STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	C 08/27/2024

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THE IVY AT GASTONIA LLC	4414 WILKINSON BLVD GASTONIA, NC 28056

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/19/24 through 08/23/24. Additional information was obtained on 8/26/24, therefore the exit date was 8/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 9QSI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 08/19/24 through 08/23/24. The corrective action plan was validated on 08/27/24. Therefore, the exit date was changed to 8/27/24.(Event ID# 9QSI11). The following complaint intakes were investigated: NC00217416, NC00205580, NC00210913, NC00211258, NC00215834, NC00217941, and NC00220894. 3 of the 14 allegations resulted in a deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F684 at a scope and severity J. CFR 483.25 at tag F689 at a scope and severity J. The tags F684 and F689 constituted Substandard Quality of Care. An extended survey was conducted. Immediate jeopardy began on 10/5/23 for F684 and was removed on 10/13/23. Immediate Jeopardy for F689 began on 10/5/23 and was removed on 10/10/23.	F 000		
F 552	Right to be Informed/Make Treatment Decisions	F 552		10/1/24

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

Electronically Signed | 09/20/2024

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F 552 SS=D	Continued From page 1 CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, and responsible person (RP) interviews, the facility failed to notify the RP of a follow-up urologist appointment for a scheduled procedure for Resident #19. During Resident #19 urology appointment on 5/31/24, a follow-up recommendation for a cystoscopy (used to diagnose, monitor, and treat conditions affecting the bladder and urethra) procedure was recommended and scheduled for 6/04/24. Resident #19's RP was not notified of the recommendations for the scheduled cystoscopy on 6/04/24. This deficient practice affected 1 of 3 residents reviewed for notification (Resident #19). Findings included:	F 552	This Plan Of Correction constitutes this facilities written allegation of compliance with the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state of the agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	

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F 552	Continued From page 2 Resident #19 was admitted to the facility on 2/20/24 with diagnoses including obstructive and reflex uropathy (blockage preventing urine from draining properly and cause urine to back-up into kidneys), urinary retention, and use of indwelling catheter. Review of quarterly Minimum Data Set (MDS) dated 5/25/24 revealed Resident #19 was moderately cognitively impaired and assessed as having an indwelling catheter. Review of urology office note dated 5/31/24 revealed in part Resident #19 was seen on this date for urinary retention and previously failed voiding trials. Follow-up recommendation for treatment included a cystoscopy procedure in office, scheduled for 6/04/24 at 9:00 AM. Review of urology office note dated 6/04/24 revealed in part Resident #19 was seen at urology office on this date for a scheduled cystoscopy for urinary retention. Cystoscopy was completed, Resident #19 tolerated procedure well, and follow-up recommendations for treatment included a referral for a Urolift (small implants placed to lift or hold excess tissue out of the way and allowing urine to flow more freely) procedure to assist with longstanding urine retention. A telephone interview conducted with the RP on 8/21/24 at 9:28 AM revealed she was the legal guardian for Resident #19 and was responsible for reviewing all recommendations from medical appointments. She stated Resident #19 was seen by the urologist on 5/31/24 for urinary retention	F 552	(1) Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice; " All Residents have the potential to be affected by the deficient practice (2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice; " The last 30 days of appointments will be reviewed by Admin Nursing Team to ensure all Responsible parties are notified on any follow up appointments and/or any new appointments for current residents. Audit will be completed by 9/30/24. (3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. " The Assistant Director of Nursing/Designee will educate Scheduler/Transportation Aide on ensuring all Responsible Parties are made aware of any new or upcoming Resident appointments. Education will be completed by 9/30/24. " The Assistant Director of Nursing/Designee will educate all licensed nurses on ensuring all new admitted Residents paperwork is reviewed for any upcoming appointments and giving them	

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F 552	Continued From page 3	F 552		

with recommendations for a scheduled cystoscopy on 6/04/24. She revealed the facility transported Resident #19 to his scheduled urology appointment on 6/04/24 for the cystoscopy procedure. Resident #19's RP stated she was not made aware of the recommendations from Resident #19 urology appointment on 5/31/24 for the cystoscopy procedure on 6/04/24 prior to his appointment. She revealed she was notified by the Director of Nursing (DON) on 6/05/24 of the outcome and follow-up recommendations from the urology appointment and procedure on 6/04/24, and she informed the DON that she had not been made aware of the recommendations from Resident #19 urology appointment on 5/31/24 or of the scheduled cystoscopy that was completed on 6/04/24. She stated the DON was not aware Resident #19's RP had not been notified of the recommendations from Resident #19 urology appointment on 5/31/24 or of the scheduled cystoscopy on 6/04/24 and assumed the urology office had notified Resident #19's RP of the recommended procedure. Resident #19's RP felt the facility should have contacted her about the recommendations from Resident #19 urology appointment on 5/31/24 and the scheduled cystoscopy on 6/04/24 to assure that she was made aware instead of assuming the urology office would contact her.

An interview with the DON on 8/21/24 at revealed she was familiar with Resident #19 and his RP not being notified of follow-up recommendations for a urology procedure. She stated normally she would always notify a residents RP of any follow-up recommendations or scheduled procedures from appointments. She revealed in the case with Resident #19, she had received the

to the scheduler/Transportation Aide to ensure Responsible Parties are notified about appointments. Education will be completed by 9/30/24.

" The Assistant Director of Nursing/Designee will educate all licensed Nurses on reviewing all after summary visits and give all follow-up appointments to the scheduler/transportation aide for notification to Responsible Parties. Education will be completed by 9/30/24.

" The Director of Nursing/Designee will educate Admin Nursing team on brining all after summary visits and new resident packets to clinical meeting to ensure all follow up and/or new appointments have had Responsible Parties notified. Education will be completed on 9/30/24.

" Education will be added to Licensed Nursing and Scheduler/Transportation Aide new hire orientation. Education will be provided by the Assistant Director of Nursing/Designee.

(4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

" The Director of Nursing/Designee will ensure all Responsible Parties have been notified about any new and/or follow up appointments 5 days a week for 4 weeks, then 3 days a week for 4 weeks and weekly for 4 weeks during clinical meeting.

" The results of the audits will be discussed during the monthly Quality Assurance Meeting for tracking, trending, and recommendations from the IDT team

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F 552	Continued From page 4 follow-up recommendations from his urology appointment on 5/31/24 for a scheduled cystoscopy on 6/04/24 and assumed the urology office had contacted Resident #19's RP about the recommendations and procedure. The DON stated failing to notify Resident #19's RP about the follow-up recommendations and scheduled urology procedure was just an oversight or human error on her part. She revealed she was not made aware Resident # RP had not been made aware of the recommendations from his urology appointment on 5/31/24 for the scheduled cystoscopy on 6/04/24 until she contacted the RP on 6/05/24 to discuss the follow-up recommendations from the cystoscopy and realized Resident #19's RP had no knowledge of the follow-up recommendations or of the cystoscopy. She stated herself and nursing staff were responsible for making sure all RPs were notified of resident appointments, received recommendations from appointments, scheduled follow-up appointments and procedures, and were provided with any paperwork or consents to be completed and reviewed, and moving forward would ensure all resident RPs were notified of any follow-up recommendations or scheduled procedures from appointments. An interview with the Administrator on 8/21/24 at revealed she was familiar with Resident #19 and the incident with his RP not being notified of his urology appointment recommendations for a scheduled cystoscopy on 6/04/24. She stated although the DON and nursing staff typically do notify all resident RPs of any follow-up recommendations from appointments or scheduled procedures, medical offices would usually notify the RPs as well. She believed this incident was just an oversight or human error, the	F 552	for 3 months.	

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F 552	Continued From page 5 DON assumed the urology office had contacted Resident #19's RP and was not made aware until after the scheduled procedure the RP had not been notified. The Administrator stated the DON should have contacted Resident #19's RP about the follow-up recommendations from his urology appointment on 5/31/24 and his scheduled procedure on 6/04/24, moving forward the DON and nursing staff would be responsible for making sure all resident RPs were made aware of any follow-up recommendations or scheduled procedures from appointments.	F 552		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set assessment (MDS) for oxygen use (Resident #1, #6, and #8) and hospice services (Resident #1 and Resident #4) for 4 of 5 residents reviewed for accuracy of assessments. The findings included: a. Resident #1 was admitted to the facility on 1/25/24 with diagnoses that included chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). A review of Resident #1's physician orders revealed an order dated 1/26/24 for oxygen to be administered continuously via nasal cannula at 3 liters per minute (lpm).	F 641	(1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Resident (#1) was identified, and the assessment was modified on 8/22/24. " Resident (#4) was identified, and the assessment was modified on 8/22/24. " Resident (#6) was identified, and the assessment was modified on 8/22/24. " Resident (#8) was identified, and the assessment was modified on 8/22/24. (2) Address how the facility will identify other Residents having the potential to be affected by the same deficient practice;	10/1/24

