6 hours as needed for pain indicated the following:
- On 2/22/24 the resident received her med at 6:22 am and one was wasted by Nurse #12.
- On 2/25/24 the resident received her med at 1:00 am and one was wasted by Nurse #12.
- On 2/26/24 the resident received her med at 3:10 am and one was wasted by Nurse #12.

Resident #16 had a pain evaluation dated 2/28/24 which documented she had received pain

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medication within the past 5 days. She received pain medication and non-pharmacological interventions. The resident was satisfied with the current pain management plan and received her medication when requested.

On 4/30/24 at 12:45 pm Resident #16 was interviewed and stated she received her pain medication and all medication as expected and had no concerns.

On 5/1/24 at 11:40 am an interview was conducted with Resident #16. She remembered the surgical procedure and received pain medication as requested. The resident had not remembered any concerns regarding the treatment of her pain.

A drug testing collection and results dated 2/16/24 for Nurse #2 was reviewed. She was tested for Amphetamines, Barbiturates, Benzodiazepine, Burprenorphine, Cocaine, Marijuana, Methylenedioxymethamphetamine, Methamphetamine, Methadone, Opiates/Morphine, Oxycodone, and Phencyclidine. All tested negative.

A drug testing collection and results dated 2/16/24 for Nurse #7 was reviewed. She was tested for Amphetamines, Barbiturates, Benzodiazepine, Burprenorphine, Cocaine, Marijuana, Methylenedioxymethamphetamine, Methamphetamine, Methadone, Opiates/Morphine, Oxycodone, and Phencyclidine. All tested negative.

On 5/6/24/at 10:02 am an interview was attempted by telephone with Nurse #7. She was not available, and a message was left.

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A review of the hand-written statement dated 2/28/24 by Nurse #12 documented the following: "I previously have had an addiction to oxycodone and sought help through treatment. I was clean and stayed so for years. I got a couple of oxycodone from my sister that I took yesterday 2/27 before my shift."

A drug testing collection and results dated 2/28/24 for Nurse #12 was reviewed. She was tested for Amphetamines, Barbiturates, Benzodiazepine, Burprenorphine, Cocaine, Marijuana, Methylenedioxymethamphetamine, Methamphetamine, Methadone, Opiates/Morphine, Oxycodone, and Phencyclidine. The Oxycodone tested positive, and all other drugs tested negative.

On 5/6/24 at 10:05 am an interview was attempted by telephone with Nurse #12. She answered the phone and then hung up.

2) Resident #75 was admitted to the facility on 2/29/24.

Resident #75's 5-day Minimum Data Set assessment dated 3/7/24 documented her cognition as intact, received as needed pain medication, and received opioid medication.

Resident #75 had an order dated 2/20/24 for Oxycodone 5 mg every 4 hours as needed for pain.

A review of Resident #75's Narcotic Count Sheet for February 2024 documented on 2/24/24 at 7:00 pm, one tablet of oxycodone 5 mg was documented as wasted by Nurse #12 and

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witnessed by Nurse #6.

A review of a typed statement, signed by Nurse #6 and dated 3/5/24 documented, "I was called into the facility to write a statement to verify that I did waste Oxycodone with Nurse #12 for Resident #75. Those initials are not my initials. I had not wasted the Oxycodone with Nurse #12."

On 5/3/24 at 2:52 pm an interview was attempted with Nurse #6 and a voicemail was left which requested a call back.

A drug testing collection and results dated 2/16/24 for Nurse #6. She was tested for Amphetamines, Barbiturates, Benzodiazepine, Burprenorphine, Cocaine, Marijuana, Methylenedioxymethamphetamine, Methamphetamine, Methadone, Opiates/Morphine, Oxycodone, and Phencyclidine. All tested negative.

3) Resident #239 was admitted to the facility on 2/23/24 and was discharged on 4/15/24.

Resident #239 had an order for Oxycodone 10 mg every four hours as needed for pain dated 2/23/24.

A review of Resident #239's Narcotic Count Sheet indicated Oxycodone 10 mg was signed out by Nurse #12 on 2/28/24 at 12:42 am, 3:42 am, and 7:42 am (night shift).

Resident #239's pain assessment was completed on 2/27/24 at 12:07 pm, 2/27/24 at 4:47 pm, 2/28/24 at 9:21 am and 2/28/24 at 4:59 pm. She had no pain and required no Oxycodone pain medication as needed.

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Review of a 5-day Minimum Data Set assessment dated 3/1/24, documented Resident #239's cognition as intact and received opioid medications.

Review of a facility interview with Resident #239 on 3/1/24 indicated she reported she had only requested Oxycodone at 8:00 PM on 2/27/24.

The facility provided the follwing corrective action plan:

1. Corrective action for resident(s) affected by the alleged deficient practice:

Day shift nurse reported to the Unit Manager and Director of Nursing on 2/28/24 a licensed nurse had potentially taken as needed narcotics from a resident narcotic card. The Regional Nurse Consultant and Staff Development Coordinator audited all active resident's narcotics and determined medication narcotic discrepancies with 4 residents, Oxycodone 10 mg as needed tablets. No negative outcomes for the 4 residents as they were as needed medication, and the facility had this medication in backup. The medications were replaced prior to residents requesting them.

The Director of Nursing suspended the Licensed Nurse who was suspected of misappropriation during the investigation immediately on 2/28/24 upon learning of the incident. Director of nursing completed the 24-hour report to the Division of Health and Human Services on 2/28/24. The Director of Nursing then began an investigation of missing narcotics and interviewed the licensed nurses and medication aides who had worked on

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the carts of missing narcotics. The Director of Nursing submitted the five-day report upon completion of the investigation on 3/6/24 to DHHS.

The Director of Nursing notified the local Police Department on 2/28/24, the Board of Nursing and Drug Enforcement Agency (DEA) on 2/29/24, by the Director of Nursing.

Facility notified the Medical Director on 2/28/24 of the missing as needed narcotics and the residents involved.

Residents were assessed on 2/28/24 with no adverse effects as the medications were as needed medications.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:

A 100% audit was conducted on 2/28/24 by the Regional Nurse Consultant and Staff Development Coordinator of the control sheets and each medication on all medication carts to verify that all narcotic medication and control sheets were accounted for. It was discovered that the seven Oxycodone tablets among four residents were missing/not properly accounted for.

3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:

Education was initiated with all licensed nursing and medication aides by the Director of Nursing or Staff Development Coordinator on the pharmacy policy related to maintaining narcotics

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on the medication carts, signing of shift-to-shift count sheets, counting, and verifying the narcotic count was correct, wasting and signing with 2 nurses, following the physician order, as well as diversion of narcotics. Education was completed by 3/1/24. Staff will not be permitted to work after 3/1/24 until education is completed, including agency staff. Education will be a part of orientation for all new hire and agency licensed staff prior to working their first shift.

The Director of Nursing will continue to maintain file folders for narcotics in the facility for receiving and returning meds and verify narcotic medication count of delivery manifest sheets received from pharmacy. The facility will follow the facility's policy in maintaining control medications. The licensed nurses will receive and document receiving the controlled medication from pharmacy. The nurses will document the number of sheets in the narcotic count book for the number of medication packages located in the locked medication cart. If a medication is discontinued two nurses will remove the card and the medication record and document the number of cards and the sheets that remain on the cart. The nurse will give the removed sheet to the Director of Nursing to maintain. Two nurses will return the discontinued meds to pharmacy, and two nurses will sign and verify. The medications will be placed in a locked tote and placed in the locked medication room to return to pharmacy. The nurses will give a copy of the record and a copy of the return to pharmacy sheet to the Director of Nursing to maintain in a file cabinet in her office. Two nurses will complete a shift-to-shift count to verify that the number listed on the narcotic record matches the amount of medication in the cart and verify that the numbers

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of sheets are correct.

4. Monitoring Procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Director of Nursing and/or Designee began an audit of medication carts related to narcotic count being correct, the medication cards match the control sheets, the shift-to-shift count sheet are being signed at the start and the end of the shift and any narcotic that needs to be wasted is being signed appropriate by 2 nurses on 2/28/24. Auditing will be completed 5 times per week for 4 weeks, weekly for 4 weeks, then monthly. An ad hoc Quality Assurance and Performance Improvement (QAPI) team meeting was completed on 2/28/24 to review and discuss the action plan. The Director of Nursing will report all findings of audits to the QAPI team monthly for any needed improvement.

