STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. BUILDING _____ B. WING _____	C 07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	511 WINDMILL STREET WALNUT COVE, NC 27052

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/23/2024 through 6/28/24. Additional information was obtained on 07/15/24. Therefore, the exit date was changed to 07/15/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1WCT11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/23/24 through 06/28/24. Event ID# 1WCT11. Additional information was obtained on 07/15/24. Therefore, the exit date was changed to 07/15/24. The following intakes were investigated: NC00218273, NC00218275, NC00217950, NC00216371, NC00214902, NC00214616, NC00213605, NC00213151, NC00212607, NC00211887, NC00210410, NC00209610, NC00208163, NC00205920, NC00205945, and NC00205028. 4 of the 37 complaint allegations resulted in deficiencies. Immediate Jeopardy was identified CFR 483.25 at tag F689 at a scope and severity (J). The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 06/26/24 and was removed on 06/27/24. An extended survey was conducted.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F 561		7/29/24

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

Electronically Signed | 07/24/2024

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F 561	Continued From page 1 The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, residents and staff interviews, the facility failed to honor 1 resident (Resident #30) of 2 residents reviewed for safe smoking the right to take smoking breaks at their preferred times. Findings included: Resident #30 was admitted to the facility on	F 561	1. Resident #30 had an additional smoking assessment completed on 6-26-24. Resident #30 was informed of the safe smoker's procedure on how to obtain his smoking materials on 7-18-24. 2. A quality review of smoking residents was completed on 6-26-24 and 5 residents were deemed to be safe smokers. Residents with BIMs of 8> were	

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F 561	Continued From page 2 4/6/21. Review of the facility's Smoking Evaluation dated 5/22/24 indicated Resident #30 was alert, oriented and could consistently perform safe smoking techniques. The resident demonstrated fine motor skills needed to light a cigarette safely with a lighter, securely hold a cigarette, and was able to communicate the risks associated with smoking. The facility assessed Resident #30 as a safe smoker. The care plan dated 5/28/24 revealed Resident #30 was educated on the facility's smoking policies and was able to verbalize smoking safety. Interventions included: the resident will smoke during designated smoking times; and required constant supervision while smoking. The quarterly minimum data set (MDS) dated 6/4/24 indicated Resident #30 was cognitively intact. A review of the facility's smoking schedule indicated residents who smoked were allowed to smoke in the designated area on the facility's compound at 9:00 a.m., 2:00 p.m., and 9:00 p.m. with staff supervision. During an interview on 6/23/24 at 1:50 p.m., Resident #30 revealed he was only allowed to smoke at the facility three times each day per the smoking schedule and supervised by facility staff. During an interview on 6/26/24 at 10:43 a.m., the Maintenance Director stated Resident #30 was a safe smoker; had never dropped cigarettes or burned his clothing or skin while smoking. He further revealed that if a resident requested to be	F 561	interviewed on 7/18/24 by the Medical Records Director to determine if they were a current smoker and/or if they wanted to smoke. No other residents expressed the desire to smoke. These interviews will be completed on admission and as needed for resident that smoke or wish to smoke. Residents identified as safe smokers will continue to be allowed to smoke at any times of their choosing. An Ad hoc Quality Assurance Performance Improvement Committee was held on 7-10-24 to discuss the plan for implementation. 3. The Director of Nursing will provide current facility staff including all shifts, part-time and prn on safe smokers and their ability to smoke at times of their choosing by 7-22-24. The above education will be provided to new staff during orientation. By 7/18/24 the nurses were educated regarding the newly implemented smoking materials sign in and out sheet. This education will be provided to new nurses during orientation. On 7/18/24 the nurse managers added to the admission checkoff, to determine whether the new resident smokes and if they were determined through assessment to be a safe or unsafe smoker. This check off sheet is completed by a nurse manager after admission. Any new nurse manager will be provided the same education during orientation. Residents who were deemed as safe smokers were educated on the process by the Director of Nursing and Unit Managers by 7/18/24 on how to obtain their smoking materials and where	

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F 561	Continued From page 3 escorted to the designated smoke area and it was not during the scheduled smoke time, he would refuse because he would have to supervise the resident, and he could get in trouble. He did not differentiate between safe & unsafe smokers. On 6/26/24 at 4:18 p.m., the Executive Director stated that according to the smoking assessments, Resident #30 was an unsafe smoker but did not provide a reason as to why he as an unsafe smoker. She indicated that she would meet with the interdisciplinary team to discuss changing the process to allow residents deemed safe smokers the opportunity to smoke independently during times of their choosing.	F 561	to return the smoking materials when they returned to the building. 4. The Director of Nursing and Unit Managers will conduct quality monitoring of safe smokers weekly for 12 weeks to ensure they feel their right to choose when they smoke is met. Director of Nursing will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available	F 585		7/29/24

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F 585	Continued From page 4	F 585		

to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to

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F 585	Continued From page 5 prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to document the steps taken to investigate a complaint/grievance expressed on behalf of a resident, the findings or conclusions reached based on the investigation, and whether	F 585	Resident 284 no longer resides in the facility. The Social Services Director completed interviews with residents whose BIMS 8 or	

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F 585	Continued From page 6 the investigation results were reported to the complainant with a written grievance decision. This occurred for 1 of 1 resident reviewed for grievances (Resident #284). The findings included: A review of the facility's Complaint / Grievance Policy and Procedure (Document Name: N-1042; Revised on 10/24/22) was conducted. The Policy stated, "The Center will support each resident's right to voice a complaint / grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint / grievance and informed [inform] the resident of progress towards resolution....The resident should have reasonable expectations of care and services and the center should address those expectations in a timely, reasonable, and consistent manner...." The Procedures outlined in this Policy included the following, in part: "#3 [of 8]. The Grievance Officer / designee shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up. #4. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. #5. The findings of the grievance shall be recorded on the Complaint/Grievance Form.... #8. The individual voicing the grievance will receive follow up communication with the resolution, a copy of the grievance resolution will be provided to the resident upon request. Note: North Carolina will provide a copy of the resolution to the resident." Resident #284 was admitted to the facility on 6/1/23. Her cumulative diagnoses included early	F 585	>, and the responsible party of residents whose BIMs were 7 or < to ensure grievances are captured, followed up on, resolved and written resolution provided on 7-10-24. 8 grievances were identified, written, and response completed. An Ad hoc Quality Assurance Performance Improvement Committee was held on 7-10-24 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the Social Services Director on the federal regulations and guidelines related to the resident's right to ensure grievances are resolved, followed up and a written resolution provided on 7-9-24. The Executive Director and Director of Nursing will provide the facility staff, including all shifts, part-time and prn, re-education on the federal regulations and guidelines related to the resident's right to ensure grievances are adequately followed through on and resolved 7-18-24. This education will be provided to newly hired staff members. The Social Worker will conduct five resident interviews 3 times per week for 4 weeks, then weekly for 8 weeks to ensure resident's grievances are captured, resolved, and followed up with written resolution. The Executive Director will complete quality monitoring on 3 grievances weekly for 4 weeks then 2 weekly for 8 weeks to ensure grievance resolved with written summary provided. The Social Services Director and the Executive Director will report on the	

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onset Alzheimer's disease, generalized muscle weakness, and adult failure to thrive.

A review of Resident #284's electronic medical record (EMR) revealed her admission Minimum Data Set (MDS) assessment was dated 6/8/24. The resident was assessed to have severe cognitive impairment. She was independent with eating, required supervision for walking, and extensive assistance from staff for the remainder of her activities of daily living (ADLs).

Information from an Incident / Accident Report dated 7/5/23 at 2:00 AM and authored by Nurse #1 reported Resident #284 had an unwitnessed fall. She was found on the floor of her room and described to be "asleep, naked." The Incident / Accident report documented the resident was assisted off the floor and dressed. Her provider and family were contacted, and she was transported to the Emergency Department (ED) for further evaluation due to sustaining "a significant hematoma to her right side of her forehead."

Resident #284 was discharged from the facility to the hospital on 7/5/23.

A review of the facility's Grievance Log from June 2023 through the date of the review on 6/23/24 indicated that one grievance dated 7/6/23 was expressed on behalf of Resident #284 by a family member.
--The first section of the Complaint / Grievance Report dated 7/6/23 described the details of the concern as follows: "[Resident #284] was sent out to hospital inappropriate on 7-5-23."
--The second section of the Complaint / Grievance Report included the Documentation of

results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.

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Investigation. The staff member(s) assigned responsibility for the investigation read, "Nursing." Departments impacted by the complaint or grievance had an "x" next to "Nursing." The Findings of Investigation was left blank on the form. The plan to resolve the complaint / grievance read: "staff educated." Nurse #2 signed this section as completed, but it was not dated.
--The third section of the Complaint / Grievance Report was labeled as the Post-Investigation Follow Up. This section of the report included questions addressing whether the Complaint / Grievance was resolved; if the complainant was satisfied; the complainant remarks; whether the investigation results and resolution steps were reported to the Family, Resident, and/or Resident Council; and whether the results were communicated verbally, in writing, or by other means. No documentation was completed within this section of the Complaint / Grievance Report. Nurse #2 signed this section as completed, but it was not dated.

A telephone interview was conducted on 6/27/24 at 4:10 PM with Nurse #2. Nurse #2 was the staff member who completed the second and third sections of the Complaint / Grievance Report dated 7/6/23 for Resident #284. Nurse #2 recalled some of the situation related to this grievance and stated she thought it was due to how the resident was dressed when she went out to the ED. When asked what the facility's process for handling grievances involved, the nurse stated whoever took the grievance (as she did) would pass it on to the Social Worker or the Department Head for resolution. She stated she did remember providing education to Nurse #1 about this situation involving Resident #284 but

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F 585	Continued From page 9 could not recall any additional details. An interview was conducted on 6/26/24 at 3:10 PM with the facility's Director of Nursing (DON). At the time of the interview, the DON provided additional documentation to supplement the Complaint / Grievance Report dated 7/6/23. A "Huddle Report" dated 7/6/23 read, in part: "Nurses: Any patient who goes out to the hospital is to be clothed appropriately, clean, and dry before transferring to hospital ..." A Huddle Report Signature sheet (not dated) included 12 day shift nursing staff signatures and 4 night shift nursing staff signatures. At that time, the DON reported no other documentation could be located related to the 7/6/23 Complaint / Grievance Report for Resident #284. An interview was conducted on 6/27/24 at 1:05 PM with the facility's Administrator. During the interview, the Administrator reported the facility's Social Worker was designated as the Grievance Officer. However, the current Social Worker was not working at the facility when the Complaint / Grievance Report was filed for Resident #284. When the Administrator was asked what her thoughts were regarding the documentation on this Complaint / Grievance Report, she stated, "It should have been more comprehensive." Upon further inquiry, the Administrator added that the report should have included what education was provided and who received the education (and when). She also stated the Complaint / Grievance Report should have documented what follow-up was done with Resident #284's family.	F 585		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4)	F 606		7/29/24