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F 641	Continued From page 6 A review of Resident #1's medical record indicated she was admitted to hospice services on 2/8/24. A review of the quarterly Minimum Data Set assessment (MDS) dated 5/20/24 indicated Resident #1 was not coded for receiving hospice services or oxygen. b. Resident #6 was admitted to the facility on 10/4/22 with diagnoses that included COPD, emphysema, and chronic respiratory failure. A review of Resident #6's physician orders revealed an order dated 5/20/24 for oxygen to be administered via nasal cannula at 2 lpm as needed. A review of the quarterly MDS assessment dated 7/19/24 indicated Resident #6 was not coded for receiving oxygen. c. Resident #8 was admitted to the facility on 6/14/24 with diagnoses including nontraumatic intracranial hemorrhage (stroke from brain bleeding not caused by trauma) and obstructive sleep apnea. A review of Resident #8's physician orders revealed an order dated 6/14/24 for oxygen delivered via nasal cannula at 2 lpm as needed. A review of the admission MDS dated 6/19/24 indicated Resident #8 was not coded for receiving oxygen. An interview was conducted with the MDS Coordinator on 8/22/24 at 1:25 PM. She stated	F 641	" Review of MDS open assessments for accuracy prior to submission will be completed by the administrative nursing team by 9/30/24. (3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " The VP of Clinical Reimbursement/Designee will educate the Interdisciplinary Team (MDS, Dietary Manger, Registered Dietician, Social Services, Activities Director, and Therapy Manager) and other department heads responsible for completing sections of the MDS on the accuracy of MDS assessments. Education will be completed by 9/30/24. " Education will be added to the Department Head orientation. Education will be provided by the VP of clinical Reimbursement/Designee. (4) Address how the facility plans to monitor its performance to make sure that solutions are substained; " The VP of clinical services will conduct 10 MDS assessment reviews to confirm the accuracy of assessments prior to submission weekly for 4 weeks, then 5 MDS assessment reviews weekly for 4 weeks, then 1 MDS assessment review weekly for 4 weeks. " The results of the reviews will be discussed during the monthly Quality Assurance meeting for tracking, trending,	

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F 641	Continued From page 7 Resident #6's and Resident #8's MDS assessments should have been coded to reflect they were receiving oxygen and Resident #1's MDS assessment should have been coded to reflect she was receiving hospice services and oxygen. She further stated the coding inaccuracies were an oversight on her part. An interview conducted with the Administrator on 8/22/24 at 3:10 PM revealed she expected the MDS assessment to be coded accurately. d. Resident #4 was admitted to the facility 01/09/24 with a diagnosis including non-Alzheimer's dementia. Review of Resident #4's medical record revealed she was admitted to hospice services on 08/01/24. A significant change in condition Minimum Data Set (MDS) assessment dated 08/02/24 revealed Resident #4 was not coded as receiving hospice services. An interview with the MDS Coordinator on 08/23/24 at 11:39 AM revealed Resident #4's significant change MDS should have been coded to reflect she was receiving hospice services, and it was an oversight. A telephone interview with the Director of Nursing (DON) on 08/26/24 at 10:29 AM revealed she expected MDS to be coded accurately.	F 641	and recommendations from the IDT team for 3 months.	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

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F 684	Continued From page 8 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, physician and contract transport company interviews, the facility's contracted transport driver (Driver #1) failed to leave Resident #12 in place for a clinical assessment of injury after a fall that occurred during transport. Resident #12 was being transported back from a medical appointment in a contract transport van while unsecured in her wheelchair. Driver #1 made a sudden stop which caused Resident #12 to fall forward out of her wheelchair onto the van floor. Driver #1 pulled the van off to the side of the road and transferred Resident #12 off the van floor back into her wheelchair and continued back to the facility. Driver #1 was not qualified to provide a comprehensive physical assessment to determine if the resident sustained any injuries. Upon arrival at the facility, Driver #1 did not notify facility staff of the resident's fall. Resident #12 notified staff of the fall in the van and was assessed by nursing staff and noted to have swelling and a skin tear to her left knee. A hospital computed tomography (CT) scan revealed Resident #12 had suffered a distal (away from the center of the body) left fracture to the femur (break in bone above left knee joint) due to her fall in the van. This deficient practice occurred for 1 of 3 sampled residents reviewed for quality of care (Resident #12).	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 9	F 684		

The findings included:

Resident #12 was admitted to the facility on 3/26/21. Diagnoses included multiple sclerosis (MS), muscle weakness, contractures of the left knee, hip, wrist, and of the right knee and hip.

Review of quarterly Minimum Data Set (MDS) dated 9/20/23 revealed Resident #12 was cognitively intact, utilized a wheelchair for mobility, and dependent for assist with transfers. Resident #12 was also coded as having on-going pain and receiving scheduled pain medications.

Review of a physician order dated 10/01/23 revealed Resident #12 received Gabapentin (used for pain) 300 milligrams (mg) 1 tablet by mouth every 8 hours as needed (prn) for pain.

Review of a physician order dated 10/01/23 revealed Resident #12 received Acetaminophen (mild to moderate pain) 650 mg 1 tablet by mouth every 4 hours as needed for mild pain.

Review of Resident #12's Medication Administration Record (MAR) from 10/1/23 through 10/5/23 revealed the following administrations of Resident #12's prn pain medications Gabapentin 300 mg and Acetaminophen 650 mg:
- 10/1/23: Gabapentin at 10:44 AM (pain level 1) (on a scale of 1 to 10 with 10 being the worst pain possible)
- 10/2/23: Acetaminophen at 8:08 AM (pain level 0), Acetaminophen at 3:27 PM (pain level 0)
- 10/3/23: Gabapentin at 8:05 AM (pain level 7), Acetaminophen at 9:06 AM (pain level 7), Acetaminophen at 3:23 PM (pain level 8)

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F 684	Continued From page 10	F 684		

- 10/4/23: Acetaminophen at 7:55 AM (pain level 1), Acetaminophen at 7:58 PM (pain level 0)
- 10/5/23: Acetaminophen at 5:19 AM (pain level 0), Gabapentin at 3:01 PM (pain level 2)

Review of facility van incident report dated 10/05/23 written by Unit Manager #1 read in part: "[Resident #12] fell from chair after [Driver #1] pressed the brakes while out of facility being transported by outside services. [Resident #12] stated, "he slammed on the brakes, and I fell on the floor, he picked me up and put me back in chair". Assessment completed, transport company owner notified, physician notified, vital signs taken, skin assessment completed.

Review of Driver #1's statement dated 10/5/23 indicated, "[Driver #1] was driving on my way through greenlight, suddenly had to brake, [Resident #12] went forward and hit her knee against driver seat chair."

A phone interview was attempted with Driver #1, but he was unable to be reached.

An interview was conducted with Resident #12 on 08/20/24 at 11:00 AM revealed on 10/05/23 she had been transported to an appointment by the transport company and on her way back to the facility, Driver #1 had secured her wheelchair in the van but forgot to secure her into her wheelchair, so when he had to make a sudden stop she fell out of her wheelchair onto the van floor. She stated Driver #1 pulled the van off the side of the road and assisted her back into her wheelchair and transported her back to the facility. Resident #12 revealed as soon as she got back to the facility, she notified the Director of Nursing (DON) and the Administrator about the

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F 684	Continued From page 11	F 684		

fall and they asked her what happened, assessed her for injuries and at the time her left knee was swollen some and had a skin tear, but she was not in any real pain. Resident #12 revealed she believed Driver #1 should have either called 911 for help after the fall prior to putting her back into her chair or taken her to the hospital to be assessed.

Review of a physician order dated 10/05/23 revealed an order for a mobile x-ray to be completed on Resident #12's left ankle, left foot, left knee, left tibia (located on inside of leg, below knee joint, and forms top of ankle joint), and left fibula (located on outside of leg, below knee joint, and forms top of ankle joint).

Review of an on-call physician note dated 10/06/23 indicated on 10/05/23, Resident #12 had a fall from her wheelchair on transportation van. Resident #12's left knee was swollen, she complained of increased pain at a level 10 in her left knee and leg, and her x-ray results had not been received. Ibuprofen 400 mg twice daily for 3 days and Tylenol 500 mg three times daily for 3 days was ordered for Resident #12's acute pain post fall.

Review of on-call physician orders for Resident #12 dated 10/06/23 indicated Ibuprofen 400 mg twice daily for 3 days for acute pain post fall and Tylenol 500 mg three times daily for 3 days for acute pain post fall.

Review of a mobile x-ray dated 10/06/23 of Resident #12's left knee revealed a moderately displaced (more complex fracture because bones are out of alignment or in pieces) distal left fracture of the femur of indeterminate age (not

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able to determine how long-ago fracture occurred). Clinical follow-up was recommended.

Review of an on-call physician note dated 10/06/23 revealed Resident #12's x-ray results were reviewed with no new treatment orders. The on-call physician indicated to continue to monitor and follow-up with the resident's primary care physician was recommended.

Review of Resident #12's Medication Administration Record (MAR) from 10/6/23 through 10/8/23 revealed the following administrations of Resident #12's pain medications Tylenol 500 mg and Ibuprofen 400 mg and prn pain medication Gabapentin 300 mg:
- 10/6/23: Gabapentin at 12:14 AM (pain level 2), Tylenol at 2:00 PM (pain level of 10), Ibuprofen at 8:00 PM (pain level 0), Tylenol 10:00 PM (pain level of 0), and Gabapentin at 11:24 PM (pain level 1)
- 10/07/23 Tylenol at 6:00 AM (pain level 0), Gabapentin at 7:35 AM (pain level 1), Ibuprofen at 8:00 AM (pain level 0), Tylenol at 2:00 PM (pain level 0), Gabapentin at 3:24 PM (pain level 1), Ibuprofen at 8:00 PM (pain level 0), and Tylenol at 10:00 PM (pain level of 2)
- 10/08/23 Tylenol at 6:00 AM (pain level 0), Ibuprofen at 8:00 AM (pain level 0), Gabapentin at 10:47 AM (pain level 1), and Tylenol at 2:00 PM (pain level of 0)

Review of an on-call physician note dated 10/08/23 revealed Resident #12 complained of pain in her stomach area when inhaling and requested to be sent out to the hospital. Resident #12 was sent out from the facility to the hospital at 4:05 PM.