The date of completion was 3/1/24.

Validation of the corrective action plan was completed on 5/3/24:
The action plan was validated by reviewing the education provided to the staff, reviewing the interviews with staff and residents, and reviewing the daily Quality Monitoring documentation. Residents were interviewed during the survey, and none reported untreated pain. Nursing staff were interviewed and indicated they had all received education on narcotic diversion.
The facility completion date of 3/1/24 could not be validated because the facility was educating staff on 3/1/24. The competion date was 3/2/24.

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F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff and Medical Director interviews the facility failed to implement the following components of the abuse policy: (a) immediately report an allegation of sexual abuse of a severely cognitively impaired	F 607	F607 Develop/Implement Abuse/Neglect Policies: How the corrective action will be accomplished for those residents found to have been affected by the deficient	6/5/24

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F 607	Continued From page 22 female resident (Resident #7) by a moderately cognitively impaired male resident (Resident #39) to the Administrator; (b) the facility failed to provide a physical examination of a severely cognitively impaired female resident (Resident #7) by a trained/licensed professional for signs of sexual abuse; (c) the facility failed to protect a severely cognitively impaired female resident (Resident #7) and all other residents from the possibility of sexual abuse when they failed to put Resident #39 on one-to-one observations when there was an allegation of sexual abuse against Resident #7; (d) the facility failed to assess all other residents in the facility when an allegation of sexual abuse was reported; and (e) the facility failed to report the allegation of abuse to the Adult Protective Services. This deficient practice affected 1 of 3 residents (Resident #7) investigated for allegations of abuse and had the high likelihood of affecting other vulnerable residents residing in the facility. Immediate jeopardy began on 5/2/2024, when the facility failed to immediately report an allegation of sexual abuse to the Administrator, provide assessment of the alleged victim of sexual abuse, provide protection for the alleged victim of sexual abuse and protect other residents in the facility from the possibility of abuse by assessing other residents in the facility for signs of sexual abuse. Immediate jeopardy was removed on 5/17/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems that were put into place are effective.	F 607	practice: The facility failed to assess if other residents had been abused until 5/15/2024. The facility failed to report the abuse allegation to APS until 5/16/2024. As of 5/15/2024, around 5:30pm resident #4 has been placed on 1 on 1 observation. On 5/2/2024 at 9:40am Social Worker talked with Resident #4 about the incident that occurred and explained to resident #4 what he had done wrong. On 5/7/2024 the physician changed resident #4's medication to add Zoloft 25mg tablet daily by mouth for aggression. How the facility will identify other residents potentially affected by the same deficient practice Abuse questionnaires were completed by the Business Office Manager, MDS Nurse, Admissions Director and Unit Manager on all residents with Brief Interview for Mental Status (BIMS) score of 9 and above with no adverse responses. Questionnaires were completed on 5/15/2024. The questions asked were as follows, 1. Do you feel safe? 2. Has anyone ever touched you inappropriately? 3. Are you afraid of anyone in the facility? The Unit Manager and/or Floor Nurse completed skin assessment for all residents with a BIMS score below 9 as of 5/15/2024 with no negative outcomes. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur.	

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F 607	Continued From page 23 Findings included: 1.a. A review of the facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy, revised 2/2021, indicated upon receiving an allegation of physical and sexual abuse the Executive Director and Director of Health Services should be notified immediately to arrange for the examination of the resident. Resident #7 was admitted to the facility on 9/3/2022 with diagnoses of dementia, stroke, and cognitive communication deficit. Resident #39 was admitted to the facility on 8/27/2021 with diagnoses of dementia and stroke. A written statement made by Nurse Aide #6 on 5/2/2024 stated she walked into Resident #7's room and Resident #39 was sitting next to her bed, and she saw something moving under the covers that appeared to be Resident #39's hand. The statement further stated Nurse Aide #6 asked Resident #39 what he was doing, and he said, "Nothing". The written statement indicated when Resident #39 left the room he had stool on his fingers and Resident #7's brief was open and there was stool outside the brief and on her sheets. The written statement did not indicate who Nurse Aide #6 notified of the allegation of abuse. During an interview with Nurse Aide #6 on 5/14/2024 at 1:11 pm she stated she cared for Resident #7 on 5/2/2024 on the 7:00 am to 7:00 pm shift and she walked into the room between 9:00 am and 9:30 am and Resident #39 was sitting next to Resident #7's bed in his wheelchair and his hand was under the bed covers and she	F 607	As of 5/15/2024 the Regional Director of Operations and Regional Clinical Nurse educated the Director of Nursing, Administrator, Medical and Staff Development Coordinator on abuse policy to include residents right to be free from abuse to include sexual, physical, mental, verbal and misappropriation of property as well as signs of abuse and reporting of abuse or potential abuse. Education also included the process and action to protect residents if any type of abuse including sexual abuse occurs according to facility policy and procedure on abuse. Actions to include assessment of all residents involved, immediate protection for all residents, immediate reporting to Management, state agencies, Ombudsman, APS, families, physician, immediate protection for all residents, and law enforcement. On 5/16/2024 Staff Development Coordinator and/or Director of Nursing educated all nursing staff, including agency on proper procedures for reporting any suspected abuse or actual abuse immediately to the charge nurse, facility Administrator and Director of Nursing for direction. Education will include direction for resident assessment immediately following incident, physician notification by licensed nurse for direction of care for resident and need to send out to hospital for further examination. No employee or agency personnel will be permitted to work after 5/22/2024 if they have not been educated.	

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F 607	Continued From page 24 saw his hand moving around her groin area. Nurse Aide #6 stated Resident #7 was not upset but she is severely cognitively impaired. Nurse Aide #6 stated she asked Resident #39 what he was doing, and he said, "Nothing". Nurse Aide #6 stated when asked Resident #39 to leave the room there was stool on his hand. Nurse Aide #6 stated when she returned to Resident #6, she pulled down the covers and her brief was open and there was stool on the outside of her brief and on the sheets. Nurse Aide #6 stated she told Medication Aide #4 about what she witnessed, and Medication Aide #4 told her she would notify Unit Supervisor #2. On 5/14/2024 at 1:29 pm Medication Aide #4 was interviewed and stated Nurse Aide #6 told her she found Resident #39 in Resident #7's room and he had his hand under Resident #7's covers and when he pulled his hand out from under the bed covers, he had stool on his hand and Resident #7's brief was open and there was stool on the outside of her brief and on the bed covers. Medication Aide #4 stated she told Unit Supervisor #2 about the allegation of sexual abuse about 30 minutes after Nurse Aide #6 told her because Unit Supervisor #2 was in a meeting, and she did not want to disturb the meeting. Medication Aide #4 stated when Unit Supervisor #2 came to the unit after the meeting she notified her of the allegation of sexual abuse. Unit Supervisor #2 was interviewed on 5/14/2024 at 1:35 pm and she stated she did not remember what time it was when she was notified of the allegation of sexual abuse, but it was before 10:00 am. She stated she was coming from the morning meeting, and she does a round of the facility after the meeting. When she went to	F 607	How the facility will monitor its performance to ensure the deficient practice does not recur: The IDT to include the DON, Unit Manager, SDC, SW, Wound Nurse, Activities Director, Dietary Manger, Business Office Manager and Admission Coordinator will conduct random interviews of 5 employees weekly for 12 weeks in all departments to identify knowledge of the abuse policy and ability to implement to include sexual, physical, mental, verbal and misappropriation of property as well as signs of abuse and reporting of abuse or potential abuse. This process also included actions to protect residents if any type of abuse including sexual abuse occurs according to regulation F60. on abuse. The Administrator or designee will be responsible for reporting results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee. Compliance Date: 6/5/24	

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200-hall to check on Medication Aide #4 she was told about the allegation of sexual abuse. Unit Supervisor #2 stated she went to Resident #7's room and Nurse Aide #6 was providing incontinence care. She stated there was stool on the sheet, but the brief had been removed. Unit Supervisor #2 stated she reported the allegation of sexual abuse to the Director of Nursing after she checked on Resident #7.