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F 606	Continued From page 10 §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the employee file was missing evidence of pre-employment screening documents for history of abuse, neglect, exploitation, or misappropriation of residents on a staff reviewed for allegation of staff to resident abuse (Nurse Aide #1). The findings included: The facility's policy on abuse, neglect, exploitation and misappropriation dated 11/30/14 and revised on 11/16/22 was reviewed during the survey. The screening paragraph stated persons applying for employment will be screened for a history of	F 606	Nurse Aide #1's background check was obtained on 6-26-24. The Human Resources Director completed an audit of current employees to ensure background check obtained prior to employment on 7-3-24. All current employees had a background check completed by 7-22-24. An Ad hoc Quality Assurance Performance Improvement Committee was held on 7-10-24 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated Human	

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F 606	Continued From page 11 neglect, exploitation, or misappropriation of resident property. This includes but not limited to employment history, criminal background checks, abuse check with appropriate licensing board and registries prior to hire, sworn disclosure statement prior to hire, licensure or registration verification prior to hire, documentation of status of any disciplinary actions form licensing or registration boards and other registries, information from former employees. Review of NA #1's employee file revealed he was hired by the facility on 9/4/19. The employee file had orientation documents. There were no pre-employment screening documents in the employee file. During a discussion on 6/25/24 at 12:01 pm, the Executive Director stated they have looked everywhere for NA #1's pre-employment screening documents but could not find them. She stated there was a high turnover with the Human Resources (HR) job and the files may have been misplaced. The Executive Director stated they would keep searching for NA #1's file. During a follow up discussion on 6/26/24 at 11:22 am, the Executive Director stated they still could not find NA #1's files. She stated she asked NA #1 to sign a consent for a criminal background check on 6/25/24. She stated she did not allow him to work starting 6/25/24 until the facility receives the criminal background check. The Executive Director stated the new HR staff started conducting audits of all the facility employees' files.	F 606	Resources Director on ensuring background checks are obtained prior to employment on 7-10-24. The Executive Director will complete quality monitoring on five employees weekly for 8 weeks then monthly for 3 months to ensure background checks obtained prior to employment. The ED will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		7/29/24

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F 609	Continued From page 12 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report an initial allegation of staff to resident abuse to Adult Protective Services (APS) for 1 of 5 residents reviewed for abuse (Resident #71). The findings included:	F 609	The Executive Director contacted the Adult Protective Services Director to inform them that all Facility Reported Incidents will also be reported to them going forward on 7/2/24. The Facility Reported Incident on patient #71 was sent to APS on 7/10/24.	

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F 609	Continued From page 13 A review of the facility's Abuse, Neglect, Exploitation and Misappropriation policy, last revised 11/16/22, revealed the Administrator ensured the reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations. Resident #71 was admitted on 1/18/24. The facility's Executive Director completed an Initial Allegation Report to the State Agency on 6/16/24. The report designated the type of allegation as "Resident Abuse" and indicated the facility became aware of the allegation on 6/16/24 at 6:15 pm. Allegation details revealed Nurse Aide #1 (NA) was rough to Resident #71 when assisting him back to bed that morning on 6/16/24. The facsimile receipt provided by the facility was dated and timed as 6/16/24 at 8:11pm when the report was faxed to the State Agency. Further review of the report indicated APS was not notified of the allegation of abuse. During an interview on 6/25/24 at 11:28 AM, the Assistant Director of Nursing (ADON) stated she was in front the Resident # 71's room when his roommate made the allegation to her on 6/16/24. She stated she could not remember the time, but it was close to lunch time. Resident #71's family member was also present in the room when his roommate said Resident #71 was thrown against the wall by NA #1 that morning. She stated she immediately reported it to the Executive Director around noon but did not know the specifics of the allegation since the resident could not verbalize what happened. The ADON stated she called NA #1 and the night nurse to come back and write a statement. She stated she assessed Resident #1 and completed a skin check. She did not see any	F 609	On 7/15/24 the Executive Director audited Facility Reported Incidents that were completed in the last 3 months and none of those had been reported to Adult Protective Services. On 7/22/24 Regional Clinical Director of Nursing educated the Executive Director, the Director of Nursing and the Social Worker regarding the regulations related to state agency reporting. This education will also be included in any newly hired Social Workers, Directors of Nursing and Executive Directors. A monitor was initiated that will be completed with all Facility Reported Incidents for the next 3 months to ensure that these incidents are also reported to all required state agencies. This monitor will be completed by Social Work Assistant. The results of this quality monitoring will be reported by the Social Work Assistant to the Quality Assurance Performance Improvement Committee monthly for 3 months. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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F 609	Continued From page 14	F 609		

injuries or bruises. Both staff told her the incident happened around 5:30 am and both staff were present. The ADON stated both staff heard the roommate yelling for help and observed Resident #71 standing beside his roommate's bed. The resident was unsteady on his feet and was holding on to the bedside table so both staff assisted him to the floor then back to his bed. Both staff wrote statements and they both denied the resident was thrown against the wall.

During an interview on 6/25/24 at 9:35 am, the Executive Director revealed the Assistant Director of Nursing (ADON) notified her close to dinner time. The ADON told her that Resident #71's roommate told her that NA #1 threw Resident #71 against the wall. The Executive Director stated she went to talk to Resident #71's roommate and the roommate reported that NA #1 threw Resident #71 against the wall. She stated the resident did not have injuries or bruises when the ADON assessed the resident. The nurse was assisting NA #1 during the incident and wrote a statement that the allegation did not occur. The nurse reported that NA #1 did not throw resident against the wall. The Executive Director stated she did not notify APS. She stated she thought she did not need to since the resident was safe and was in the facility.

During a discussion on 6/26/24 at 5:15 pm with the Corporate Consultant and Executive Director, the Corporate Consultant stated she remembered the requirement to notify APS on 6/17/24 and discussed this with the Executive Director. The Executive Director revealed she did not notify APS about the abuse allegation. She stated that she thought the resident was safe in the facility and did not think to report it. The Corporate

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F 609	Continued From page 15 Consultant asked the Executive Director to notify APS via email during the discussion on 6/26/24.	F 609		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of	F 636		7/29/24

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F 636	Continued From page 16 the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment at least every 12 months for 1 of 34 residents (Residents #29) whose MDS assessments were reviewed. The findings included: Resident #29 was admitted to the facility on 4/6/18. Her cumulative diagnoses included non-traumatic brain dysfunction, Alzheimer's dementia, and manic depression.	F 636	1. The Minimum Data Set (MDS) Coordinator completed, and transmitted an annual assessment for Resident 29 on 6/26/24. A discharge assessment was completed and transmitted for Resident 62 by the MDS Coordinator on 7/9/24. 2. The MDS Coordinator completed an audit of current residents to assess for late or missing assessments. 4 other residents were identified as having late assessments. These assessments were completed and transmitted between	

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F 636	Continued From page 17 A review of Resident #29's Minimum Data Set (MDS) assessments revealed her last comprehensive (annual) assessment was dated 5/4/23. The resident's electronic medical record (EMR) indicated on the date of the review (6/24/24), her next comprehensive MDS assessment dated 6/12/24 had not yet been completed. The EMR included a banner at the top of the listing of Resident #29's MDS assessments which read: "Next Full: "ARD (Assessment Reference Date): 5/4/2024 39 days overdue [calculated from 5/4/24 to 6/12/24]." An interview was conducted on 6/26/24 at 8:49 AM with the facility's MDS Coordinator. The MDS Coordinator stated she was new to the facility with a start date of 6/19/24. She reported she had pulled a report to show late or missing MDS assessments when she came to work on 6/21/24. The MDS Coordinator stated Resident #29 initially had a quarterly MDS scheduled for 6/12/24. However, when she saw an annual MDS was due on 5/4/24, she changed the quarterly MDS to an annual MDS assessment. The MDS Coordinator confirmed the annual MDS assessment was overdue. An interview was conducted on 6/27/24 at 1:05 PM with the facility's Administrator. During the interview, the concern related to an annual MDS not having been completed every 12 months was discussed. The Administrator reported she felt confident the timeliness of MDS assessments would improve with the new MDS nurse now in place.	F 636	6/24/24-7/15/24. 3. The Executive Director re-educated the MDS Coordinator and Interdisciplinary Team on the proper timing and completion of MDS assessments per regulation on 7-10-24 4. The Executive Director will conduct random audits of 5 current MDS assessments 3 times per week for 4 weeks, then weekly for 3 months, to ensure proper timing and completion of MDS. The MDS Coordinator will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		7/29/24

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F 641	Continued From page 18 §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 staff interviews and record reviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment to reflect the use of an anticoagulant and antipsychotic medication for 1 of 5 residents (Resident #54) reviewed for unnecessary medications and failed to accurately complete a Minimum Data Set (MDS) assessment to reflect a resident's cognitive mental state for 1 of 23 residents (Resident #59) reviewed for MDS accuracy. The findings included: 1. Resident #54 was admitted to the facility on 1/12/22. The resident's cumulative diagnoses included a history of transient ischemic attack (a temporary condition caused by a reduction in blood flow to a portion of the brain) and cerebral infarction (a stroke which may occur because of disrupted blood flow to the brain), atrial fibrillation (a type of heart arrhythmia), major depressive disorder, and psychotic disturbance. A review of Resident #54's electronic medical record (EMR) revealed the following physician orders were received as follows: --On 1/12/22, an order was received for 150 milligrams (mg) dabigatran (an anticoagulant medication) to be administered as one capsule by mouth twice a day for venous thromboembolism prophylaxis (prevention of blood clots). Dabigatran was continued for Resident #54 up to the date of the review on 6/27/24. --On 6/28/23, an order was received for 5 mg of	F 641	Resident #54's Minimum Data Set's (MDS') was corrected in the areas of anticoagulants and antipsychotic to accurately reflect the resident's status on 6/28/24.Resident #59's Minimum Data Set's (MDS') was corrected in the areas of cognition to accurately reflect the resident by the Social Worker and submitted by the MDS Nurse on 7/22/24. A quality review was completed on the current residents' MDSs in the areas of cognition (section C), of falls (section J), and of anticoagulants and antipsychotics (section N) to validate the most recent MDS assessment have been coded to accurately reflect the status of the residents by the MDS nurse on 7/22/24. An ADHOC Quality Assurance Performance Improvement Committee will be held on 7-10-24 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the new MDS Coordinator and Social Worker on accurately coding of cognition, (Section C). The Executive Director educated the new MDS Coordinator on how to accurately code anticoagulants and antipsychotics (Section N) on 7/20/24. The Executive Director will conduct	

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F 641	Continued From page 19 aripiprazole (an antipsychotic medication) to be administered to the resident as one-half tablet by mouth twice daily for psychosis. This order for aripiprazole was discontinued on 11/2/23 with a new order received on 11/3/23 for 5 mg aripiprazole to be administered to the resident as one tablet by mouth once daily. The resident's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated 11/23/23. The Medication section of this MDS assessment reported the resident received, in part, an antipsychotic during the 7-day look back period. However, the MDS did not report that an anticoagulant was administered to Resident #54 during this look back period. A review of the resident's November 2023 Medication Administration Record (MAR) confirmed Resident #54 received both an antipsychotic and anticoagulant medication during the 7-day look back period. Resident #54's next assessment was a quarterly MDS dated 11/29/23. The Medication section of the 11/29/23 MDS assessment indicated the resident received an antipsychotic during the 7-day look back period. The MDS did not report an anticoagulant was administered to Resident #54 during this look back period. A review of the resident's November 2023 MAR confirmed Resident #54 received both an antipsychotic and an anticoagulant medication during the 7-day look back period. A quarterly MDS assessment was completed on 2/29/24. The Medication section of the 2/29/24 MDS assessment indicated Resident #54 received an antipsychotic during the 7-day look back period. The MDS did not report an	F 641	random Quality reviews of 5 residents' MDS assessments in the areas of cognition (Section C), falls (Section J) and anticoagulants/antipsychotics (section N) to ensure MDS coded accurately on 5 random residents 2 times a week for 8 weeks then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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anticoagulant was administered to Resident #54 during this look back period. A review of the resident's February 2024 MAR confirmed Resident #54 received both an antipsychotic and an anticoagulant during the 7-day look back period.