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Review of the hospital discharge summary dated 10/09/23 revealed Resident #12 was seen at emergency department (ED) for a fall and shortness of breath. Resident #12 had an abrasion and edema (swelling) to the left knee and a CT scan was obtained and revealed a distal femur fracture on the left and some possible bruising to the ribs as a result of the fall. The consulting ED provider did not recommend any emergency intervention given that Resident #12 was non-ambulatory, and wheelchair bound. Resident #12 was discharged back to the facility with an order for Naproxen (treat fever and pain) 375 mg by mouth twice daily and follow-up with orthopedics.

During interview with Resident #12 on 8/20/24 at 11:00 AM she revealed on the day after the fall (10/06/23), her pain had gotten worse around her left knee and the facility administered her pain medications and completed an x-ray of her left side. She stated a couple of days later (10/08/23) she started having some trouble breathing and was sent out to the hospital where they confirmed she had broken her left leg and bruised her ribs because of the fall. Resident #12 revealed the hospital administered her some more pain medication, referred her to an orthopedist, and sent her back to the facility.

An interview conducted with Director of Nursing (DON) on 8/21/24 at 12:06 PM revealed she was familiar with Resident #12. She stated on the afternoon of 10/05/23, Resident #12 had entered the facility by herself in her electric wheelchair after being transported to a medical appointment by their contract transport company. The resident stated that she had fallen on the van and Driver #1 picked her up and placed her back into her

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wheelchair after the fall and transported her back to the facility. She (the DON) revealed she immediately assessed Resident #12 for injury and noted a skin tear to her left knee with some swelling. The DON stated she notified the physician of Resident #12's fall on 10/05/23 and received an order for a mobile x-ray of the left knee. A mobile x-ray was completed on 10/06/23 and revealed a distal left leg fracture of the femur but was not able to determine the age of the fracture due to Resident #12's contractures and follow-up was recommended. She revealed the on-call physician was notified of the results and did not order any further treatment until reviewed by the facility physician. The DON stated on 10/08/23 Resident #12 was complaining of stomach pain when taking a deep breath and requested to be sent out to hospital. The on-call physician was notified, and orders were received for her to be sent out. She indicated a CT scan completed at the hospital on 10/08/23 revealed Resident #12 had suffered a left leg fracture of the femur and suspected bruised ribs from the fall in the van. Resident #12 returned to the facility with an order to follow-up with orthopedics outpatient. The DON also revealed after Resident #12 had fallen into the van floor, Driver #1 should have immediately contacted the facility and medical personnel to come and assess Resident #12 prior to moving her back into her wheelchair to keep from possibly causing further injury or trauma.

A telephone interview conducted with the physician on 8/21/24 at 4:55 PM revealed he was familiar with Resident #12 and her fall on the van on 10/05/23. He stated he was notified on the day the accident had occurred and approved a mobile x-ray order for Resident #12's left side extremities

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due to her left knee showing signs of swelling. He revealed the mobile x-ray and the CT scan from the hospital both showed Resident #12 had suffered a left leg femur fracture due to the fall and recommended follow-up with outpatient orthopedic. The physician stated Resident #12 had MS which caused her to have contractures in all her extremities and suspected demineralization (loss of bone minerals faster than can be replaced) that made it easier for injury. He revealed he had been told by the DON that Driver #1 did not have her assessed by medical personnel prior to moving her after the fall. He indicated he would expect medical personnel to be notified immediately anytime a resident sustains a fall so an assessment of injury can be completed prior to them being moved. He stated moving a resident prior to them being assessed could cause further injury or trauma.

An interview was conducted with the Administrator on 8/21/24 at 5:27 PM revealed she was familiar with Resident #12. She stated on 10/05/23, Resident #12 had been transported by their contract transport company to an appointment. She indicated when the resident arrived back at the facility, the resident reported that during her transport back to the facility she was not secured into her wheelchair and had fallen out of her wheelchair onto the van floor. Resident #12 stated Driver #1 had stopped the van and assisted her back into her chair and brought her back to the facility. The Administrator revealed while the DON was assessing Resident #12 for injury and contacting the physician, Driver #1 came into the facility and she attempted to interview him (Driver #1) about the incident, but he refused to give statement and left the facility. The Administrator indicated she contacted the

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Contract Transport Company Owner to notify them about the incident. She stated the owner of the transport company assisted her with receiving a written statement about the incident from Driver #1 and was able to view camera footage from the van to corroborate Resident #12's statement of how the fall occurred, that she had not been secured into her wheelchair, and Driver #1 did not contact medical personnel to assess her (Resident #12) after the fall prior to transporting her back to facility. The Administrator revealed Resident #12 had suffered a left leg femur fracture and bruised ribs from the fall. She stated according to the information received from the transport company, Driver #1 was no longer employed with the company and had received prior education on accident protocols which included notifying the facility and medical personnel when a resident had been involved in an accident prior to moving resident or proceeding forward with transport.

A telephone interview conducted with the Contract Transport Company Owner on 8/22/24 at 9:29 AM indicated on 10/05/23, he was notified by the facility of the fall incident involving Driver #1 and Resident #12. He stated he received a written statement from Driver #1 and reviewed video footage from the van. Driver #1 failed to secure the lap belt and when he (Driver #1) had to stop suddenly Resident #12 fell out of her wheelchair onto the van floor. He revealed after the fall, Driver #1 pulled the van over, assisted Resident #12 back into her wheelchair and transported her back to the facility. He stated Driver #1 was no longer employed with the company and all drivers received training prior to transporting on van safety and the protocol on what to do if an accident occurred. The Contract

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Transport Company Owner stated Driver #1 should have pulled over, stopped the van, contacted 911 and the facility, and waited for Resident #12 to be assessed by medical personnel prior to her being moved to prevent any further injury to the resident.

The facility was notified of immediate jeopardy on 8/22/24 at 5:50 PM.
The facility provided the following corrective action plan:
1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

" The identified resident (Resident #12) is still a current Resident at the facility. Resident #12 was picked up by a contract transportation driver from a scheduled neurology appointment for transport back to the facility. Prior to leaving the appointment, the contracted driver secured Resident #12 wheelchair, but failed to secure Resident #12 seatbelt leaving her unsecured. During transport, the contracted driver had to slam on brakes causing Resident #12 to fall forward from her wheelchair into the van floor. Contracted Driver pulled off road and assisted Resident #12 back into her wheelchair and then continued to transport Resident #12 back to the facility. Contracted Driver failed to contact 911 and/or facility prior to moving Resident #12 from van floor and prior to placing her back into wheelchair after fall. The following actions after this incident:
" On 10/5/23, the facility initiated immediate investigation on 10/5/23.
" On 10/5/23, Resident #12 medical director (MD) and responsible person (RP) made aware of incident.

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" On 10/5/23, Order obtained for x-ray to the left ankle, left foot, left knee, left tibia and left fibula.
" On 10/6/23, Resident #12 complained of pain on a level of 10 on a level 0-10, MD notified, and new orders obtained for the following: Ibuprofen 400mg take 1 tablet by mouth twice daily x3 days for acute pain post fall and Tylenol 500mg take 1 tab by mouth three times daily x3 days for acute pain s/p fall. Pain medication effective with a pain scale of 0 noted.
" On 10/6/23, x-ray results were obtained and showed the following, Left tibia/fibula- No fracture or dislocation is identified, bony structures are osteoporotic. Left ankle-No acute fracture, dislocation or osseous lesion, bony structures are osteoporotic. Left Knee- moderately displaced fracture of the distal diaphysis of the femur of indeterminate age. No dislocation is identified. Left Foot-soft tissue swelling of the foot. Bony structures are osteoporotic. No acute fracture or dislocation is identified. There is moderate hallux valgus (bony bump that forms on joint at the base of big toe), mild degenerative change of the interphalangeal (hinge shaped joint in toe) joint, first metatarsophalangeal (joint that connects toes to foot bone) joint and midfoot is present.
" On 10/8/2023, Resident #12 complained of pain when she inhales in her stomach area especially the left upper quad. Resident and Daughter requested for Resident to be sent out to the Hospital for Evaluation and treatment. Vital signs at that time were as follows: BP 114/72, P 68, Resp. 18, Temp. 97.8. Resident transported via ambulance and MD was notified of the transport.
" On 10/8/23 hospital x-ray revealed an acute comminuted (break into three or more pieces) and mildly displaced distal femoral fracture with

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minimal angulation. Soft tissue swelling adjacent to the fracture. A left hip gamma nail (metal implant used to stabilize fractures) seen, no dislocation. No evidence of knee joint effusion (abnormal fluid accumulation within knee joint).
" On 10/9/23, Resident #12 returned back to the facility via stretcher accompanied by two emergency management technicians (EMT) attendants. Resident complained of pain and discomfort to the left femur upon assessment pain meds were administered and effective. New orders from emergency department (ED) for Naproxen 375mg PO BID. Ortho follow up appointment with Orthopedic surgery as soon as possible.
" On 10/9/23, Facility made Resident #12 an Ortho appointment on 10/10/23 at 2:15pm. RP and MD made aware of the appointment.
" On 10/10/23, Resident #12 was taken to Ortho via facility transport. Ortho plan on 10/10/23 state Resident is not a strong surgical candidate given knee contracture, would not recommend a long leg cast at that time. Instead recommended a knee immobilizer and limit range of motion of including weight-bearing.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
" The Director of Nursing reviewed the accidents for the last three months and there were no other situations where licensed nurses did not assess the resident before the resident was moved. Review completed on 10/9/23.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
" The van drivers were re-educated on 10/9/23