The Director of Nursing was interviewed on 5/14/2024 at 5:37 pm and stated she was in her office and between 9:30 am and 9:40 am on 5/2/24 when Unit Supervisor #2 came to her office and reported the allegation of sexual abuse of Resident #7. She stated she was told by Unit Supervisor #2 that Nurse Aide #6 went into Resident #7's room and Resident #38 was sitting beside her bed in his wheelchair with his hand under the sheet and when she came into the room, he pulled his hand out. The Director of Nursing stated she was told Resident #38 had stool on his hand. The Director of Nursing stated they began an investigation immediately and the police were called. She stated she was not aware Medication Aide #4 had not reported the allegation of sexual abuse to Unit Supervisor #2 until 30 minutes after it was reported to her. The Director of Nursing stated that all allegations of abuse should be reported immediately.

The previous Administrator was interviewed on 5/15/2024 at 8:42 am and he stated he had moved to another facility but was the administrator of the building at the time of the allegation of sexual abuse. He stated he was told by the Director of Nursing about the allegation of sexual abuse, and an investigation was initiated immediately. He stated he was not aware

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Medication Aide #4 had not report the allegation until 30 minutes after she was told by Nurse Aide #6. He stated all allegations of abuse should be reported to the administration immediately.

b. The facility's Abuse Prevention, Intervention, Reporting and Investigation Policy, revised 2/2021, indicated a physical examination of the resident should be conducted by an appropriately trained/licensed professional (attending physician, emergency room physician).

Unit Supervisor #2 was interviewed on 5/14/2024 at 1:35 pm and she stated she was coming from her morning meeting on 5/2/2024 before 10:00 am, when she did a morning round, and went to the 200-hall to check on Medication Aide #4. She stated Medication Aide #4 told her Nurse Aide #6 walked into Resident #7's room and Resident #39 was sitting in his wheelchair beside the bed with his hand under the sheet. She stated she was told Resident #39 had stool on his hand and Resident #39's brief was open and there was stool on the sheet and on the outside of the brief. Unit Supervisor #2 stated she went to Resident #7's room and Nurse Aide #6 was providing incontinence care for Resident #7. Unit Supervisor #2 stated she did not assess Resident #7 and she did not know if anyone else assessed Resident #7.

The Director of Nursing was interviewed on 5/14/2024 at 5:37 pm and she stated it was reported to her on 5/2/2024 between 9:30 and 9:40 am that Resident #38 was found by Nurse Aide #6 in Resident #7's room sitting beside her bed in his wheelchair with his hand under the covers. She stated when Resident #38 pulled his hand from the covers he had stool on his fingers

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and when Nurse Aide #6 pulled back Resident #7's covers her brief was open and there was stool on the outside of her brief and on the sheets. The Director of Nursing stated someone did assess Resident #7, but she was not sure who had provided the assessment. A follow-up interview was conducted with the Director of Nursing on 5/15/2024 and she stated there was not a physical assessment of Resident #7 immediately after the allegation of sexual abuse was reported. She stated there was a skin assessment completed on 5/2/2024 on the 7:00 pm to 7:00 am shift.

A phone interview was conducted with Nurse #6 on 5/15/2024 at 12:03 pm and she stated she did a skin assessment on 5/2/2024 between 9:00 pm and 10:00 pm and Resident #7 did not have any bruising or injuries to her perineum.

The previous Administrator was interviewed on 5/15/2024 at 8:42 am and he stated the Medical Director was made aware of the allegation of sexual abuse immediately, but he did not know when Resident #7 was physically assessed after the incident.

c. The facility's Abuse Prevention, Intervention Reporting, and Investigation Policy stated a resident who is allegedly mistreated by another resident is removed from contact with that resident during the investigation. The policy further stated residents are to be protected during incident investigations; and residents will be protected from the alleged offender.

A written statement made by Nurse Aide #6 on 5/2/2024 stated she walked into Resident #7's room and Resident #39 was sitting next to her

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bed, and she saw something moving under the covers that appeared to be Resident #39's hand. The statement further stated Nurse Aide #6 asked Resident #39 what he was doing, and he said, "Nothing". The written statement indicated when Resident #39 left the room he had stool on his fingers and Resident #7's brief was open and there was stool outside the brief and on her sheets.

During an interview with Nurse Aide #6 on 5/14/2024 at 1:11 pm she stated she cared for Resident #7 on 5/2/2024 on the 7:00 am to 7:00 pm shift and she walked into the room between 9:00 am and 9:30 am and Resident #39 was sitting next to Resident #7's bed in his wheelchair and his hand was under the bed covers and she saw his hand moving around her groin area. Nurse Aide #6 stated Resident #7 was not upset but she is severely cognitively impaired. Nurse Aide #6 stated she asked Resident #39 what he was doing, and he said, "Nothing". Nurse Aide #6 stated when she sent Resident #39 out of the room there was stool on his hand. Nurse Aide #6 stated when she returned to Resident #6, she pulled down the covers and her brief was open and there was stool on the outside of her brief and on the sheets. Nurse Aide #6 stated she told Medication Aide #4 about what she witnessed, and Medication Aide #4 told her she would notify Unit Supervisor #2. Nurse Aide #6 stated Resident #39 was in his room when she went to tell Medication Aide #4 about the allegation of sexual abuse but there was not anyone with him and they did not put him on one-to-one observation until the Patient Care Associate (PCA) came to sit with him. She stated she did not know what time the PCA was assigned to Resident #39.

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On 5/14/2024 at 1:29 pm Medication Aide #4 was interviewed and stated Nurse Aide #6 told her she found Resident #39 in Resident #7's room and he had his hand under Resident #7's covers and when he pulled his hand out from under the bed covers, he had stool on his hand and Resident #7's brief was open and there was stool on the outside of her brief and on the bed covers. Medication Aide #4 stated she told Unit Supervisor #2 about the allegation of sexual abuse about 30 minutes after Nurse Aide #6 told her because Unit Supervisor #2 was in a meeting, and she did not want to disturb the meeting. Medication Aide #4 stated Resident #38 was not put on one-to-one observation until later that morning when the Patient Care Associate (PCA) was assigned to watch him and after she left at 3:00 pm that day he was put on every 15-minute checks. Medication Aide #4 stated staff were supposed to check to see where Resident #39 was every 15 minutes and document that we saw him. She stated she did not know why Resident #39 was not kept on one-to-one observation.

Unit Supervisor #2 was interviewed on 5/14/2024 at 1:35 pm and she stated she did not remember what time it was when she was notified of the allegation of sexual abuse, but she stated it was before 10:00 am. She stated she was coming from the morning meeting, and she does a round of the facility after the meeting and when she went to 200-hall to check on Medication Aide #4 she was told about the allegation of sexual abuse. Unit Supervisor #2 stated she went to Resident #7's room and Nurse Aide #6 was providing incontinence care. She stated there was stool on the sheet, but the brief had been removed. Unit Supervisor #2 stated she reported

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the allegation of sexual abuse to the Director of Nursing after she checked on Resident #7. Unit Supervisor #2 stated Resident #39 was in the hallway away from his room when she went to check on Resident #7, she stated they did not put Resident #39 on one-to-one observation until after she reported the allegation of sexual abuse to the Director of Nursing and then he went to every 15-minute checks the next day. Unit Supervisor #2 stated Resident #39 is very mobile in his wheelchair and he wanders around the facility.

The Police Officer was interviewed on 5/15/2024 at 10:05 am and he stated he came to the facility on 5/2/2024 at 9:58 am to investigate. He stated when he arrived at the facility Resident #7 was in his wheelchair in the hallway and no one was supervising him when he approached him to interview him.

During an interview with the Patient Care Associate (PCA) on 5/14/2024 at 2:01 pm, who spoke only Spanish, and the Director of Nursing provided interpretation, the PCA stated she was assigned to Resident #39 at 12:15 pm on 5/2/2024 and she observed him until 3:00 pm. She stated she kept notes in her notebook of where he went during the one-to-one observation. The PCA stated Resident #39 tried to get close to Resident #7 once on 5/2/2024 when she was observing him, but she redirected him.

On 5/14/2024 at 11:12 am Resident #7 was observed in her wheelchair on the 200-hall and she went up and down the hallway but did not go into any resident rooms. Staff were observed at the nurses' desk but did not redirect Resident #7 back to the 100-hall where she resided. Resident

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#7 rolled past Resident #39's room door twice in her wheelchair during the observation. Resident #7 was observed until 11:20 am.