On 3/18/24, Resident #54's order (dated 11/3/23) for 5 mg aripiprazole was discontinued. A new order was written for 5 mg aripiprazole to be given as one tablet by mouth daily for mood. This order was discontinued on 3/22/24.

A quarterly MDS assessment was completed on 3/29/24. The Medication section of the 3/29/24 MDS assessment continued to indicate Resident #54 received an antipsychotic during the 7-day look back period. The MDS did not report an anticoagulant was administered to Resident #54 during this look back period. A review of the resident's March 2024 MAR confirmed Resident #54 did not receive the antipsychotic medication. However, he did receive an anticoagulant during the 7-day look back period.

Another quarterly MDS assessment was completed on 5/16/24 for Resident #54. The Medication section of the 5/16/24 MDS assessment no longer indicated the resident received an antipsychotic during the 7-day look back period. However, it again indicated the resident did not receive an anticoagulant during this look back period. A review of the resident's May 2024 MAR confirmed Resident #54 did not receive the antipsychotic, but he did receive an anticoagulant medication during the 7-day look back period.

An interview was conducted on 6/27/24 at 4:25

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PM with the facility's MDS Coordinator. During the interview, concerns regarding the accurate reporting of Resident #54's medications on his MDS assessments was discussed. The Medication section of each MDS assessment dated 11/23/23, 11/29/23, 2/29/24, 3/29/24, and 5/16/24 was reviewed, along with Resident #54's corresponding MARs. Upon review, the MDS Coordinator confirmed Resident #54's MDS assessments dated 11/23/23, 11/29/23, and 2/29/24 should have reported the resident received an anticoagulant during the 7-day look-back period. She also confirmed the 3/29/24 MDS should not have indicated the resident received an antipsychotic but should have reported he received an anticoagulant. And finally, Resident #54's 5/16/24 MDS should have reported the resident received an anticoagulant during the 7-day look-back period.
The MDS Coordinator stated she was new to the facility with a start date of 6/19/24. She reported she would need to correct the Medication section on each of Resident #54's MDS assessments discussed.

An interview was conducted on 6/27/24 at 4:40 PM with the facility's Administrator. At that time, the concerns related to inaccuracies on Resident #54's MDS assessments was discussed. The Administrator reported she would expect the MDS Nurse to conduct an accurate chart review which included the resident's MARs when completing the MDS assessments.

2. Resident #59 was readmitted to the facility on 1/9/24. The resident's cumulative diagnoses included coronary artery disease, diabetes mellitus, and wound infections left hip and right heel.

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The resident's most recent quarterly Minimum Data Set (MDS) assessment dated 3/15/24 indicated Resident #59 had severe cognitive impairment.

During an interview and observation with Resident #59 on 6/23/24 at 11:05 am, he was observed lying in his bed watching television. During the interview, Resident #59 was able to recall recent and remote events, including, past where he grew up, most recent employment and job duties, and current health concerns and treatments. He stated that he was first admitted in November 2023, he stated that he wasn't thinking clearly due to bad infections in his wounds. He stated that he had felt more like himself since coming back to the facility in January 2024.

During an interview with Nurse #4 on 6/23/24 at 1:15 pm, she stated that she worked with Resident #59 often and stated that he was alert and oriented and was able to make his needs known. She stated that he had some confusion months ago but been cognitively intact since being readmitted following an extensive hospital stay for an infection.

During an interview on 6/28/24 at 2:23 pm with the facility's social worker, she stated she was responsible for completing the cognitive mental status score for all residents. She stated that the cognitive score for Resident #59 was incorrect. She would not clarify why she had been scoring him so low since he was readmitted in January 2024 other than to say it was done in error and would be corrected.

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F 641	Continued From page 23 During an interview with the Director of Nursing on 6/28/24 at 2:25 pm, she stated that Resident #59 was alert and oriented per her assessment of him on a day-to-day basis. She stated that the social worker would be doing a new assessment of Resident #59's current cognitive mental status for his current quarterly MDS assessment that is in progress. During an interview with the facility's Administrator on 6/28/24 at 2:40 pm, she stated she would expect the MDS Nurse and Social worker to conduct accurate chart reviews and assessments of all residents.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 644		7/29/24

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F 644	Continued From page 24 Based on staff interviews and record reviews, the facility failed to incorporate a resident's Preadmission Screening and Resident Review (PASRR) Level II determination and recommendations into the resident's care planning for 2 of 3 residents (Resident #4 and Resident #72) who were reviewed for PASRR. The findings included: 1. Resident #4 was admitted to the facility on 9/6/22 with cumulative diagnoses which included general anxiety disorder, major depressive disorder, mood disorder, bipolar disorder, and schizophrenia. A review of the resident's Electronic Medical Record (EMR) included a PASRR Level II Determination Notification letter dated 5/4/23. The letter indicated Nursing Facility Placement was appropriate with no end date. A determination of the specialized services required to meet Resident #4's needs consisted of follow-up psychiatric services provided by a psychiatrist. Resident #4's most recent comprehensive Minimum Data Set (MDS) was an annual assessment dated 12/2/23. The Identification Information section of the MDS indicated the resident did not have a PASRR Level II status. An MDS modification to this assessment was completed on 6/21/24. The modification corrected a data entry error and changed the Identification Information section to report Resident #4 was a PASRR Level II due to serious mental illness. A review of Resident #4's current care plan (last	F 644	Residents #4 & #72 had their care plans updated to include their level 2 PASARR on 6/26/2024 An audit of residents with a level 2 PASARR was conducted to ensure that their care plan was reflective of the level 2 PASSAR on 7/18/24-7/20/24. All care plans for residents identified with Level 2 PASARRs were added at that time. During the audit, it was noted that 3 residents had been miscoded on their most recent comprehensive assessment, so modifications were completed & submitted on 7/20/24. The Executive Director educated the Social Worker and MDS Coordinator on ensuring that level 2 PASARR's are reflected on the care plan on 7/10/24. The Social Worker Assistant will monitor care plans of 5 residents with level 2 PASSARS weekly for 12 weeks to ensure that the care plan is reflects the level 2 PASSAR's. The Social Work Assistant will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated	

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revised on 5/23/24) revealed it did not include an area of focus which addressed the resident's PASRR Level II determination.

An interview was conducted on 6/26/24 at 8:43 AM with the facility's MDS Coordinator. Upon request, the MDS Coordinator reviewed Resident #4's past and current care plans to see if an area of focus related to her PASRR Level II determination had been completed for this resident. She reported it had not been done. The MDS Coordinator stated she was new to the facility with a start date of 6/19/24. The Coordinator reported she had found an error on the resident's 12/2/23 MDS related to her PASRR Level II status and submitted a modification to correct the error. The MDS Coordinator stated she had not reviewed Resident #4's care plan but confirmed the resident had been determined to have PASRR Level II status on a prior comprehensive assessment (a significant change of condition MDS dated 12/1/22).

An interview was conducted on 6/26/24 at 10:25 AM with the facility's Director of Nursing (DON) in the presence of the MDS Coordinator. During the interview, the DON reported she was unsure as to who assumed the responsibility to develop a care plan related to a resident's PASRR Level II determination. When both the MDS nurse and the DON were asked if there should be an area of focus related to a resident's PASRR Level II determination included in a care plan, they both agreed there should be.

An interview was conducted on 6/27/24 at 10:43 AM with the facility's Administrator. During the interview, an inquiry was made as to who was responsible to develop a PASRR Level II care

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plan for residents requiring one. The Administrator reported the facility's Social Worker (SW) was responsible for initiating a PASRR Level II care plan when it was appropriate to do so. She stated the MDS Nurse was then responsible to ensure that care area was included in the care planning process.

2. Resident #72 was admitted to the facility on 12/20/23 with cumulative diagnoses which included schizophrenia.

A review of the resident's Electronic Medical Record (EMR) included a PASRR Level II Determination Notification letter dated 12/20/23. The letter indicated the PASRR expiration date was 1/19/24. The letter read in part: "Placement Determination: Nursing Facility Placement is appropriate for limited nursing facility stay, lasting no more than thirty (30) calendar days."

Resident #72's admission Minimum Data Set (MDS) assessment was dated 12/27/23. The Identification Information section of the MDS indicated the resident did not have a PASRR Level II status. An MDS modification to this assessment was completed on 6/21/24. The modification corrected a data entry error and changed the Identification Information section to report Resident #72 was a PASRR Level II due to intellectual disability.

Further review of the resident's EMR included a PASRR Level II Determination Notification letter dated 1/30/24. The letter indicated Nursing Facility Placement was appropriate with no end date. A determination of the specialized services required to meet Resident #72's needs consisted

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of follow-up psychiatric services provided by a psychiatrist.

A review of Resident #72's current care plan (last revised on 5/16/24) revealed it did not include an area of focus which addressed the resident's PASRR Level II determination.

An interview was conducted on 6/26/24 at 8:35 AM with the facility's MDS Coordinator. Upon request, the MDS Coordinator reviewed Resident #72's past and current care plans to see if an area of focus related to his PASRR Level II determination had been completed for this resident. She reported it had not been done. The MDS Coordinator stated she was new to the facility with a start date of 6/19/24. The Coordinator reported she had found an error on the resident's 12/27/23 MDS related to his PASRR Level II status and submitted a modification to correct the error. The MDS Coordinator stated she had not reviewed Resident #72's care plan.