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by the Administrator on the proper procedures if a resident was to have a fall/injury or abnormal event in the facility van, that 911 is to be called prior to moving the resident. The education was already a component of the Transportation Driver orientation given by Administrator/Designee.
" The Administrator notified the contract transportation company on 10/5/23 via phone, and stated that until proof of driver training to include wheelchair procedures and calling 911, then contracted transportation will not be utilized.
" Beginning 10/9/23, Any transportation from contract services was required to provide the driver's PASS (Passenger Assistance Safety and Sensitivity) training to the Administrator/Designee prior to transporting the facilities residents. These competencies are maintained by the Administrator/Designee.
" The contracted transportation supervisor who is PASS (Passenger Assistance Safety and Sensitivity) Certified completed education for contracted drivers on 10/12/23 and ongoing; prior to transporting facility residents. This education included both wheelchair patent procedures and to contact 911 immediately should any emergencies with patients occur during transport.

4. Address how the facility plans to monitor its performance to make sure that solutions are sustained.
" Beginning 10/9/23 Director of Nursing/Designee audited incident/accident logs to ensure no resident had a fall during transportation and 911 wasn't called. Director of Nursing/Designee reviewed incident/accident logs 5 days a week for 4 weeks, 3 days a week for 4 weeks and weekly for 4 weeks.
" On 10/9/23 Administrator made the decision to take audits to the monthly Quality Assurance

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meeting for tracking, trending, and recommendations from the IDT team.

Alleged Date of Immediate Jeopardy Removal and corrective action plan completion: 10/13/23

The facility's corrective action plan was validated on 8/27/24 by the following: Interviews with facility transporters revealed they had received education on proper procedures if a resident was to have a fall, injury, or accident in the facility van, that 911 was to be called immediately, do not move resident until assessed by a medical professional, and call facility to notify of incident. The education was included as a component of the transportation orientation. Contract transport company re-education dated 10/12/23 verified staff were educated on passenger safety and sensitivity training, wheelchair procedures, and calling 911 immediately for any emergencies during transport. Review of the audit tool for the review of the incident/ accident logs was completed with no issues noted. Interviews were also conducted with alert and oriented residents who had been transported since October 2023 with no concerns, incidents, or accidents identified. Interview with the Administrator revealed she had educated facility transport drivers on proper procedures if a fall, injury, or accident occurred while transporting to include calling 911 immediately and not moving resident until assessed by medical personnel and notifying facility of the incident. The Administrator also verified the contract transport company had educated their drivers on the proper wheelchair procedures, calling 911 for any emergencies during transport, and safety and sensitivity training. The facility's immediate jeopardy removal date and the corrective action completion

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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 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, physician and the contract transport company's owner, the facility's contracted transport driver (Driver #1) failed to provide safe transportation when Resident #12's lap belt was not applied leaving her unsecured in her wheelchair. Resident #12 was being transported back from a medical appointment when Driver #1 made a sudden stop resulting in Resident #12 falling forward out of her wheelchair onto the van floor on her left knee and rolling onto her left side. Driver #1 pulled the van off to the side of the road and transferred Resident #12 off the van floor back into her wheelchair and continued back to the facility. Resident #12 had swelling and a skin tear to her left knee. A hospital CT (computed tomography) scan revealed Resident #12 had suffered a distal (away from the center of the body) left fracture to the femur (break in bone above left knee joint) due to her fall in the van. This deficient practice occurred for 1 of 3 sampled residents reviewed for accidents (Resident #12).	F 689	Past noncompliance: no plan of correction required.	

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The findings included:

Review of the contract van vehicle anchorages for the 4-point wheelchair securement systems manual dated 2007 read in part: The illustrated manual provided directions for securing wheelchairs for transport in the transportation van. Tracks on the floor of the van (L-track) where the pin connectors of the retractors locked in place and straps connected to the wheelchair by a J-hook (a J-shaped metal hook affixed to the fabric straps that were attached to the connector pins). The manual illustrated the position of the pin connectors indicated two rear connectors were directly behind the wheelchair and the two front pin connectors were secured to the front and side of each side of the wheelchair. The instructions directed to follow the tie down angles in the illustration and attached the J-hooks on the wheelchair frame in the proper locations and apply resident seatbelt.

Resident #12 was admitted to the facility on 3/26/21. Diagnoses included multiple sclerosis (MS), muscle weakness, contractures of the left knee, hip, wrist, and of the right knee and hip.

Review of quarterly Minimum Data Set (MDS) dated 9/20/23 revealed Resident #12 was cognitively intact, utilized a wheelchair for mobility, and dependent for assist with transfers. Resident #12 was also coded as having on-going pain and receiving scheduled pain medications.

Review of a physician order dated 10/01/23 revealed Resident #12 received Gabapentin 300 milligrams (mg) 1 tablet by mouth every 8 hours as needed (prn) for pain.

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Review of a physician order dated 10/01/23 revealed Resident #12 received Acetaminophen 650 mg 1 tablet by mouth every 4 hours as needed for mild pain.

Review of Resident #12's Medication Administration Record (MAR) from 10/1/23 through 10/5/23 revealed the following administrations of Resident #12's prn pain medications Gabapentin 300 mg and Acetaminophen 650 mg:
-10/1/23: Gabapentin at 10:44 AM (pain level 1) (on a scale of 1 to 10 with 10 being the worst pain possible)
-10/2/23: Acetaminophen at 8:08 AM (pain level 0), Acetaminophen at 3:27 PM (pain level 0)
-10/3/23: Gabapentin at 8:05 AM (pain level 7), Acetaminophen at 9:06 AM (pain level 7), Acetaminophen at 3:23 PM (pain level 8)
-10/4/23: Acetaminophen at 7:55 AM (pain level 1), Acetaminophen at 7:58 PM (pain level 0)
-10/5/23: Acetaminophen at 5:19 AM (pain level 0), Gabapentin at 3:01 PM (pain level 2)

Review of facility van incident report dated 10/05/23 written by Unit Manager #1 read in part: "[Resident #12] fell from chair after [Driver #1] pressed the brakes while out of facility being transported by outside services. [Resident #12] stated, "he slammed on the brakes, and I fell on the floor, he picked me up and put me back in chair". Assessment completed, transport company owner notified, physician notified, vital signs taken, skin assessment completed.

Review of Driver #1's statement dated 10/5/23 indicated, "[Driver #1] was driving on my way

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through greenlight, suddenly had to brake, [Resident #12] went forward and hit her knee against driver seat chair."

A phone interview was attempted with Driver #1, but he was unable to be reached.

An interview was conducted with Resident #12 on 08/20/24 at 11:00 AM revealed on 10/05/23 she had been transported to an appointment by the transport company and on her way back to the facility, Driver #1 had secured her wheelchair in the van but forgot to secure her into her wheelchair, so when he had to make a sudden stop she fell out of her wheelchair onto the van floor. She stated Driver #1 pulled the van off the side of the road and assisted her back into her wheelchair and transported her back to the facility. Resident #12 revealed as soon as she got back to the facility, she notified the Director of Nursing (DON) and the Administrator about the fall and they asked her what happened, assessed her for injuries and at the time her left knee was swollen some and had a skin tear, but she was not in any real pain. Resident #12 revealed the fall in the van happened so fast that she didn't have time to feel scared or even think about what had happened, but she did feel that Driver #1 should have secured her into her chair especially since due to her MS diagnosis she was not able to secure herself.

Review of physician order dated 10/05/23 revealed an order for a mobile x-ray to be completed on Resident #12's left ankle, left foot, left knee, left tibia (located on inside of leg, below knee joint, and forms top of ankle joint), and left fibula (located on outside of leg, below knee joint,

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and forms top of ankle joint).

Review of on-call physician note dated 10/06/23 indicated on 10/05/23 Resident #12 had a fall from her wheelchair on transportation van. Resident #12's left knee was swollen, she complained of increased pain at a level 10 in her left knee and leg, and her x-ray results had not been received. Ibuprofen 400 mg twice daily for 3 days and Tylenol 500 mg three times daily for 3 days was ordered for Resident #12's acute pain post fall.

Review of on-call physician orders for Resident #12 dated 10/06/23 indicated Ibuprofen 400 mg twice daily for 3 days for acute pain post fall and Tylenol 500 mg three times daily for 3 days for acute pain post fall.

Review of a mobile x-ray dated 10/06/23 of Resident #12's left knee revealed a moderately displaced (more complex fracture because bones are out of alignment or in pieces) distal left fracture of the femur of indeterminate age (not able to determine how long-ago fracture occurred). Clinical follow-up was recommended.

Review of an on-call physician note dated 10/06/23 revealed Resident #12's x-ray results were reviewed with no new treatment orders. The on-call physician indicated to continue to monitor and follow-up with the resident's primary care physician was recommended.

