STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING ______ B. WING ______	C 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 05/30/24 and exited on 05/31/24. Additional information was obtained through 06/14/24; therefore, the exit dated was changed to 06/14/24. Event ID#6LNF11. The following intakes were investigated: NC00217383 and NC00216884. Two (2) of the 6 allegations resulted in deficiencies.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after	F 622		7/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/03/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 622	Continued From page 1	F 622		

admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and

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F 622	Continued From page 2 (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to allow a resident with behaviors to remain in the facility and to provide written documentation which stated the reason the facility could not meet the residents needs for 1 of 3 resident (Resident #6) reviewed for transfer and discharge. The findings included: Resident #6 was admitted to the facility for respite services through Hospice on 5/09/24 and discharged on 5/09/24. Diagnosis included malnutrition, chronic pain, depression, and anxiety. Review of nursing note dated 5/09/24 written by the Director of Nursing (DON) at 4:06 PM revealed telephone call placed to Hospice Nurse,	F 622	1. Resident #6 was transferred to the Emergency Department on 05/09/2024 due to behaviors. Since that date Resident #6 has expired. 2. An audit was completed on 07/02/2024, by the Director of Nursing on transfers/discharges for the past 30 days to ensure that documentation is appropriate to support the transfer/discharge. No issues were found relating to inappropriate transfers/discharges. 3. Current Nurses were provided education by the Director of Nursing and Assistant Director of Nursing pertaining to needed documentation to support a transfer/discharge to the hospital on	

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updated that Resident #6 is agitated and wanting to smoke. She stated Resident #6 was agitated at home; wife needs a break. She verbalized that he received Haldol (treat behavioral issues) 1 MG and Ativan (treat anxiety) 1 MG prior to leaving on transport to facility. Hospice Nurse speaks with Hospice provider, orders received for Xanax 1 MG by mouth now and to repeat in 1 hour: Rocephin (treat possible urinary tract infection) IM (intramuscularly) 1 gram (GM) now.

Review of nursing note dated 5/09/24 written by the DON at 6:25 PM revealed Resident #6 had been up and down, propelling wheelchair throughout facility. Offered snack, which was accepted. An on-call Hospice Nurse was in the facility, asked if willing to continue with 5-day respite, stated the facility was not able to meet his needs and cannot do respite. She was arranging transport to hospital.

A telephone interview with the Hospice nurse on 5/30/24 at 4:11 PM revealed she was familiar with Resident #6 and had been providing for his care at his home through Hospice. She stated during her home visits with Resident #6, he was alert and oriented but would show signs of agitation off and on and attempt to get up out of his wheelchair unassisted to walk around the house to go to the bathroom, or to go outside and smoke but was easily re-directed. She revealed on 5/09/24 around lunchtime she and the Hospice Social Worker (SW) were at Resident #6 home and observed him showing signs of agitation and trying to get up out of his wheelchair to walk around and go outside to smoke and although he was easily re-directed his spouse informed them that she was exhausted and needed a break. The Hospice Nurse stated the Hospice SW began

F 622

05/31/2024.

4. The Director of Nursing and/or designee will be responsible for completing quality improvement monitoring tool to ensure that transfers/discharges are appropriate and have supporting documentation 3x/week for 8 weeks then 1x/week for 4 weeks, then monthly for 3 months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring.

Date of compliance 07/09/2024

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F 622	Continued From page 4 trying to find respite services for Resident #6 so his spouse could have a break and she administered him medication to calm his agitation. She revealed the Hospice SW spoke with the facility and informed them of why Resident #6 needed respite services and sent Hospice notes from the previous day which documented his agitation and behaviors and the facility agreed to take him. She stated she was present at Resident #6 home when he left for the facility around 2 PM and had informed transport that he had been having some agitation and wanting to get up from his wheelchair to walk around, the medications she had administered him prior, and sent those medications with him to the facility. She also stated that she called the facility, but could not recall who she spoke with, at 2:45 PM while Resident #6 was in transit to give a report and informed them of his behaviors and that she had administered medications to help calm him and those medications had been sent with him to the facility. The Hospice Nurse revealed after Resident #6 had arrived at the facility she received a telephone call from the Director of Nursing (DON) between 3:30- 4:00 PM stating Resident #6 was agitated and trying to get up from his wheelchair unassisted and that they were not going to be able to provide for his care due to these behaviors because they did not have the staff to be able to provide one-on-one supervision. She stated she informed the DON that Resident #6 did not require one-on-one supervision that he was easily re-directed and that she had administered him Haldol and Xanax earlier to help calm him, both of which were sent with him to the facility, and she would call the Hospice NP for orders to administer these medications. She revealed she contacted Hospice NP and received a verbal order for	F 622		