An interview was conducted on 6/26/24 at 10:25 AM with the facility's Director of Nursing (DON) in the presence of the MDS Coordinator. During the interview, the DON reported she was unsure as to who assumed the responsibility to develop a care plan related to a resident's PASRR Level II determination. When both the MDS nurse and the DON were asked if there should be an area of focus related to a resident's PASRR Level II determination included in a care plan, they both agreed there should be.

An interview was conducted on 6/27/24 at 10:43 AM with the facility's Administrator. During the interview, an inquiry was made as to who was

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F 644	Continued From page 28 responsible to develop a PASRR Level II care plan for residents requiring one. The Administrator reported the facility's Social Worker was responsible for initiating a PASRR Level II care plan when it was appropriate to do so. She stated the MDS Nurse was then responsible to ensure that care area was included in the care planning process.	F 644		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		7/29/24

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F 657	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and revise a care plan after a resident's antipsychotic medication was discontinued and after fall mats were no longer used. This occurred for 2 of 5 residents (Resident #54 and #59) whose care plans were reviewed for accuracy. The findings included: 1. Resident #54 was admitted to the facility on 1/12/22. A review of Resident #54's electronic medical record (EMR) revealed the following physician orders were received as follows: --On 6/28/23, an order was received for 5 milligrams (mg) of aripiprazole (an antipsychotic medication) to be administered to the resident as one-half tablet by mouth twice daily for psychosis. This order for aripiprazole was discontinued on 11/2/23 with a new order received on 11/3/23 for 5 mg aripiprazole to be administered to the resident as one tablet by mouth once daily. Resident #54's most recent care plan included an area of focus which reported Resident #54 was on antipsychotic therapy related to psychosis (Initiated 1/28/22). The planned goal was for the resident to remain free of antipsychotic drug-related complications (Initiated 1/28/22). On 3/18/24, Resident #54's 11/3/23 order for 5 mg aripiprazole was discontinued. A new order was written for 5 mg aripiprazole to be given as one tablet by mouth daily. This order was discontinued on 3/22/24.	F 657	Resident #59 had their fall mat resolved from their care plan on 6/27/24. Resident #54's care plan problem/goal/interventions related to antipsychotic medications were resolved on 6/27/24. On 7/19/24, the Executive Director, Director of Nursing, the Unit Manager, and the Social Work Assistant audited all current resident's care plans to ensure that they were accurate regarding fall mats and antipsychotic medications. An Ad hoc Quality Assurance Performance Improvement Committee was held on 7-10-24 to formulate and approve a plan of correction for the deficient practice. The Executive Director, the Director of Nursing, the Social Worker, the MDS Coordinator, the Discharge Planner and the Unit Managers regarding the regulations related to accuracy in care plans on 7/24/24. This education will also be included in any newly hired Social Workers, Directors of Nursing, MDS Coordinators, Unit Managers and Executive Directors. A monitor was initiated that will be completed by the MDS Coordinator of 3 care plans weekly for 4 weeks, then 1 care plan weekly for 8 weeks to ensure that care plans are accurate regarding fall mats and psychotropic medications. The results of this quality monitoring will be	

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F 657	Continued From page 30 A quarterly MDS assessment was completed on 3/29/24. The Medication section of the 3/29/24 MDS assessment continued to indicate Resident #54 received an antipsychotic during the 7-day look back period. A review of the resident's March 2024 Medication Administration Record (MAR) confirmed Resident #54 did not receive the antipsychotic medication. Resident #54's most recent MDS assessment was completed on 5/16/24. The Medication section of this 5/16/24 MDS assessment no longer indicated the resident received an antipsychotic during the 7-day look back period. A review of the resident's May 2024 MAR also confirmed Resident #54 did not receive the antipsychotic during the look back period. An interview was conducted on 6/27/24 at 4:25 PM with the facility's MDS Coordinator. During the interview, concerns regarding Resident #54's care plan was discussed. The Medication section of his 3/29/24 and 5/16/24 MDS assessments were reviewed, along with the resident's corresponding MARs. Upon review, the MDS Coordinator confirmed Resident #54's aripiprazole was discontinued on 3/22/24. The MDS Coordinator stated she was new to the facility with a start date of 6/19/24. She reported that she would have wanted to remove the use of an antipsychotic medication from Resident #54's care plan when he was taken off of it on 3/22/24. The MDS Coordinator noted there were two assessments reviews completed (3/29/24 and 5/16/24) when Resident #54's care plan should have been reviewed and revised to reflect the discontinuation of the antipsychotic medication.	F 657	reported by the MDS Coordinator to the Quality Assurance Performance Improvement Committee monthly for 3 months. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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2. Resident #59 was readmitted to the facility on 1/9/24.

The resident's most recent quarterly Minimum Data Set (MDS) assessment dated 3/15/24 indicated Resident #59 had severe cognitive impairment.

Resident #59's most recent care plan dated 11/23/23 included an area of focus which reported Resident #59 had a history of falls. Interventions included Resident #59's bed was to be against the wall and he should have fall mats at his bedside.

During an interview with Nurse Aide #3 on 6/23/24 at 12:35 pm, she stated had worked with Resident #59 several times and she had never noticed any fall mats at his bedside and his bed had always been in the center of his side of the room. She stated she had been working at the facility for 5 months.

During an interview with Nurse #4 on 6/23/24 at 1:15 pm, she stated that Resident #59 has had no mats by his bedside since returning from the hospital earlier in the year. She stated that he was "out of it" when he was first admitted in 11/16/23. She stated Resident #59 was combative and would attempt to throw himself out of bed and they were worried he would also try to get up out of the bed without assistance even though he couldn't stand on his own, so they had placed fall mats by his bed and had pushed his bed against the wall for his own safety. She stated he had been alert and oriented since returning from the hospital with no fall concerns at this time and they had not used the interventions of placing the resident's bed against the wall

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F 657	Continued From page 32 and/or using floor mat. Attempts to reach previous MDS coordinator were unsuccessful. During an interview with the Director of Nursing (DON) on 6/28/24 at 2:25 pm she stated Resident #59 was first admitted in November 2023 and was discharged a week later to the hospital with terrible infections to his wounds that he was admitted with. She stated that Resident #59 was combative and was very confused. Fall mats and the bed against the wall were ordered and added to the care plan. The DON stated the resident was readmitted 1/6/24 with no cognitive issues. She stated fall mats were not needed and the bed was in the center of the room. She stated the intervention for the fall mats and bed against the wall for Resident #59 should have been removed months ago when he returned to the facility. She stated Resident #59's care plan had not been updated and that would be corrected immediately. The DON added that she had not been able to keep up with updating the care plans and that the previous MDS coordinator was responsible for assisting with that. She stated the facility had a brand new MDS coordinator, who started on 6/19/23, and part of her job would be to help her review and update care plans.	F 657		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		7/29/24

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F 689	Continued From page 33 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews and a life safety surveyor interview the facility failed to ensure the safety of residents in the designated smoking area of the facility when a staff member supervising the residents who smoked lit Resident #78's cigarette and allowed the resident to smoke with a combustible tank of compressed oxygen attached to the back of her wheelchair while she sat in the wheelchair. Residents who were also smoking were seated near the oxygen tank. The oxygen tank was turned off while the residents smoked. Even if turned off, it is not safe to smoke around an oxygen tank, oxygen-enriched levels can remain on tubing, clothing, hair, and skin increasing the risk for fire and/or explosion. Supplemental oxygen can make fires burn faster and hotter. This practice was for 1 of 8 sampled residents but placed 7 additional residents at risk for the high likelihood of serious injury or harm. Immediate jeopardy began on 6/26/24 when a staff member lit Resident #78's cigarette with an oxygen tank attached to her wheelchair. The immediate jeopardy was removed on 06/27/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included:	F 689	1. Resident #78 was assessed for smoking on 4/11/24. The assessment identified the resident required supervision due to the inability to safely light a cigarette with a lighter. The maintenance director was assigned to supervise the smoke break at 9 am and failed to notice and remove the oxygen tank on the back of the wheelchair on resident #78 on 6/26/24. 2. The Director of Nursing and Unit Managers identified residents with oxygen use through active physician orders on 06/26/2024. The list of these residents was provided to the social worker who educated the residents that oxygen / oxygen tanks are prohibited in or around the designated smoking area on 06/26/2024 and documented education provided in the residents' chart. The Director of Nursing and Unit Manager identified residents that smoke through smoking assessments on 06/26/2024 and this was verified against the list of current smokers. The list of residents was provided to the social worker who educated the identified residents on ensuring oxygen tanks were to be removed from the wheelchair before entering the smoking area on 06/26/2024 and documented education provided in the resident's chart. 3. The Director of Nursing educated the	

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F 689	Continued From page 34 Resident #78 was readmitted to the facility on 04/10/24. Her diagnoses included chronic obstructive pulmonary disease. Review of Resident #78's physician's orders dated 04/10/24 included an order for continuous oxygen at 3.5 liters via nasal canula. Resident #78's smoking evaluation dated 04/10/24 revealed the Resident was a smoker and was able to communicate why oxygen must always be shut off prior to lighting cigarettes. Resident #78 was not able to light cigarettes safely with a lighter. Resident #78 was marked as smokes safely (Does not allow ashes or lit material to fall while smoking, inhaling or holding smoking item. Remains alert and aware while smoking. Does not forget he/she is smoking or falls asleep holding item. Does not endanger self or others while smoking. Does not burn furniture, clothing, skin, self, or others. Turns oxygen off prior to lighting cigarette. Smokes only in designated area). The summary of the evaluation revealed resident was marked as required supervision while smoking. Review of Resident #78's admission Minimum Data Set (MDS) dated 04/17/24 revealed she had moderate cognitive impairment and was on oxygen therapy. The Current Tobacco Use section was marked "No". Review of Resident #78's care plan dated 04/17/24 revealed a focused area for smoking and interventions included the Resident would not smoke with oxygen tank attached to wheelchair. On 06/26/24 at 9:15 AM an observation of residents in the designated smoking area, from	F 689	Maintenance Director on ensuring oxygen is removed from the wheelchair prior to entering smoking area and the dangers of smoking around oxygen, which is combustible and could cause a fire and/or burns on 06/26/2024. The Unit Manager placed an oxygen rack next to the exit to the courtyard, in the vending machine room, for the oxygen tanks to be placed in before exiting the building, on 06/26/2024. 100% of facility staff to include contract staff were educated by the Director of Nursing and Unit Manager on removing oxygen tanks and placing portable oxygen tanks in the secure oxygen rack prior to residents entering the courtyard smoking area on 06/26/2024. The Director of Nursing re-educated licensed nurses, certified nursing assistants, non-direct staff, contracted staff that includes therapy, housekeeping and dietary staff on the smoking policy, which includes oxygen is not permitted in the designated smoking area, and ensuring oxygen tanks are removed from the wheelchair and or ambulatory residents before entering the smoking area due to the dangers of smoking around oxygen on 06/26/2024. The Executive Director placed signs on the door entering the smoking area as a reminder to ensure oxygen tanks removed from the wheelchair and placed in oxygen rack before entering smoking area as well as signs that state NO OXYGEN OR OXYGEN TANKS BEYOND THIS POINT on 06/26/2024. The Executive Director placed NO	