The Director of Nursing was interviewed on 5/14/2024 at 5:37 pm and she stated they put Resident #39 on one-to-one observation after the incident was reported.

On 5/15/2024 at 3:08 pm the Director of Nursing was interviewed again and stated she was not aware Resident #39 was not put on one-to-one observation until 12:15 pm. She stated they decided to monitor him on every 15-minute checks after 3:00 pm on 5/2/2024 because they felt they could watch him closely enough with every 15-minute checks to ensure Resident #7 and all other residents were safe.

d. The facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy, revised on 2/2021, indicated the facility will assess and interview all residents who came in contact with the accused when investigating an abuse allegation.

Unit Supervisor #4 was interviewed on 5/14/2024 at 5:25 pm and stated she had not physically assessed Resident #7 on 5/2/2024 after the allegation of sexual abuse was reported. Unit Supervisor #4 stated she was not asked to do assessments or interviews with any other residents after the allegation of sexual abuse was reported on 5/2/2024.

During an interview with the Director of Nursing on 5/15/2024 at 3:08 pm she stated the facility did not complete physical assessments with residents that were cognitively impaired or

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interview any residents that were not cognitively impaired to see if there were any further allegations of sexual abuse in the facility when the sexual abuse allegation was reported on 5/2/2024.

The previous Administrator was interviewed by phone on 5/15/2024 at 8:42 am and he stated when the allegation of sexual abuse of Resident #7 by Resident #39 was reported on 5/2/2024 the facility moved Resident #7 to another room on a different hallway; placed Resident #39 on every 15-minute checks; and the Medical Director and police were notified of the allegation of abuse. The previous Administrator stated he spoke with the Medical Director after the incident on 5/2/2024 to see if the facility needed to do anything else to protect Resident #7 and other residents and the Medical Director stated they had done everything they could do.

The current Administrator was interviewed on 5/17/2024 at 4:42 pm and stated the facility's staff have received in-service education regarding the facility's Abuse Prevention, Intervention, Reporting, and Investigation Policy. The current Administrator stated the staff should have assessed all residents who came in contact with the accused when the allegation was reported on 5/2/2024.

e. The facility's Abuse Prevention, Intervention, Reporting, and Investigation policy, revised 2/2021, indicated the facility would notify Adult Protective Services when an allegation of abuse is reported.

The Director of Nursing was interviewed on 5/15/2024 at 4:03 pm and she stated the facility

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did not notify the North Carolina Division of Social Services, Adult Protective Services regarding the allegation of sexual abuse of Resident #7 that was reported on 5/2/2024. She stated she was not aware she should notify Adult Protective Services.

The previous Administrator was interviewed by phone on 5/15/2024 at 8:42 am and he stated when the allegation of sexual abuse of Resident #7 by Resident #39 was reported on 5/2/2024 the facility moved Resident #7 to another room on a different hallway; placed Resident #39 on every 15-minute checks; and the Medical Director and police were notified of the allegation of abuse. The previous Administrator stated he spoke with the Medical Director after the incident on 5/2/2024 to see if the facility needed to do anything else to protect Resident #7 and other residents and the Medical Director stated they had done everything they could do.

The Administrator was notified of immediate jeopardy on 5/15/2024 at 4:43 pm.

The facility provided the Credible Allegation of Immediate Jeopardy Removal:

F607 Abuse Reporting:
The facility failed to implement the abuse policy related to reporting and protection.
Identify Those recipients who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance.
On 5/2/2024 CNA #1 observed Resident # 39's hand under the covers of Resident #7 in her bed in resident #7's room at around 9:00am. CNA # 6 announced for Resident # 39 to abstain from touching Resident # 2. CNA #7 removed Resident

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39 from Resident # 7's room.
After an allegation of sexual abuse, a nurse was not notified immediately; staff was cleaning up the resident before a nurse came to the room, a nurse did not complete an initial assessment until that night on 7p-7a shift. The facility failed to provide a physical examination of a cognitively impaired female resident (Resident #7) by an appropriately trained/licensed professional for signs of sexual abuse or other forms of abuse immediately after a moderately cognitively impaired resident (Resident #39) was found in his wheelchair at her bedside with his hand under her covers on 5/2/2024. Resident #7 was not assessed by the Medical Director until 5/6/2024. Medical Director ordered Zoloft 25 milligrams by mouth daily for aggression on 5/6/2024. Resident # 39 was not put on 1 on 1 monitoring until 12:15 pm. The resident stayed on 1 on 1 until 3 pm and then was on every 15-minute checks. Resident #39 was placed on one-to-one supervision on 5/15/2024 at around 5:30 pm. The facility failed to assess if other residents had been abused until 5/15/2024. The facility failed to report the abuse allegation to APS until 5/16/2024.

Abuse questionnaires were completed by the Business Office Manager, MDS Nurse, Admissions Director and Unit Manager on all residents with Brief Interview for Mental Status (BIMS) score of 9 and above with no adverse responses. Questionnaires were completed on 5/15/2024. The questions asked were as follows, 1. Do you feel safe? 2. Has anyone ever touched you inappropriately? 3. Are you afraid of anyone in the facility? The Unit Manager and/or Floor Nurse completed skin assessment for all residents with a BIMS score below 9 as of

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F 607	Continued From page 35 5/15/2024 with no negative outcomes. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. As of 5/15/2024 the Regional Director of Operations and Regional Clinical Nurse educated the Director of Nursing, Administrator, Medical and Staff Development Coordinator on abuse policy to include residents right to be free from abuse to include sexual, physical, mental, verbal and misappropriation of property as well as signs of abuse and reporting of abuse or potential abuse. Education also included the process and action to protect residents if any type of abuse including sexual abuse occurs according to facility policy and procedure on abuse. Actions to include assessment of all residents involved, immediate protection for all residents, immediate reporting to Management, state agencies, Ombudsman, APS, families, physician, immediate protection for all residents, and law enforcement. On 5/16/2024 Staff Development Coordinator and/or Director of Nursing educated all nursing staff on proper procedures for reporting any suspected abuse and immediate reporting to the Administrator and Director of Nursing for direction. Education will include direction for resident assessment immediately following incident, physician notification by Nurse for direction of care for resident and need to send out to hospital for further examination. On 5/2/2024 at 9:40am Social Worker talked with Resident #39 about the incident that occurred and explained to resident #39 what he had done wrong. On 5/7/2024 the physician changed	F 607		

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resident #39's medication to add Zoloft 25mg tablet daily by mouth for aggression. As of 5/15/2024, around 5:30pm resident #39 has been placed on 1 on 1 observation.

On 5/15/2024 the facility completed AdHoc QAPI to review investigation and current action plan to ensure all components were done and followed. The facility administrator and Director of Nursing are responsible for continued compliance.

Alleged date of IJ removal: 5/17/2024

The Credible Allegation of IJ Removal was validated on 5/17/2024. The facility provided documentation of the in-service education that was provided to all staff which included the review of the facility's Abuse Policy and included immediate reporting of any allegations of abuse to the Administrator immediately; provide a physical examination by a trained/licensed professional for any signs of sexual abuse; provide protection for the resident that is the victim of abuse; provide protection for all other residents when an allegation of abuse is reported; and report any allegations of abuse to the proper authorities. The Staff Development Coordinator was interviewed and stated they have ensure all staff are educated regarding the reporting of abuse allegations to the administrator immediately; provide a physical examination by the physician or if the physician is not available send the resident to the emergency department for evaluation if there is an allegation of sexual abuse; provide protection for the abused individual and all other residents; and reporting of allegations of abuse to the proper authorities. She stated all staff that have been allowed to work have had the abuse education. During the

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F 607	Continued From page 37 validation of the Credible Allegation of IJ Removal observations of Resident #39 were made and the facility was providing one-to-one observation of the resident. The facility staff (sampled from all disciplines) were able to verbalize the types of abuse; what steps they should take to assess and protect the resident of an alleged abuse; and what authorities should be notified of allegations of abuse. The facility provided skin assessments that were completed on residents with a Brief Interview for Mental Status (BIMS) of less than 9 and interview forms that were completed on all residents with a BIMS of 9 or above that were conducted on 5/15/2024. The facility also notified Adult Protective Services of the allegation of sexual abuse for Resident #7 on 5/16/2024. The facility provided minutes of their Quality Assurance Performance Improvement (QAPI) meeting which was conducted on 5/15/2024. The alledged IJ removal date of 5/17 24 was validated.	F 607		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F 623		6/5/24

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(iii) Include in the notice the items described in paragraph (c)(5) of this section.