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F 622	Continued From page 5 Resident #6 to be administered the Xanax and Haldol and repeat in an hour if needed and received a verbal order for him to be administered a shot of Rocephin IM. She stated she called back to the DON and informed her of the verbal orders from the Hospice NP to administer Resident #6 the Xanax and Haldol that was sent with him to the facility and repeat in an hour if needed and to also administer Rocephin IM which he was not sent with, but the DON stated the facility had access to medication in their emergency cart. The Hospice Nurse revealed after staffing the situation with her supervisor they decided it would be best for the on-call Hospice Nurse to go to the facility that evening and check on Resident #6 and when she contacted the facility to check on Resident #6 and let them know the on-call Hospice Nurse would be coming she spoke with DON who informed her they had not administered Resident #6 the medications she had given them verbal orders for an hour prior to assist with calming his agitation and behaviors. She stated later that evening she spoke with on-call Hospice Nurse who stated when she arrived at the facility they informed her Resident #6 was not going to be able to stay, they were not be able to provide for his needs, he would need other placement, and requested for him to be sent out to the hospital and they would not allow her to administer him his medications that had been ordered. She also stated while the on-call Hospice Nurse was there she observed Resident #6 to have some agitation and wanting to get out of his wheelchair unassisted but that he was easily re-directed and was even calm when she was pushing him around the facility in his wheelchair. She revealed she did speak with the Hospital NP the following day on 5/10/24 who was very upset Resident #6 had been sent out to the	F 622		

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F 622	Continued From page 6 hospital in the first place and once they administered Resident #6 medications the facility had been ordered to administer and didn't, he was calm, polite, and fell asleep with no issues. The Hospice Nurse revealed she believed that if the facility had followed their instructions and administered Resident #6 the medications as ordered there would have been no issues and she was not sure why the facility had decided they did not want to keep Resident #6 because they were made aware of his agitation and behaviors prior to him being admitted, he was sent with medications to assist with his agitation behaviors, did not require one-on-one services, and he was not combative or harmful to himself or others. A telephone interview with the on-call Hospice nurse on 5/30/24 at 5:27 PM stated she was familiar with Resident #6. She stated on 5/09/24 at 5:00 PM she had received a telephone call from her supervisor asking if she would go to the facility and check on Resident #6 who was just admitted for respite services and was showing some signs of agitation and trying to get up from his wheelchair unassisted and the facility had received orders from Hospice NP to administer medications to assist with these behaviors. She revealed on the way to the facility she had called to let them know she was coming to check on Resident #6 and spoke with DON who informed her they had not administered him any medications, he could not stay at the facility per Administration and Hospice would be finding him alternative placement. The on-call Hospice Nurse stated when she arrived at the facility the DON was standing in the hallway next to Resident #6 who was sitting in his wheelchair, and he was showing no signs of being aggressive or	F 622		

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F 622	Continued From page 7 attempting to hurt himself or others. She revealed Resident #6 did attempt to stand up from his wheelchair, but was easily re-directed, and when she asked if she could administer medications that had been ordered to assist with making him more comfortable, the DON stated no, and they wanted him out. She stated she assisted Resident #6 around the facility in his wheelchair and assisted him with laying down on the bed in his room and he was compliant with no issues. The on-call Hospice Nurse revealed she asked the DON for Resident #6 paperwork that had been sent to the facility prior to his admission and she stated the facility did not receive any paperwork and the facility would not be able to provide for his care and he could not stay at the facility and needed to be sent to the hospital and find placement elsewhere. She stated she spoke with her supervisor and to accommodate the facility wishes, Resident #6 was sent out to the hospital along with his medications that had been sent with him from home. The on-call Hospice Nurse revealed the hospital performed a urinalysis and minimal labs on Resident #6 which came back clear and showed no issues and administered him the medications the facility had previously been ordered to administer, Resident #6 was pleasant and did not appear agitated during this time. An interview with Nurse #3 on 5/31/24 at 9:05 AM revealed she had worked 2nd shift on 5/09/24 and was familiar with Resident #6. She stated when she arrived for shift on 5/09/24, Resident #6 was at the facility and was having some agitation and trying to get up out of his chair unassisted but was easily re-directed by staff. She recalled being told by the DON Resident #6 did not need to be at the facility and a Hospice nurse would be coming	F 622		

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F 622	Continued From page 8	F 622		

to visit and would have to find him another placement. She revealed once the Hospice nurse arrived, Resident #6 was sent to the hospital, and she assumed he had been discharged from the facility based on what she was told earlier by the DON. She stated she was not aware of Resident #6 having any orders for medications to assist with his behaviors while at the facility and was not instructed to administer him any medications.