Review of Resident #12's Medication Administration Record (MAR) from 10/6/23 through 10/8/23 revealed the following administrations of Resident #12's pain medications Tylenol 500 mg (three times daily),

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Ibuprofen 400 mg (twice daily), Gabapentin 300 mg (prn):
-10/6/23: Gabapentin at 12:14 AM (pain level 2), Tylenol at 2:00 PM (pain level of 10), Ibuprofen at 8:00 PM (pain level 0), and Tylenol 10:00 PM (pain level of 0)
-10/07/23: Tylenol at 6:00 AM (pain level 0), Gabapentin at 7:35 AM (pain level 1), Ibuprofen at 8:00 AM (pain level 0), Tylenol at 2:00 PM (pain level 0), Gabapentin at 3:24 PM (pain level 1), Ibuprofen at 8:00 PM (pain level 0), Tylenol at 10:00 PM (pain level of 2), and Gabapentin at 11:24 PM (pain level 1)
-10/08/23 Tylenol at 6:00 AM (pain level 0), Ibuprofen at 8:00 AM (pain level 0), Gabapentin at 10:47 AM (pain level 1), and Tylenol at 2:00 PM (pain level of 0)

Review of an on-call physician note dated 10/08/23 revealed Resident #12 complained of pain in her stomach area when inhaling and requested to be sent out to the hospital. Resident #12 was sent out from the facility to the hospital at 4:05 PM.

Review of the hospital discharge summary dated 10/09/23 revealed Resident #12 was seen at emergency department (ED) for a fall and shortness of breath. Resident #12 had an abrasion and edema (swelling) to the left knee and a CT scan was obtained and revealed a distal femur fracture on the left and some possible bruising to the ribs as a result of the fall. The consulting ED provider did not recommend any emergency intervention given that Resident #12 was non-ambulatory, and wheelchair bound. Resident #12 was discharged back to the facility with an order for Naproxen (treat fever and pain)

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375 mg by mouth twice daily and follow-up with orthopedics.

During interview with Resident #12 on 8/20/24 at 11:00 AM she revealed on the day after the fall (10/06/23), her pain had gotten worse around her left knee and the facility administered her pain medications and completed an x-ray of her left side. She stated a couple of days later (10/08/23) she started having some trouble breathing and was sent out to the hospital where they confirmed she had broken her left leg and bruised her ribs because of the fall. Resident #12 revealed the hospital administered her some more pain medication, referred her to an orthopedist, and sent her back to the facility.

An interview conducted with Director of Nursing (DON) on 8/21/24 at 12:06 PM revealed she was familiar with Resident #12. She stated on the afternoon of 10/05/23, Resident #12 had returned to the facility after being transported to a medical appointment by their contract transport company and stated that she had fallen on the van. She revealed she immediately assessed Resident #12 for injury and noted a skin tear to her left knee with some swelling. The DON stated she notified physician of Resident #12's fall on 10/05/23 and received an order for a mobile x-ray of left knee. A mobile x-ray was completed on 10/06/23 and revealed a distal left leg fracture of the femur but was not able to determine the age of the fracture due to Resident #12's contractures and follow-up was recommended. She revealed the on-call physician was notified of the results and did not order any further treatment until reviewed by the facility physician. The DON stated on 10/08/23 Resident #12 was complaining of stomach pain when taking a deep breath and requested to be

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sent out to hospital. The on-call physician was notified, and orders were received for her to be sent out. She indicated a CT scan completed at the hospital on 10/08/23 revealed Resident #12 had suffered a left leg fracture of the femur and suspected bruised ribs from the fall in the van, Resident #12 returned to the facility with an order to follow-up with orthopedics outpatient.

A telephone interview conducted with the physician on 8/21/24 at 4:55 PM revealed he was familiar with Resident #12 and her fall on the van. He stated he was notified on the day the accident had occurred and approved a mobile x-ray order for Resident #12's left side extremities due to her left knee showing signs of swelling. He revealed the mobile x-ray and the CT scan from the hospital both showed Resident #12 had suffered a left leg femur fracture due to the fall and recommended follow-up with outpatient orthopedic. The physician stated Resident #12 did have MS which caused her to have contractures in all of her extremities and suspected demineralization (loss of bone minerals faster than can be replaced) making it easier for injury, Resident #12 would still have had to fallen hard onto a hard surface to sustain that type of injury. He revealed he had been told by the DON that Driver #1 did not secure Resident #12 into her wheelchair causing her to fall. He indicated he would expect that all residents be secured while being transported in their wheelchairs.

An interview was conducted with the Administrator on 8/21/24 at 5:27 PM revealed she was familiar with Resident #12. She stated on 10/05/23, Resident #12 had been transported by

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their contract transport company to an appointment. She indicated when the resident arrived back at the facility, the resident reported that during her transport back to the facility she was not secured into her wheelchair and had fallen out of her wheelchair onto the van floor. Resident #12 stated Driver #1 had stopped the van and assisted her back into her chair and brought her back to the facility. The Administrator revealed while the DON was assessing Resident #12 for injury and contacting the physician, she attempted to interview Driver #1 about the incident, but he left the facility, so she contacted the Contract Transport Company Owner to notify them about the incident. She stated the Contract Transportation Company Owner assisted her with receiving a written statement about the incident from Driver #1 and was able to view camera footage from the van to corroborate Resident #12's statement of how the fall occurred and that she had not been secured into her wheelchair. The Administrator revealed Resident #12 had suffered a left leg femur fracture and bruised ribs from the fall. She stated according to the information received from the transport company, Driver #1 was no longer employed with the company and had received prior education on securing residents and their wheelchairs during transport.

A telephone interview conducted with the Contract Transport Company Owner on 8/22/24 at 9:29 AM revealed on 10/05/23, he was notified by the facility of the fall incident involving Driver #1 and Resident #12. He also revealed he received a written statement from Driver #1 and reviewed video footage from the van to confirm Resident #12's statement about the fall. He stated according to the van video footage, Driver

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#1 was transporting Resident #12 from an appointment back to the facility and secured Resident #12's wheelchair into the van but failed to secure her into her wheelchair by using the lap belt. He stated during this transport, Driver #1 had to stop suddenly causing Resident #12 to fall out of her wheelchair onto the van floor. He revealed after the fall, Driver #1 pulled the van over, assisted Resident #12 back into her wheelchair and transported her back to the facility. He stated Driver #1 was no longer employed with the company and all drivers received training prior to transporting on van safety and proper ways to secure residents in wheelchairs in vans. The Contract Transport Company Owner stated Driver #1 should have secured Resident #12 lap belt in her wheelchair to keep her from falling forward out of her wheelchair and once the fall had occurred, he should have stopped the van, contacted 911 and the facility, and waited for Resident #12 to be assessed by medical personnel prior to her being moved.

The facility was notified of immediate jeopardy on 8/22/24 at 5:50 PM.
The facility provided the following corrective action plan:
1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

" The identified resident (Resident #12) is still a current Resident at the facility. Resident #12 was picked up by a contract transportation driver from a scheduled neurology appointment for transport back to the facility. Prior to leaving the appointment, the contracted driver secured Resident #12 wheelchair, but failed to secure

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Resident #12 seatbelt leaving her unsecured. During transport, the contracted driver had to slam on brakes causing Resident #12 to fall forward from her wheelchair into the van floor. Contracted Driver pulled off road and assisted Resident #12 back into her wheelchair and then continued to transport Resident #12 back to the facility. Contracted Driver failed to contact 911 and/or facility prior to moving Resident #12 from van floor and prior to placing her back into wheelchair after fall. The following actions after this incident:

" On 10/5/23, Facility initiated immediate investigation on 10/5/23.

" On 10/5/23, Resident #12 medical director (MD) and responsible person (RP) made aware of incident.

" On 10/5/23, Order obtained for x-ray to the left ankle, left foot, left knee, left tibia and left fibula.

" On 10/6/23, Resident #12 complained of pain on a level of 10 on a level 0-10, MD notified, and new orders obtained for the following: Ibuprofen 400mg take 1 tablet by mouth twice daily x3 days for acute pain post fall and Tylenol 500mg take 1 tab by mouth three times daily x3 days for acute pain s/p fall. Pain medication effective with a pain scale of 0 noted.

" On 10/6/23, x-ray results were obtained and showed the following, Left tibia/fibula- No fracture or dislocation is identified, bony structures are osteoporotic. Left ankle-No acute fracture, dislocation or osseous lesion, bony structures are osteoporotic. Left Knee- moderately displaced fracture of the distal diaphysis of the femur of indeterminate age. No dislocation is identified. Left Foot-soft tissue swelling of the foot. Bony structures are osteoporotic. No acute fracture or dislocation is identified. There is moderate hallux

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valgus (bony bump that forms on joint at the base of big toe), mild degenerative change of the interphalangeal (hinge shaped joint in toe) joint, first metatarsophalangeal (joint that connects toes to foot bone) joint and midfoot is present.

" On 10/8/2023, Resident #12 complained of pain when she inhales in her stomach area especially the left upper quad. Resident and Daughter requested for Resident to be sent out to the Hospital for Evaluation and treatment. Vital signs at that time were as follows: BP 114/72, P 68, Resp. 18, Temp. 97.8. Resident transported via ambulance and MD was notified of the transport.

" On 10/8/23 hospital x-ray revealed an acute comminuted (break into three or more pieces) and mildly displaced distal femoral fracture with minimal angulation. Soft tissue swelling adjacent to the fracture. A left hip gamma nail (metal implant used to stabilize fractures) seen, no dislocation. No evidence of knee joint effusion (abnormal fluid accumulation within knee joint).