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F 689	Continued From page 35 the vending room exit door, revealed Resident #78 sitting in a wheelchair, smoking a lit cigarette and had a portable oxygen tank attached to the back of her wheelchair. Her nasal canula tubing was draped over the back of the wheelchair. There were 7 other residents smoking in the smoking area along with 5 staff. The 5 staff in the smoking area included the Maintenance Director, the Human Resources Coordinator, the Central Supply/Scheduler, and 2 contract housekeepers. This surveyor went to the Director of Nursing (DON) and asked her to observe the residents in the smoking area. There was no designated area for oxygen tank storage at the exit door. On 06/26/24 at 9:22 AM an observation was conducted of the designated smoking area with the DON. The DON stated, "Oh no" and went to the smoking area and removed the oxygen tank from the sleeve on the back on Resident #78's wheelchair. The DON stated the oxygen tank should have been removed from the wheelchair prior to exiting the building to go to smoke. The DON did not indicate why the oxygen tank should not be attached to the resident's wheelchair while she smoked. An interview was conducted with the Maintenance Director 06/26/24 at 10:15 AM and he stated he monitored the 2:00 PM smoke break. He stated one of the Nurse Aides (NA) usually escorted the residents to the smoking area. He stated all the residents were already outside when he got to the smoking area. He was unable to specifically recall the exact time he arrived in the smoking area. The Maintenance Director recalled he had opened the door for the residents to exit to the smoking area before he went to get the cigarette box containing the residents' smoking materials.	F 689	OXYGEN / NO OXYGEN TANKS signs in the designated smoking area on 06/26/2024. The Director of Nursing and Unit Manager completed Skilled Check Off Competency for Smoking Safety in accordance with policies and procedures for oxygen safety precautions for oxygen use and not smoking around oxygen, for Licensed nurses, certified nursing assistants, department managers, receptionist, maintenance assistant and activity assistant; these are the staff members that are allowed to supervise smokers. These individuals listed have completed the skills check off competency includes smoking times, where to obtain smoking materials, oxygen tank removal, apron use, the location of fire blankets, fire extinguishers, and where to obtain the list of unsafe smokers on 06/26/2024. Newly hired staff will be provided the same education. The daily assignment sheets identify who is assigned to supervise the smokers and the daily assignment sheets are posted at both nurse’s stations. If the assignments are changed, the nurse is responsible to communicate that to the newly assigned personnel. The skilled check off sheet that identifies the responsibilities for supervising the smokers is in notebooks placed in the vending machine room near the entrance to the designated smoking area and at each nurse’s station. The responsibilities of the supervisor of the smokers are: To know where smoke times are posted, at exit to courtyard.To obta	

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F 689	Continued From page 36 He stated the Scheduler/Central Supply staff, Housekeeper #3, and the Human Resources Coordinator were already in the designated smoking area. He stated after opening the door for the residents to exit, he went to the nursing station to retrieve the residents' smoking materials. The Maintenance Director explained he took the cigarettes out to the smoking area. He said he lit all the residents' cigarettes because they were not allowed to keep smoking materials with them. He stated on 06/26/24 during the 9:00 AM smoke break, he lit Resident #78's cigarette. He said he did not notice the portable oxygen tank on the back of her wheelchair. He stated he had not received any education related to smoking and oxygen tanks. He further stated he knew oxygen was flammable and could explode. He said there were no signs warning against oxygen use in the smoking area. He stated, when the DON removed the oxygen tank from her wheelchair, Resident #78 told him the nurse had told her she could go to the smoking area with her portable oxygen tank if it was set on zero (0). The Maintenance Director stated the NAs usually removed the oxygen tanks prior to escorting the resident outside to smoke. He stated he did not know where the NAs stored the tanks when they removed them from the residents' wheelchairs. He stated he had no instructions in his office and no books containing instructions for storing portable oxygen. On 06/26/24 at 11:15 AM an observation and follow-up interview were conducted with the Maintenance Director. During the observation, measurements were obtained to show the proximity of the tank to the facility and to the resident for the risk of fire. The Maintenance Director measured from the vending room exit	F 689	in smoking materials from the South Hall Medication Cart Assists residents to smoke area as needed. Removes any Oxygen tank and places in designated storage area in vending room (ask nurse for assistance in turning off oxygen as needed) Prior to beginning smoke breaks, ensures that there is no oxygen or oxygen tanks anywhere in the courtyard. Utilizes smoking aprons from the designated smoking area located in the grey bin. Sanitize hands. Passes out cigarettes to each resident. Lights each resident’s cigarette. Faces the residents smoking and continuously monitor their safety. Knows location of fire extinguisher Knows location of fire blanket Assists the residents back in the building after smoke break. Replaces any oxygen tanks from storage to the resident (ask nurse to turn on oxygen if needed) Knows to return smoking materials to designated South Hall Medication Cart An ADHOC Quality Assurance Performance Improvement Committee was held on 06/26/2024 to formulate and approve a plan of correction for the deficient practice. 4. Quality monitors were implemented to ensure that new measures to protect staff, residents, and visitors in the designated smoking area. These monitors will be completed by the Executive Director,	

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F 689	Continued From page 37 door to the location where Resident #78 was positioned in the designated smoking area. The measurements revealed Resident #78 was sitting 67 feet from the vending room exit door and 4 feet from other residents on each side of her wheelchair. There was a fire extinguisher with a full charge on one post and a fire blanket located in a metal box on another post. There were two "Designated Smoking Area" signs. There were no signs to warn against having oxygen in the designated smoking area. An interview was conducted with Resident #78 on 06/26/24 at 11:45 AM and she stated her portable oxygen tank was off when she went to the designated smoking area at 9:00 AM. She stated she had been going outside with her portable oxygen tank attached to the back of her wheelchair for the last month. She stated she had been in the facility for three months and had started smoking regularly one month ago. She stated no one had ever told her she could not go outside with her portable oxygen tank attached to the back of her wheelchair until the DON removed her portable oxygen that morning (6/26/24). Resident #78 stated she transfers herself to her wheelchair and propels her wheelchair herself to the smoking area. The Resident stated prior to 06/26/24, Unit Manager #3 had gone out to the smoking area when Resident #78 had her portable oxygen tank on her wheelchair. She stated Unit Manager #3 told her it was okay to go outside to smoke with the portable oxygen tank on her chair as long as it was off. She stated she goes outside once in the morning and once in the evening. On 06/26/24 at 1:45 PM a follow up interview with Resident #78 was conducted and she stated she	F 689	Director of Nursing, Unit Manager and/or Activity Director 5 times a week for 4 weeks, then 3 times a week for 8 weeks. The results of this monitoring will be presented to the quality assurance performance improvement committee monthly for 3 months.	

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turned off her oxygen tank before she went to smoke. She stated she stopped at the nursing station on her way to the smoking area for the 9:00 AM smoke break, she got out of her wheelchair, turned off her oxygen, got back in the wheelchair and wheeled herself down the hall to the smoking area. She stated she did not recall if there was a nurse or other staff at the nursing station when she stopped there.

On 06/26/24 at 3:35 PM during an observation Resident #78 demonstrated her ability to transfer from her bed to her wheelchair and from her wheelchair she stood and walked to the back of her wheelchair. She demonstrated she could turn her portable oxygen tank setting from 0 to 3 on the tank stationed in the portable tank holder on her wheelchair. Resident #78 stated she never removed or had staff remove her oxygen tank prior to going to the smoking area to smoke. She stated she always had her oxygen tank attached to her wheelchair when she went to smoke.

On 06/26/24 at 12:15 PM an interview was conducted with NA #3 stated Resident #78 got up on her own every morning, transferred herself to her wheelchair, and transported herself to the smoking area. NA #3 stated Resident #78 was very independent and did not wait for staff to assist her with transfers or escort her to the smoking area. NA #3 stated she did not adjust the setting on Resident #78's portable oxygen tank. She stated Resident #78 adjusted the settings on her oxygen tank on her own.

An interview was conducted on 06/26/24 at 12:20 pm with Unit Manager #3. She stated she had smoked with Resident #3 in the past. She stated she did not go to Resident #78's room and talk to

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her on the morning of 06/26/24. She stated Resident #78 had started going out to smoke 1 month ago after being in the facility for about 3 months. Unit Manager #3 stated she stocked the cigarette box and knew Resident #78 did not smoke much. Unit Manager #3 stated Resident #78 may have asked her to turn off her portable oxygen tank prior to going to smoke but she did not know Resident #78 was going to smoke. Unit Manager #3 stated she probably assumed Resident #78 was going back to her room. Unit Manager stated Resident #78's oxygen order was for continuous oxygen. Unit Manager #3 stated she was not sure where Resident #78 went after she turned the oxygen off. Unit Manager #3 stated she should not have turned off Resident #78's oxygen when she did not know where the Resident went after she turned the oxygen off. She stated Resident #78 could have gone to smoke or could have gone to her room; she did not know which. Unit Manager #3 stated that it was Resident #78's right to request the oxygen be turned off.

On 06/26/24 at 12:55 PM an interview was conducted with Housekeeper #3. She stated at times she went to the designated smoking area to smoke while on her break while the residents were smoking. She stated she worked for a housekeeping agency and did not monitor residents. She stated she did not assist residents outside to the smoking area because it was not part of her job duties. She said she did not notice whether Resident #78 had a portable oxygen tank on her wheelchair that morning. She added she had not received training or education that pertained to smoking or oxygen tanks.

An interview was conducted on 06/26/24 at 1:10

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PM with the Central Supply/Scheduler and she stated she was in the smoking area 5 minutes prior to residents' arrival to the area. Central Supply/Scheduler stated from where she was positioned in the smoking area, she did not see the portable oxygen tank on back of Resident #78's wheelchair on 06/26/24. She stated she had never changed the setting on Resident #78's oxygen tank. She stated if asked, she would take a resident's oxygen tank to their room and put it in portable holder. She stated she received oxygen tank training during orientation and yearly through an online training program. She stated the training included the dangers of oxygen, flammables, and smoking. She added if she had noticed the oxygen tank on the back of Resident #78's wheelchair, she would have removed the tank from the smoking area due to the danger.

On 06/26/24 at 1:25 PM an interview was conducted with Housekeeper #2. She stated she was not responsible for monitoring residents. She further stated she did not assist in escorting residents to the smoking area because it is 'not in her scope'. She said she had never paid attention to or noticed an oxygen tank on Resident #78's wheelchair. She stated that although she had not received training that pertained to smoking or oxygen use, she knew it could cause an explosion.