A telephone interview with the Hospital Nurse Practitioner (NP) on 5/31/24 at 10:34 AM revealed he was working at the hospital on evening of 5/09/24 and was familiar with Resident #6. He stated Resident #6 arrived at the hospital from the facility, with concerns of agitation and increased behaviors. He stated while at the hospital, they completed lab work and a urinalysis which revealed no issues and administered the medications the facility had been ordered to administer previously. He revealed he never observed Resident #6 to be aggressive, agitation was minimal, attempted to get up and walk around but was easily re-directed and once his medications were administered, he was calm and fell asleep. The Hospital NP stated he was never given a clear understanding as to why the facility did not administer Resident #6 the medication that had been previously ordered by Hospice, why the facility was not able to provide for his care, or why Resident #6 was sent to the hospital, and felt like the facility had "dumped" Resident #6 for no reason.

An interview with the Director of Nursing (DON) on 5/31/24 at 1:52 PM revealed she was familiar with Resident #6. She stated she was working on 05/09/24 and received a telephone call she believed from the Admission Director or the

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Administrator that Resident #6 was in route to the facility for a 5-day respite stay admission. She revealed she was not notified of Resident #6 care needs or behaviors and after he arrived, he became agitated and was trying to get up and down out of his wheelchair unassisted trying to walk around the facility. The DON stated that she called the Hospice Nurse and informed her of Resident #6 behaviors, and she did not think they would be able to provide for his care and he may need to be sent to another placement and the Hospice Nurse gave verbal orders to administer medications to help calm him and to assist with the agitation and repeat in one hour. She revealed she could not recall whether the medication was ever administered or not and had no reason for why they did not administer the medications. She stated she contacted the interim Administrator and discussed Resident #6 behaviors and the facility not being able to provide for his care and the decision was made to contact Hospice and inform them the facility could not provide care for Resident #6 and they would need to find alternative placement. The DON revealed when the on-call Hospice Nurse arrived at the facility, she informed her that per administration, Resident #6 would not be able to stay at the facility due to them not being able to provide for his care and they would need to send him out to the hospital or find alternative placement. The DON revealed the on-call Hospice nurse assisted with Resident #6 being sent out to the hospital, per the facility request.

A telephone interview with the interim Administrator on 6/03/24 at 4:00 PM revealed he was not present at the facility on 5/09/24 but had received a telephone call from the Admission Director sometime after lunch stating they would

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F 622	Continued From page 10 be admitting Resident #6 on this date under respite services for Hospice. He stated later that afternoon he received a telephone call from the DON stating Resident #6 had arrived at the facility and had started to become agitated, was trying to get up out of his wheelchair to walk around and would require one-on-one supervision and they did not have the staff available to provide him with one-on-one supervision. He revealed the DON stated they were not aware of him having these behaviors prior to him being admitted to the facility and were not able to provide for his care needs, and that she had contacted Hospice to inform them of this and that they would need to find an alternative placement and Hospice agreed. The Administrator stated to his knowledge, Hospice came to the building that evening and decided it was best for him to be sent out to the hospital and he did not return. When asked if he was aware of the Hospice notes received by the facility as part of the admission referral documenting Resident #6 had been showing signs of agitation and having behaviors such as getting up from his wheelchair to walk around or of the Hospice social worker relaying this information by telephone to the Admission Director prior to him being accepted by the facility, the Administrator stated no he had not been made aware of that information. He also stated that he was not aware the DON had spoken with the Hospice nurse and received orders to administer medications that were sent with Resident #6 to the facility for his agitation and repeat in an hour and to administer an injection for agitation if needed that was available at the facility and those orders were not followed and medications were not administered. The Administrator revealed he was not informed of on-call Hospice nurse not being allowed to	F 622		