" On 10/9/23, Resident #12 returned back to the facility via stretcher accompanied by two emergency management technicians (EMT) attendants. Resident complained of pain and discomfort to the left femur upon assessment pain meds were administered and effective. New orders from emergency department (ED) for Naproxen 375mg PO BID. Ortho follow up appointment with Orthopedic surgery as soon as possible.

" On 10/9/23, Facility made Resident #12 an Ortho appointment on 10/10/23 at 2:15pm. RP and MD made aware of the appointment.

" On 10/10/23, Resident #12 was taken to Ortho via facility transport. Ortho plan on 10/10/23 state Resident is not a strong surgical candidate given knee contracture, would not recommend a

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long leg cast at that time. Instead recommended a knee immobilizer and limit range of motion of including weight-bearing.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
No other Residents have had a fall/accident/or injury during a transport due to not being properly secured during transportation. Director of Nursing reviewed last 3 months of accident/incidents to ensure no other falls occurred during transport to and from the facility due to not being properly secured. Audit was completed on 10/9/23.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
" An immediate in-service initiated on 10/9/23 by Maintenance Director on Q-straint system in van and how to properly secure a resident in the van, for facility transportation drivers. This education consisted of hands on and return demonstration, and verbal education.
" Van Drivers were educated by Administrator on ensuring Driver Transport safety checklist to be completed for all transports completed by the facility van drivers prior to leaving the facility with the resident. Education completed on 10/9/23.
" On 10/6/23 the contracted transportation company had a safety meeting with all drivers re-educating them on ensuring Residents are properly secured in van prior to transports
" Education will be added to new Transportation Driver orientation and given by the Administrator. Administrator added education to new hire orientation on 10/9/23.

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F 689	Continued From page 35 4. Address how the facility plans to monitor its performance to make sure that solutions are sustained; " Beginning 10/9/23, Administrator/designee will review transportation book and ensure that Driver Transport Safety checklist for all transports completed by The Ivy van drivers Monday-Friday for 12 weeks. " Beginning 10/9/23, someone from Administration observed Residents that were being transported via van to ensure Resident was properly secured in van prior to leaving the facility for transport, Administration observed 5 days a week for 4 weeks, 3 days a week for 4 weeks and weekly for 4 weeks. " On 10/9/23 the Administrator made the decision to take the results of the observations to the monthly Quality Assurance meeting for tracking, trending, and recommendations from the IDT team. Alleged Date of Immediate Jeopardy Removal: 10/10/23 Alleged Date of Corrective Action Completion: 10/13/23 The facility's corrective action plan was validated on 8/27/24 by the following: Interviews with facility transporters revealed they had received education on restraint system in van and how to properly secure a resident in the van as well as the driver safety checklist that was to be completed prior to leaving facility with residents. The facility transporters also stated they had to verbalize their understanding of the education they had received and complete a demonstration showing they were capable of securing residents inside the van properly for transport. The facility	F 689		

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transporters revealed they only transported residents in manual wheelchairs inside the facility vans and any resident that required a geriatric-chair (a padded chair with a wheeled base) for transport, would have to be transported by non-emergent EMS transport and any resident with an electric wheelchair would have to be transported by their contract transport company. Contract transport company re-education dated 10/06/23 verified staff were educated on ensuring residents are secured in vans according to the manufacturer's instructions prior to transport. Review of facility orientation education for new hire transport drivers verified the education included the driver safety checklist and educational and video material on van restraint system and securing residents properly into van prior to transport. Review of the audit tools and driver safety checklist was completed with no issues noted. An observation was made on 8/23/24 of facility transporter securing a resident in their wheelchair inside the van in accordance with the manufacturer's instructions prior to being transported. Interviews were also conducted with alert and oriented residents who had been transported since October 2023 with no concerns identified. No additional transportation incidents were identified since October 2023. Interview with the Administrator revealed she had educated facility transport drivers on properly securing residents into the vans, completing van safety checklist, hands-on observations of drivers securing residents into vans prior to transport, completed audits and reviews of driver safety checklist with no issues. The Administrator also stated the facility had only transported residents with manual wheelchairs in their facility vans, residents who required a geriatric chair were transported by non-emergent EMS transport and

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F 689	Continued From page 37 residents with an electric wheelchair were transported by contract transport. The facility's immediate jeopardy removal date was validated as 10/10/23 and the corrective action completion date was validated as 10/13/23.	F 689		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to post cautionary and safety signage outside of resident rooms that indicated the use of oxygen for 4 of 4 residents (Resident #1, #6, #8, and #42) reviewed for respiratory care. The findings included: a. Resident #1 was admitted to the facility on 1/25/24. A review of the quarterly Minimum Data Set (MDS) dated 5/20/24 indicated Resident #1 was not coded for receiving oxygen. A review of Resident #1's physician orders revealed an order dated 1/26/24 for oxygen to be administered continuously via nasal cannula at 3	F 695	(1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Resident #1 was identified, and Oxygen in Use sign placed on door frame by Admin Nursing. " Resident #6 was identified, and Oxygen in Use sign placed on door frame by Admin Nursing. " Resident #8 was identified, and Oxygen in Use sign placed on door frame by Admin Nursing. " Resident #42 was identified, and Oxygen in Use sign placed on door frame by Admin Nursing. " Oxygen in Use sticker placed at front entrance door on 9/1/24 by Administrator.	10/1/24

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F 695	Continued From page 38 liters per minute (l/min). An observation on 8/19/24 at 4:03 PM revealed Resident #1 was lying in bed wearing a nasal cannula with oxygen being administered at 3 l/min. There was no cautionary or safety signage posted at the entrance to Resident #1's room to indicate oxygen was in use. An observation of Resident #1 conducted on 8/20/24 at 11:00 AM revealed she was sitting on the side of her bed with oxygen being administered via nasal cannula at 3 l/min. There was no safety signage posted at the entrance to Resident #1's room to indicate oxygen was in use. b. Resident #6 was admitted to the facility on 10/4/22. A review of the quarterly MDS dated 7/19/24 indicated Resident #6 was not coded for receiving oxygen. A review of Resident #6's physician orders revealed an order dated 5/20/24 for oxygen to be administered via nasal cannula at 2 l/min as needed. An observation on 8/20/24 at 11:00 AM revealed Resident #6 was sitting in her wheelchair wearing a nasal cannula with oxygen being administered at 2 l/min. There was no cautionary or safety signage posted at the entrance to Resident #6's room to indicate oxygen was in use. An observation on 8/22/24 at 9:45 AM revealed Resident #6 was lying in bed and wearing a nasal cannula with oxygen being administered at 2	F 695	(2) Address how the facility will identify other Residents having the potential to be affected by the same deficient practice; " 100% room audit was completed on 9/2/24, to ensure that all Residents with Oxygen in use had Oxygen in Use sign placed on door frame. Audit was completed by Administrative Nursing team. (3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " Assistant Director of Nursing/Designee will educate all licensed nurses on ensuring if a new oxygen order is obtained, then a Oxygen in Use sign must be placed on the door frame of Residents room. Education will be completed by 9/30/24. " Assistant Director of Nursing/Designee will educate all licensed nurses on ensuring that any new Resident admitted to the facility with Oxygen orders has an Oxygen in Use sign placed on Door frame. Education will be completed by 9/30/24. " Education will be added to New Hire Licensed Nurse education and given by Assistant Director of Nursing/Designee. (4) Address how the facility plans to monitor its performance to make sure that solutions are substained;	

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F 695	Continued From page 39 l/min. There was no cautionary or safety signage posted at the entrance to Resident #6's room to indicate oxygen was in use. c. Resident #8 was admitted to the facility on 6/14/24. A review of the admission MDS dated 6/19/24 indicated Resident #8 was not coded for receiving oxygen. A review of Resident #8's physician orders revealed an order dated 6/14/24 for oxygen to be administered via nasal cannula at 2 l/min as needed. An observation conducted on 8/19/24 at 12:21 PM revealed Resident #8 was lying in bed sleeping and wearing a nasal cannula with oxygen being administered at 2 l/min. There was no cautionary or safety signage posted at the entrance to Resident #8's room to indicate oxygen was in use. An observation conducted on 8/20/24 at 9:30 AM revealed Resident #8 was lying in bed sleeping and wearing a nasal cannula with oxygen being administered at 2 l/min. There was no safety signage posted at the entrance to Resident #8's room to indicate oxygen was in use. d. Resident #42 was admitted to the facility 8/13/24. A review of the admission MDS dated 8/19/24 revealed Resident #42 was coded for receiving oxygen therapy during the assessment period. A review of Resident #42's physician orders	F 695	" Director of Nursing/Designee will review new order listing report 5 days a week for 4 weeks, 3 days a week for 4 weeks and weekly for 4 weeks to ensure any Resident with a new oxygen order has a Oxygen in use sign place on door frame of room. " The results of the reviews will be discussed during the monthly Quality Assurance meeting for tracking, trending, and recommendations from the IDT team for 3 months.	

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indicated an order dated 8/14/24 for oxygen to be administered via nasal cannula at 3 l/min continuously.

An observation conducted on 8/19/24 at 4:43 PM revealed Resident #42 was lying in bed wearing a nasal cannula with oxygen being delivered at 3 l/min. There was no cautionary or safety signage posted at the entrance to Resident #42's room to indicate oxygen was in use.