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in

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completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §

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F 623	Continued From page 40 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the resident and/or Resident Representative (RR) written notification of the reason for a hospital transfer for 2 of 2 residents reviewed for hospitalization (Residents #78 and #86) and the facility failed to send a copy of a 30-day discharge notice to the Ombudsman for 1 of 1 resident (Resident #64) reviewed for facility-initiated discharge. The findings included: 1. Resident #78 was originally admitted to the facility on 1/5/24. Resident #78's medical record revealed she was transferred to the hospital on 1/5/24 and readmitted back to the facility on 1/12/24. Additionally, Resident #78 was transferred to the hospital on 1/29/24 and readmitted back to the facility on 2/16/24. There was no documentation of a written notice of transfer provided to the resident and/or RR. On 4/30/24 at 11:15 AM, an interview occurred with the wound nurse, who had transferred Resident #78 to the hospital on 1/29/24. She stated that when a resident was transferred to the hospital, a medication list, resident summary, and bed hold policy was sent with them. The RR was notified via phone. During an interview with the Social Worker on 4/30/24 at 3:32 PM, she stated she didn't provide any written information to the resident and/or RR when a resident was transferred to the hospital.	F 623	F623 Notice Requirements Before Transfer/Discharge How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 5 received discharge/transfer notices on 5/29/24 in person by the Unit Manager related to the transfer/discharge on 1/5/24 and 1/29/24. Resident #5's Responsible Party was mailed the discharge/transfer notice on 5/30/24 by the Business Office Manager. Resident #86 discharged home 2/10/24 with a significant other. On 5/16/2024, the facility Social Worker provided the facility Ombudsman a copy of resident #64's 30-day notice. How the facility will identify other residents potentially affected by the same deficient practice On 5/21/24, the Admission Coordinator and Director of Nursing reviewed all residents who had facility initiated discharged/transfers, including hospital in the past 30 days. Any identified residents not having the appropriate discharge/transfer notice and their Responsible Party were provided a copy of the facility's "Notice of Bed-Hold Policy and Transfer" along with the appeal process information by the Regional Nurse Consultant and Business Office Manager on 5/22/24.	

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F 623	Continued From page 41 The Director of Nursing was interviewed on 4/30/24 at 3:34 PM and explained when a resident was transferred to the hospital the nursing staff called the RR but didn't mail anything to them in writing. On 5/1/24 at 8:40 AM, an interview was conducted with the Administrator who was familiar with the regulation. He stated he was unaware written notification to the resident and/or RR for the reason for a hospital transfer was not being sent and would expect the regulation to be followed. 2. Resident #86 was admitted to the facility on 12/09/23. Resident #86's admission Minimum Data Set (MDS) dated 12/15/23 indicated his cognition was intact. Review of Resident #86's electronic medical record read he was transferred to the hospital on 01/02/24. There was no documentation in the resident's medical record that written notice of transfer or discharge was provided to the resident and/or Resident Representative (RR). Resident #86 returned to the facility on 01/10/24. An interview was conducted on 4/30/24 at 3:32 PM with the facility Social Worker (SW). She stated she had been at the facility since Aug 2022 and was not mailing a notice of discharge or transfer to the RR when the resident was admitted to the hospital. She was unaware she needed to send notification to the resident or RR in writing.	F 623	What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On May 21, 2024, the Regional Nurse Consultant educated the administrative nurses, Social Worker, Business Office Manage and Admission Director on the discharge/transfer process. Director of Nursing and Staff Development Coordinator provided education for all licensed nurses including agency, on May 21, related to sending the “Notice of Bed-Hold Policy and Transfer” with the resident upon transfer to the hospital. When a resident is transferred to the hospital the assigned charge nurse will give the resident a copy of the “Notice of Bed-Hold Policy and Transfer” notice. A copy of the “Notice of Bed-Hold Policy and Transfer” will be given to the Social Worker for a copy to be mailed to the resident’s Responsible Party then uploaded to the resident’s electronic medical record. A copy of the Discharge Notice, Appeal Form, Bed Hold Policy, Bed Hold Notice and envelope with the post mark will be kept in a binder in the Social Worker’s office. This education will be incorporated into the new hire orientation process for licensed nurses, including new agency licensed nurses, Admission Coordinator, Business Office Manager and Social Worker. Licensed nurses, including Licensed agency nurses will not be permitted to work after 5/22/2024 if they have not been educated. The Staff	

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F 623	Continued From page 42 An interview was conducted on 4/30/24 at 3:34 PM with the Director of Nursing (DON). She stated when a resident was transferred to the hospital the nursing staff called the RR but did not provide written notice of transfer or discharge. An interview was conducted on 5/1/24 at 8:40 AM with the Administrator who was familiar with the regulation. He stated he was unaware of written notification to the resident and/or RR for the reason for a hospital transfer was not being sent and would expect the regulation to be followed. 3. Resident #64 was admitted to the facility on 8/29/2023 and continued to reside in the facility. A quarterly Minimum Data Set assessment dated 3/7/2024 indicated Resident #64 was cognitively intact. Review of Resident #64's record revealed a 30-day notice of discharge was provided to the resident on 5/7/2024. Further review revealed no evidence a copy of the notice was provided to the Ombudsman. During an observation and interview with Resident #64 on 5/15/2024 at 10:32 am he stated he was told he would be discharged soon but was not able to state why he was being discharged. He stated the facility gave him a notice of discharge and told him he had to leave. Resident #64 stated he was ready to get out of the facility. During an interview by phone with the Ombudsman on 5/15/2024 at 11:59 am she stated the facility should report a 30-day discharge notice to her within 48 hours of issuing the notice to the resident. The Ombudsman	F 623	Development Coordinator will be responsible for ensuring that this education is completed before employees' work. How the facility will monitor its performance to ensure the deficient practice does not recur: The Administrator will audit facility-initiated discharges 5 times a week for 12 weeks to ensure that the proper discharge/transfer notification process notification has been sent to the resident and responsibly party. The Administrator or designee will be responsible for reporting results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee. Compliance Date: 6/5/24	

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F 623	Continued From page 43 stated she had not received the notification Resident #64 received a 30-day discharge notice. On 5/14/2024 a phone interview was conducted with the Social Worker, and she stated she issued the 30-day discharge notice on 5/7/2024 to Resident #64 but she did not notify the Ombudsman because she had waited for the Business Office Manager to give her the documentation of the facility's attempts to collect the debts Resident #64 owed to the facility. The Business Office Manager was interviewed on 5/15/2024 at 12:55 pm and she stated she supplied the documentation of the attempts to collect the debts of a resident who was issued a 30-day discharge notice for non-payment. She stated Resident #64 wanted to return home and he was able to care for himself. She stated the Social Worker did not need the documentation of the attempts to collect the debts to notify the Ombudsman of the 30-day discharge notice the Social Worker gave Resident #64 on 5/7/2024. On 5/17/2024 at 4:42 pm the Administrator was interviewed and stated the Social Worker should have notified the Ombudsman when Resident #64 was issued the 30-day discharge notice for non-payment.	F 623		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F 640		6/5/24

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(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or,