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F 622	Continued From page 11 administer these medications and being told Resident #6 was not allowed to stay at the facility and for him to be sent to the hospital, he was of the understanding that Hospice had made the decision for him to leave. He also revealed the information that he had received was Resident #6 was agitated and trying to get up out of his wheelchair and staff were not able to care for him, he was not aware Resident #6 behaviors were easily redirected or that there was medication available that could have helped. The Administrator stated had he known all of the information he would have instructed staff to follow recommendations from Hospice, administer Resident #6 medications as instructed, and communicate with Hospice prior to Resident #6 being sent out and discharged from facility.	F 622		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid	F 626		7/9/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 626	Continued From page 12 nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, Hospice staff, Hospital Nurse Practitioner, and staff interviews, the facility failed to allow resident to return to the facility after being sent to the hospital for a medical evaluation using the residents' behaviors prior to discharge as a basis for their decision for 1 of 3 residents reviewed for transfer and discharge (Residents #6). The findings included: Resident #6 was admitted to the facility for respite services through Hospice on 5/09/24 and discharged on 5/09/24. Diagnosis included malnutrition, chronic pain, depression, and anxiety. Review of nursing note dated 5/09/24 written by the Director of Nursing (DON) at 4:06 PM	F 626	1. Resident #6 was transferred to the Emergency Department 05/09/2024 due to behaviors. Since that date Resident #6 has expired. 2. An audit was completed on 07/02/2024, by the Director of Nursing on transfers/discharges for the past 30 days to ensure that any resident transferred/discharged to the hospital was admitted to the first available bed, if warranted. 3. Executive Director, Director of Nursing and Admissions personnel were provided education on 07/02/2024 by the Vice President of Clinical Services pertaining to admitted residents that have been transferred/discharged to the hospital to	

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F 626	Continued From page 13 revealed telephone call placed to Hospice Nurse, updated that Resident #6 is agitated and wanting to smoke. She stated Resident #6 was agitated at home; wife needs a break. She verbalized that he received Haldol (treat behavioral issues) 1 MG and Ativan (treat anxiety) 1 MG prior to leaving on transport to facility. Hospice Nurse speaks with Hospice provider, orders received for Xanax 1 MG by mouth now and to repeat in 1 hour: Rocephin (treat possible urinary tract infection) IM (intramuscularly) 1 gram (GM) now. Review of nursing note dated 5/09/24 written by the DON at 6:25 PM revealed Resident #6 had been up and down, propelling wheelchair throughout facility. Offered snack, which was accepted. Hospice on-call Nurse was in the facility, asked if willing to continue with 5-day respite, stated the facility was not able to meet his needs and cannot do respite. She was arranging transport to hospital. A telephone interview with the on-call Hospice nurse on 5/30/24 at 5:27 PM stated she was familiar with Resident #6. She stated on 5/09/24 at 5:00 PM she had received a telephone call from her supervisor asking if she would go to the facility and check on Resident #6 who was just admitted for respite services and was showing some signs of agitation and trying to get up from his wheelchair unassisted and the facility had received orders from Hospice NP to administer medications to assist with these behaviors. She revealed on the way to the facility she had called to let the know she was coming to check on Resident #6 and spoke with DON who informed her they had not administered him any medications, he could not stay at the facility per Administration and Hospice would be finding him	F 626	be readmitted to the first available bed if warranted. 4. The Director of Nursing and/or designee will be responsible for completing Quality Improvement Monitoring Tool to ensure that residents transferred/discharged to the hospital are readmitted to the first available bed 3x/week for 8 weeks then 1x/week for 4 weeks, then monthly for 3 months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring. Date of compliance 07/09/2024	

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F 626	Continued From page 14 alternative placement. The on-call Hospice Nurse stated when she arrived at the facility the DON was standing in the hallway next to Resident #6 who was sitting in his wheelchair, and he was showing no signs of being aggressive or attempting to hurt himself or others. She revealed Resident #6 did attempt to stand up from his wheelchair, but was easily re-directed, and when she asked if she could administer medications that had been ordered to assist with making him more comfortable, the DON stated no, and they wanted him out. She stated she assisted Resident #6 around the facility in his wheelchair and assisted him with laying down on the bed in his room and he was compliant with no issues. The on-call Hospice Nurse revealed she asked the DON for Resident #6 paperwork that had been sent to the facility prior to his admission and she stated the facility did not receive any paperwork and the facility would not be able to provide for his care and he could not stay at the facility and needed to be sent to the hospital and find placement elsewhere. She stated she spoke with her supervisor and to accommodate the facility wishes, Resident #6 was sent out to the hospital along with his medications that had been sent with him from home. The on-call Hospice Nurse revealed the hospital performed a urinalysis and minimal labs on Resident #6 which came back clear and showed no issues and administered him the medications the facility had previously been ordered to administer, Resident #6 was pleasant and did not appear agitated during this time. She stated she called and spoke with the DON while Resident #6 was at hospital requesting him to return to the facility and explaining he had been administered the ordered medications, appeared calm with no issues, and that his labs were normal and the DON stated no,	F 626		

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F 626 Continued From page 15 F 626

he would not be able to return. She revealed due to the time of night she was not able to find alternative placement, so the hospital agreed to keep Resident #6 for the night until alterative placement with another facility could be arranged the following morning. The on-call Hospice Nurse stated Resident #6 was sent to another facility for respite the following morning.