An observation of Resident #42 was conducted on 8/20/24 at 11:30 AM. Resident #42 was lying in bed wearing a nasal cannula with oxygen being delivered at 3 l/min. There was no safety signage posted at the entrance to Resident #42's room to indicate oxygen was in use.

An observation conducted at the main entrance of the facility on 8/19/24 at 5:30 PM revealed there was no cautionary or safety signage posted to notify those entering the building that oxygen was in use.

An interview was conducted with the Administrator on 8/22/24 at 3:10 PM. She stated she had not noticed there was no safety signage posted at the facility's main entrance to indicate oxygen was in use but that it should be posted. The Administrator further stated safety signage for oxygen use was not posted outside of resident rooms because she was not aware that was still a requirement.

An interview was conducted with the Director of Nursing on 8/23/24 at 10:56 AM. She stated safety signage for the use of oxygen was not posted at the facility entrance or outside of resident rooms because they were not aware the

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F 695	Continued From page 41 signage was required.	F 695		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, Consultant Pharmacist, Nurse Practitioner, and Physician interviews, the facility failed to administer medications as ordered by the Physician that included Bosulif (medication for leukemia) and Olanzapine (an antipsychotic medication). This occurred for 2 of 5 residents (Resident #9 and Resident #13) reviewed for significant medication errors. Findings included: 1. Resident #9 was admitted to the facility 08/24/22 with a diagnosis including chronic myelocytic leukemia (cancer of white blood cells). Review of Resident #9's Physician orders revealed an order dated 01/20/23 for Bosulif 100 milligrams (mg) 2 tablets by mouth every day related to leukemia. Review of Resident #9's annual Minimum Data Set (MDS) assessment dated 08/31/23 revealed she was cognitively intact with no behaviors. Review of Resident #9's Medication Administration Records (MARs) from December 2023 through August 2024 revealed Bosulif was initialed by nursing staff as being administered as	F 760	(1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Resident #9 was identified and a head to toe skin assessment was completed by Director of Nursing on 8/1/24, with no negative findings noted. " Resident #13 was identified and a head to toe skin assessment was completed by Director of Nursing on 2/16/24, with no negative finding noted. (2) Address how the facility will identify other Residents having the potential to be affected by the same deficient practice; " 100% MAR to cart audit will be completed by Admin Nursing team to ensure all correct dosages of medication is available on cart per doctors orders. Audit will be completed by 9/30/24. " 100% Cart audit will be completed by Admin Nursing team to ensure no other resident has excessive amount of pills in cart. Audit will be completed by 9/30/24.	10/1/24

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F 760	Continued From page 42 ordered. An interview with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) on 08/21/24 at 11:53 AM revealed the facility became aware on 08/01/24 that Resident #9 had a surplus of Bosulif on the medication cart. She explained Bosulif was provided by an outside specialty pharmacy and the facility only received 60 pills a month so she was unsure why there would be leftover medication in the cart. The ADON/IP stated she checked the medication cart where Resident #9's Bosulif was stored, and she noted three opened bottles of Bosulif with varying amounts of pills in each bottle. She stated one bottle indicated it was dispensed in December 2023, one bottle indicated it was dispensed in January 2024, and the last bottle indicated it was dispensed in February 2024. The ADON/IP stated Resident #9 was a participant in an all-inclusive care program which provided her Bosulif. She stated the Physician at the all-inclusive care program was notified that Resident #9 did have a surplus of Bosulif medication and the facility was unable to determine why there would be a surplus of the medication. An interview with the Director of Nursing (DON) on 08/21/24 at 12:06 PM revealed the facility became aware of Resident #9 having a surplus of Bosulif on the medication cart on 08/01/24 and notified the Physician of the surplus. The DON stated the Bosulif was provided by a specialty pharmacy that was associated with the all-inclusive care program Resident #9 participated in. She stated the Physician for the all-inclusive care program came to the facility and she checked the medication cart with the	F 760	(3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " Assistant Director of Nursing/Designee will educate all licensed Nursing staff and Medication aides on the 7 rights of medication administration. Education will be completed by 9/30/24. " Assistant Director of Nursing/Designee will educate all licensed nurses staff and Medication aides on ensuring when refilling medications that the correct dosage is being ordered. Education will be completed by 9/30/24. " Assistant Director of Nursing/Designee will educate all licensed Nursing staff and Medication aides on ensuring Physician□s orders are being followed when administering medications. Education will be completed by 9/30/24. " Education will be added to Licensed Nursing staff and Medication aides new hire orientation and give by Assistant Director of Nursing/Designee. (4) Address how the facility plans to monitor its performance to make sure that solutions are substained; " Director of Nursing/Designee will conduct MAR to cart audits three days a weeks for 4 weeks, 2 days a week for 4 weeks and weekly for 4 weeks to ensure no excessive amounts of medication for residents are on the carts. " Director of Nursing/Designee will	

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F 760	Continued From page 43 Physician. The DON stated they found three bottles of Bosulif with varying amounts of medication in each bottle in the medication cart and one bottle indicated it was dispensed in December 2023, one bottle indicated it was dispensed in January 2024, and another bottle indicated it was dispensed in February 2024. She stated she wasn't sure why there would be a surplus of Bosulif. A telephone interview with the Physician at the all-inclusive care program on 08/21/24 at 2:49 PM revealed Resident #9 had been taking Bosulif for leukemia for approximately 2 years. He explained the medication was very expensive and was paid for by the all-inclusive care program in which Resident #9 was a member. The Physician stated Bosulif was prepared each month by a specialty pharmacy, was delivered to his office, and a nurse from his office delivered the medication to the facility. He stated that he received a telephone call from one of the nurses in his office around the first of August 2024, that delivered the Bosulif to the facility and she notified him there was a surplus of the medication in the medication cart. The Physician stated he came to the facility and found three bottles of Bosulif, each containing a differing amount of the medication, and there were 87 extra tablets. He stated the bottles indicated they were dispensed in January 2024, February 2024, and March 2024. The Physician stated the specialty pharmacy called his office every month to make sure Bosulif was still needed before they prepared the medication, and it was not possible they would send extra medication due to the cost. He stated there was no way to know for sure, but since Resident #9 had not been hospitalized in the past two years, it appeared there were days	F 760	conduct one Medication Administration observation daily 5 days a week for 4 weeks, then one daily 3 days a week for 4 weeks and then one daily weekly for 4 weeks to ensure Residents are receiving correct dosages and amounts of medication. " The results of the reviews will be discussed during the monthly Quality Assurance meeting for tracking, trending, and recommendations from the IDT team for 3 months.	

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from January 2024 through March 2024 when she did not receive the two tablets of medication she was supposed to receive. The Physician stated the surplus of Resident #9's Bosulif on the medication cart would be considered a significant medication error. He stated he reached out to Resident #9's oncologist and explained the situation with Bosulif and he was informed that if her laboratory tests were unchanged, the resident did not suffer any harm. The Physician stated he checked Resident #9's laboratory work after the error occurred in August 2024, and her laboratory work was unchanged.

An interview with the Administrator on 08/21/24 at 5:28 PM revealed she was aware of the concerns with Resident #9 not receiving her Bosulif as ordered. She stated she felt that since Resident #9 was alert and oriented she would have asked staff if her medication cup did not contain Bosulif and she felt that Resident #9 did receive her medication as ordered.

An interview with Resident #9 on 08/22/24 at 9:25 AM revealed there was a time when she was not receiving her Bosulif as ordered (she was unsure of the time frame) and now she checked her medication cup each morning to make sure she received Bosulif.

A telephone interview was conducted on 08/23/24 at 11:57 AM with Nurse Practitioner (NP) #2 from Resident #9's oncology office. NP #2 stated she was aware of concerns that Resident #9 had not received her Bosulif as ordered but her most recent laboratory work in August 2024 revealed she was almost in remission and did not suffer any harm from missing medication.

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2. Resident #13 was admitted to the facility 04/10/19 with a diagnosis including schizophrenia.

Review of Resident #13's Physician orders dated 02/24/24 revealed an order for Olanzapine 10 milligrams (mg) one tablet at bedtime for schizophrenia.

Review of Resident #13's February 2024, Medication Administration Record (MAR) revealed nursing staff initialed the MAR as administering the Olanzapine as ordered.

Resident #13's quarterly Minimum Data Set (MDS) assessment dated 07/21/24 revealed he was moderately cognitively impaired and had other behaviors 4 to 6 days during the look back period.

An interview with the Director of Nursing (DON) on 08/23/24 at 7:53 AM revealed the facility became aware on 02/16/24 of Resident #13 receiving Olanzapine 20 mg once daily instead of Olanzapine 10 mg daily. She stated Resident #13 received Olanzapine 20mg daily from 02/05/24 until 02/16/24. The DON stated she could not recall how the facility became aware of Resident #13 receiving the incorrect dose of Olanzapine, but when it was brought to her attention she notified the Nurse Practitioner (NP) and Responsible Party (RP), removed Olanzapine 20 mg from the medication cart, and ordered the correct dose of Olanzapine from the pharmacy. The DON stated she was not sure how the incorrect dose was able to be requested from pharmacy or why the error occurred.