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F 640	Continued From page 45 for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a Minimum Data Set (MDS) discharge assessment within the required time frame for 1 of 6 residents reviewed for discharge (Resident #58). Findings include: Resident #58 had been admitted on 11/1/23. An admission MDS assessment had been completed on 11/8/23. Nursing documentation dated 11/18/23 at 1:05 PM noted Resident #58 had been discharged home. No discharge MDS assessment was observed in Resident #58's record. An interview with the MDS Coordinator was conducted on 4/30/24 at 3:38 PM. She explained when she became aware of a resident's pending discharge, she opened the MDS assessment at that time. She stated yesterday she noticed Resident #58's MDS discharge assessment had not been transmitted and explained she was unsure how it had been missed. On 5/01/24 at 2:59 PM an interview with the corporate Nurse Consultant was conducted. She stated she would expect MDS assessments to be transmitted within the required timeframe.	F 640	F640 Encoding/Transmitting Resident Assessments: How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 4/29/24, while conducting a random audit of the MDS calendar and assessments, the MDS Coordinator discovered Resident #58" s discharge assessment had not been completed and transmitted. Resident #58's discharge assessment was completed on 4/29/24 and transmitted on 4/30/24. How the facility will identify other residents potentially affected by the same deficient practice The Regional MDS Coordinator completed an audit of all residents discharged in the past 60 days on 4/30/2024 to review for discharge tracking appropriately opened, completed, and transmitted and found no other tracking that were missed. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Regional MDS Nurse educated the facility MDS Nurse on proper opening, coding, and transmission of tracking documents per RAI manual guidelines on	

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F 640	Continued From page 46	F 640	5/29/2024. How the facility will monitor its performance to ensure the deficient practice does not recur: The Regional MDS Nurse or designee will review 5 random resident assessments weekly for 12 weeks, for appropriate opening, completion, and transmission of discharge trackers. The MDS Coordinator or designee will be responsible for reporting results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee. Compliance Date: 6/5/2024	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the area of medication for 1 of 26 residents whose MDS assessments were reviewed (Resident #24). Findings include: Resident #24 had been readmitted on 9/28/22 with diagnoses including Stroke and coronary artery disease.	F 641	F641 Accuracy of Assessments How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. MDS nurse completed a review of resident #24's assessment and modified section N for anticoagulants on 2/13/24. This was completed 4/30/24 and transmitted successfully 5/7/24. How the facility will identify other residents	6/5/24

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UNIVERSAL HEALTHCARE/RAMSEUR	7166 JORDON ROAD RAMSEUR, NC 27316

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F 641	Continued From page 47 Review of Resident #24's Significant Change in Status MDS assessment dated 2/13/24 noted he had received anticoagulant (blood thinner) and antiplatelet (blood clot inhibitor) medication. Review of Resident #24's February 2024 Medication Administration Record (MAR) did not reveal he had received anticoagulant medication but had received antiplatelet medication. On 4/30/24 at 3:38 PM an interview with the MDS Coordinator was conducted. She explained when she completed MDS assessments she also checked the MAR. She stated anticoagulant should not been coded, only antiplatelet medication. On 5/01/24 at 2:59 PM an interview with the Corporate Nurse Consultant was conducted. She stated she would expect MDS assessments to be accurate.	F 641	potentially affected by the same deficient practice Regional MDS nurse completed an audit of all residents that had anticoagulants coded in the last 60 days on 4/30/2024 to review for accuracy of resident receiving anticoagulants. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Regional MDS Nurse educated facility MDS Nurse on coding of anticoagulants in section N of the MDS per RAI manual guidelines on 5/29/2024. How the facility will monitor its performance to ensure the deficient practice does not recur: Regional MDS Nurse or designee will review 5 random resident assessments, weekly for 12 weeks, for appropriate coding of anticoagulants in section N of the MDS. The MDS Coordinator or designee will be responsible for reporting results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI commit. Compliance Date: 6/5/24	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		6/5/24

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F 656	Continued From page 48	F 656		

objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.

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F 656	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to develop an individualized and comprehensive care plan for a resident with urinary incontinence, a resident at risk for aspiration and failed to care plan antibiotic use. This was for 4 of 25 residents whose care plans were reviewed (Resident #2, #85, #66, and #78). The findings included: 1. Resident #2 was admitted to the facility on 10/10/23 with diagnosis that included displaced subtrochanteric fracture of right femur, and diabetes mellitus with diabetic polyneuropathy. The quarterly Minimum Data Set (MDS) assessment dated 02/02/24 indicated Resident #2's cognition was intact. She had no behavior and no rejection of care. She was dependent on staff for toileting hygiene, shower/bath, and she required maximum assistance with personal hygiene. She was occasionally incontinent of bladder and always incontinent of bowel. Review of Resident #2's active care plan, dated 10/11/23, revealed no care plan related to incontinence care. An interview was conducted on 4/30/24 at 3:34 PM with the Director of Nursing (DON). She stated a focus or intervention area for incontinence care should have been part of Resident #2's care plan. An interview was conducted on 05/01/24 at 1:04 PM with the Minimum Data Set (MDS) Nurse.	F 656	F656 Development/Implement Comprehensive Care Plan How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #2 and #78□s care plans were reviewed and updated by the MDS Coordinator on 5/3/24. Residents #85 and #66 were discharged from the facility on 5/3/24. How the facility will identify other residents potentially affected by the same deficient practice: Regional MDS nurse completed 100% audits for residents with occasional incontinence coded on the MDS for care plan to reflect coding, anyone with a diagnosis of dysphagia for care plan for risk for aspiration, anyone with IV antibiotic currently for an appropriate care plan, and anyone with long term antibiotic for an indefinite antibiotic care plan. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: Regional MDS nurse re-educated the facility MDS Nurse on proper care plan process per the RAI manual to include a comprehensive Care Plan for residents who trigger for urinary incontinence, risk of aspiration, and any resident receiving antibiotics as	

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F 656	Continued From page 50 She verified there were no areas on Resident #2's care plan for assistance needed with incontinence care and there should have been an intervention added to the activities of daily living (ADL) focus. She stated it was an oversight that this intervention was not added on Resident #2's care plan. An interview was conducted on 05/01/24 at 3:21 PM with Resident #2. She stated she did have incontinent episodes of urine and she was always incontinent of bowel. She further stated she required staff to assist her with continence are. 2. Resident #85 was admitted to the facility on 12/29/22 with diagnosis that included dysphagia, oropharyngeal phase. Resident #85 expired on 02/02/24. The annual Minimum Data Set (MDS) assessment dated 11/18/23 indicated Resident #85's cognition was severely impaired. His swallowing and nutrition section was coded for swallowing disorder. Review of Resident #85's active care plan, dated 01/05/23, revealed no care plan related to dysphagia or aspiration precautions. An interview was conducted on 4/30/24 at 3:34 PM with the Director of Nursing (DON). She stated Resident #85's care plan should be person centered and should have included a focus or intervention for aspiration precautions due to his diagnosis for dysphagia. An interview was conducted on 05/01/24 at 1:04 PM with the Minimum Data Set (MDS) Nurse. She verified there were no areas on Resident	F 656	of 5/30/24. MDS nurses and Unit Managers will review nursing notes and orders daily during clinical meetings Monday through Friday for any new orders or diagnosis of urinary incontinence, aspiration, and antibiotic use to ensure care plan is developed as needed. How the facility will monitor its performance to ensure the deficient practice does not recur: Regional MDS Nurse or designee will review 5 random resident care plans, weekly for 12 weeks for appropriate care planning of incontinence, dysphagia/risk for aspiration, IV antibiotics, and long term/indefinite antibiotics The MDS Coordinator or designee will be responsible for reporting results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee. Compliance Date: 6/5/24	

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F 656	Continued From page 51	F 656		

#85's care plan to include aspiration precautions. She stated it was an oversight that this was not added on Resident #85's care plan.

3. Resident #66 was admitted to the facility on 04/09/24 with diagnosis that included infection and inflammatory reaction due to internal right knee prosthesis requiring intravenous (IV) antibiotics.

Review of Resident #66's active care plan, dated 04/09/24, revealed no care plan related to intravenous (IV) antibiotics.

An interview was conducted on 4/30/24 at 3:34 PM with the Director of Nursing (DON). She stated Resident #66's care plan should be person centered and should have included an area for intravenous (IV) antibiotics.

An interview was conducted on 05/01/24 at 1:04 PM with the Minimum Data Set (MDS) Nurse. She verified there were no areas on Resident #66's care plan to include intravenous (IV) antibiotics. She stated it was an oversight that this was not added on Resident #66's care plan.

4. Resident #78 was admitted to the facility on 1/5/24 with diagnoses that included neoplasm of the brain and dysphagia (difficulty swallowing).

A review of Resident #78's medical record revealed an order dated 3/14/24 for Ciprofloxacin (an antibiotic) 750 milligrams (mg) 1 tablet twice a day for polymicrobial bacterial infection (acute and chronic diseases caused by various combinations of viruses, bacteria, and fungi).