An interview with Nurse #3 on 5/31/24 at 9:05 AM revealed she had worked 2nd shift on 5/09/24 and was familiar with Resident #6. She stated when she arrived for shift on 5/09/24, Resident #6 was at the facility and was having some agitation and trying to get up out of his chair unassisted but was easily re-directed by staff. She recalled being told by the DON Resident #6 did not need to at the facility and a Hospice nurse would be coming to visit and finding him another placement. She revealed once the Hospice nurse arrived, Resident #6 was sent to the hospital, and she assumed he had been discharged from the facility based on what she was told earlier by the DON. Nurse #3 stated later in the evening she received a call from hospital physician stating Resident #6 was ready to return to the facility and requested to speak with the DON, so she contacted the DON and informed her the hospital had called and Resident #6 was ready to return to the facility and she stated no that he was not to return to the facility and needed to find alternative placement. She revealed she called back and relayed the information from the DON to the hospital physician who stated there was nothing wrong with Resident #6 and if they did not agree to take him back, they would report the issue to the state. She stated she called the DON back and relayed the information from the hospital physician and the DON stated that was fine, but

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F 626	Continued From page 16 they were not going to allow him back. Nurse #3 revealed her shift ended after her last conversation with the DON and she had no knowledge of what happened after that conversation. She stated she was not aware of Resident #6 having any orders for medications and was not instructed to administer him any medications. A telephone interview with the Hospital Nurse Practitioner (NP) on 5/31/24 at 10:34 AM revealed he was working at the hospital on evening of 5/09/24 and was familiar with Resident #6. He stated Resident #6 arrived at the hospital from the facility, with concerns of agitation and increased behaviors. He stated while at the hospital, they completed lab work and a urinalysis which revealed no issues and administered the medications the facility had been ordered to administer previously. He revealed he never observed Resident #6 to be aggressive, agitation was minimal, attempted to get up and walk around but was easily re-directed and once his medications were administered, he was calm and fell asleep. The hospital NP stated the on-call Hospice Nurse had contacted the facility about Resident #6 being able to return and the facility would not allow him to return, stating they needed to find him an alternative placement. He revealed at this point, Resident #6 had been at the hospital for 5 hours with no signs of medical issues and showing no signs of behaviors, so he contacted the facility himself to inform them Resident #6 was ready to return to the facility and spoke with a nurse who stated she had been informed that Resident #6 had been discharged and would not be returning and she would have to contact her DON for further instructions. He stated the facility	F 626		

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F 626	Continued From page 17 nurse called him back stating that per the DON, the facility would not be accepting Resident #6 back to the facility and would need to find alternative placement. The hospital NP revealed he requested to have the DON contact him so they could discuss why Resident #6 was not able to return to the facility and even offered to send him back with medications and scripts for medications to assist with his care, and if the facility refused to allow Resident #6 back, he would make a report to the state. He stated the facility nurse stated she would inform the DON and ask her to contact him, and he never received a call back. He stated he was never given a clear understanding as to why the facility did not administer Resident #6 the medication that had been previously ordered, why he was sent to the hospital, or why he was not allowed to return and felt like the facility had "dumped" Resident #6 for no reason causing him to have to spend the night at the hospital when they could have taken him back that evening, provided for his care, and found placement the following day if needed. An interview with the Director of Nursing (DON on 5/31/24 at 1:52 PM revealed she was familiar with Resident #6. She stated she was working on 05/09/24 and received a telephone call she believed from the Admission Director or the Administrator that Resident #6 was in route to the facility for a 5-day respite stay admission. She revealed she was not notified of Resident #6 care needs or behaviors and after he arrived, he became agitated and was trying to get up and down out of his wheelchair unassisted trying to walk around the facility. The DON stated that she called the Hospice Nurse and informed her of Resident #6 behaviors, and she did not think they	F 626		