A telephone interview with the Consultant

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F 760	Continued From page 46 Pharmacist on 08/22/24 at 1:35 PM revealed Resident #13 had active orders for Olanzapine 20 mg and Olanzapine 10 mg in the computer and when staff requested a refill of Olanzapine in March 2024, they checked 20 mg needed to be refilled instead of 10 mg. She stated she was not sure why Resident #13 had two active orders in the computer for Olanzapine, but since the facility requested a 20 mg refill, they received a 20 mg refill. A telephone interview with Nurse Practitioner (NP) #3 on 08/23/24 at 12:13 PM revealed she was aware Resident #13 had received Olanzapine 20 mg daily for 11 days in February 2024, instead of the ordered Olanzapine 10 mg daily. She stated eleven days was a long time to receive the incorrect dose of Olanzapine and she considered that a significant medication error. NP #3 stated when she was notified of Resident #13 receiving the incorrect dose of Olanzapine, she wrote orders to gradually reduce the dose from 20 mg to 10mg. She stated Resident #13 had taken Olanzapine 20 mg in the past and did not suffer any harm.	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		10/1/24

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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THE IVY AT GASTONIA LLC	4414 WILKINSON BLVD GASTONIA, NC 28056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 48 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement Special Droplet Contact Precautions when Nurse #1 and Nurse Aide (NA) #1 entered Resident #4's room without donning Personal Protective Equipment (PPE); failed to ensure staff implemented their infection control policy for hand hygiene when Nurse #2 failed to wear gloves during insulin administration and perform hand hygiene after insulin administration for Resident #28; and when Unit Manager #1 failed to perform hand hygiene after removing dirty gloves and before donning clean gloves during wound care for Resident #12. These failures occurred during a COVID-19 outbreak at the facility for 3 of 5 residents reviewed for infection control practices (Resident #4, Resident #28, Resident #12). Findings included: The Special Droplet Contact Precautions (SDCP) signage, with a revised date of 02/09/2022, noted	F 880	(1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; " Nurse # 1was identified and Director of Nursing provided one on one education on donning and doffing PPE when needed for isolation rooms. Education completed on " Nurse Aide #1 was identified and Director of Nursing provided one on one education on donning and doffing PPE when needed for isolation rooms. Education completed on 9/20/24. " Nurse #2 was identified and no longer employee at facility as of 9/13/24. " Unit Manager #1 was identified and Director of Nursing provided one on one education on facilities clean dressing change and hand hygiene policy. Education completed on 9/20/24.	

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F 880	Continued From page 49 staff should follow the instructions on the signage before entering the resident's room which included, "All healthcare personnel must: 1) clean hands before entering and when leaving the room, 2) wear a gown when entering room and before leaving, 3) wear N-95 or higher level respirator before entering the room and remove after exiting, 4) wear protective eyewear (face shield or goggles), and 5) wear gloves when entering room and remove before leaving". The facility's policy titled, "Hand Hygiene" last revised 10/26/23 read in part as follows: "All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). Hand hygiene is indicated and will be performed under the conditions listed in the hand hygiene table. Hand Hygiene Table: 1) before and after handling clean or soiled dressings, 2) before performing resident care procedures, 3) before applying and after removing PPE, including gloves, and 4) after handling items potentially contaminated with blood or body fluids. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves". 1.a. A continuous observation of Resident #4's room on 08/19/24 from 12:29 PM to 12:30 PM revealed SCDP signage posted and PPE supplies on the room door. NA #1 entered the room with a lunch meal tray wearing only a surgical mask without donning any PPE per the instructions on	F 880	(2) Address how the facility will identify other Residents having the potential to be affected by the same deficient practice; " All Residents have the potential to be affected by deficient practice. (3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur; " Assistant Director of Nursing/Designee will educate all licensed nursing staff on Facilities Insulin Pen policy and procedures. Education will be completed by 9/30/24. " Assistant Director of Nursing/Designee will educate all licensed nursing staff on facilities Clean Dressing Change Policy and Procedure. Education will be completed by 9/30/24. " Assistant Director of Nursing/Designee will educate all staff on facilities Hand Hygiene policy and procedure. Education will be completed by 9/30/24. " Assistant Director of Nursing/Designee will educate all staff on Facilities Infection Prevention and Control Program policy and procedure. Education will be completed by 9/30/24. Staff not educated by 9/30/24, will not be allowed to work until education is completed. " Assistant Director of Nursing/Designee will educate all staff on proper donning and doffing of PPE when	

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F 880	Continued From page 50 the signage. NA #1 placed the meal tray on the overbed table, sanitized her hands with ABHR, and exited the room. An interview with NA #1 on 08/19/24 at 1:06 PM revealed she did not realize Resident #4 was on SDCP until she was already in the room. She stated she had been trained to read and follow signage on resident room doors and it was an oversight. An interview with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) on 08/19/24 at 2:12 PM revealed she expected all nursing staff to follow posted signage on resident room doors by donning and doffing all PPE as instructed. An interview with the Director of Nursing (DON) on 08/23/24 at 7:53 AM revealed she expected staff to follow posted signage on resident room doors by using PPE as instructed. b. A continuous observation of Resident #4's room on 08/19/24 from 12:32 PM through 12:34 PM revealed SCDP signage posted and PPE supplies on the room door. Nurse #1 entered Resident #4's room wearing only a surgical mask without donning any PPE per the instructions on the signage. Nurse #1 checked Resident #4's blood glucose, removed her gloves, performed hand hygiene with (ABHR), picked up the glucometer, and exited the room. An interview with Nurse #1 on 08/19/24 at 12:34 PM revealed she did not don the PPE listed on the signage for Resident #4 because she thought the sign was for Enhanced Barrier Precautions (a type of TBP that doesn't require full PPE with	F 880	needed for isolation rooms and/or Residents requiring isolation precautions. Education will be completed by 9/30/24. Staff not educated by 9/30/24, will not be allowed to work until education is completed. " Education will be added to Licensed Nursing staff and all staff new hire orientation and will be given by Assistant Director of Nursing/ Designee. (4) Address how the facility plans to monitor its performance to make sure that solutions are substained; " Director of Nursing/Designee will conduct 4 random audits 5 days a week for 4 weeks, then 3 random audits 3 days a week for 4 weeks, then 1 random audit weekly for 4 weeks, to ensure staff is donning and doffing the proper PPE for Residents requiring isolation precautions. " Director of Nursing/ Designee will conduct 4 random audits 5 days a week for 4 weeks, then 3 random audits for 3 days a week for 4 weeks, then 1 random audit weekly for 4 weeks to ensure staff is following proper hand washing procedures. " Director of Nursing/Designee will conduct 1 dressing change observation 5 days a week for 4 weeks, then 1 dressing change observations 3 days a week for 4 weeks, then 1 dressing change observation weekly for 4 weeks to ensure Licensed Nursing staff is following facilities clean dressing change policy and procedure during dressing changes.	

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F 880	Continued From page 51 each entry to a resident room). She stated she should have looked at the sign more closely and it was an oversight. An interview with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) on 08/19/24 at 2:12 PM revealed she expected all nursing staff to follow posted signage on resident room doors by donning and doffing all PPE as instructed. An interview with the DON on 08/23/24 at 7:53 AM revealed she expected staff to follow posted signage on resident room doors by using PPE as instructed. 2. A continuous observation of Nurse #2 on 08/20/24 from 8:16 AM through 8:18 AM revealed she gathered Resident #28's insulin pen and an alcohol swab, entered his room, opened the alcohol swab, swabbed his right upper arm with the alcohol swab, administered the insulin injection into his right upper arm, collected the insulin pen and exited the room. Nurse #2 did not apply gloves to administer Resident #28's insulin injection and did not perform hand hygiene after administering the insulin. An interview with Nurse #2 on 08/20/24 at 8:18 AM revealed she got in a hurry and that's why she did not wear gloves when she administered Resident #28's insulin injection and she should have performed hand hygiene after administering the insulin. An interview with the DON on 08/23/24 at 7:53 AM revealed she expected staff to wear gloves when administering insulin and perform hand hygiene after removing gloves.	F 880	" Director of Nursing/Designee will conduct 4 insulin pen administration observation 5 days a week for 4 weeks, 3 insulin pen administration observation 3 days a week for 4 weeks, then 1 insulin pen administration observation weekly for 4 weeks to ensure licensed nursing staff are wearing gloves while administering insulin. " The results of the reviews will be discussed during the monthly Quality Assurance meeting for tracking, trending, and recommendations from the IDT team for 3 months.	

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F 880	Continued From page 52	F 880		

An interview with the ADON/IP on 08/23/24 at 10:59 AM revealed gloves should be worn when insulin was administered, and hand hygiene should be performed after removing gloves.

3. A continuous observation of Unit Manager #1 on 08/20/24 from 4:40 PM through 5:00 PM revealed with gloved hands she cleaned Resident #12's ischial (the curved bone forming the base of the pelvis) wound with wound cleanser, removed her gloves, opened a clean gauze dressing, applied clean gloves, measured the wound, applied calcium alginate (an absorbent dressing) and a dry dressing to the wound, removed her gloves, and sanitized her hands with ABHR. Unit Manager #1 did not perform hand hygiene after removing dirty gloves and before touching a clean dressing.

An interview with Unit Manager #1 at 5:07 PM revealed she usually performed hand hygiene each time she removed her gloves and before touching other items and she did not when providing wound care for Resident #12 due to an oversight.

An interview with the DON on 08/23/24 at 7:53 AM revealed hand hygiene should be performed after gloves were removed and before putting on clean gloves.

An interview with the ADON/IP on 08/23/24 at 10:59 AM revealed hand hygiene should be performed each time gloves are removed and before putting on clean gloves.