An Infectious Disease progress note dated 4/5/24 read that Resident #78 was on Ciprofloxacin for a

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F 656	Continued From page 52 polymicrobial bacterial infection for at least a year. Review of the active care plan, dated 4/11/24, revealed Resident #78 was not care planned for the use of an indefinite antibiotic. A significant change in status Minimum Data Set (MDS) assessment dated 4/17/24 indicated Resident #78 had severe cognitive impairment and was coded for the use of an antibiotic. On 5/1/24 at 12:00 PM, an interview occurred with the MDS Coordinator who reviewed Resident #78's active care plan, verified a care plan was not present for the indefinity use of an antibiotic and felt it was an oversight. The Director of Nursing was interviewed on 5/1/24 at 2:22 PM and stated it was her expectation for the care plan to be person centered and should have included the use of the indefinite antibiotic.	F 656		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		6/5/24

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F 657	Continued From page 53 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise the care plans in the areas of antibiotic use and JP drain (A Jackson-Pratt (JP) drain is a surgical suction drain that gently draws fluid from a wound to help recover after surgery) for Resident #81. This was for 1 of 3 residents reviewed for care plans. The findings included: Resident #81 was admitted to the facility on 03/07/24 with diagnosis that included urinary tract infection (UTI), abscess to left kidney requiring a JP drain, and right foot diabetic ulcer. Record review revealed the JP drain and the peripherally inserted central catheter (PICC) line were removed on 03/25/24. Resident #81's active care plan, dated 04/04/24, revealed a focus that read resident had a peripherally inserted central catheter (PICC) line	F 657	F657 Care Plan Timing and Revision How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The MDS coordinator reviewed resident #81's care plan and revised it to reflect the current status of discontinued PICC line, JP drain, and IV antibiotics. This was completed on 5/9/2024. How the facility will identify other residents potentially affected by the same deficient practice Director of Nursing and Administrative Nurses completed an audit of current residents to ensure any with a PICC line, JP, or IV antibiotics removed accurately reflected status in care plan.	

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F 657	Continued From page 54 and a JP drain, requiring intravenous (IV) antibiotics and IV antibiotics for renal abscess. Date initiated: 04/04/24. An interview was conducted on 05/01/24 at 1:04 PM with the Minimum Data Set (MDS) Nurse. She verified the areas on Resident #81's care plan for peripherally inserted central catheter (PICC) line, JP drain, and IV antibiotics for renal abscess should have been removed. She stated it was an oversight that these areas on Resident #81's care plan had not been updated and removed. An interview was conducted on 4/30/24 at 3:34 PM with the Director of Nursing (DON). She stated the focus areas for peripherally inserted central catheter (PICC) line, JP drain, and IV antibiotics for renal abscess should have been removed on Resident #81's care plan.	F 657	What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Regional MDS nurse re-educated the facility MDS Nurse on proper care plan process per the RAI manual to include a timely revision of the care plan as changes occur. MDS nurses will review nursing notes and orders daily during clinical meetings Monday through Friday for any new orders or diagnosis of urinary incontinence, aspiration, and antibiotic use to ensure care plan is developed as needed. Completed on 5/30/24. How the facility will monitor its performance to ensure the deficient practice does not recur: Regional MDS Nurse or designee will review 5 random resident care plans, weekly for 12 weeks for appropriate care plan revision of resident s with JP drains, PICC lines, and IV antibiotics that have been discontinued. The MDS Coordinator or designee will be responsible for reporting results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee. Compliance Date: 6/5/2024	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		6/5/24

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F 689	Continued From page 55 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §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, observations, and staff interviews, the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions (Resident #31). This was for 1 of 4 residents reviewed for accidents. The findings included: Resident #31 was admitted to the facility on 1/22/19 with diagnoses that included dementia and lack of coordination. A review of Resident #31's medical record revealed on 1/27/23 she was found lying beside her bed and stated she fell off the bed while sleeping. It was noted that her room was rearranged and fall mat placed to the left side of the bed for safety. No further falls were indicated in Resident #31's medical record. An annual Minimum Data Set (MDS) assessment dated 1/23/24 indicated Resident #31 had severe cognitive impairment and received supervision for bed mobility and moderate assistance with transfers. She was coded with no falls since the last assessment. Resident #31's active care plan, last reviewed 4/22/24, included a focus area for risk for falls due to impaired balance, history of falls, diagnosis of dementia with poor safety	F 689	F689 Free of Accident Hazards/Supervision/Devices How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #31's fall mats were placed beside her bed on 5/1/2024 by the Unit Manager. How the facility will identify other residents potentially affected by the same deficient practice On May 22, 2024, the Director of Nursing and Reginal Nurse Consultant reviewed residents with falls for the past 30 day to ensure the appropriate fall interventions were implemented. Those residents identified without the appropriate fall intervention in place, had it immediately implemented by the Unit Manager. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. On May 22, 2024, initial education began with the licensed clinical staff and certified nursing assistants (including agency	

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F 689	Continued From page 56 awareness and psychotropic medication use. An intervention, dated 1/27/23, included fall mat. On 4/30/24 at 11:35 AM, Resident #31 was observed lying in bed with her eyes closed. The bed was in the lowest position, however there was no fall mat beside the bed, in the room or bathroom. On 5/1/24 at 8:18 AM, Resident #31 was observed lying in bed with her eyes closed. The bed was in the lowest position but there was no fall mat beside the bed, in the room or bathroom. An interview occurred with Nurse #4 on 5/1/24 at 9:00 AM. She indicated she had worked at the facility for a few months and had not seen a fall mat being used for Resident #31. On 5/1/24 at 12:11 PM an interview occurred with Nurse Aide (NA) #6 and NA #7, who were familiar with Resident #31. They could not recall seeing fall mats in her room and were unaware one should be present. They stated they would have been informed during rounds and the nursing staff if a fall mat was to be utilized. An interview was completed with the Unit Supervisor #2 on 5/1/24 at 2:18 PM who recalled a fall mat present to the side of the bed for Resident #31 in the past but was unsure what happened to it. On 5/1/24 at 2:22 PM, the Director of Nursing (DON) was interviewed and recalled Resident #31 had a fall mat present in her room when an audit had been completed during March 2024. She was unaware the fall mat was not being used for Resident #31 nor why they were not present in	F 689	clinical personnel) on ensuring the fall interventions are in place daily by the Staff Development Coordinator, Director of Nursing and/or Unit Managers. This education included notification of the intervention via communication through the care guide and Fall Intervention Communication Form. Education was completed on May 21, 2024, with the Administrative Clinical Nurses (Unit Manager, Director of Nursing, Staff Development Coordinator and Wound Nurse) on maintaining a falls log during the morning clinical meeting for monitoring of observation rounds and ensuring all interventions are carried over to the resident care guide for CNA access by the Regional Nurse Consultant. This education will be incorporated into the new hire orientation process for licensed nurses, CNA's and agency clinical personnel. Licensed nurses, CNA's and agency clinical personnel will not be permitted to work after 5/22/2024 if they have not been educated. How the facility will monitor its performance to ensure the deficient practice does not recur: Administrative nurses and IDT team will conduct observation rounds 3 times a week for 12 weeks to ensure the fall interventions are in place as care planned. The Director of Nursing or designee will be responsible for reporting results of all	

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F 689	Continued From page 57 her room. The DON stated it was her expectation for fall interventions to be implemented by the staff.	F 689	audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee. Compliance Date: 6/5/2024	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		6/5/24

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F 842	Continued From page 58 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to clarify a consultation note and discontinue an order for PICC (peripherally inserted central catheter) line	F 842	F842 Resident Records – Identifiable Information How the corrective action will be accomplished for those residents found to	