An interview was conducted with the Human Resources Coordinator on 06/26/24 at 1:30PM and she stated she assisted with smoke breaks at times. She stated she assisted with monitoring the 9:00 AM smoke break on the morning of 06/26/24. The Human Resources Coordinator said she was already outside when the residents exited the building to smoking area. She stated

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she did not notice the oxygen tank on Resident #78's wheelchair. She stated she had never witnessed the Resident #78 with an oxygen tank on her wheelchair. She said if she had observed the oxygen tank on the back of the wheelchair, she would have removed the tank and she would have asked the Central Supply/Scheduler what to do with the tank. She stated she knew an oxygen tank was not supposed to go outside.

On 06/26/24 at 2:30 PM a phone interview was conducted with the NC DHHS Life Safety Surveyor, and he stated that smoking and/or an open flame in the vicinity of a compressed oxygen cylinder is a fire hazard. He further stated it did not matter if the oxygen tank was off, it still posed a risk of fire and/or explosion.

An interview was conducted on 06/26/24 at 5:15 PM with the Administrator and DON. The Administrator stated Resident #78's oxygen tank should not have been in the smoking area. She stated it was not the Maintenance Director's designated job duty to monitor the residents while they smoked. She stated the staff in the smoking area were responsible for monitoring the residents while they smoked. The DON stated she the daily assignment sheets included the NAs' names assigned to smoke breaks on each shift. The DON stated the Maintenance Director often offered to monitor the smoke breaks when the assigned NA was busy. The DON stated on weekends the assigned NA monitored the smoke breaks. She stated the smoke break assignment was subject to change to meet the facility needs. The Administrator stated the smoke break assignment falls under the "Other duties as assigned" description. The DON stated training related to smoking and oxygen use was provided

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for facility staff during orientation and yearly but was not provided to housekeeping, dietary, and therapy. The Administrator stated all staff were responsible for residents' safety while on the facility grounds. She stated that included break time if the staff were in the smoking area while residents were there smoking. She stated staff should have made sure Resident #78 did not enter the designated smoking area with her portable oxygen tank attached to her wheelchair because she was aware that oxygen was flammable and smoking near a tank whether it was turned on or off could potentially explode and harm residents.

The Administrator was notified of immediate jeopardy on 06/26/24 at 6:36 PM.

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

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

1. The corrective action for alleged deficient practice was accomplished by:
Prior to the incident, Resident # 78 was in her bed, utilizing the Oxygen concentrator in her room. Resident #78 self-transferred into her wheelchair with a portable oxygen tank that was turned off, on the back of her wheelchair. The resident attached the end of the tubing to the portable oxygen tank and placed the nasal canula tubing in the bag on the wheelchair. The oxygen was not turned on and the nasal canula was not applied. Resident self-propelled into smoking area while Maintenance Director held the door for her and other residents as they were entering the

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courtyard to smoke. The resident was observed smoking in the courtyard with a portable oxygen tank attached to her wheelchair by the surveyor. The surveyor observed the tank on the back of the wheelchair while the resident was in the courtyard smoking, the surveyor left the courtyard observation to notify the Director of Nursing (DON) who was in her office that she had a concern in the courtyard and asked her to walk to the courtyard. When the DON arrived at the door that enters the courtyard, the surveyor asked the DON if she saw anything wrong. The Director of Nursing immediately went to the courtyard and removed the oxygen tank from the back of resident #78's wheelchair on 06/26/2024. The surveyor observed 4 staff members, the Maintenance Director, the Human Resources Director and 2 housekeepers, in the designated smoking area while the resident was smoking with a portable oxygen tank on the back of her wheelchair. Immediately after the Director of Nursing removed the tank from the resident's wheelchair and placed the tank in the secured portable holder in residents #78's room, the Director of Nursing assessed the smoking area through observation for safety signage as it related to no smoking with oxygen and identified there was no signage regarding no oxygen in smoking area. The only sign posted was Designated Smoking Area. The Maintenance Director, Human Resources Director nor the 2 housekeepers were educated or trained on the importance of monitoring for the use of oxygen. None of the staff in the designated smoking area noticed the oxygen tank on the back of the wheelchair.

Resident #78 was assessed for smoking on 4/11/24. The assessment identified the resident

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required supervision due to the inability to safely light a cigarette with a lighter. The maintenance director was assigned to supervise the smoke break at 9 am and failed to notice and remove the oxygen tank on the back of the wheelchair on resident #78 on 6/26/24. The Director of Nursing and Unit Manager identified residents with oxygen use through active physician orders on 06/26/2024. The list of these residents was provided to the social worker who educated the residents that oxygen / oxygen tanks are prohibited in or around the designated smoking area on 06/26/2024 and documented education provided in the residents' chart. The Director of Nursing and Unit Manager identified residents that smoke through smoking assessments on 06/26/2024 and this was verified against the list of current smokers. The list of residents was provided to the social worker who educated the identified residents on ensuring oxygen tanks were to be removed from the wheelchair before entering the smoking area on 06/26/2024 and documented education provided in the resident's chart.

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

The Director of Nursing educated the Maintenance Director on ensuring oxygen is removed from the wheelchair prior to entering smoking area and the dangers of smoking around oxygen, which is combustible and could cause a fire and/or burns on 06/26/2024.

The Unit Manager placed an oxygen rack next to the exit to the courtyard, in the vending machine

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room, for the oxygen tanks to be placed in before exiting the building, on 06/26/2024. 100% of facility staff to include contract staff were educated by the Director of Nursing and Unit Manager on removing oxygen tanks and placing portable oxygen tanks in the secure oxygen rack prior to residents entering the courtyard smoking area on 06/26/2024.

The Director of Nursing re-educated licensed nurses, certified nursing assistants, non-direct staff, contracted staff that includes therapy, housekeeping and dietary staff on the smoking policy, which includes oxygen is not permitted in the designated smoking area, and ensuring oxygen tanks are removed from the wheelchair and or ambulatory residents before entering the smoking area due to the dangers of smoking around oxygen on 06/26/2024.

The Executive Director placed signs on the door entering the smoking area as a reminder to ensure oxygen tanks removed from the wheelchair and placed in oxygen rack before entering smoking area as well as signs that state NO OXYGEN OR OXYGEN TANKS BEYOND THIS POINT on 06/26/2024.

The Executive Director placed NO OXYGEN / NO OXYGEN TANKS signs in the designated smoking area on 06/26/2024.

The Director of Nursing and Unit Manager completed Skilled Check Off Competency for Smoking Safety in accordance with policies and procedures for oxygen safety precautions for oxygen use and not smoking around oxygen, for Licensed nurses, certified nursing assistants, department managers, receptionist, maintenance

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assistant and activity assistant; these are the staff members that are allowed to supervise smokers. These individuals listed have completed the skills check off competency includes smoking times, where to obtain smoking materials, oxygen tank removal, apron use, the location of fire blankets, fire extinguishers, and where to obtain the list of unsafe smokers on 06/26/2024.

The daily assignment sheets identify who is assigned to supervise the smokers and the daily assignment sheets are posted at both nurse's stations. If the assignments are changed, the nurse is responsible to communicate that to the newly assigned personnel. The skilled check off sheet that identifies the responsibilities for supervising the smokers is in notebooks placed in the vending machine room near the entrance to the designated smoking area and at each nurse's station. The responsibilities of the supervisor of the smokers are:

o To know where smoke times are posted, at exit to courtyard
o To obtain smoking materials from the South Hall Medication Cart
o Assists residents to smoke area as needed
o Removes any Oxygen tank and places in designated storage area in vending room (ask nurse for assistance in turning off oxygen as needed)
o Prior to beginning smoke breaks, ensures that there is no oxygen or oxygen tanks anywhere in the courtyard
o Utilizes smoking aprons from the designated smoking area located in the grey bin
o Sanitize hands
o Passes out cigarettes to each resident
o Lights each resident's cigarette
o Faces the residents smoking and

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continuously monitor their safety
- o Knows location of fire extinguisher
- o Knows location of fire blanket
- o Assists the residents back in the building after smoke break
- o Replaces any oxygen tanks from storage to the resident (ask nurse to turn on oxygen if needed)
- o Knows to return smoking materials to designated South Hall Medication Cart

An ADHOC Quality Assurance Performance Improvement Committee was held on 06/26/2024 to formulate and approve a plan of correction for the deficient practice.

Date of Immediate Jeopardy Removal 6/27/24. The title of the person responsible for implementing the acceptable credible allegation for immediate jeopardy removal.

The Administrator is responsible for the credible allegation of immediate jeopardy removal.

Alleged date of IJ removal 06/27/24.

A validation of immediate jeopardy removal was conducted on 06/27/24 as evidenced by the following verification of education for licensed nurses, certified nursing assistants, non-direct care staff, contracted staff that included therapy, housekeeping, and dietary staff on the smoking policy, which included oxygen is not permitted in the designated smoking area, and ensuring oxygen tanks are removed from the wheelchair and or ambulatory residents before entering the smoking area. Observation revealed a tank holder in the vending area next to the exit door leading to the smoking area. The exit door had a

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F 689	Continued From page 48 sign that read "No Oxygen or Oxygen Tanks Beyond This Point" and signs in the smoking area that read "No Oxygen/No Oxygen Tanks". The IJ removal date of 6/27/24 was validated.	F 689		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those	F 791		7/29/24

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F 791	Continued From page 49 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interview, the facility failed to provide dental services to 1 of 1 sampled resident (Resident #30) with several missing and/or chipped teeth who requested dental services. Findings included: Resident #30 was admitted to the facility on 2/22/24 with diagnoses which included: chronic obstructive pulmonary disease, congestive heart failure, and nicotine dependence (cigarettes). The admission assessment dated 2/22/24 indicated Resident #30 had loose, broken/chipped teeth. The physician's order dated 2/22/24 indicated the facility was to provide Resident #30 with dental services as needed. The quarterly minimum data set (MDS) dated 6/4/24 indicated Resident #30 was cognitively intact; had no weight loss; and received a diet of regular texture.	F 791	Resident #30 was seen by the dentist on 7/16/24. 2. The Director of Nursing/Unit Manager completed interviews with residents having a BIMs of 8 or greater on 7/19/24, to question and assess resident for dental issues. The Director of Nursing/Unit Managers observed/assessed residents with a BIMs of 7 or less on 7/19/24 for any signs and symptoms of dental pain. Residents with issues identified, had the physician notified and appointments made. An Ad hoc Quality Assurance Performance Improvement Committee was held on 7-10-24 discuss the plan for implementation. 3. The Director of Nursing re-educated licensed nurses on ensuring dental pain is addressed and dental referral is made by 7-23-24. 4. The Director of Nursing will conduct quality monitoring of 2 residents with a BIMs of 8 or greater and 3 residents with	

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F 791	Continued From page 50 The care plan dated 6/13/24 revealed Resident #30 had oral/dental health problems related to poor dental hygiene. Interventions included: coordinate arrangements for dental care, transportation as needed/as ordered. During an interview on 6/23/24 at 1:35 p.m., Resident #30 was observed finishing his lunch of chicken, mixed vegetables, and potato wedges. The resident stated he was able to eat baked chicken but had problems chewing some meats. There was also a fresh peach observed on his overbed table. The resident revealed a family member brought the peach to him and he hoped it was soft enough for him to chew. The resident had missing bottom front teeth with only one bottom front tooth. The resident stated that in the six months since his admission to the facility, he had requested dental services because chewing meat was sometimes difficult. He did not recall the names of the facility staff to whom he made the request for dental services. During an interview on 6/26/24 at 12:28 p.m., the Social Worker revealed the facility's contracted dental provider conducted monthly exam visits, as well as triage visits to the facility. She further explained that when a resident required a social service referral, the nursing staff would notify her verbally or place the referral in the designated notebook located at each of the two nursing stations which she checked every week. The Social Worker confirmed Resident #30 had not been seen by the contracted dental provider since his admission to the facility and was not currently on the upcoming scheduled dental visit for July 2024. She stated she was not made aware of the resident's dental needs but would immediately include the resident on the list of residents to be	F 791	BIMs of 7 or less residents to assess for dental pain weekly 8 weeks, then monthly for 4 months to ensure dental referrals made timely. The Director of Nursing will report on the results of the quality monitoring to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring updated as indicated.	