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F 626	Continued From page 18 would be able to provide for his care and he may need to be sent to another placement and the Hospice Nurse gave verbal orders to administer medications to help calm him and to assist with the agitation and repeat in one hour. She revealed she could not recall whether the medication was ever administered or not and had no reason for why they did not administer the medications. She stated she contacted the interim Administrator and discussed Resident #6 behaviors and the facility not being able to provide for his care and the decision was made to contact Hospice and inform them the facility could not provide care for Resident #6 and they would need to find alternative placement. The DON revealed when the on-call Hospice Nurse arrived at the facility, she informed her that per administration, Resident #6 would not be able to stay at the facility due to them not being able to provide for his care and they would need to send him out to the hospital or find alternative placement. She stated the on-call Hospice Nurse assisted with Resident #6 being sent out to the hospital and someone from the hospital (she could not recall the name) called her later that evening asking again if Resident #6 could return to the facility, and she informed no he could not return due to the facility not being able to provide care for his needs and to contact Hospice. She revealed the hospital physician did contact the facility about Resident #6 returning and spoke with Nurse #3 who did call her about the situation, and she informed her that Resident #6 was not allowed to return but she did not speak with the hospital physician herself. The DON stated the decision for Resident #6 not to return to the facility was a decision made by her and the Administrator.	F 626		

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F 626	Continued From page 19 An interview with the Admission Assistant on 5/31/24 at 2:35 PM revealed she was familiar with Resident #6. She stated on 5/09/24 she had received a telephone call from the Admission Director who was not at the facility, informing her of Resident #6 admission for respite services. She revealed Resident #6 arrived at the facility around 2:45 PM and she went to discuss the Advanced Directive and admission paperwork with him at 3:30 PM and observed Resident #6 sitting in the hallway in his wheelchair with the DON standing beside of him. She stated Resident #6 did appear to be slightly agitated and did attempt to get up out of his wheelchair one time but was easily re-directed but was not being combative or attempting to hurt himself or others. The Admission Assistant revealed after having Resident #6 sign his Advance Directive, the DON stated there was no use to go over the admission paperwork with Resident #6 because he would not be staying due to his behaviors and not being able to provide his care and Hospice would have to find him another placement. She stated after that she left the hallway and went back to her office, the following day she was notified Resident #6 was sent out to the hospital and did not return. A telephone interview with the interim Administrator on 6/03/24 at 4:00 PM revealed he was not present at the facility on 5/09/24 but had received a telephone call from the Admission Director sometime after lunch stating they would be admitting Resident #6 on this date under respite services for Hospice. He stated later that afternoon he received a telephone call from the DON stating Resident #6 had arrived at the facility and had started to become agitated, was trying to get up out of his wheelchair to walk	F 626		

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F 626	Continued From page 20 around and would require one-on-one supervision and they did not have the staff available to provide him with one-on-one supervision. He revealed the DON stated they were not aware of him having these behaviors prior to him being admitted to the facility and were not able to provide for his care needs, and that she had contacted Hospice to inform them of this and that they would need to find an alternative placement and Hospice agreed. The Administrator stated to his knowledge, Hospice came to the building that evening and decided it was best for him to be sent out to the hospital and he did not return. When asked if he was aware of the Hospice notes received by the facility as part of the admission referral documenting Resident #6 had been showing signs of agitation and having behaviors such as getting up from his wheelchair to walk around or of the Hospice social worker relaying this information by telephone to the Admission Director prior to him being accepted by the facility, the Administrator stated no he had not been made aware of that information. He also stated that he was not aware the DON had spoken with the Hospice nurse and received orders to administer medications that were sent with Resident #6 to the facility for his agitation and repeat in an hour and to administer an injection for agitation if needed that was available at the facility and those orders were not followed and medications were not administered. The Administrator revealed he was not informed of on-call Hospice nurse not being allowed to administer these medications and being told Resident #6 was not allowed to stay at the facility and for him to be sent to the hospital, he was of the understanding that Hospice had made the decision for him to leave. He also revealed the information that he had received was Resident #6	F 626		

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F 626	Continued From page 21 was agitated and trying to get up out of his wheelchair and staff were not able to care for him, he was not aware Resident #6 behaviors were easily redirected or that there was medication available that could have helped. He stated he was also not aware of the hospital NP attempting to contact the DON to discuss Resident #6 behaviors and that once he was administered the medications at the hospital he was less agitated and continued to be easily re-directed, and the DON would not return the hospital NP call and messages had to be sent through Nurse #3 at the facility that Resident #6 was not allowed to return. The Administrator stated had he known all of the information he would have instructed to follow recommendations from Hospice, administer Resident #6 medications as instructed, and communicate with Hospice and the Hospital NP prior to not allowing Resident #6 to return to the facility.	F 626		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide incontinence care to a resident prior to her wetting through her brief and her pants for 1 of 3 residents (Resident #4) reviewed for activities of daily living (ADL). The findings included:	F 677	1.Resident #4 was provided incontinent care by staff on 05/10/2024. 2.Current residents that require staff assistance with toileting needs were audited for timely incontinent care by the Director of Nursing on 07/02/2024. 3. On 07/02/2024 to 07/08/2024 the	7/9/24

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Continued From page 22

Resident #4 was admitted to the facility on 04/20/23 and readmitted on 12/29/23 with diagnoses which included cerebral vascular accident (CVA or stroke), hypertension, diabetes mellitus type II, congestive heart failure and muscle weakness.