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F 842	Continued From page 59 care (Resident #78). This was for 1 of 3 residents reviewed for antibiotic use. The findings included: Resident #78 was originally admitted to the facility on 1/5/24. She was recently readmitted from the hospital on 2/16/24 with a diagnosis of polymicrobial bacterial infection (acute and chronic diseases caused by various combinations of viruses, bacteria, and fungi) with a PICC line present. A review of Resident #78's active physician orders included an order dated 2/17/24 for PICC line dressing change every seven days. Review of an Infectious Disease progress note dated 4/5/24, indicated the PICC line would be removed on 4/5/24. Resident #78's April 2024 Medication Administration Record (MAR) was reviewed and indicated the order to change the PICC line dressing every seven days was still active from 4/5/24 to 4/30/24. On 5/1/24 at 12:11 PM, an observation of personal care was made with Nurse Aides (NAs) #6 and #7 of Resident #78. There was no PICC line observed to either arm. Unit Supervisor #2 was interviewed on 5/1/24 at 2:18 PM. She indicated when a resident returned from an appointment the paperwork was reviewed by herself. She reviewed the Infectious Disease progress note dated 4/5/24 and stated she was unsure why the order to change the PICC line dressing every seven days had not	F 842	have been affected by the deficient practice. Resident #78's PICC line orders were discontinued on 5/1/2024 by the Unit Manager. Unit Manager #2 was educated by the Regional Nurse Consultant on reviewing and following up on physician consultations on 5/29/24. How the facility will identify other residents potentially affected by the same deficient practice The Director of Nursing and Unit Managers completed a review of current resident's medical consultations for the past 30 days, to ensure physician recommendations were reviewed for physician order changes on 5/31/2024. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Transportation Driver and Unit Managers were educated by the Director of Nursing on the following process: The Transportation Driver will be responsible for providing the Unit Managers or Director of Nursing the residents discharge summary/summary of visit once they have returned from a medical appointment or consultation. The Unit Managers or Director of Nursing will review the documents and follow up with any recommendations. This education will be incorporated into the new hire orientation process for Transportation Drivers, Unit	

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F 842	Continued From page 60 been discontinued and removed from the MAR as the PICC line had been removed on 4/5/24 at the appointment. Unit Supervisor #2 felt it was an oversight. On 5/1/24 at 2:22 PM, the Director of Nursing stated she would have expected a clarification order to be obtained to discontinue the PICC line dressing change every seven days when it was removed on 4/5/24.	F 842	Managers and Director of Nursing. Individuals in these positions will not be permitted to work after 5/22/2024 if they have not been educated. How the facility will monitor its performance to ensure the deficient practice does not recur: The Director of Nursing or designee will review consultations 5 times a week for 12 weeks, during Clinical Morning Meeting to ensure physician recommendations have been addressed. The Director of Nursing or designee will be responsible for reporting results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee. Compliance Date: 6/5/24	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective	F 867		6/5/24

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systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, 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

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

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement 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

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F 867	Continued From page 63 annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following an annual recertification and complaint survey on 06/11/21. This was for two deficiencies that were cited in the areas of Accuracy of Assessments and Free of Accident Hazards/Supervision/Devices. During a complaint survey on 05/16/23, one deficiency was cited in the area of Free of Accident Hazards/Supervision/Devices. In addition, four deficiencies were cited during the annual recertification and complaint survey on 02/23/23 in the areas of Encoding/Transmitting Resident	F 867	F867 QAPI/QAA Improvement Activities How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility Administrator and Quality Assurance Performance Improvement (QAPI) team during the monthly QAPI meeting on 6/3/2024 reviewed citation F640, F641, F657 and F689. The team also worked through the 5 whys and determined the root cause analysis during this meeting. The Administrator was reeducated by the	

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F 867	Continued From page 64 Assessments, Accuracy of Assessments, Care Plan Timing and Revision, and Free of Accident Hazards/Supervision/Devices. The deficient practice in the areas of Encoding/Transmitting Resident Assessments, Accuracy of Assessments, Care Plan Timing and Revision, and Free of Accident Hazards/Supervision/Devices were recited on the current recertification and complaint survey of 05/06/24. The duplicate citations during three federal surveys of record and one complaint survey show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: F640- Based on record review and staff interviews, the facility failed to complete a Minimum Data Set (MDS) discharge assessment within the required time frame for 1 of 6 residents reviewed for discharge (Resident #58). During the facility's recertification survey of 02/23/23 the facility failed to complete and transmit a discharge Minimum Data Set (MDS) assessment and failed to transmit a discharge MDS assessment. This was for 2 of 2 residents selected to be reviewed for submission of Resident Assessments within the required timeframe. In an interview with the Administrator on 05/02/24 at 1:07 PM, he felt the repeat citations were due to Minimum Data Set (MDS) Nurse turnover. F641- Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) in the area of	F 867	Regional Corporate Nurse regarding the purpose of the Quality Assurance and performance Improvement (QAPI) Program. The education included the objectives of the QAPI program including to identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan as needed, the purpose of the QAPI program to provide a means for resident care and safety issues to be resolved, and how the committee monitors issues and follows up with unresolved issues that have been identified. This was completed on 5/30/2024. How the facility will identify other residents potentially affected by the same deficient practice The administrator completed a review of annual and complaint surveys for the prior 3 years to identify areas of repeat deficient practice as of 6/3/24. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur. Regional Clinical Nurse and/or the Regional Director of Operations completed retraining with the Facility Administrator on 5/30/24, on the identification, completion, and monitoring of the QAPI Action Plan. This included understanding the importance of having a robust QAPI program for identification of areas of opportunity for improvement. All department managers, including Social	

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F 867	Continued From page 65 medication for 1 of 26 residents whose MDS assessments were reviewed (Resident #24). During the facility's recertification survey of 06/11/21 the facility failed to code the Minimum Data Set (MDS) accurately in the areas of prognosis, range of motion, and Preadmission Screening Resident Review (PASRR) level 2. This was for 3 of the 19 MDS's reviewed for accuracy. During the facility's recertification survey of 02/23/23 the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of medications for 2 of 21 residents whose MDS were reviewed. In an interview with the Administrator on 05/02/24 at 1:07 PM, he felt the repeat citations were due to Minimum Data Set (MDS) Nurse turnover. F657- Based on record review and staff interviews, the facility failed to review and revise the care plans in the areas of antibiotic use and JP drain (A Jackson-Pratt (JP) drain is a surgical suction drain that gently draws fluid from a wound to help recover after surgery) for Resident #81. This was for 1 of 3 residents reviewed for care plans. During the facility's recertification survey of 02/23/23 the facility failed to review and revise the care plan in the areas of falls, pressure ulcers, and medications. This was for 6 of 18 resident records reviewed. In an interview with the Administrator on 05/02/24 at 1:07 PM, he felt the repeat citations were due to Minimum Data Set (MDS) Nurse turnover.	F 867	Work, Director of Nursing, Business Office Manager, Activities Director, Housekeeping Manager, Maintenance Director, Admissions Director, Medical records coordinator, Rehab Director, MDS nurses, Human Resources, and Central Supply received education on 5/30/24 by the regional clinical nurse on F867 and the facility QAPI program. Any new facility department manager will receive this training during their orientation by the facility Administrator and/or Director of Nursing. Regional Director of Operations and/or Corporate Clinical Nurse will review QAPI minutes monthly to ensure improvement and monitoring of areas of deficient practice. How the facility will monitor its performance to ensure the deficient practice does not recur: The Regional Clinical Nurse and/or Regional Director of Operation will review the facility QAPI minutes and reports monthly for 3 months. The Administrator or designee will be responsible for reporting results of all audits to the QAPI (Quality Assurance Performance Improvement) committee for review and revision monthly x 3 months or longer if deemed so by QAPI committee. Compliance Date: 6/5/2024	

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F 867	Continued From page 66 F689- Based on record review, observations, and staff interviews, the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions (Resident #31). This was for 1 of 4 residents reviewed for accidents. During the facility's recertification survey of 06/11/21 the facility failed to provide supervision to 2 residents with known behavioral symptoms to prevent the physical assault, unwanted physical contact, and/or unwanted advancements into the personal space of cognitively impaired residents. This was for 2 of 3 residents reviewed for resident to resident altercations. During the facility's recertification survey of 02/23/23 the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions. This was for 1 of 8 residents reviewed for accidents. During a complaint investigation survey on 05/16/23 the facility failed to provide a safe transfer for a resident who was at high risk for fractures, was non-ambulatory and required extensive assistance with a mechanical lift for transfers. This deficient practice was for 1 of 3 sampled residents reviewed for accidents. In an interview with the Administrator on 05/02/24 at 1:07 PM, he felt the repeat citations were due to the facility's leadership turnover.	F 867		