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F 791	Continued From page 51 examined by the dentist during the upcoming July 2024 visit.	F 791		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with the facility staff and Dietary District Manager, the facility failed to: 1) Wash hands / change gloves between handling soiled and clean dishes to prevent cross-contamination and failed to allow all clean service ware and dishware to air dry during 1 of 1 observation of the dish washing practices; 2) Label, date, and seal food items stored in the Dietary Department's walk-in freezer and dry food storage room; and 3) Maintain a sanitary environment in 1 of 2 nourishment rooms by having black dried substances behind the ice	F 812	DA #1 and DA #2 had education regarding infection control procedures on 6-26-24. The service ware that had cross contamination was cleaned again per facility protocol on 6-26-24 with the Regional Dietary Manager overseeing the process. The contaminated dishware was cleaned and dried maintaining infection control procedures by the Dietary District Manager on 6-26-24. All unlabeled, undated, and unsealed food items were removed from stock in the freezer and dry	7/29/24

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F 812	Continued From page 52 machine and beside and under the refrigerator (Long Hall nourishment room). The findings included: 1. A continuous observation was conducted on 6/26/24 from 9:15 AM to 9:30 AM of the facility's dish washing process using a high temperature dish machine. Upon entering the dish room, one Dietary Assistant (DA #1) was observed to be working on the dirty side of the dish machine as he stripped down meal trays and loaded the dish racks. Upon entry to the dish room, the second Dietary Aide (DA #2) was also observed to be working on the dirty side of the dish machine as he sprayed the meal trays and plates with water, loaded the dish rack, and slid the dish rack into the dish machine. Without washing his hands and donning gloves, DA #2 was observed as he crossed over to the clean side of the dish machine, removed the clean dish rack and slid it to the clean side of the machine after the wash/rinse cycle was completed. DA #2 removed the meal trays individually from the dish rack and used a white towel (kept on the windowsill above the countertop on the clean side) to wipe each tray prior to stacking them on a rolling cart. After doing so, DA #2 was observed to don a pair of disposable gloves without washing his hands. He then returned to the dirty side of the dish machine. At that time, the facility's District Manager entered the dish room and instructed DA #2 to wash his hands and to be sure to stay on the clean side of the dish machine. Details of the observations made over the last 5 minutes were discussed with the District Manager. The District Manager was observed as she educated DA #1 and DA #2 and instructed them to re-wash the meal trays that had been wiped with a towel	F 812	food storage room on 6-26-24 by the Dietary District Manager. The nourishment room on Long Hall had the dried black substance behind the ice machine and beside/under the refrigerator on 6-25-24 by the Housekeeping Supervisor and the Maintenance Director. On 6-27-24 the Executive Director and Dietary District Manager inspected the stock in the kitchen freezer and dry food storage area with no negative findings identified. On 6-27-24 the Dietary District Manager observed cleaning and air drying of the dishware for breakfast and lunch with no negative findings identified. On 6-27-24, the Housekeeping Supervisor, the Maintenance Director and the Executive Director inspected the nourishment room at the front nurse's station with no negative findings identified. An Ad hoc Quality Assurance Performance Improvement Committee was held on 7-10-24 to formulate and approve a plan of correction for the deficient practice. On 7-19-24 the District Dietary Manager terminated the employment of the Dietary Manager. The District Dietary Manager educated the new dietary manager and dietary staff on safe storage and infection control practices on 7-20-24. The same education will be provided to newly hired dietary managers and dietary staff. On 7-22-24 the Executive Director educated the Housekeeping Supervisor, the Maintenance Director, and the	

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F 812	Continued From page 53 and placed on the rolling cart. She then removed two white towels (including one on the windowsill) kept in the dish machine area. An interview was conducted with both the Dietary Manager and District Manager on 6/27/24 at 9:49 AM. During the interview, the Dietary Manager reported the Department's staff have been educated in the past that if someone worked on the clean side of the dish machine, he/she must stay on that side while the staff member on the dirty side stayed on the dirty side. When asked what their thoughts were regarding the observed practice of using a towel to dry the clean service ware, the District Manager stated, "Everything has to be air-dried." 2. An initial tour was conducted of the Dietary Department on 6/23/24 at 10:35 AM. The Dietary Manager was not available to join the initial tour of the Department. Observations made at the time of the initial tour identified the following concerns in the walk-in freezer: --An opened box dated 5/28 with an opened and unsealed interior plastic bag was observed to contain approximately 16 beef patties. The plastic bag was not closed, leaving the beef patties exposed to air (not sealed). The patties had a thin layer of ice crystals on them at the time of the observation. --An opened box dated 6/11 with an opened and unsealed interior plastic bag was observed to contain 13 beef patties. Neither the box nor the plastic bag was closed, leaving the beef patties exposed to air (not sealed). --An opened box dated 6/11 with an opened and unsealed interior plastic bag was observed to contain approximately 20 pollock fish filets. The plastic bag was not closed, leaving the filets	F 812	Maintenance Assistant regarding daily observations of the nourishment rooms for infection control issues, cleanliness, and the need for repairs. The housekeeping supervisor educated the housekeeping staff on 7-22-24. This education will be provided to newly hired maintenance or housekeeping staff. . The Executive Director (ED) will conduct quality monitoring (audit) of the kitchen area and dietary storage facilities, 3 times per week for 8 weeks, then weekly for 4 weeks to ensure all foods labeled and dated. The Dietary Manager will conduct quality monitoring on handwashing and observation of dirty to clean areas in kitchen 3 times per week for 8 weeks then weekly for 4 weeks staff compliance. The Executive Director will conduct audits of the nourishment rooms 2 times weekly for 4 weeks, then weekly for 8 weeks. The ED will report on the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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exposed to the air (not sealed) in the walk-in freezer.
--An opened box dated 5/7 with an opened and unsealed interior plastic bag was observed to contain sheet pan-sized frozen pizza dough. The plastic bag was not closed (not sealed), leaving the frozen dough exposed to the air in the walk-in freezer. Ice crystals were observed on the surface of the frozen dough.

Observations made at the time of the initial tour on 6/23/24 at 10:55 AM identified the following concerns in the dry food storage room (pantry):
--A 5 pound (#) opened bag of bread crumbs stored in the pantry was not sealed or dated as to when it had been opened. There was approximately 1# of bread crumbs remaining in the unsealed bag.
--A 5# partial can of dehydrated mashed potatoes was observed to be stored on a pantry shelf. The can's foil seal was completely pulled off the can and laid loosely on top of it. Plastic wrap was also observed to be loosely placed around the plastic container. The container was not sealed. It was dated as having been opened on 6/11.

A follow-up tour of the Dietary Department was conducted on 6/24/24 at 2:21 PM with the facility's Dietary Manager. At that time, the concerns identified in the initial tour conducted on 6/23/24 were again observed in both the walk-in freezer and the dry food storage room.

On 6/24/24 at 2:21 PM, a review of the concerns identified during the 6/23/24 initial tour of the Department was shared with the Dietary Manager. Accompanied by the Dietary Manager, a follow-up observation was conducted of the food items in both the walk-in freezer and dry

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food storage room that had been identified with concerns. Upon inquiry, the Dietary Manager reported staff were expected to store food items in sealed containers labeled with the date the food item was opened.

An interview was conducted on 6/25/24 at 2:44 PM with the Dietary District Manager. At that time, the findings of the Dietary Department's initial and follow-up tours were discussed. The Dietary District Manger reported that each time a food product was used, the inner plastic lining should be tied (or somehow sealed), the box closed completely and dated as to when it had been opened.

3. a) An observation of the long hall nourishment room on 6/24/24 at 10:37 am in the presence of Nurse Aide (NA) #2 revealed black dried powdery substance on a white blanket crammed behind the ice machine. The same black dried powdery substance was noted on the wall behind the pipes that were attached to the ice machine. The plastic baseboard under the pipes behind the ice machine was peeling off the wall. The black dried powdery substance was observed between the wall and the baseboard that was peeling off. The floor tiles in the nourishment room were dull and had debris. NA #2 stated she did not know what the black stuff was.

b) An observation of the corner wall opposite the ice machine on 6/24/24 at 10:37 am in the presence of NA #2 revealed black dried powdery substance under the refrigerator and behind it. The plastic baseboard on the side of the refrigerator was peeling off and black dried powdery substance was noted in between the wall and the baseboard that was peeling off. Parts

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of the floor tiles under the refrigerator were missing and the black dried powdery substance was noted in their place. The black powdery substance was also noted to have extended to the tiles in front of the refrigerator. NA #2 stated she did not know what they were. She stated she obtained ice and snacks for the residents inside the long hall nourishment room and left immediately. She did not stay inside the nourishment room longer than necessary, so she did not pay attention to the room situation.

c) An observation on 6/24/24 at 10:37 am of the cabinet under the sink in the nourishment room revealed debris all over the cabinet floor. A greenish round furry circle approximately 3 inches x 3 inches was noted at the right corner of the cabinet floor. NA #2 stated she never opened the cabinet door and never saw how it looked.

During an interview on 6/24/24 at 10:55 am, Housekeeper #1 stated she was assigned to clean the long hall nourishment room. She stated they had three housekeepers that were scheduled daily. She stated she was able to clean all her assigned rooms daily. The Housekeeper stated she picked up the trash and checked the rooms first thing in the morning. She went back to wipe surfaces and swept and mopped the floors. She stated she reported any repairs needed to the Maintenance Director.