Review of Resident #4's Care Area Assessment (CAA) summary dated 01/15/24 for activities of daily living (ADL) revealed resident was to receive assistance of 1 to 2 staff members with ADL, transfers, mobility, and toileting to prevent falls or injury. Resident #4 was to receive peri-care every 2 hours and as needed to prevent skin breakdown and infection.

Review of Resident #4's quarterly Minimum Data Set (MDS) assessment dated 03/11/24 revealed she was severely cognitively impaired, and staff were to anticipate her needs. The assessment also revealed she required partial to moderate assistance of 1 to 2 staff members with toileting hygiene and required substantial to maximal assistance of 1 to 2 staff members with lower body dressing.

Review of Resident #4's care plan dated 05/10/24 revealed a focus area for the resident having an ADL self-care performance deficit related to disease process, impaired balance and pain. The interventions included for toilet use the resident required assistance of 1 to 2 for toileting hygiene and for dressing required 1 staff assistance with dressing and undressing. Resident #4's care plan also revealed a focus area for the resident having frequent urinary incontinence related to disease process, inability to communicate needs and poor toileting habits. The interventions included the resident used

F 677

Director of Nursing and the Assistant Director of Nursing initiated staff education to the nursing department to cover timeliness of incontinence care.

4.The Director of Nursing or designee will conduct random audits related to incontinent care 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 weeks then monthly for 3 months The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring.

Date of compliance 07/09/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 23 disposable briefs, clean peri-area with each incontinent episode, check as required for incontinence, wash, rinse and dry perineum, change clothing as needed (prn) after incontinence episodes and monitor/document any signs or symptoms of urinary tract infection (UTI). An observation on 05/31/24 at 11:17 AM of incontinence care on Resident #4 revealed the resident being assisted to the bathroom in her room via wheelchair by Nurse Aide (NA) #4 and NA #5. NA #4 assisted the resident up out of her wheelchair and Resident #4 stood at the grab bar in the bathroom while NA #4 held onto her, and NA #5 proceeded to clean her from front to back. When NA #4 removed the resident's brief it was saturated from front to back with urine and there were stool smears on the brief and the inside of the brief had begun to bunch up. When NA #4 threw the brief in the trash can it made a loud thud. NA #5 continued to clean Resident #4 until she was clean and then NA #4 and NA #5 put a clean brief on the resident and sat her down in the wheelchair to change her pants because she had saturated her brief and wet through her pants. NA #4 changed the resident's pants, washed the resident's hands and washed her hands and pushed the resident in her wheelchair to the dining room for lunch. An interview on 05/31/24 at 12:40 PM with NA #4 revealed she was assigned to care for Resident #4 on the 7:00 AM to 3:00 PM shift. She stated she typically rounded every 2 hours on her residents but said she had not gotten to round on Resident #4 the first time until 11:17 AM. NA #4 stated the NA on night shift (11:00 PM to 7:00 AM) must have gotten her up early because Resident #4 typically didn't wet her brief through	F 677		

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F 677	Continued From page 24 to her pants. She said she had just been busy and had just not gotten to the resident. NA #4 explained that Resident #4 was typically up when she arrived for her shift at 7:00 AM and usually early riser residents are gotten up on the last round between 5:00 AM and 6:30 AM and that was likely the last time she received incontinence care until 11:17 AM. A telephone interview on 06/04/24 at 2:01 PM with the Director of Nursing revealed it was her expectation that all residents be round on every 2 hours and changed as needed. She stated if NA #4 was busy she should have asked for assistance from one of the other NAs working and said no resident should be left without incontinence care and wet through their pants.	F 677		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		7/9/24

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	345329	A. BUILDING ______ B. WING ______	C 06/14/2024