During an interview on 6/24/24 at 11:07 am, the Maintenance Director stated he cleaned parts of the ice machine every month and drained it every 3 months. He showed the cleaning log posted beside the ice machine and pointed out that it was last cleaned on 5/7/24. He removed the white blanket with black dried powdery substance

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F 812	Continued From page 57	F 812		

and stated he did not know what the black substance was. He stated the water filter for the ice machine was changed in March 2024. The pipes behind the ice machine started to leak slowly so he placed the blanket to catch the slow drip and forgot to take it off. The Maintenance Director stated the black substance on the wall behind the pipes was from the condensation from the pipes attached to the ice machine. He observed the cabinet under the sink and stated somebody had removed the screws. He stated all the cabinets under the sink were screwed shut. The Maintenance Director stated housekeeping was responsible in cleaning the nourishment room.

During a follow up interview on 6/24/24 at 11:20 am, the Housekeeper was shown the black dried powdery substance at the back of the ice machine and beside and under the refrigerator. She stated she cleaned the long hall nourishment room yesterday. She stated she observed the black powdery substance behind the ice machine last week but did not have stuff to clean it. She stated she did not report it. Housekeeper #1 observed the cabinet under the sink and stated she never opened those. She further stated she did notice the black powdery substance beside and under the refrigerator. Housekeeper #1 stated she would clean the nourishment room as soon as she could.

During a walking tour on 6/25/24 at 9:50 am, the Executive Director observed the dried black powdery substance behind the ice machine and beside and under the refrigerator. She also observed the debris and the greenish furry area at the corner of the cabinet under the sink. She stated housekeeping should be cleaning this. She

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F 812	Continued From page 58 stated she would have maintenance repair the nourishment room. During an interview on 6/25/24 at 10:59 am, Unit Manager #2 stated she went into the long hall nourishment room only to obtain snacks or ice for the resident when she worked the cart. She stated she observed the condition of the ice machine and refrigerator two months ago and saw housekeepers going inside the nourishment room daily and thought they were cleaning the room. During an interview on 6/26/24 9:29 am, Unit Manager #1 stated she was assigned the long hall and stated she rarely went into the nourishment room, so she was not aware of the condition of the cabinet under the sink and the black substance behind the ice machine, beside the refrigerator, and under the refrigerator. She stated management did room rounds every morning and checked their assigned residents and their rooms. The team looked at wall paint, vents, toilets, air conditioner units, and other things that might need maintenance or cleaning. She stated checking the nourishment room should be added to the management team assignments. During a follow up interview on 6/26/24 at 10:59 am, the Executive Director stated the housekeeper cleaned the nourishment room and the maintenance staff fixed the tile under the refrigerator and the base boards. The wall had been cleaned and repainted around the refrigerator and the ice machine. The cabinet under the sink had been cleaned and repainted.	F 812		
F 908 SS=D	Essential Equipment, Safe Operating Condition	F 908		7/29/24

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F 908	Continued From page 59 CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on record review, observations. and interviews with facility staff, the Dietary District Manager, and an Appliance Service Technician, the facility failed to notify the Administration of a concern related to the ignition of the stovetop burners, turn off the gas to the pilot lights of the malfunctioning gas burners and oven, and provide the maintenance required to keep 1 of 1 gas stove/oven combination appliance in safe operating condition. The findings included: An initial kitchen tour was conducted of the Dietary Department on 6/23/24 at 10:35 PM. The Dietary Manager was not available at the time of the initial tour. A follow-up kitchen tour was conducted with the Dietary Manager on 6/24/24 at 2:21 PM. An observation made during the follow-up tour revealed the Dietary Department's gas stove / oven combination was aged with one control knob missing on the front of the appliance. Two other control knobs were each missing one-half of the knob on the front of the appliance. At that time, the Dietary Manager reported the missing and damaged control knobs had melted off when flames ignited from the front of the stove top when it was turned on. Upon further inquiry regarding the ignition and burning of the stove top control knobs, the Dietary Manager reported one	F 908	The maintenance director placed a lock out/tag out sign on the stove. The gas company came cleaned the connecting tubes that delivers the gas to the burners. He then tested the connecting tubes to ensure that there was no backflash of gas. He then turned the gas off to the stove. The company that services gas stoves came out next, tested all burners and the oven. He determined that 4 of the burners were safe for use. He turned off the gas to the 2 right burners and to the oven. The 2 burners on the right were and the oven had lock out/tag out signs placed on them. On 7-18-24, the gas was cut off to the existing stove, a gas cap was put into place. A picture of this was provided via email to Roger Fortman, Life Safety Inspector. The existing stove was removed from the facility. A new stove was approved and ordered on 6-28-24. The maintenance director inspected all other pieces of kitchen equipment to ensure the equipment was safe for use on 7-19-24 with no other issues noted. On 7-20-24, education was provided by the Executive Director, Regional Dietary Manager and Maintenance Man, to dietary staff on how to identify unsafe equipment, stop use of unsafe equipment and to	

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F 908	Continued From page 60 of the times this occurred was when Cook #1 worked. Cook #1 was working at the time of the follow-up kitchen tour. Accompanied by the Dietary Manager, an interview was conducted on 6/24/24 at 2:42 PM Cook #1. During the interview, Cook #1 was asked to describe what had occurred when a control knob from the stove burned off. She stated, "For me, it happened about a month ago....I turned it [the stove top] on and the flame just ignited and came out the front of the stove top and burned off the right side [of the 2nd to the left knob]." The cook stated the flame went out when she turned off the control knob. When the Dietary Manager was asked who knew about this problem, she stated the District Manager was aware of the concerns about the stove / oven and had noted the Department's need for a new appliance on recent monthly reports. At that time, further inspection of the gas stove top and oven revealed the grease tray under the stove top had a 12-inch diameter hole which appeared to have rusted through. The Dietary Manager reported the grease tray posed "too much of a hazard to use the oven." She reported the oven was no longer used due to this risk and stated the kitchen's convection oven was utilized instead of the gas oven. A return to the kitchen was made on 6/24/24 at 3:05 PM. At that time, a follow-up interview was conducted with Cook #1. When asked, the cook reported she had worked at the facility for approximately 10 years. When asked what she did when the flame came out the front of the stove, she reported she hurried up and turned the burner off. She waited for a little while, then re-started the stove top because she "had to use	F 908	report any unsafe equipment to the Maintenance Director and to not to use unsafe equipment until it has been inspected by the maintenance department. This education will also be included in any new hire education. The Maintenance Director and/or the Executive Director will be conducting quality monitors of kitchen equipment 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, then weekly for 8 weeks to ensure the kitchen equipment is functioning safely. The results of this quality monitoring will be reported by the Maintenance Director to the Quality Assurance Performance Improvement Committee monthly for 3 months. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	

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it." The stove top ignited properly that time.

A follow-up interview was conducted on 6/24/24 at 3:10 PM with the Dietary Manager. During the interview, the Dietary Manager reported one day when the control knobs on the front of the stove stop caught on fire, she told the facility's Maintenance Director about it. A request was then made for the facility's Maintenance Director to come to the Dietary Department.

On 6/24/24 at 3:15 PM, the Maintenance Director joined the Dietary Manager in the kitchen. Another observation was conducted of the stove / oven combination appliance at that time. From the observation, the stove top initially had 6 knobs plus an oven control knob on the front of the appliance. The 2nd and 3rd knobs from the left appeared partially burned off and the 2nd knob from the right was completely missing. At 3:23 PM, the Maintenance Director removed the control knob for the oven to prevent inadvertent use of the oven due to the large hole in the grease tray. When asked if he thought the stove top was a safety hazard, he said "Well, I don't know." The Maintenance Director reported he had not previously been told of an occasion when a flame came out the front of the stove.

On 6/24/24 at 3:35 PM, the facility's Administrator was asked to come to the Dietary Department to join the Dietary Manager and Maintenance Director. The Corporate Consultant accompanied the Administrator to the kitchen. When the Administrator and Corporate Consultant were shown the gas stove / oven appliance and told of the concerns with it, the Administrator stated, "How come nobody told me before?" When the Administrator was asked if

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she thought it would be safe to use the appliance, she stated she was not an expert. Therefore, she reported they would make calls to find someone who could determine whether the appliance could be safely used.

On 6/24/24 at 5:00 PM, the Administrator reported the stovetop and oven had been "tagged off" so they would not be used. She stated someone was coming to the facility to repair the appliance on this date (6/24/24).

Accompanied by an appliance service technician and the Maintenance Director, a follow-up interview was conducted on 6/24/24 at 5:45 PM with the Administrator. The Administrator reported the gas company had already been out and the appliance service technician had now worked on the stove / oven. The stovetop had 6 burners. The Administrator reported the left two burners and the middle two burners were now deemed operable per the gas company. She stated the gas company service technician told her the burners were clogged, causing a blow back when they were ignited. The appliance service technician also reported the pilot lights for the right two burners were turned off and he was going to put a lock out on them. Also, the pilot assembly on the oven had broken off so this pilot light also needed to be turned off (which he did). The service technician stated the bottom line was that it was now safe to use 4 (of the 6) burners on the stove top. He stated that the other two burners and the oven could not be used. During the interview conducted with the appliance service technician, he was asked whether the gas stove / oven posed a potential hazard prior to its cleaning, repair and the pilot light being turned off for two burners and the oven. He stated since he

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came to the facility after the gas company had already been there, he couldn't speak to the potential hazard the appliance may have posed.

A follow-up interview was conducted on 6/25/24 at 2:18 PM with the Maintenance Director. At that time, the Maintenance Director was asked if any maintenance requests had been made related to the stove / oven in the Dietary Department over the past one year. The Director stated, "I don't think I have any."

An interview was conducted on 6/25/24 at 2:44 PM with the Dietary District Manager. At that time, the District Manager stated, "I was never aware of it [the gas stovetop] catching on fire before this survey. I was never told it caught on fire." However, the District Manager stated she was aware the pilot light on this appliance was hard to light and that the oven was not being used. When asked what her thoughts were with regards to the condition of this appliance, she stated, "I felt like it was very dangerous." The District Manager reported she had been suggesting a replacement of the appliance because "it was old." She added that if she had known more about the problems with the stove / oven, she would have talked with the facility's Administrator. When asked how long the problems with the stove / oven existed, the District Manager stated she understood it started about a month ago. Upon inquiry as to what she would have preferred to have happened, the District Manager stated she would have wanted the Dietary Manager to report the problems to maintenance first, put a request into the Maintenance Log, and bring up the concerns to the Administrator during the morning meeting. The District Manager also reported she should

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have been informed of these concerns herself. A follow-up interview was conducted on 6/27/24 at 9:49 AM with the Dietary Manager and Dietary District Manager. At that time, the District Manager reported she had instructed the dietary staff "not to use the gas stove top at all." She confirmed a new appliance was ordered for the Dietary Department.

On 7/15/24, the Administrator provided the facility's semi-annual (dated 10/9/23) and annual (dated 4/10/24) Fire Suppression Inspection Certificates for review. Results from the Inspection and Testing of the Emergency Power Off (gas shut off) for the kitchen indicated this item passed the inspection on both 10/9/23 and 4/10/24.