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F 880	Continued From page 25 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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F 880	Continued From page 26 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to follow their Infection Control Policy for Enhanced Barrier Precautions (EBP), when the Wound Nurse failed to wear a gown while providing wound care to 2 of 3 residents (Resident #2 and Resident #3) reviewed for infection control. The findings included: Review of the facility's Infection Control Policy, Enhanced Barrier Precautions last updated on 08/2022 revealed the following: Under Policy Interpretation and Implementation: "1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MRDOs) to residents. 2. EBPs employ targeted gown and glove use during high contact activities when contact precautions do not otherwise apply. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: h. wound care (any skin opening requiring a dressing). 5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.	F 880	1. Residents #2 and #3 were identified as needing Enhanced Barrier Precautions. Wound Care Nurse and Assisted Director of Nursing were immediately provided education on Enhanced Barrier Precautions by the Vice President of Clinical Services. 2. An Audit was conducted by the Assisted Director of Nursing on 05/31/2024, identifying residents that meet the requirements for Enhanced Barrier Precautions. At this time, it was verified that appropriate personal protective equipment (gowns and gloves) was readily available to staff to utilize when caring for residents on Enhanced Barrier Precautions. 3. On 05/31/2024 the Director of Nursing and the Assistant Director of Nursing initiated staff provided education to the nursing department pertaining to Enhanced Barrier Precautions and wearing personal protective equipment per the industry standards. 4. The Director of Nursing or designee will conduct QI monitoring on F880 to ensure staff are following Enhanced Barrier	

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F 880	Continued From page 27 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk." a. An observation on 05/31/24 at 10:31 AM of wound care by the Wound Nurse assisted by the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) was completed on Resident #2. There was no personal protective equipment (PPE) available on the door or in a bin outside the door of the resident's room. The Wound Nurse had on gloves and changed them according to their handwashing policy and procedure during the resident's wound care but did not wear a gown while providing wound care. An interview on 05/31/24 at 11:44 AM with the Wound Nurse revealed she realized after providing Resident #2 wound care that she should have donned a gown prior to doing the wound care because the resident was on Enhanced Barrier Precautions (EBP). She stated she knew better but was nervous and just forgot to put on the gown. The Wound Nurse said the facility lets staff know who is on EBP by putting signage on the door and providing PPE on the door or in a bin near the resident's door. An interview on 05/31/24 at 10:55 AM with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) revealed she thought the wound care for Resident #2 went well except the Wound Nurse did not wear a gown while providing wound care. She stated she wasn't sure why the resident didn't have PPE on her door or near her room unless it was because she was recently moved, and the caddie of PPE did not move with her to her new room. The	F 880	Precautions when providing direct care 5x/week for 4 weeks, then 3x/week for 8 weeks, then monthly for 6 months. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The findings of the monitoring tool will be discussed/reviewed in QAPI meeting monthly until committee determines substantial compliance has been met and recommends moving to a quarterly monitoring. Date of compliance 07/09/2024	

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F 880	Continued From page 28	F 880		

ADON/IP further stated the facility utilized signage on the door and PPE on the door or near the resident's room in a bin to communicate the resident was on EBP to the staff. She said she didn't think about the Wound Nurse not wearing a gown until after the wound care had been completed. The ADON/IP indicated she would provide the Wound Nurse with additional education on wearing PPE during wound care.

A telephone interview on 06/04/24 at 2:01 PM with the Director of Nursing (DON) revealed it was her expectation that the Wound Nurse follow the EBP Policy and Procedure and wear a gown while providing wound care to residents.

b. An observation on 05/31/24 at 10:44 AM of wound care by the Wound Nurse assisted by the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) was completed on Resident #3. There was a caddie on the door to the resident's room with PPE supplies including masks, gowns, and gloves. The Wound Nurse had on gloves and changed them according to their handwashing policy and procedure during the resident's wound care but did not wear a gown while providing wound care.

An interview on 05/31/24 at 11:44 AM with the Wound Nurse revealed she realized after providing Resident #3 wound care that she should have donned a gown prior to doing the wound care because the resident was on Enhanced Barrier Precautions (EBP). She stated she knew better but was nervous and just forgot to put on the gown. The Wound Nurse said the facility lets staff know who is on precautions by putting signage on the door and providing PPE on the door or in a bin near the resident's door.

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F 880	Continued From page 29 An interview on 05/31/24 at 10:55 AM with the Assistant Director of Nursing (DON) / Infection Preventionist (IP) revealed she thought the wound care for Resident #3 went well except the Wound Nurse did not wear a gown while providing wound care. She stated there was PPE readily available in the caddie on the resident's door, but the Wound Nurse had not donned a gown prior to performing wound care on the resident. The ADON/IP further stated the facility utilized signage on the door and PPE in a caddie on the door or near the resident's room in a bin to communicate the resident was on EBP to the staff. She said she didn't think about the Wound Nurse not wearing a gown until after the wound care had been completed. The ADON/IP indicated she would provide the Wound Nurse with additional education on wearing PPE during wound care. A telephone interview on 06/04/24 at 2:01 PM with the Director of Nursing (DON) revealed it was her expectation that the Wound Nurse follow the EBP Policy and Procedure and wear a gown while providing wound care to residents.	F 880		